University Hospitals Sussex
NHS Foundation Trust

# Meeting of the Board of Directors

**10:00 to 13:45** on Thursday 02 May 2024

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

## AGENDA – MEETING IN PUBLIC

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| Item:1 | Time: 10:00 | **Welcome and Apologies for Absence**<br>To note | Verbal | Presenter: Alan McCarthy |
| | | **Confirmation of Quoracy**<br>To note<br>*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**<br>To note | Verbal | Presenter: All |
| Item:3 | 10:00 | **Minutes of UHSussex Board Meeting held on 08 February 2024**<br>To approve | Enclosure | Presenter: Alan McCarthy |
| Item:4 | 10:05 | **Matters Arising from the Minutes**<br>None | N/A | Presenter: Alan McCarthy |
| Item:5 | 10:05 | **Report from Chief Executive**<br>To receive and note overview of the Trust's activities | Enclosure | Presenter: George Findlay |
| | | **<u>INTEGRATED PERFORMANCE REPORT</u>**<br>*To receive and note all items:* | | |
| Item:6 | 10:20 | **Integrated Performance Report**<br>*To receive and note*<br>• ***Chief Executive's Introduction***<br>• ***Patient***<br>• ***People***<br>• ***Sustainability***<br>• ***Quality***<br>• ***Systems and Partnerships***<br>• ***Research and Innovation***<br>• ***National Oversight Framework*** | Enclosure | Presenters:<br>George Findlay<br>Maggie Davies<br>David Grantham<br>Karen Geoghegan<br>Katie Urch and Maggie Davies<br>Andy Heeps<br>Katie Urch<br>Darren Grayson |
| Item:7 | 10:45 | **NHSE Undertakings Progress Report**<br>To note | Enclosure | Presenter: Darren Grayson |

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| Item:8 | 10.55 | *At this point the Chair will invite Board members to ask questions and discuss any pertinent areas of the Integrated Performance Report and agree any necessary actions.* | | |
| Item:9 | 11:25 | **Board Assurance Framework and Corporate Risk Register highlight report**<br>To approve | Enclosure | Presenter:<br>Darren Grayson<br>Glen Palethorpe |
| Item:10 | 11.30 | **NHS Sussex System Plan & Trust Operational and Capital Plan 2024/25**<br>To approve | Enclosure | Presenters:<br>Roxanne Smith<br>Andy Heeps<br>Karen Geoghegan<br>David Grantham |
| | 12.00 | ***Short Break*** | | |
| | | **ASSURANCE REPORTS FROM COMMITTEES** | | |
| | | ***Escalated Items Only:*** | | |
| Item:11 | 12.10 | **Report from the Research & Innovation Committee *including Research and Innovation***<br>To note assurance from Committee and recommendations from the Committee<br>- **from the meeting held on the 24 April 2024** | Enclosure | Presenter:<br>Jackie Cassell |
| Item:12 | 12.10 | **Report from Patient & Quality Committee**<br>To note assurance from Committee and recommendations from the Committee<br>- **from the meetings held 27 February 2024, 26 March 2024, 23 April 2024:**<br>- **Learning from Deaths Quarter 3**<br>To note | Enclosure | Presenter:<br>Lucy Bloem |
| Item:13 | 12:25 | **Report from People Committee**<br>To note assurance from Committee and recommendations from the Committee<br>- **from the meeting held on the meetings held on the 27 March 2024, 23 April 2024**<br>- **NHS Staff Survey Results 2023/24**<br>To note | Enclosure | Presenter:<br>Paul Layzell |
| Item:14 | 12:35 | **Report from Finance & Performance Committee**<br>To note assurance from Committee and recommendations from the Committee<br>- **from the meetings held on the 25 April 2024** | Enclosure | Presenter:<br>Philip Hogan |
| Item:15 | 12:45 | **Report from Quality & Safety Improvement Programme Committee**<br>To note assurance from Committee and recommendations from the Committee<br>- **from the meeting held on the 24 April 2024** | Enclosure | Presenter:<br>Paul Layzell |
| Item:16 | 12:50 | **Report from Audit Committee** | Enclosure | Presenter: |

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| | | To note assurance from Committee and recommendations from the Committee<br>- **from the meeting held on the 18 April 2024** | | David Curley |
| | | **WELL LED & COMPLIANCE** | | |
| Item:17 | 13.00 | **Operation Bramber**<br>To note | Verbal | Presenter:<br>Darren Grayson |
| Item:18 | 13:10 | **Company Secretary Report**<br>To note | Enclosure | Presenter:<br>Glen Palethorpe |
| | | **OTHER** | | |
| Item:19 | 13:15 | **Any Other Business**<br>To receive any notified business and action | Verbal | Presenter:<br>Alan McCarthy |
| Item:20 | 13:20 | **Questions from the public**<br>To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting. | Verbal | Presenter:<br>Alan McCarthy |
| Item:21 | 13:45 | **Date and time of next meeting:**<br>The next meeting in public of the Board of Directors is scheduled to take place at **10.00 on Thursday 01 August 2024.**<br><br>**To resolve to move to into private session**<br>*The Board now needs to move to a private session due to the confidential nature of the business to be transacted* | Verbal | Presenter:<br>Alan McCarthy |

# Minutes

University Hospitals Sussex
NHS Foundation Trust

**Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 08 February 2024, held in the Boardroom, Second Floor, Washington Suite, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH and virtually via Microsoft Teams Live Broadcast.**

**Present:**

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| Alan McCarthy MBE DL | Chair |
| Dr George Findlay | Chief Executive |
| Professor Jackie Cassell | Non-Executive Director (from Item 13) |
| Claire Keatinge | Non-Executive Director |
| Lucy Bloem | Non-Executive Director |
| Professor Paul Layzell CBE | Non-Executive Director |
| Bindesh Shah | Non-Executive Director |
| Professor Malcolm Reed | Non-Executive Director |
| David Curley | Non-Executive Director (via MS Teams until item 17) |
| Philip Hogan | Non-Executive Director |
| Wayne Orr | Non-Executive Director (Designate) |
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| 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 |
| Roxanne Smith | Chief Strategy Officer |
| Sandi Drewett* | Chief Culture Officer |

*Non-voting member of the Board

**In Attendance:**

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| Glen Palethorpe | Company Secretary |
| Tamsin James | Board and Committees Manager (Minutes) |
| Ben Smith | Deputy Company Secretary (Production) |
| Catherine Bridger | Board and Committees Manager (Production) |

**TB/02/24/1 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 Claire Keatinge's last as she was retiring from the Trust as Non-Executive Director from the 31 March 2024. The Board also shared their welcome to Philip Hogan and Wayne Orr both of whom had joined the Trust as Non-Executive Directors.

1.3 There were apologies for absence received from Lizzie Peers. The Chairman acknowledged that Jackie Cassell would be late attending the meeting due to another matter.

**TB/02/24/2 DECLARATIONS OF INTERESTS**

2.1 There were no other interests declared.

**TB/02/24/3 MINUTES OF THE MEETING HELD ON 09 NOVEMBER 2023**

3.1 The Board received the minutes of the meeting held on 09 November 2023.

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

**TB/02/24/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING**

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

**TB/02/24/5 CHIEF EXECUTIVE REPORT**

5.1 George Findlay began by taking the opportunity to say thank you to staff highlighting that December, January and February 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 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 and maintain patient safety in the face of such adversity. However, it was positively shared that the total patient waiting list had reduced by 11,000 patients in 11 weeks, the first time such a continued reduction had been achieved since the pandemic. Geroge also drew out the significant improvements in Accident & Emergency performance against national standards.

5.3 George drew the Board's attention to the achievements, awards and recognition section of the report and drew out some of the key highlights, including the Chief Nursing Officer awards which were presented to four nursing and midwifery colleagues across the Trust. A Consultant Midwife had been honoured with the prestigious Chief Midwifery Officer award for their significant and outstanding contribution to midwifery practice. Also, a Consultant Vascular & Endovascular Surgeon had received a lifetime achievement award from the Vascular Society for Great Britain and Ireland. George went on to praise many colleagues from across the Trust which had all been recognised from Star of the Month Awards and Long Service Awards, and on to those international teams being recognised nationally for their respective contribution, commitment, and compassion in healthcare. George added the Trust's first Volunteers' Conference took place at the Charmandean Centre in Worthing, kindly funded by the dedicated charity for the Trust, My University Hospitals Sussex.

5.4 George highlighted that the opening of the new Southlands Community Diagnostic Centre in Shoreham was 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 had opened with brand-new CT and MRI scanners, which would enable seeing up to 45,000 patients per year. There were also three new x-ray rooms, all in one dedicated space.

5.5 George went on to express that a new Urology Investigation and Treatment Centre at Princess Royal Hospital, was improving patient outcomes and transforming healthcare. The new 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. The Trust was the first in the country to use a new economical and environmentally friendly sterilisation machine. The Trevor Mann Baby Unit (TMBU) – at the Royal Sussex County Hospital was now using an innovative genetic test that could help identify newborn babies at risk from hearing loss if treated with a common antibiotic.

5.6 George added that work on the Stage 2 of the 3Ts development at the Royal Sussex County Hospital was 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.

5.7 George explained that the Trust's workforce is valued, and work is undertaken that offers a host of broad support programmes which acknowledges and recognises everything they do for our patients, each other, and the Trust. George highlighted the events taking place such as the Race Equality Week; Women's Network; training events; Disability awareness; Workforce Health Checks and extensive health and wellbeing programme.

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

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

**TB/02/24/6 INTEGRATED PERFORMANCE REPORT**

6.1 The Chair introduced the performance report for University Hospitals Sussex, and informed the Board that this report shows the Trust's performance to December 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.

6.2 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. The increased scrutiny into the Trust's financial landscape and delivery of a number of demands at once was causing difficulties. From a quality perspective, there were continued improvements in the SHMI mortality rate, and continued achievements aligning to the Trust's quality True Norths.

**TB/02/24/7 PATIENT**

7.1 Maggie Davies presented the Patient section of the Integrated Performance Report and explained to the Board that the True North metric for the Patient Committee was to have 90% or more of patients rating Friends and Family Testing (FFT) surveys as Very Good or Good.

7.2 The Board was advised that during Q3 over 50,000 patients responded to the Trust's FFT returning an 87.7% 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 had fallen below the national average. Inpatient reported experience had been recorded as 93.5%, 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.

**TB/02/24/8 PEOPLE**

8.1 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.

8.2 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 were being correlated and the Trust was keen to share these in detail in due course.

8.3 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.

**TB/02/24/9 SUSTAINABILITY**

9.1 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.

9.2 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 M9 was £5.6m. The actual deficit is £26.1m, which was £20.5m 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 continued to be developed and the forecast is maintained at breakeven. Karen explained that operational plans remained significantly challenged in order to deliver the additional activity necessary to support the 78-week waits ambition.

9.3 In relation to Cash, Karen explained the position remained at £13.1m and outlined the variances and timings differences on contractual payments.

9.4 Karen provided the Board with an update on Capital expenditure which is £46.9m against a plan of £51.6m. Karen went on to explain that efficiency performance is slightly below plan which predominantly relates to procurement schemes and additional bed de-escalation requirements.

9.5 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 103.2% of activity resulting in the income value activity being 1.8% lower than the 105% target.

9.6 Karen informed the Board of the identified risks and added that tiered support meetings continue with the divisions addressing their financial challenges.

Forecasts and recovery actions are being incorporated into a Trust roadmap to review year end delivery options.

**TB/02/24/10 QUALITY**

10.1 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.

10.2 The Board was advised the highest percentage of reported patient safety incidents are graded as low or no harm which for December 2023 was 758, a significant and positive increase throughout quarter 3 2023/24.

10.3 Maggie explained to the Board that the Trust had seen an increase 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.

10.4 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.

10.5 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.

10.6 Katie Urch went on to update the Board on the key messages in respect of the mortality True North. Katie advised the Board that the UHSussex crude 12-month rolling mortality rate for non-elective admissions is at 106.7. Katie outlined the Trust's actions when the SHMI is above 100 for a diagnostic group or specific hospital site and the developments that are in place to support the framework for triangulating high standardised mortality rates with other intelligence, such as the Learning from Deaths programme, National audit programme, Model Health System data.

**TB/02/24/11 SYSTEMS & PARTNERSHIPS**

11.1 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.

11.2 **A&E**

Andy advised the Board that the Trust treated 68% of patients within 4 hours of attending all A&E departments during December 2023. The Trust's remit of Emergency Department recovery plans included all divisional actions to improve flow across the hospital sites and there remained the aim to improve outflow through the hospitals and improve flow from ED and reduce the long stays.

11.3 There had been an increase in 60-minute ambulance handovers delays, the majority of which was in RSCH and at Worthing and Andy explained that long

waits were a symptom of lack of flow within the hospital due to reduced timely discharges.

11.4 **RTT**
Andy updated the Board that the Trust continued to be under NHSE Tier 1 oversight in relation to patients waiting longer than 65 weeks for treatment from referral. Andy confirmed that there were clear specialty plans to improve the trajectory to reduce RTT long waits. Their remained the expectation that focus would shift to the requirement to reduce the overall Patient Tracking List (PTL) to avoid the increase in patient numbers waiting beyond 78-weeks.

11.5 **Cancer**
The Trust's 62-day performance in December had positively increased against the national average. Recovery plan actions to reduce the backlog of people waiting from referral had focused on five challenged tumour sites was being progressed within the aim to be on trajectory by the end of March 2024.

11.6 **Diagnostics**
The Trust had 33.2% of patients waiting more than 6 weeks in December for a diagnostic test against a 5% target. The National average for November 23 was 23.3%.

11.7 Andy concluded by stating that the Trust's key 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. He expressed these all remained challenged in the current operational and financial constraints, however mitigating actions were being undertaken to further support these areas.

**TB/02/24/12 RESEARCH AND INNOVATION**

12.1 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.

12.2 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.

12.3 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 R&I strategy had now launched and was supporting the delivery of the UHSussex R&I ambitions.

**TB/02/24/13 NATIONAL OVERSIGHT FRAMEWORK**

13.1 Darren Grayson presented the National Oversight Framework (NOF) 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.

13.2 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.

13.3 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.*

13.4 The Board reflected on the Integrated Performance Report update and recognised the importance of excellent care, every time, and its delivery against the True North metrics. The IPR shared with our patients the importance of progress whilst highlighting the operational challenges the Trust is facing.

13.5 Alan McCarthy expressed that it remained an essential factor for the Trust to use the Patient First system to drive the organisation forward and improve its processes 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.

13.6 Claire Keatinge thanked the Executives of the Board for the update and raised a question to Maggie Davies relating to the issues around the increase in pressure ulcers, falls and MRD's particularly at night, and how this affected the elderly on the wards. Maggie explained that the Trust has robust pathways in place to care for its vulnerable patients and discussions with the wider system remain underway to support discharge planning to ensure the Trust continues to deliver the best care and ensuring our patients are cared for in their preferred place of care. Andy Heeps added that the Sussex system discharge to assess model is challenged particularly since the pandemic, however this remained an area of structural and investment focus in order to normalise the model and protect our patients in the best way possible.

13.7 Paul Layzell shared that in relation to David's earlier update within the IPR, it was important to highlight that the People Committee receive regular oversight of its Breakthrough Objective Staff Voice That Counts which is supported by the Freedom to Speak Up Guardian service, which provides positive assurance that the Trust's diverse workforce receive support when needed. Compared nationally, Paul explained that the Guardian service was in line with other Trusts and there remained key confidence levels that issues were dealt with in confidence and were escalated appropriately. George Findlay added that there remained a lot of focus, energy and time to ensure the workforce could feel comfortable in raising issues and for them to be assured that attention would be applied to following up any concerns. Lucy Bloem added that addressing of the concerns remained imperative along with providing feedback on the actions taken.

*[Jackie Cassell joined the meeting at this point.]*

13.8 Lucy Bloem went on to highlight that the Quality Committee had received its regular Infection Prevention and Control quarterly report and although it was highlighting above trajectory in a number of areas locally it was important to note the data was favourable against a number of national infection metrics. Katie Urch iterated that the team worked hard to ensure the national comparisons data remained favourable against these national metrics. This led to the Board to undertake further discussions relating to performance, and whilst many areas remain challenged it was noted that it was important for

patients to understand the incredible work undertaken to mitigate these challenges.

13.9 The Chair asked that in relation to the financial controlled environment whether there was divisional ownership across the Trust. Karen explained that meetings with the Divisions had taken place which supported the roadmap to year end. Further discussions have been undertaken relating to the controlled environment and the levels of Executive approvals required, which is all embedding well. Andy Heeps added that there remained clear learning opportunities to drive spend, and regular meetings with the Divisions are undertaken which had highlighted some emerging opportunities regarding the structural imbalances.

13.10 Claire Keatinge questioned the implications of the current financial deficit against the reported cash balance. Karen explained that the cash levels remained challenged in the deficit position, and it remained important that cash was managed effectively. It was outlined to the Board that there would be an ability to borrow funds however that would come with a set of scrutiny and regulations which was not a clear option at this point. It was pointed out that the current financial regime operates at a system level and the regime for 2024/25 is continuing to be finalised over the coming months.

13.11 Following a question raised by Alan relating to system benchmarking, Karen explained that the national cost collection return was submitted in good time this year. The financial quantum and accounts were fully reconciled; and highlighted that the costs had proportionally increased ahead of the activity delivered in many areas and that the majority of the Trust's cost quantum increase was driven by workforce costs.

13.12 Bindesh Shah questioned the Cancer patient backlogs and how this was being managed from a financial perspective. George Findlay explained that as part of the Tier-1 arrangements, improvement trajectories, particularly for cancer, is noted by the National team as a priority and remains a key focus of improvement for the Trust.

**TB/02/24/14 QUALITY & SAFETY IMPROVEMENT PLAN (QSIP)**

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

14.2 The Trust had 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.

14.3 Darren explained that 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. The Trust remained 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.

14.4 Four delivery workstreams had 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.

14.5 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, November and December, and has now moved into the delivery phase building on the work that has been established and delivering results in areas such as quality governance and general surgery and RSCH/PRH both of which were Corporate Projects.

14.6 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 were being delivered in a timely way through an open and transparent reporting framework and ensuring effective Board oversight.

14.7 The Board **NOTED** the update.

**TB/02/24/15 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 that 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. The review of the 14 risks saw the quarter 4 scores 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.

15.3 The Board noted that nine risks were exceeding their 2023/24 target score, with five of these scoring 20. It was reported at quarter 3 and agreed by the Board that the two Quality 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, where there was a low level of confidence, they would reduce to their target scores by the year end.

15.4 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.

15.5 Glen advised that as the Trust developed its 2024/25 plan the opportunity would 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.

15.6 David Curley advised the Board that the Audit 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. Glen added that following the scrutiny of the BAF at Audit Committee it had been agreed that the future reporting would make these processes explicit along with recording the dates of the latest receipt of key sources of assurance, which had been actioned and drawn out within the report presented today.

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

**TB/02/24/16 REPORT FROM AUDIT COMMITTEE CHAIR FROM THE MEETING ON 16 JANUARY 2024**

16.1 David Curley as Chair of the Audit Committee, Glen Palethorpe presented the Chair's report from the meeting held on 16 January 2024 and drew out the following key points.

16.2 David advised the Board that the Committee had spent some time discussing the BAF and the risk register and noted the developments being made to the 2023/2024 BAF reporting structure especially those in relation to the provision of information in respect of assurance received during the quarter and a summary of the delivery of the planned actions.

16.3 David stated that the Committee had 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. David highlighted the reflection 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, along with the continued process for updating the BAF, recognising through discussion the drivers of the respective continued elevated risks, noting many had been flagged at the last quarterly update.

16.4 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 continue to enable delivery at each Audit Committee meeting.

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

*[David Curley left the meeting at this point.]*

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

**TB/02/24/17 REPORT FROM PATIENT & QUALITY COMMITTEE CHAIR FROM THE MEETING ON THE 28 NOVEMBER 2023, 19 DECEMBER 2023, AND 30 JANUARY 2024.**

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

17.2 Lucy advised the Board that the Committee had met three times since the last Board meeting and during those meetings had received updates 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, Learning from Deaths; Safeguarding; and medicines management 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.

17.3 Lucy advised that it had become apparent that there were some essential 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.

17.4 Lucy outlined 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.

17.5 Lucy stated that a comprehensive Pharmacy and Medicines Governance Q3 Report had highlighted some gaps in assurance, and the committee had 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.

17.6 The Learning from Deaths Q3 was being presented to Board today for noting and provided oversight on the progress 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. A progress update had been provided relating to training the SJR and reviewers, and the appointed lead chairing the mortality panel. In response to the significant SJR backlog an update was provided relating to the action plan which highlighted that the backlog was reducing, and the work remained on course.

17.7 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. The Board discussed the smoking cessation improvement workstream and heard that funding discussions remained in progress with the ICB.

17.8 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.

17.9 The Board **NOTED**:

- The Report from the Quality Committee Chair.
- The Q3 Mortality Learning from Deaths Report.

**TB/02/24/18 CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) YEAR 5**

18.1 Maggie Davies advised the Board that the UHSussex Clinical Negligence Scheme for Trusts (CNST) Year 5 submission was presented to the Board for approval in January 2024 ahead of its submission to the ICB in early February, where it was reviewed ahead of its final submission to NHS Resolution. Maggie advised the Board that feedback was expected by 31 March 2024.

**TB/02/24/19 REPORT FROM THE RESEARCH & INNOVATION COMMITTEE CHAIR FROM THE MEETING ON THE 30 JANUARY 2024.**

19.1 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.

19.2 Claire advised that a research activity report and dashboard had been presented to the Committee highlighting the developed KPIs supporting the development of performance targets at a divisional and service level.

19.3 The Committee had received a report of delivery against the Research True North of increasing the participation in research; 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; 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; a report on innovation which provided the Committee with information on the development of an innovation group that is dedicated to supporting staff to progress bids for external innovation funding.

19.4 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,

19.5 Katie Urch provided an update to the Board summarising the fruitful discussions that had been undertaken with Brighton & Sussex Health Research Partnership providing assurance 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.

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

**TB/02/24/20 REPORT FROM PEOPLE COMMITTEE CHAIR FROM THE MEETING ON THE 31 JANUARY 2024.**

20.1 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.

20.2 Paul highlighted the work underway and the positive progress being made in terms ward models of care and recruitment of healthcare assistants and nursing recruitment following assurance being provided regarding some mitigating activity through positive recruitment to nursing associate roles and by the summary on Internationally Educated Nurses and plans to secure Graduate recruitment.

20.3 Paul explained that the Committee had received a deep dive on Health and Wellbeing arrangements and on arrangements for the management of stress highlighting that the supportive training for staff and managers had been arranged. However, it was important to raise that the Health and Wellbeing Plan is substantially reliant on Charitable Funds support and considered it necessary to highlight this risk while associated bids would be presented to the Charity's Trustees.

20.4 Paul highlighted that an update had been received from the Freedom to Speak Up Guardian service providing assurance that the arrangements offered strong availability of the service to staff and that their reporting processes with give assurance to staff that issues are recorded and resolved. 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.

20.5 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.

20.6 The Board **NOTED** the Report from the People Committee Chair.

**TB/02/24/21 REPORT FROM SUSTAINABILITY COMMITTEE CHAIR FROM THE MEETINGS ON THE 30 NOVEMBER 2023 AND THE 1 FEBRUARY 2024.**

21.1 In the absence of Lizzie Peers as Chair of the Sustainability Committee, Alan McCarthy invited Bindesh Shah to update the Board on the meeting and the assurances received in relation to Sustainability.

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

21.3 The Board was advised that the Committee had received an update on Productivity, Efficiency and Environmental Sustainability and noted the rich data that was available to the Trust that would support the continuing work being undertaken in these areas.

21.4 Finally, Bindesh noted that the Trust had also received updates in respect of Capital and IM&T highlighting that the Committee received an update on the EPR implementation.

21.5 The Board **NOTED** the Report from the Sustainability Committee.

**TB/02/24/22 REPORT FROM SYSTEMS & PARTNERSHIPS COMMITTEE CHAIR FROM THE MEETING ON THE 1 FEBRUARY 2024.**

22.1 The Chairman invited Bindesh Shah, the 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.

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

22.3 In relation to job planning the Board discussed the breadth of the project and the developed improvement workstreams and the project governance overseeing the delivery of this project was noted. The technical challenges encountered in the delivery of the enhanced booking processes were outlined which had seen some delay to the programme and that a further workstream was being added to the programme to ensure that there enhanced validation within the booking processes highlighting the importance of standardisation of processes to the achievement of the project goals.

22.4 The Board reflected on the assurance provided within the review of the Trust's self-assessment undertaken by the ICB and **APPROVED** the Emergency Preparedness, Response and Resilience Annual Report for publication on the Trust website.

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

**TB/02/24/23 ROYAL COLLEGE OF SURGEONS INVITED SERVICE REVIEW**

23.1 George Findlay explained that the report had been commissioned to provide an assessment of the structure and content of the Trust's improvement plan to address long standing challenges within the surgery service at RSCH. George added that he commissioned this review as he took up the position as Chief Executive as part of due diligence he undertook just after his appointment to secure a picture of the challenges facing the Trust. This information was then used 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.

23.2 George expressed that the Trust remained determined to make the improvements that its workforce and patients need and deserve, therefore invited the Royal College of Surgeons (RCS) to come and review matters in May 2023 which was primarily to test the Trust's improvement plans and to ensure that our workforce had the opportunity to raise, in confidence, any concerns they had. Many of the problems that exist date back many years and sadly cannot be solved overnight. The RCS review recognises the Trust's improvement plans and the results they have produced so far and George explained that some significant strides forward had been made but recognised there was much more to do.

23.3 The Board heard that the Chief Medical Officer Professor Katie Urch provided within the papers a summary of the RCS findings, their recommendations and the Trust's initial response. George explained that there were some tough messages for the workforce and as Trust leaders, and for patients, however it was pivotal to provide candour that would promote the opportunity to make further significant, and positive changes.

23.4 The Board discussed at length the concerns raised and the expectations to deliver positive change; despite the pressured environments experienced over many years the Board were focused on the main overriding task of improving care, and providing the workforce with the tools they need to do the job.

23.5 Alan McCarthy emphasised that there were many areas of progress to feel positive about and that the Board should share their optimism about that and use this feedback constructively to recognise the efforts that not only the Trust Board but it's workforce should be proud of; but reflected that there remained much more to do to provide further assurance which would continue to flow through the Quality & Safety Improvement Programme and through the CQC reports. Alan added that in respect of comments on poor behaviours he and the Board were clear that such behaviour would not be tolerated within the Trust.

23.6 The Board **NOTED** the Royal College of Surgeons Invited Service Review update.

**TB/02/24/24 OPERATION BRAMBER**

24.1 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. 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.

**TB/02/24/25 COMPANY SECRETARY REPORT**

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

25.2 Glen explained that two of the Trust's Non-Executive Directors were retiring, these being 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 Glen informed the Board that the date of commencement for Wayne Orr was incorrectly recorded as 29 January 2024 with the actual commencement to be the 19 February 2024.

25.3 The Board was advised that the main Board meetings for 2024/25 were scheduled to continue to be held quarterly on a Thursday, and these would 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. Also, for 2024/25 there continued to be four Council of Governors meetings held in public. These were 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.

25.4 Glen explained that 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.

25.5 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.

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

**TB/02/24/26 OTHER BUSINESS**

26.1 There was no other business to discuss.

**TB/02/24/27 QUESTIONS FROM MEMBERS OF THE PUBLIC**

27.1 The Board received six questions from one member of the public in advance of the meeting relating to the Trust demonstrating the elimination of unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act against disabled people, in particular patients receiving medical cannabis.

27.2 Katie Urch responded to the medical and pharmacy aspects of the questions and directed the response on eliminating discrimination and promoting equality to David Grantham. Each individual question received an in-depth answer providing relevant data assessments and assurances regarding the programmes of work underway in strengthening and developing staff networks.

27.3 The Board **NOTED** the questions received by the member of the public and agreed that the subsequent detailed response be placed on the Trust website for information purposes. Available here: https://www.uhsussex.nhs.uk/about/board/board-meetings/

**TB/02/24/28 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/02/24/29** The Chair formally closed the meeting.

**TB/02/24/30 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 02 May 2024**.

**Tamsin James**
**Board & Committees Manager**
**February 2024**

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:** | 02 May 2024 |
| **Report Title:** | Chief Executive's Report | | | | |
| **Sponsoring Executive Director:** | Dr George Findlay, Chief Executive | | | | |
| **Author(s):** | | | | | |
| **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** **Date: May 2024**

**From: Chief Executive – Dr George Findlay**

## 1. THANK YOU

1.1. The past three months have been characterised by an unseasonal extension of winter pressures into Spring, with all our hospitals continuing to operate either at, or even above full capacity for prolonged periods. Consequently, we have had to call Business Continuity Incidents on several occasions at each of our main hospitals to redirect resources and call upon greater support from system partners to help more patients leave hospital in a safe and timely manner.

1.2. While we have seen an increase in attendances at all our Emergency Departments, more significant has been the growing proportion of acutely unwell people who have needed urgent admission onto a ward. At the same time, an unsustainable number of our beds have been occupied by patients who are medically ready for discharge (MRD) but who are unable to leave hospital while they are waiting for non-acute care elsewhere to be arranged or become available.

1.3. On average, we have been caring for more than 300 MRD patients a day, and sometimes many more, which is the equivalent to more than ten full wards that need to be staffed and resourced despite their patients no longer requiring acute hospital care. Sadly, this has resulted in longer waits in our Emergency Departments recently due to beds not being available when they are needed most.

1.4. We deeply regret how this has affected patients and I wish to apologise to anyone who has experienced this in recent months. We are working extremely hard to address the problem, with high profile improvement programmes to ensure we are doing all we can to improve flow through our hospitals, and by working very closely with our system partners – but they too are experiencing significant systemic pressures.

1.5. At the beginning of April, we also had to declare a Critical Incident when a highly contagious strain of a diarrhoea and vomiting bug circulated in the Chichester area led to an outbreak at St Richard's Hospital at a time when the hospital was already operating at full capacity. Several wards were closed, visiting suspended and ambulance diversions put in place to Worthing Hospital and Princess Royal A&E units. I am hugely grateful for the support of colleagues in these hospitals, as well as the way everyone at St Richard's responded to the incident. Their efforts were acknowledged by an outpouring of supportive and kind messages on social media.

1.6. Messages of support mean so much when people are working so hard, and I wish to thank everyone who took the time to show their appreciation of our staff.

Throughout winter, our have stepped up and responded so admirably to keep patients safe and minimise disruption and waiting times as far as possible. I wish to take this opportunity to thank them all for their hard work, dedication, and incredible resilience. The past six months have been hugely challenging, and we need to acknowledge the toll this can take and do everything in our gift to support them.

1.7. Support comes in many guises, from health and wellbeing services to ensuring departments have the right number of staff, as well as access to up-to-date equipment. We have worked hard to invest where we can and improve staffing, equipment, governance, and culture. Our formal response to the Care Quality Commission on 10 April, following publication of our latest hospital reports in January, highlighted many of the improvements we have been able to make despite operational and financial challenges.

1.8. For example, we have reduced turnover among nursing, midwifery and medical colleagues, reviewed staffing numbers and developed a new standardised staffing template. Together, these measures should improve staffing levels and reduce pressure on clinical teams. Our divisional directors of nursing are also leading a review of equipment availability to plug any gaps and help ensure colleagues have the right items they need to provide excellent care.

1.9. We have a new incident reporting system that alerts our chief medical officer, chief nurse, and patient safety director to all moderate or more severe harms, and which makes it easier to flag issues and share feedback and learning. And we are also working to improve interprofessional communication through human factors safety training and promoting the principles of the Civility Saves Lives project.

1.10. We know there is much more we need to do, and the months ahead will be challenging again, but we have plans in place to address issues. Over the past three months we have attended council scrutiny committees in West Sussex, Brighton & Hove, and East Sussex to talk about our improvement plans, as well as the higher than usual regulatory and media scrutiny we have been experiencing. The committees appreciated our openness, and we look forward to updating them throughout the coming year. We are also grateful to the ongoing support from Healthwatch in Sussex, as they fulfil their statutory duties as our critical friend and provide support as an independent advocate for our patients.

1.11. Our comprehensive Quality and Safety Improvement Programme, in combination with other major programmes of work to reduce waiting times for emergency, elective and cancer care, are the way we are implementing the positive changes we, our patients, and partners want to see. In recent months, we have invested in new technology and introduced new governance arrangements and reporting processes. Our plans are detailed and robust, and designed to ensure that both us and our stakeholders can have confidence in the services and standards we are delivering.

1.12. At just three years old, University Hospitals Sussex remains a young Trust, and it is important to remember that merging two large organisations during a pandemic

was both complex and complicated. Each of our legacy trusts brought strengths and weaknesses to the partnership and, distilling the best from each, and forging successful change, takes time. It cannot be rushed - but our trajectory is sound, and the pace of maturity is accelerating.

1.13. We are realistic about the challenges that lay ahead, but we are optimistic as well. We have a team of 20,000 compassionate and talented people, the support of our communities, and of our partners and stakeholders too. Together, we can realise our immense potential as one of the largest trusts in the country and continually improve care and health services for the people of Sussex.

## 2. ACHIEVEMENTS, AWARDS AND RECOGNITION – CONGRATULATIONS!

2.1. 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, 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.

2.2. In February and March, a record **1,500 nominations were received for our annual staff recognition awards**. The Patient First STAR awards are an important landmark occasion in our calendar and this year's strength of nominations demonstrates how much colleagues, patients and families want to celebrate the hard work, dedication, and innovation of so many members of staff, teams and departments across the Trust. In April, a large judging panel met to deliberate upon each category and on Friday 28 June everyone shortlisted for an award will be invited to our prize ceremony and celebration event, kindly funded by our trust charity *My University Hospitals Sussex*.

2.3. Our **Practice Development Education team for Children's Services** has been awarded the NHS South East Nursing and Midwifery Green Week award for Clinical Leadership, Systems and Workforce. The award recognises the team's efforts to deliver a green education programme for NHS staff, led by **Sadie Sullivan**, Practice Development Nurse. The initiative helps improve knowledge to provide effective, safe and compassionate care to children and young people, who are being treated in hospital and have mental health concerns. The programme which embodies the Trust's *Patient First, Planet First* green plan, was also accepted for presentation at the Royal College of Nursing Education Conference in April.

2.4. Specialist head and neck cancer dietitian **Kirsty Clutterbuck** has published a cookbook specifically designed for patients with head and neck cancer and receiving treatments such as chemo and radiotherapy. The "Not so porridge" cookbook features recipes specifically designed to help patients with altered or complete loss of taste, painful swallowing or a loss of appetite. The book was funded by the Sussex Cancer Fund and copies can be bought from the charity, with proceeds used to support patients with cancer in Sussex.

2.5. An award commemorating a much-loved colleague has been established by the Critical Care and Pharmacy departments at Royal Sussex County Hospital,

recognising individuals who have championed patients and their safety. The **new Jess West Award** is named in memory of **Critical Care pharmacist, Jess West**, who worked at Royal Sussex County and Princess Royal hospitals for more than 15 years. Jess was the Trust's first dedicated Critical Care pharmacist, and as leader of the pharmacy team was fundamental to the safe running of the intensive care unit. Jess sadly passed away after a short illness in February 2023.

2.6. The **Sussex Orthopaedic Treatment Centre (SOTC) team** are joint winners of the national **Sustainability Partnership of the Year award** for a green study they conducted that cut carbon their footprint, reduced costs, and saved time for more than 1,000 patients. Last year, the team won funding to pioneer the creation of a green digital pathway for elective orthopaedic surgery patients at SOTC at Princess Royal Hospital. Their goal was to reduce the need for face-to-face visits from referrals to leaving hospital, to take the patient journey from paper to digital and look at the carbon footprint savings at the end of the six-month. SOTC is now set to increase its use of more sustainable, digital resources by introducing a new electronic notes system.

2.7. An innovative pathway, first established in the Trust at St Richard's, has seen nearly **250 patients undergo same day total laparoscopic hysterectomy** – the most in the South East. A total laparoscopic hysterectomy allows the surgeon to remove the uterus using a keyhole technique, which avoids a large cut to the lower abdomen, is much quicker, less painful and means patients can go home just hours after surgery. **Consultant gynaecology surgeon Miss Melanie Tipples and surgical care practitioner Sam Roberts** have both contributed to new national best practice guidance for the procedure.

2.8. **Consultant neurologist, Professor Dennis Chan**, has led a study that shows people at risk of Alzheimer's disease have impaired spatial navigation before problems with other mental functions, including memory, manifest themselves. It is hoped the findings, which have been published in the Alzheimer's and Dementia journal, might lead to developing a diagnostic support tool for the NHS in the coming years.

2.9. Colleagues wished a **fond farewell to paediatric ambulatory care assistant Jean Redfern**, a much-loved member of the Bluefin children's ward at Worthing Hospital, who has retired after 50 years with the Trust. Jean began her career at Southlands Hospital in the early 1970s after being an inpatient on a surgical ward where she was keen to help and so supported staff making beds. The ward sister asked her if she would like a job and, within the hour, she was giving an application form! In the half century since, Jean has worked in many departments, from gynaecology and orthopaedics to surgery and maxillofacial before joining paediatric care 35 years ago.

2.10. Our chief finance officer, **Karen Geoghegan is joining NHS England South-East** as its regional director of finance. Karen has an exemplary track record as our executive lead for finance since 2014 and can be immensely proud of her many achievements and the sound financial management she has provided over the past 10 years. She has provided strength, stability, and rigour throughout a huge period of change and ably contributed to every major decision taken by the board. We wish her every success in her new regional leadership role.

2.11. Our chairman **Alan McCarthy MBE is retiring** in June, following the completion of his second three-year term at the helm of the Trust Board and

Council of Governors. I want to take this opportunity to thank Alan for being such a staunch ally for the Trust and a great source of support and advice for the executive team, and especially for me as chief executive. We will miss working with him but wish him every happiness in his retirement. Joining us this summer, **our new chair will be Philippa Slinger**, a mental health nurse by background with more than 25 years of board level experience, working in mental health, acute care, and the private sector. Philippa is aware of the challenges we face, and I am excited to start working with her on our long-term improvement journey.

## 3. INVESTING IN OUR HOSPITALS AND SERVICE IMPROVEMENTS

3.1. Patients can now access diagnostic scans in Bognor at the **new Community Diagnostic Centre** (CDC). The mobile CDC, run by the Trust but located on the Bognor Regis campus at the University of Chichester, provides easy access to diagnostic pathways, including CT and MRI scanning, and offers accurate and timely diagnoses away from our main hospitals. This new facility works alongside the CDC in Falmer, based at the AMEX stadium, to form a network led by the Trust's main CDC at Southlands Hospital in Shoreham-by-Sea.

3.2. Patients are being seen more quickly and safely thanks to **innovative changes at the Emergency Department at Princess Royal Hospital**, Haywards Heath. From piloting a new GP-led Urgent Treatment Centre, introducing a rapid assessment and treatment service and launching a new Ambulatory Clinical Decision Unit (ACDU), the team is improving flow through the department and allowing medical teams to focus more on the sickest patients. Due to these innovations, the Emergency Department has been **awarded £10,000 by the National Institute for Health Care and Research** to further explore the potential of their new scoring system and how it is supporting the success of the ADCU.

3.3. A **new Health Information Point (HIP)** is providing a free and confidential health information service for patients, visitors, staff and volunteers at the Royal Sussex County Hospital. The offer includes guided internet access for health-related queries; expert advice on improving health literacy; information on healthy living, as well as medical conditions, treatments, tests and medicines; and signposting to local support services and self-help groups.

3.4. A **new garden has opened at Worthing Hospital** outside of The Friends Café in the North Wing, providing a peaceful haven to help boost the wellbeing of patients, visitors, and staff. The space, which had remained unused for years, was transformed over six months to become a calming, accessible sanctuary, complete with vibrant planting and outdoor seating. The garden has been funded by the Friends of Worthing Hospitals and the Trust's dedicated charity, *My University Hospitals Sussex*. A mural was also commissioned by the Trust's Organ Donation Committee.

3.5. Our **Breast screening services have developed a sustainable electronic system** that helps increase uptake for breast screening across Sussex and is being used by more than 150 GP surgeries. The new system is part of a local action plan to get more people to attend their screening and is the first system of its kind in the country. After carrying out pilots of the new electronic reports with local GPs, the new system received very positive feedback with colleagues estimating that is has halved the time it takes to process paper-based reports.

3.6. Demolition work is well underway on the Barry Building at the Royal Sussex County Hospital to make way for a **new Sussex Cancer Centre**. The redevelopment of the plot marks stage 2 of the £750m 3Ts redevelopment of the hospital campus. Over the next few months, the old hospital estate and surrounding buildings will be carefully dismantled, and a revised planning application submitted for our new £155 million Sussex Cancer 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.

## 4. SUPPORTING OUR PEOPLE

4.1. Our staff are our most precious resource, and we have a comprehensive, broad-ranging 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. Staff can now sign up for a free check up with our new health check nurses. Each appointment includes blood pressure, BMI and pulse check, along with advice and signposting for lifestyle changes such as weight loss, stopping smoking, alcohol reduction and mental wellbeing.

4.3. A new 'Managing mental health and wellbeing at work' training course is being introduced and run in-house by Health, Wellbeing and Engagement managers Tracy Grover and Kelly Salter. The course is designed for managers and staff in positions of responsibility.

4.4. The Trust's first Disability Awareness Conference took place in March the Royal Sussex County Hospital. Organised by the Disabled Staff Network, but open to all staff, the event featured speakers from a variety of organisations, including Kim Hoque (Lead of the Disability Employment Charter) and Stuart Moore (NHS & Genius Within), as well as informative and educational breakout sessions.

4.5. We continue to help colleagues approaching or going through the menopause with various resources and events. The most recent was a meeting of the Trust's Menopause Café on 27 March which explored the topic of Testosterone with guest speaker and GP with an advanced certificate in menopause care, Dr Rhianydd McGlone.

4.6. The Trust's new Health and Wellbeing Network met for the second time on 14 March, with guest speakers including Freedom to Speak Up Guardian Trish Marks and health check nurse Rachel Gardiner. The group also talked about the Trust's two other new staff networks focusing on Carers and Women, as well as this year's NHS Staff Survey results.

4.7. On 1 January, the Trust's Crisis Fund had been in operation for one year, with 608 applications out of 697 received supported with grants and/or general cost of living awards to the value of £122,374. A further 149 staff were supported in January and February 2024, with awards given to the value of £32,000.

4.8. Our Financial Wellbeing Support Officer, Tracy Cox Horton, has now been at the Trust for eight months and has supported 1,633 staff with budgeting, NHS

pensions advice, inheritance tax guidance, debt management and financial services signposting. Tracy has also run 15 training courses with 238 attendees.

## 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 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.

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| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 6. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 02 May 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 March 2024 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.

**Key Recommendation(s):**

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

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# Integrated Performance Report

## March 2024

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# Chief Executive Summary

Please see enclosed the performance report for University Sussex Hospitals. It shows our performance to March 2024 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 Quarter 4 the Trust saw continued performance challenges for emergency performance linked with seasonal 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 exceeded the recovery target set by NHS England in the 62 day backlog for cancer in March. NHS England has formally commended the Trust for the scale and pace of its cancer recovery.

Elective pathways and RTT performance improved in Q4, despite constraints to performance relating to industrial action and emergency pressures. The waiting list continues to fall since September which means that the Trust capacity has been higher than demand in Q4. While the performance for the Trust remains challenging, encouraging progress has been made in the planned care pathways and plans are developed in line with the national operating plan to deliver further improvements in 24/25.

Diagnostics performance improved marginally in March by 3% relative to December-23. Plans to tackle diagnostic backlogs with support from the community diagnostic centres are planned into 2024/25.

For our Emergency Care pathways, we have experienced challenging quarter treating 69.1% of patients within 4 hours of attending compared to 68.7% Q4 2023/24. The financial year 2023/24 saw A&E performance overall of 69.9% for our catchment, which was 6.5% improved compared to the preceding year.

Financially, the Trust saw a £14.95M adverse variance from plan for income and expenditure to Month 12. The key drivers of the deficit are the excess cost of inflation in 23/24 and the impact of pay award costs in excess of funding, costs above plan of mental health specialling, medical premium rates and junior doctor deployment, and activity related clinical supplies and drugs.

From a quality perspective, there has been continued improvement in the SHMI mortality rate. Staffing indicators show appraisal rates above 80% and continued improvement in STAM rates, reduced vacancy rates and sickness rates consistent with the same time last year. Furthermore, our friends and family test (FFT) data shows a small decline in patient reported experience in the February and March - this is in line with national public confidence in the NHS. Our registered nurse staffing fill rates improved marginally in quarter 4.

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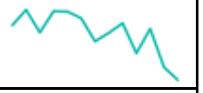
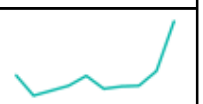
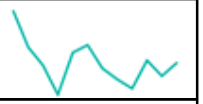
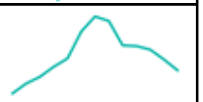
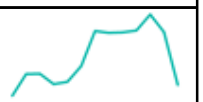
| True North Metrics | | | | | |
|---|---|---|---|---|---|
| | Patient First Domain | Metric | Value | Target | Trend |
| **Pt** | Patient | Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good | 86.3% | 90.0% |  |
| **P** | People | Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score | 7.28 | 7.06 |  |
| **S** | Sustainability | Financial Stability - Variance from breakeven plan YTD | -14,952k | 0k |  |
| **Q** | Quality | Clinical outcomes/effectiveness - SHMI equal to or less than 100 | 104.7 | 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 | 69.1% | 76.0% |  |
| **SP** | Systems & Partnerships | Cancer - To achieve the 62 day standard<br>(All referrals - National standard revised Oct 2023) | 55.68% | 85.00% |  |
| **SP** | Systems & Partnerships | RTT Elective care - >=65 Weeks | 3658 | 3000 |  |
| **SP** | Systems & Partnerships | Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment. | 326 | 0 |  |
| **RI** | Research & Innovation | Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies | 26 | 35 |  |

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# Patient

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

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**Patient First Domain**

- The Trust's purpose is to deliver excellent care every time and patient experience is central to delivery of excellent care.
- The True North for Patient is for patients to have an excellent experience of care and this is measured by the Friends and Family Test (FFT). The test asks patients attending A&E as well as inpatients, outpatients and maternity service users to rate their experience of care and to give a reason for their answer.
- Based on available FFT data, the significant majority of patients (89% in Q4) are satisfied that they have a good or very good experience. This is comparable to Q1, Q2 and Q3 2023/24, however overall trajectory through 2023 is slightly downward. Positivity in A&Es has overall been declining through 2023 and 2024 but is above December 2022 levels and the national average. Inpatient experience is below national average.
- For UHSx, 35,390 patients provided a review in Q4 with an average response rate of 24%.
- 350 complaints were received in Q4, an 18.5% increase on Q3 and also above Q2. Currently, 187 complaints remain open beyond the 60 working days against a Trust target of 80%. This is due to complaints caseloads, delays in obtaining clinical responses, complexity of complaints, and delays in signing letters. One more complaint was closed (n=351) than was received in Q3.
- 3,184 concerns were received by PALS (an increase on previous quarters) with 489 plaudits.
- Themes in negative patient feedback continue to relate to waiting (on site and for treatment), clinical treatment (including missed diagnosis in EDs), inpatient care, communication and staff behaviours, and discharge – these are the drivers behind the patient experience strategy 2022-25 with further mitigations including the development of discharge hubs and the fundamentals of care programme to improve quality of care on the wards

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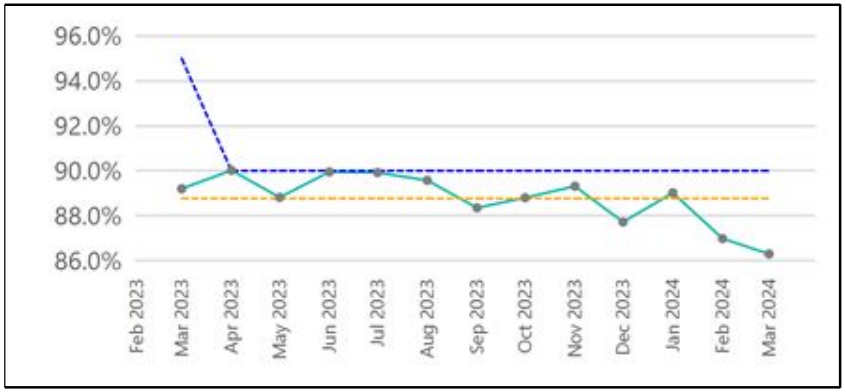
## True North

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 89.2% | 90.0% | 88.8% | 90.0% | 89.9% | 89.6% | 88.4% | 88.8% | 89.3% | 87.7% | 89.0% | 87.0% | 86.3% |

### Overview

A steady but small decline in patient reported experience as measured by FFT is evident through 2023/24. A decline is also noted over the same period for A&Es, however it remains above the national average. Inpatient reported positivity remains below the national average.




### What the chart tells us

Overall, Trust FFT positive rating for February is 88% - this is a reduction on the previous month, and overall trajectory is downward with increasing % of negative reviews – confounded by deteriorating patient experience in EDs (although above national average).
The most prevalent theme in negative reviews: 'waiting'
Outpatient reported experience (96% positive) improved in month and above with national average however inpatient positivity is below the national average (92% v 94%). Maternity, at 96% positive, is above national average (latest data January 2024)

### Intervention and Planned Impact

Emergency department improvements are overseen by S&P breakthrough objectives with ED performance correlating with patient reported experience. Patient experience audits are being undertaken on the wards to identify concerns early for resolution and the Welcome Standards programme is being rolled out to improve experience of reception and those in greeting roles.

### Risks/Mitigations

Themes in negative patient feedback continue to relate to waiting times on site, clinical treatment, communication and staff behaviours as detailed within the Patient Experience Strategy.

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## Watch Metrics for Patient

| Metric | 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 | 89 | 88 | 75 | 117 | 100 | 120 | 125 | 98 | 121 | 74 |
| Patient experience - Total open formal complaints | 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 |
| | Staff Engagement - If I spoke up about something that concerned me I am confident my organisation would address my concern | 41.5% |

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| **Patient First Domain** |
| --- |
| The Trust relies on its staff across an enormous range of professions to treat 1000s of people per day. Having enough staff across all of these roles and ensuring they are satisfied and engaged in their work is what delivers high quality care. We therefore monitor a range of staff based metrics to give us insight into staff experience and how well services are resourced with the people they need. These include measures of satisfaction and engagement with the Trust, vacancy rates which can constrain particular services, temporary staffing usage, staff adherence to statutory and mandatory training requirements, their health (in terms of sickness absence) and their demographic characteristics etc.<br>The Trust's People True North focuses on staff engagement with the aim to be in the top half of acute Trusts for the NHS National Staff Survey (NSS). This is monitored through a monthly pulse survey and has shown significant improvement in 23-24, reflected also in the NSS for 2023. The Trust has also reduced its turnover and vacancy rates throughout 23-24 but has continued to make use of more staff, including bank and agency, in excess of planned establishments reflecting extra work or capacity provided. |

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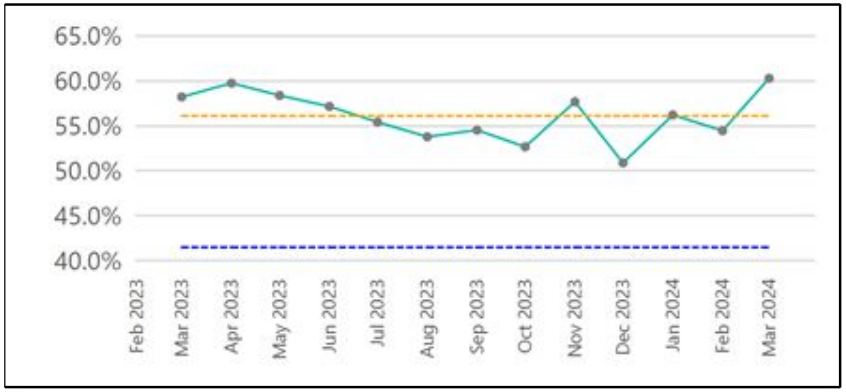
Metric: Staff Engagement - If I spoke up about something that concerned me I am confident my organisation would address my concern

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 58.2% | 59.8% | 58.4% | 57.2% | 55.4% | 53.8% | 54.5% | 52.7% | 57.7% | 50.9% | 56.2% | 54.5% | 60.3% |

**Overview**

The Trust aims to have a learning culture where staff feel confident to raise issues or concerns and that these are responded to. This supports patient and staff safety and satisfaction as well as improvement. The Trust measures this through a monthly staff survey.




**What the chart tells us**

The data shows the percentage of staff responding positively to the question 'if I spoke up about something I am confident my organisation would do something about it'. It shows improvement in the monthly score to its highest at 60.29% in March 2024. The Divisional breakdown suggests this is driven in part by a substantial increase in bank staff reporting positively.

**Intervention and Planned Impact**

The Trust has closed the 'staff voice that counts' breakthrough objective for 23-24 following the embedding of its independent Freedom to Speak Up Guardian service. It will though continue to support work on staff feeling to confident to raise issues and that is safe to do as part of the 'safety culture' workstream of its Quality and Safety Improvement Programme (QSIP) and normal promotion and development work. There is an action plan to support FTSU development in 24-25. The Trust would expect to maintain a higher level of confidence in speaking up in 24-25 and will continue to monitor monthly.

**Risks/Mitigations**

There is a risk that staff do not recognise the breadth of opportunities to feed-back or speak up and focus only on the role of the FTSUG. This is mitigated by promoting all of the pathways and opportunities to raise issues to staff.
There is a risk staff do not recognise that they have been heard or that action has been taken or that no feedback is provided. This is mitigated by monitoring feedback is given on issues raised through risk management processes (Datix) or via the FTSUG. Leaders are also encouraged and supported to listen to staff and feed-back with toolkits and training.

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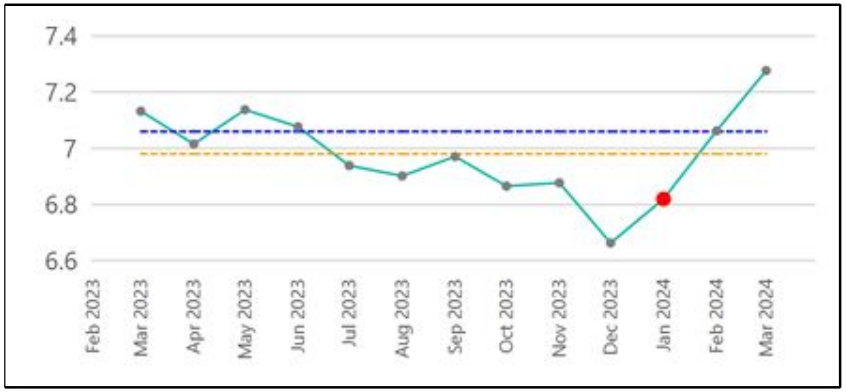
## True North

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7.13 | 7.02 | 7.14 | 7.08 | 6.94 | 6.90 | 6.97 | 6.87 | 6.88 | 6.66 | 6.82 | 7.06 | 7.28 |

### Overview

The Trust's People True North is to have the most engaged staff in the NHS. Studies have shown that higher levels of staff engagement in the NHS are associated with higher quality of patient care and more generally that high levels of engagement are linked to productivity.




### What the chart tells us

The Trust measures engagement using a monthly staff survey and applying the same methodology as the national NHS staff survey to produce a composite 'engagement score'. This reflects the extent to which staff respond positively about their motivation and involvement at work and sense of advocacy for the organisation (do they speak well of it?). Over the course of 23-24 the Trust has seen improvement in its engagement score, ending the year with a score of 7.3 - equivalent to the best performing Trusts in the NHS staff survey 2023. That level is unlikely to be sustained but work on improving staff satisfaction and engagement will continue in 2024-25.

### Intervention and Planned Impact

The Trust is finalising a 'people plan' for 24-25 which will build on work in 23-24 to support staff satisfaction and engagement across the seven NHS 'people promises' . These set out the reasonable expectations of staff that NHS employers like the Trust should meet. Staff feedback from the NHS staff survey and work on culture and other data (such as FTSUG reports) have all informed the plans. The Trust is also part of an 'exemplar programme' across the SE Region supporting Trusts to share learning and approaches to great people management and on delivering the NHS people promises which also supports this work. The delivery of these plans is overseen by the People Committee and Board. The aim is to bring the Trust up to the level of others across the seven people promises in the 2024 NHS staff survey. Currently it is below average for 6 of the 7.

### Risks/Mitigations

There is a risk that making improvements is challenged by lack of capacity to engage in this work eg through operational pressures and/or that external factors such as the cost of living or dissatisfaction with NHS pay impact on staff morale. The Trust also has a number of improvement programmes to implement in 24-25 that will involve changes for some staff to their work, and which may also therefore impact morale in the short term. These risks will, as far as possible, be mitigated by clear communication and engagement of staff on such cases for change and the benefits they will bring.

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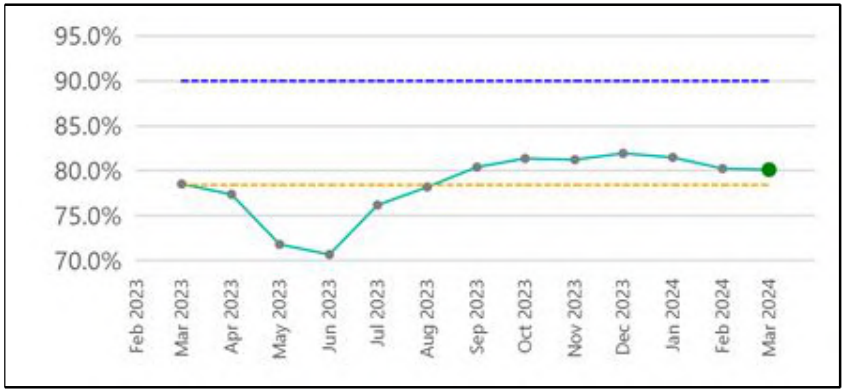
## Driver

Metric: Training & development - Appraisals completed

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 78.5% | 77.4% | 71.8% | 70.7% | 76.2% | 78.2% | 80.4% | 81.4% | 81.2% | 81.9% | 81.5% | 80.3% | 80.1% |

### Overview

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




### What the chart tells us

The Non-Medical Appraisal rate was 80.1% in March 2024 (preliminary data) vs 80.3%. in February  This represents a small monthly fall every month since December 2023 (81.94%) and remains below the Trust target of 90%, although remains higher than 2023/24 H1 (< 78.5% overall compliance).

Notable improvements in March 2024 from CNO Division (+ 8.0% points), CMO (+6.1% points), CPO (+2.7% points). 11/16 Divisions are reporting > 80% compliance.  This is an improvement from February 2024 (8/16 Divisions reporting > 80% compliance), although the overall Trust compliance has fallen slightly.

Areas of concern are Specialist Division (63.1% compliance, 3.2% point fall since March 2024) and CGO (49.4% compliance).

### Intervention and Planned Impact

CGO staff listings are currently under review, following review of CEO staff listings.  HR Business Partners are continuing to support Divisional Management Teams in Action Planning (incl. in response to 2023 NHS Staff Survey).  Non-Medical Appraisal is a Key Metric for Leadership, Culture & Development (LCD) Strategic Initiative, and therefore discussed at Divisional SDRs and raised at Trust SDR.

### Risks/Mitigations

Well-structured appraisal is positively associated with Staff Engagement, organisation and patient outcomes (incl. lower mortality).  Quality of appraisals (as reported in ongoing appraisee feedback) remains high.  Of the 5,600 respondents since 2022, 86%+ agreed it felt safe to talk about personal issues, appraisal was positive overall, and the feedback was useful.
In the NHS Staff Survey 2023, At People Promise level we improved our Appraisal score in 2023 (4th strongest improvement by People Promise Element).  At question level, our 3 x scores for Appraisal *quality* improved in 2023 (some of our strongest improvements overall).  However Appraisal *compliance* fell slightly in 2023, impacting the overall Appraisal score.
The risk is therefore missed opportunities to improve Staff Engagement, organisational and patient outcomes, and risk of regulatory non-compliance (CQC, NHSE).

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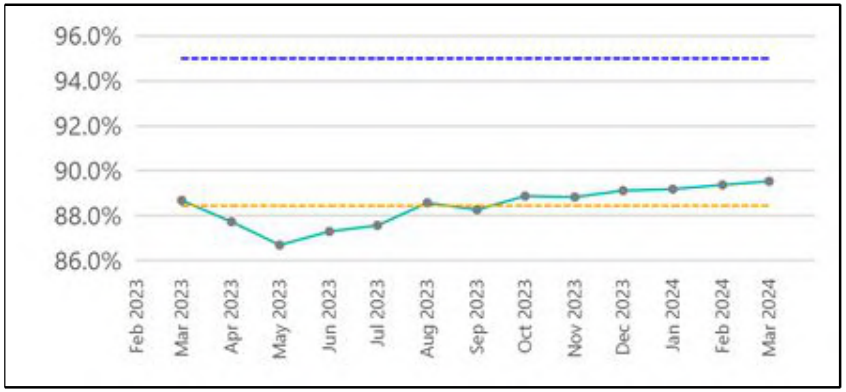
## Driver

Metric: Training & development - STAM Weighted Average

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 88.7% | 87.7% | 86.7% | 87.3% | 87.6% | 88.6% | 88.3% | 88.9% | 88.8% | 89.1% | 89.2% | 89.4% | 89.5% |

### Overview

Statutory and Mandatory Training (STAM) is training that the Trust has determined is essential to particular staff and/or roles and compliance is monitored. It is training designed to support the health and safety of patients and things like data security. It is usually delivered on-line although elements are face to face and often to agreed national standards/expectations.




### What the chart tells us

In March 2024 the Trust STAM rate was 89.54% which is the highest rate in the last 12 months of continuous monitoring. All Divisions are reporting an improvement in the last quarter with 9/17 Division being compliant and the remaining 8 divisions reporting compliance at above 86%.

The Trust is performing well against the STAM weight target of 90% and are currently 0.46% under our compliance levels.

In terms of the modules, five of the eleven modules are performing at above 90% (Adult Safeguarding, Children Safeguarding, EDI, Health &Safety and conflict resolution), six modules are performing below 90% with Oliver McGowan the poorest performer with 80.32% although this was only introduced in July 2023.

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| Intervention and Planned Impact |
| --- |
| •Resuscitation Services and Moving & Handling now have a permanent home at the RSCH with dedicated training space. This has aided increases in compliance as attendance at training has improved.<br><br>STAM subjects can now be passported in and out of the organisation through the IRIS/ESR interface<br><br>Compliance has dipped slightly in some areas and across people division due to major junior doctor changeover – 500+ junior doctors move on a single day at the beginning of the month. |
| 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.<br><br>•The Oliver McGowan training is now reported on the Scorecard due to being a mandated training although nationally it is not part of the Core Skills Training Framework which is the framework we work to for STAM. Therefore this does not affect the scorecard rates<br><br>•Work continues to improve attendance at face to face sessions which is always difficult during periods of high pressure – industrial action and winter pressures<br><br>•STAM subjects can now be passported in and out of the organisation through the IRIS/ESR interface<br><br>•An ongoing TNA is underway to ensure that staff have the correct STAM subjects mapped against their profile has now been completed in all subjects with the exception of Resus which is being currently undertaken. |
| **Risks/Mitigations** |
| There is a risk that operational pressures mean that staff do not always complete training. This is mitigated through monitoring and follow up. There is also a risk that training requirements will increase which is mitigated by ensuring 'portability' of training and using assessment of competence where possible, so reducing repeat training requirements. |

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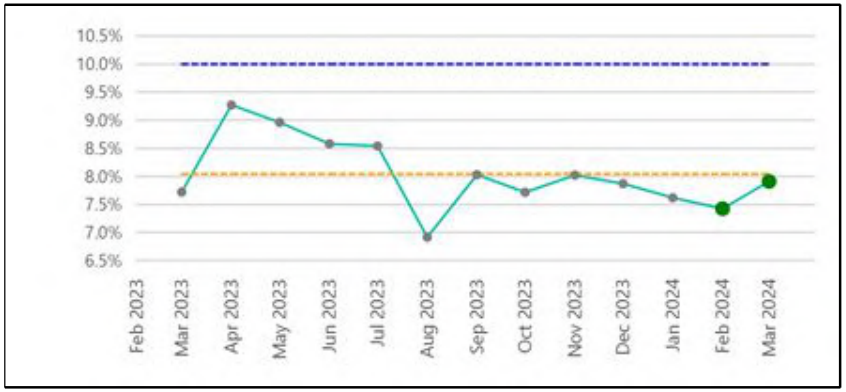
## Driver

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7.7% | 9.3% | 9.0% | 8.6% | 8.5% | 6.9% | 8.0% | 7.7% | 8.0% | 7.9% | 7.6% | 7.4% | 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's budgeted establishment stands at 16,967 FTE (up 59 FTE in a month and 640 FTE in the last year). Compared to this, staff in post is now 15,624 FTE (down 29 FTE in a month but up 558 FTE in the last year). The Trust currently has 1,342 FTE of vacancies (up 81 FTE in the last 12 months, due to growth in establishment outpacing growth in staff in post). The vacancy rate is currently 7.9%, compared to 7.7% in March 23.

Vacancies for band 5 registered nurses remain stable at 13.04%, a slightly improved position from M11. Similarly, vacancies for Healthcare Assistants are stable at 7.73%, a 50% reduction compared to same time prior year.

### Intervention and Planned Impact

There is a significant graduate nurse recruitment campaign in progress and calendar of HCA recruitment events, longer term, the recruitment and training of Nursing Associates will provide a talent pipeline for future registered nurses. Nursing Associates will also act as a valuable resource that can be deployed in a targeted way based on patient need and acuity. A business case for internationally educated nurses is being developed to supplement domestic supply.
An enhanced workforce control environment is being maintained to support alignment with financial plans, this includes bank, agency and substantive recruitment and deployment.
Work continues to implement the Trust's diverse recruitment action plan including developments to on-line EDI/recruitment training.

### Risks/Mitigations

There is a risk to the funding of international recruitment, the case will be considered at Business Case Scrutiny Panel. There may be insufficient local supply.
There is a shortage of registered nurses in the local area, however, strong graduate and local campaigns in train to mitigate.

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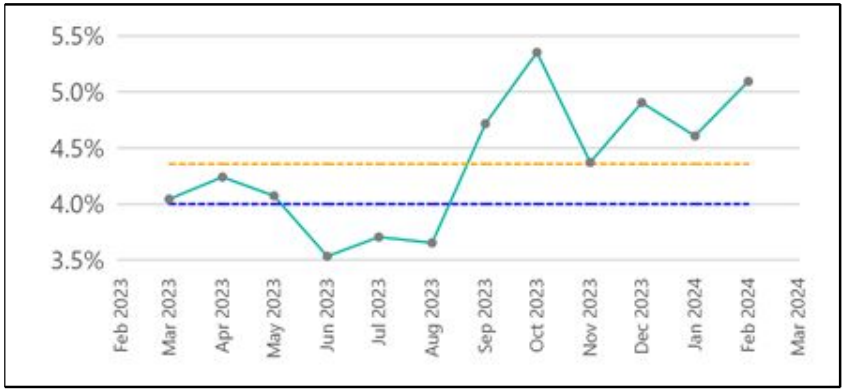
## Driver

Metric: Workforce efficiency - Absence Sickness in month

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.0% | 4.2% | 4.1% | 3.5% | 3.7% | 3.7% | 4.7% | 5.4% | 4.4% | 4.9% | 4.6% | 5.1% |

## Overview

No Data




## What the chart tells us

At the time of writing we have sickness data for Jan and Feb 24 for Q4. The 12 month Sickness Absence rate was 5.1% February (5.5% Feb 23) and 4.9% January (5.2% Jan 23) showing a declining trend. However the one month rate for February was also 5.1% equalling the Feb 23 rate whilst the Jan 24 rate of 4.6% was lower than Jan-24.

By staff group, the main areas of concern continue to be Clinical Support and Estates. However, both have shown reductions compared to Q4 2023, with Clinical Support down from 11.4% to 9.2%, and Estates down from 8.3% to 7.9%. The "Add Prof, Scientific and Tech" staff group (approx. 500 non AHP Scientific, Therapeutic and Technical staff such as Pharmacy) also has a high level of Sickness Absence, with the 12 month rate currently at 7.2% (6.9% in Feb 23).

## Intervention and Planned Impact

A range of interventions continue to be delivered this quarter including:

- a dedicated team in HR supporting management of long term sickness cases
- HR working with Divisions on hotspot areas
- training of managers in sickness absence both through central courses and specific targeted sessions in Divisions e.g. Estates and Facilities Supervisors Academy (combined over 500 attended in 23/24)
- drop in sessions for managers trialled in CSS
- reasonable adjustments working group
- update to Health and Wellbeing policy (waiting for TMC approval)

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| **Risks/Mitigations** |
| --- |
| Risks<br><br>High sickness rates impact on staff health and wellbeing, staffing levels, patient continuity of service, morale and resourcing costs.<br><br>Mitigations<br>The interventions are having an impact on reducing sickness levels.<br><br>Governance arrangements are in place to both monitor sickness absence with daily absence information being shared and to control the impact on services e.g. ensuring safe staffing levels are in place whilst controlling costs. |

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## Watch Metrics for People

| Metric | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Turnover (12 month) | 9.5% | 9.4% | 9.2% | 9.0% | 9.0% | 8.8% | 8.8% | 8.7% | 8.5% | 8.4% | 7.8% | 7.8% | 7.5% |
| Workforce capacity - FTE Budgeted | 16327 | 16597 | 16626 | 16625 | 16633 | 16758 | 16799 | 16866 | 16906 | 16889 | 16896 | 16908 | 16967 |
| Workforce capacity - FTE Substantive contracted | 15066 | 15058 | 15136 | 15199 | 15212 | 15598 | 15450 | 15564 | 15550 | 15559 | 15609 | 15653 | 15624 |
| Workforce capacity - FTE Substantive contracted variance from Budget | 1261 | 1539 | 1490 | 1427 | 1421 | 1160 | 1349 | 1302 | 1356 | 1329 | 1288 | 1256 | 1342 |
| Workforce capacity - Number of leavers | 145 | 119 | 93 | 108 | 125 | 187 | 153 | 116 | 99 | 94 | 98 | 90 | 97 |
| Workforce capacity - Number of Starters | 209 | 226 | 226 | 175 | 188 | 550 | 297 | 289 | 195 | 143 | 192 | 204 | 142 |
| Workforce efficiency - Absence 12 month sickness rate | 5.3% | 5.4% | 5.3% | 5.2% | 5.0% | 4.9% | 5.1% | 5.0% | 4.8% | 4.8% | 4.9% | 5.1% | |
| Workforce efficiency - Absence Total in month. | 13.8% | 14.1% | 13.8% | 13.8% | 14.3% | 13.7% | 15.7% | 16.6% | 15.5% | 15.6% | 15.7% | 16.3% | |

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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 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| YTD Actual | 5,756 | 9,605 | 10,527 | 12,771 | 16,900 | 24,579 | 29,249 | 18,230 | 26,060 | 29,541 | 19,355 | 14,952 |
| YTD Plan | 2,763 | 4,919 | 4,834 | 5,700 | 6,184 | 5,960 | 5,772 | 5,220 | 5,584 | 3,856 | 1,689 | 0 |

**Overview**

The Trust submitted a breakeven financial plan for 2023/24 and had a revised forecast outturn of £10.33m.

The actual deficit for the 2023/24 financial year is £14.95m.

The deficit for the 2023/24 financial year is recognised and supported by the Sussex Integrated Care Board (ICB).

Elective restoration performance for the financial year is 103.9%, against a target of 105%, and the Trust has been subject to an income clawback of £2.90m

The cash position is £20.07m, £39.94m below the plan. This variance is:
- £19.95m to support the deficit to the breakeven plan; and
- £19.99m to support the delivery of the capital programme, in excess of internally generated cash sources.

Capital expenditure, chargable against the Trust Capital Delegated Expenditure Limit (CDEL) for the 2023/24 financial year is £84.16m, against a plan of £84.87m. The £0.71m expenditure below the plan is in line with the position agreed with the Sussex ICB, which will enable the Sussex ICB system to achieve it's overall plan for 2023/24.

Efficiency performance is cumulatively £9.13m below plan.

Agency expenditure is 3.0% of the pay expenditure. This is a 0.1% improvement from M09 and is below the 3.7% target.

| M12 YTD | Annual Plan | Plan | Actual | Variance |
|---|---|---|---|---|
| | £m | £m | £m | £m |
| I&E | 0.00 | 0.00 | 14.95 | (14.95) |
| Cash | 60.01 | 60.01 | 20.07 | (39.94) |
| Capital | 84.87 | 84.87 | 84.16 | 0.70 |
| Efficiency | 62.00 | 62.00 | 52.87 | (9.13) |
| Agency Ceiling | 34.33 | 34.33 | 29.95 | 4.38 |

**What the chart tells us**

The actual deficit is **£14.95m**, which is **£14.95m** above plan.

The Elective Recovery Fund (ERF) 'clawback' has been included in the position, against the 105% NHSE target; and contributes to the reported deficit by £2.90m. Financial performance was 103.9% ytd

The key drivers of the deficit outwith the Trust's direct control are the excess cost of inflation in 23/24 and the impact of pay award costs in excess of funding.

The key drivers of the deficit which are within the Trust or System's direct control continue to include excess costs above plan of mental health specialling, medical premium rates and junior doctor deployment and activity related clinical supplies and drugs, including high cost drugs.

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| Intervention and Planned Impact |
| --- |
| The 2023/24 financial year has now been completed, however the exit run-rate will have an ongoing impact on the 2024/25 financial year.<br><br>The Trust is in the process of developing the actions which are required to support the delivery of the 2024/25 plan, which include:<br>Continuation and further strengthening of the enhanced control environment and pay controls;<br>A review of the budget holder delegated limits and requisitioning arrangements;<br>An increased focus on compliance with financial controls and compliance reporting; and<br>Full identification of the Efficiency Programme, which will need to be developed and matured at pace to ensure full-year delivery of the target. |

| Risks/Mitigations |
| --- |
| The actual reported deficit for the 2023/24 financial year is £14.95m, which is recognised and supported by the Sussex Integrated Care Board (ICB).<br><br>This financial position reflects the draft accounts submitted to NHSE and the Trust's external auditors on 24th April. No further changes are anticpated. The final accounts will be presented to Audit committee and Trust Board in June 2023, once the year end audit is completed.<br><br>The Trust is in the process of submitting a deficit plan of £39.9m for the 2024/25 financial year. This requires delivery of a challenging £75m efficiency programme alongside delivery of operational targets including the 65-week wait for planned care and improved perofrmance across urgent care.<br><br>Pay costs are a significant component of the Trust's expenditure and also a significant driver of financial performance. The Trust will need to consider the current level of pay rates and also instigate headcount/establishment reductions to ensure delivery of the financial plan and address areas of growth, in line with national expectations and actions taken by other provider Trusts. |

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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 | Jan-24 | Feb-24 | Mar-24 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 103.9% | 109.1% | 102.4% | 99.2% | 101.4% | 103.1% | 103.7% | 103.6% | 107.2% | 106.4% | 106.6% | 111.5% | **103.9%** |
| Target | 107.0% | 107.0% | 107.0% | 107.0% | 107.0% | 107.0% | 105.0% | 103.0% | 105.0% | 105.0% | 105.0% | 105.0% | |

**Overview**

Post the revised baseline adjustment made for industrial action (IA), the elective recovery target for the Trust was confirmed at 105%, 5% above 2019/20 published activity levels.

As evident in the data above, elective activity performance has started to increase from Dec 23 onwards, despite further incidences of IA. Alongside increasing productivity, the Trust has been working to secure further opportunities to increase income, improve % performance and reduce the financial impact of ERF clawback.

NHSE Methodology to agree a year-end ERF income value based on an average performance of Q1- Q3, resulted in a shortfall in expected income to the Trust, impacting the year end ERF performance and adversely impacting the year end position.

Year end performance was 103.9% against the 105% target a 1.1% shortfall.

It is anticipated that an adjustment to account for this shortfall will be made in 24/25 plans and targets for the Trust, this is to be confirmed.

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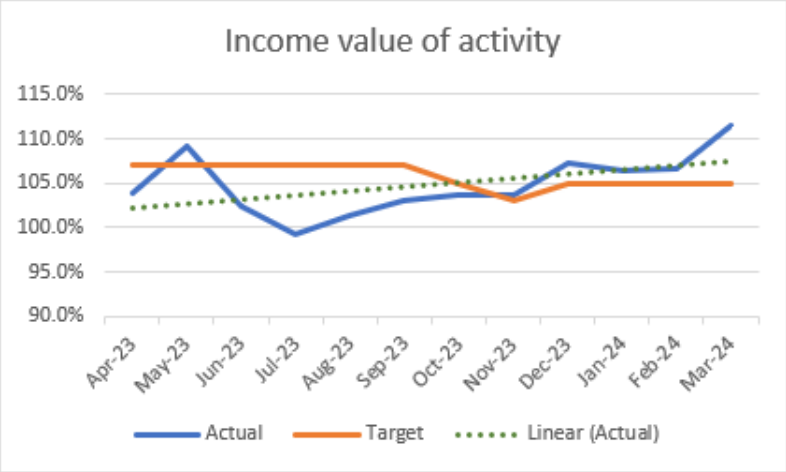


**What the chart tells us**

Performance for the 24/25 financial year is **103.9%** in comparison to the 2019/20 baseline target (100%). This means that the income value of activity was **1.1%** lower than the 105% target. The income clawback was £2.97m.

Industrial action has had a significant impact on the achievement of activity targets throughout the whole year. The impact equated to c.**3.0% lost income** (£8.2m). Without industrial action, performance levels could have been at c**106.9%** for the year-to-date.

There were 11 days of industrial action in Q4 and average performance achieved for that quarter was **108.2%**.

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| Intervention and Planned Impact |
| --- |
| Operational plans were deployed to support the reduction of 78 week waits and cancer patients. These plans resulted in an elevated internal productivity which is seen in the Q4 performance, despite ongoing IA and increased urgent and emergency care requirements over the winter period.<br><br>Independent Sector capacity was secured to support activity in quarter 4 of this financial year.<br><br>Further opportunities to increase income, improve % performance via a focus on ensuring all activity is captured and coded will continue in 2024/25. |

| Risks/Mitigations |
| --- |
| The full year performance was 103.9%, this was achieved amid continued industrial action and high Urgent and Emergency Care activity.<br><br>The £2.97m clawback was within the year end performance of £14.95m.<br><br>The elective recovery target for 2024/25 is 109%, plans for delivery are being developed and assured. |

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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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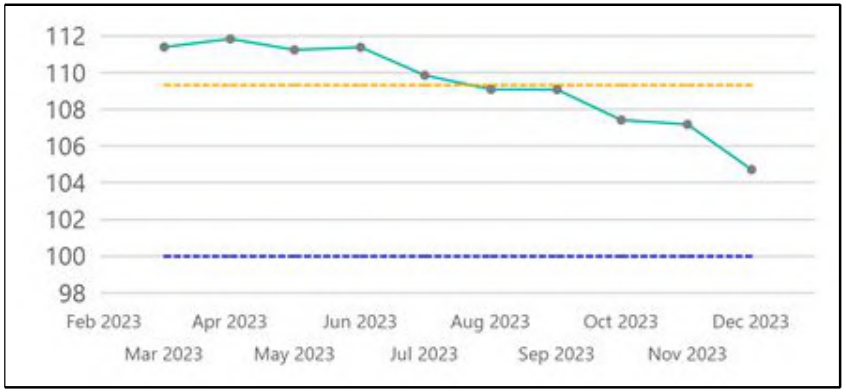
## True North

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 |
|---|---|---|---|---|---|---|---|---|---|
| 111.4 | 111.8 | 111.2 | 111.4 | 109.9 | 109.1 | 109.1 | 107.4 | 107.2 | 104.7 |

### 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 rolling data up to and including December 2023), is 104.9. 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 (103), WH (104) and RSCH (113) 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 come down over the past 12 months from 138 in Jan 23 to 116 in Dec 23, however SRH now sits at 113 and all sites are over 100 and Trust-wide Out-of-Hospital SHMI is 107.

### 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

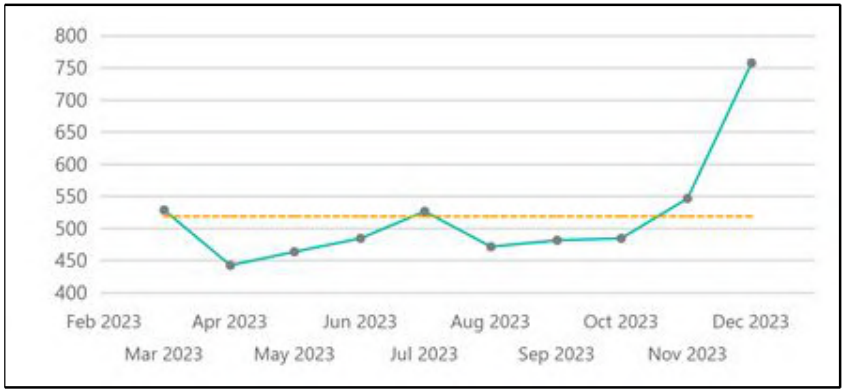
| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 |
|---|---|---|---|---|---|---|---|---|---|
| 529 | 443 | 464 | 485 | 527 | 472 | 482 | 485 | 547 | 758 |

### Overview

**Patient Safety Incident Reporting**

Trust-wide 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%.




### What the chart tells us

February has seen a significant increase to 53.47 (per 1000 bed-days) which remains marginally below above the 2022 national average of 54.9. Datix Cloud IQ launched 6th February 2024. February evidenced a rise in reporting numbers from Feb 23 (2378) to 3045 Feb 24.
March has seen a  Trust-wide decrease in rate of reporting to 46.67 (per 1000 bed-days) which remains below above the 2022 national average of 54.9, and the Trust target of 60.
The highest percentage of reported patient safety incidents are graded as no harm (70%).
Falls, pressure damage/medication and staffing are the most common themes within the low harm categories.

**Intervention and Planned Impact**

The Go-Live for the reporting of incidents module was launched in February 2024. Training and comms underway. Trust has purchased the DCIQ extraction tool for the BI team to allow for an accurate and seamless data feed.
Since 2015, the organisation has deployed the NHSE Serious Incident I Framework, using Root Cause Analysis (RCA) methodologies and approaches. Whilst a proportion of those involved in patient safety and investigations have embarked on systems-based learning through various training packages (e.g. HSIB silver investigations training), the majority of our learning response leads need to be socialised to this new approach to safety. Therefore, as part of our PSIRP and the launch for PSIRF, we have launched a complete suite of training for learning response leads and those investigating incidents.
The new Patient Safety Syllabus launched in February 2024. The training suite includes three 'levels' which have all be written and mapped out in accordance with the Patient Safety training syllabus curriculum. Those individuals identified to be learning response leads are expected to complete all three levels – level 1, 2a, and 2b.

- Level 1 – Patient Safety Fundamentals
- Level 2a – Patient Safety and Safety Science
- Level 2b – Practical applications – learning response leads

DCIQ Patient Safety Improvement and Risk Management System
The Go-Live for the reporting of incidents module was launched in February 2024. Training and comms underway. Trust has purchased the DCIQ extraction tool for the BI team to allow for an accurate and seamless data feed.

**Risks/Mitigations**

- There has been a noted rise in incidents presenting to PSIRG regarding patient harm from patient deterioration and lost to follow up, cancer, surgery delays, patient flow. RTT neurology/ophthalmology.
- Mental Health: High risk remains in both emergency departments and paediatric areas with Tier 4, LA and specialist placement. 2 high profile inquest pending regarding suicide on hospital premises.
- PSIRF Face to Face training modules commenced following go live from SIF to PSIRF on 04/12/23.
- Divisions are being encouraged to review and close legacy incidents (pre DCIQ launch February 2024) as soon as possible.
- The Trust uses an electronic reporting system RLDATIX IQ which is used to report nationally and verified data to the National Reporting and Learning System (NRLS) and LfPSE (from February 2024).
- The serious incident data (pre-launch of PSIRF in December 2023) has been extracted directly from the Strategic Executive Information System (StEIS) which is an established and recognised source of data nationally.
- In addition, all near miss, moderate/severe harm and death are reviewed by a senior panel on a weekly basis at the Patient Safety Incident Response Group (PSIRG). Following PSIRF the level of harm, patient/family engagement and investigation is decided.
- March evidenced a decrease in overall reporting numbers (2856) from Feb 24 but remains above March 23 numbers (2689). The After-Action Review for March demonstrates the following contributory factors: staff 'report/data overload/fatigue'/ NHSE Learning from Patient Safety Events (LfPSE) have added 14 mandatory questions to the form, making it a longer form for staff now to complete added to by industrial action/BCI status and acute operational pressures (particularly in ED).

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## Breakthrough

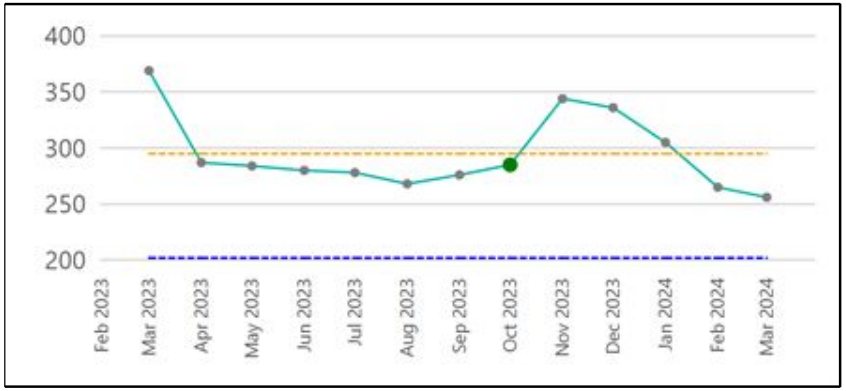
Metric: Safety - To reduce falls whilst in the care of UHSussex by 30%

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 369 | 287 | 284 | 280 | 278 | 268 | 276 | 285 | 344 | 336 | 305 | 265 | 256 |

### Overview

The quality True North for harm in our organisation is "zero harm" occurring to our patients when in our care. Harms contribute significantly to poor patient experience and outcomes and staff experience. Falls is the top contributor in terms of Harms across the UHSx.

The Quality Breakthrough Objective: regarding falls prevention and management is to reduce falls by 30%.




### What the chart tells us

After a challenging Q3, Q4 has demonstrated 4 consecutive months of falls reduction.

256 falls for Mar is 19% lower than 12 baseline average, levelling out for seasonal 'spikes', the 12 months average reduced by 10 falls to 289 in March

### Intervention and Planned Impact

10 out of 23 focus wards achieved their 30% falls reduction target in March : Ford, Lavant (SRH), Buckingham (WGH), C10, B8, A9/B9, B10, AAU, Renal (RSCH), SRH (New Timber/Lindfield). 30% reduction sustained for 2 consecutive months on 2 wards, 3 consecutive months on 2 wards, 4 consecutive months on 3 wards, and 6 consecutive months on B10 (RSCH).

Process improvement trial on Boxgrove Ward to improve Safe Care data accuracy ahead of roll-out trust-wide.

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| Risks/Mitigations |
| --- |
| • The standardised reporting dashboard on Tendable now released with an action plan template to be created for capturing ward actions resulting from lower audit scores<br>• Falls standards 'quick reference guide' being created as a ward-level crib sheet for all wards in April.<br>• Focus on patients who fall more than once (currently 23% of falls, down from 27% in Feb '24). Wards being encoraged to use learning from each Rapid Review form to reduce recurrence.<br>• HFC team lead now inputting into the Deconditioning workstream of LOS project, to ensure a single set of aligned actions.<br>• Tendable falls dashboard created in March. Working with IT team to create a Tendable actions template in April, for use in tracking actions against wards' falls standards performance. In March, Lying & Standing BP adherence showed largest trust and site-wide gaps. Trust action captured in improvement plan to improve this process |

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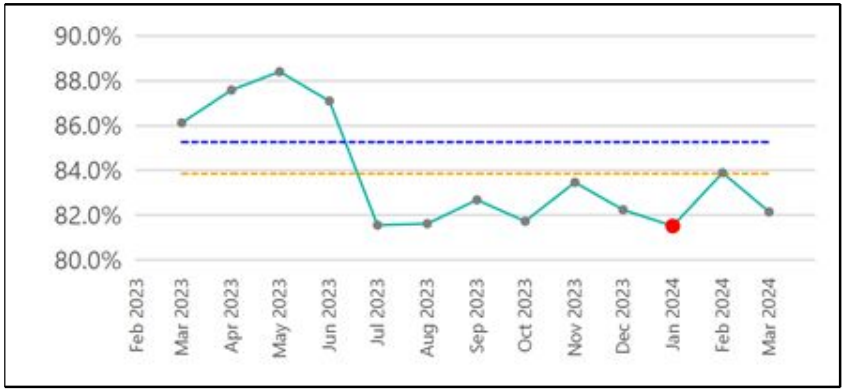
## Driver

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 86.1% | 87.6% | 88.4% | 87.1% | 81.6% | 81.6% | 82.7% | 81.7% | 83.5% | 82.2% | 81.5% | 83.9% | 82.2% |

### Overview

Patients have the right to be cared for 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 efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Safe levels of staffing and an adequate skill mix are central to the delivery of high-quality care (volume 2 Government response to 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 the day shifts each month.
Registered Nurses /Midwives had a reduced fill rate in July August 2023. There is a more consistent trend over the period of August 2023 to March 2024. The trust merged the 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.
Reference RN fill: The band 5 vacancies has remained above 13% across all sites since November 2023

### 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. A trust wide review of rosters and establishments has been completed in March/April by the Deputy Chief Nurse for Workforce and Professional Development. The review aligned rosters to budget and next steps will be to complete a trust Safer Nursing Care Tool audit in the month of May.

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| Risks/Mitigations |
| --- |
| There are currently 13.04% Band 5 Registered Nurse vacancies and turnover of 6.03% across UHSussex. The impact of this is that there may be an inability to fill absence and escalation shifts. There is also high demand for registrants and HCAs with specialist skills to care for patients with mental ill health. 27 enhanced care support workers commenced in post in January to care for patients with mental illness ill health as part of a trust pilot. The pilot will be evaluated in May/June to determine next steps.<br>Rolling recruitment continues for band 5, included targeted campaigns for areas with high vacancy and a focus targeted recruitment of student nurses. 98 internationally educated nurses joined the WF between October and April. There are 217 registered nurses (58 with registration) in the pipleline and will join the WF by October 2024.<br><br>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 nursing and midwifery workforce. |

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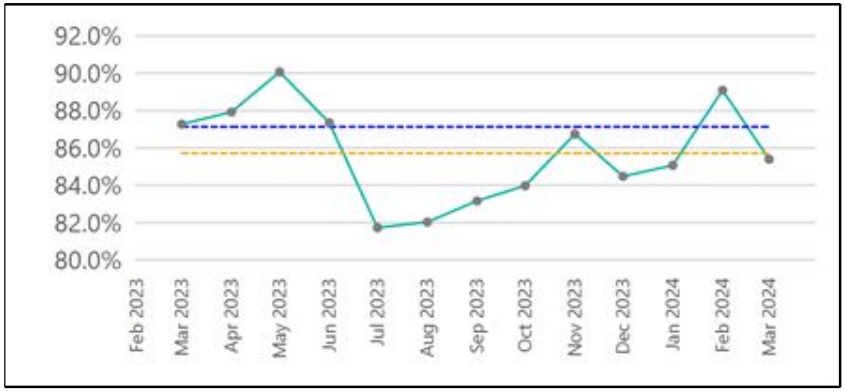
## Driver

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 87.3% | 87.9% | 90.1% | 87.4% | 81.7% | 82.0% | 83.2% | 84.0% | 86.7% | 84.5% | 85.1% | 89.1% | 85.4% |

### Overview

Patients have the right to be cared for 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 efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Safe levels of staffing and an adequate skill mix are central to the delivery of high-quality care (volume 2 Government response to 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 the night shifts each month. Registered Nurses /Midwives had a reduced fill rate in July August 2023. There is a gradual increasing trend over the period of August 2023 to March 2024 noting the fill rate is better than the day fill rate due to night pay enhancements. The trust merged the 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.
Reference RN fill: The band 5 vacancies has remained above 13% across all sites since November 2023

### 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. A trust wide review of rosters and establishments has been completed in March/April by the Deputy Chief Nurse for Workforce and Professional Development. The review aligned rosters to budget and next steps will be to complete a trust Safer Nursing Care Tool audit in the month of May.

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| Risks/Mitigations |
| --- |
| There are currently 13.04% Band 5 Registered Nurse vacancies and turnover of 6.03% across UHSussex. The impact of this is that there may be an inability to fill absence and escalation shifts. There is also high demand for registrants and HCAs with specialist skills to care for patients with mental ill health. 27 enhanced care support workers commenced in post in January to care for patients with mental illness ill health as part of a trust pilot. The pilot will be evaluated in May/June to determine next steps.<br>Rolling recruitment continues for band 5, included targeted campaigns for areas with high vacancy and a focus targeted recruitment of student nurses. 98 internationally educated nurses joined the WF between October and April. There are 217 registered nurses (58 with registration) in the pipleline and will join the WF by October 2024.<br>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 nursing and midwifery workforce. |

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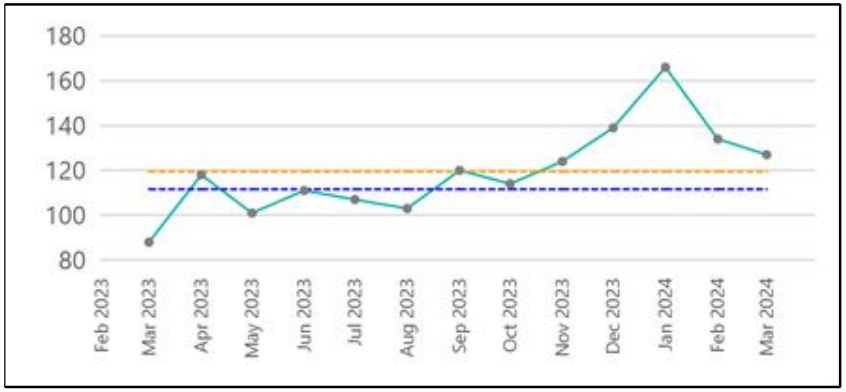
## Driver

Metric: Safety - Grade 2+ pressure ulcers

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 88 | 118 | 101 | 111 | 107 | 103 | 120 | 114 | 124 | 139 | 166 | 134 | 127 |

### Overview

Hospital-acquired pressure injury is a common yet mainly preventable condition. Risk factors for developing a hospital-acquired pressure injury include older age, immobility, altered mental condition, urinary or faecal incontinence, hospitalisation for fracture, surgical intervention, reduced appetite, and nasogastric tube or intravenous nutrition. Research has shown that pressure injuries may be preventable. The strategy for preventing pressures injuries relies on two interdependent domains: pressure injury risk identification and pressure injury risk mitigation.




### What the chart tells us

March 2024: 129 patients graded Category 2 and above pressure ulcers = 2.12 per 1000 bed days, (2.09 rolling 12 month average).

Overall,129 hospital acquired Category 2 and above pressure ulcers have been reported for February, a decrease since previous month. (135).

When comparing HA pressure ulcers Category 2 and above by site:

WH-SRH decreased from 98 in February to 81 in month.

RSCH-PRH increased from 37 in February to 48 in month

| **Intervention and Planned Impact** |
| --- |
| Ward leadership reviews are ongoing to ensure that skin checks are being completed at least once every 24 hours, in addition to:<br>Ward leadership reviews to ensure daily management of high-risk patients, ensuring that preventive pressure relieving equipment is implemented at the earliest opportunity. Educating and embedding of standard communication/handover to reduce risks particularly when patients are moved between clinical areas.<br>A focus on ensuring that the pressure ulcer risk assessments are being reassessed when patients transferred between clinical areas.<br>Recognising and capturing low harm learning opportunities to reduce risk and prevent pressure ulcer deterioration.<br>Continue to educate teams, embedding expectations relating to record keeping and non-concordance particularly when a patient who has capacity declines pressure prevention nursing interventions.<br>An increase in clinical photography across the Trust as led by the Clinical Media centre is being discussed and developed.<br>Progressing with the support of CNO a Trust wide approach for slide sheets ensuring best practice to prevent shearing.<br>The TVN Team are working collaboratively to agree a Trust wide dressing formulary for wound management ensuring consistency and to be in line with community partners.<br>Discussions are being held to establish a process/funding to undertake annual mattress audits, with supplies.. |
| **Risks/Mitigations** |
| Management of high-risk patients – missed opportunities for using<br>preventative pressure relieving equipment at the earliest opportunity.<br>Staff not recognising deteriorating wounds, and the management of infection<br>prevention. The improvemewnt actions are listed in : Intervention and planned impact section. |

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## Watch Metrics for Quality

| Metric | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical outcomes/effectiveness - Timeliness of observations against targets (NEWS2) | 67.9% | 68.7% | 69.3% | 68.7% | 67.2% | 64.4% | 64.6% | 64.4% | 65.0% | 63.7% | 64.4% | 64.4% | 65.4% |
| HCAI - Number of hospital attributable C.diff cases (HOHA/COHA) | 13 | 6 | 11 | 9 | 11 | 11 | 15 | 18 | 13 | 18 | 16 | 9 | 20 |
| HCAI - Number of hospital attributable E.coli cases (HOHA/COHA) | 23 | 18 | 17 | 20 | 25 | 23 | 15 | 17 | 12 | 25 | 20 | 20 | 14 |
| HCAI - Number of hospital attributable Klebsiella species cases (HOHA/COHA) | 3 | 6 | 8 | 8 | 11 | 8 | 12 | 11 | 6 | 8 | 9 | 4 | 3 |
| HCAI - Number of hospital attributable MRSA cases (HOHA/COHA) | | | 2 | 1 | 1 | 1 | | | | | | | 2 |
| HCAI - Number of hospital attributable MSSA bacteraemia cases (HOHA/COHA) | 3 | 3 | 11 | 6 | 9 | 9 | 5 | 7 | 7 | 9 | 8 | 8 | 11 |
| HCAI - Number of hospital attributable Pseudomonas cases (HOHA/COHA) | | 1 | 1 | 2 | 5 | 4 | 7 | 6 | 4 | 4 | 1 | 2 | 4 |
| Safety - % of Deaths with Comfort Obs in Place | 69.1% | 73.4% | 71.8% | 72.8% | 70.5% | 70.0% | 73.4% | 64.8% | 69.2% | 73.0% | 74.5% | 77.0% | 67.2% |
| Safety - Total moderate, severe or death incidents | 24 | 11 | 14 | 46 | 23 | 15 | 23 | 18 | 8 | 8 | 23 | 46 | 55 |

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# Systems & Partnerships

| | Metric | Target |
|---|---|---|
| True North | Cancer - To achieve the 62 day standard<br>(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<br>The delivery of this is measured through the following NHS constitutional metrics:<br>• A&E: treatment and admission or discharge within 4 hours;<br>• Referral To Treatment (RTT) definitive treatment within 18 weeks;<br>• Cancer: diagnosis and treatment within 62 days<br>• Diagnostics: investigation undertaken within 6 weeks<br>While there were some markers of improvement in operational performance metrics through Q4 2023/24, performance remained challenged<br>A&E performance improved materially year-on-year, but deteriorated in month 12.<br>The Trust remains in Tier 1 as part of the NHSE oversight framework for cancer and RTT.<br>The scale and pace of cancer recovery has been commended by NHS England. The Cancer backlog reduced and the trust met it's backlog reduction target. 28-day FDS performance improved to 73.1% in Feb-24.<br>The overall RTT waiting list reduced month-on-month throughout Q4, reducing by over 12,000 compared to September, but is 9.5% higher on Mar-24 than prior year. The Trust reported no 104-week waits in March and both the 78-week and 65-week wait positions improved. But the Trust continues to be a national outlier for the number of long waiting patients, and the shape of the PTL means this will continue to present a challenge over the coming year. |

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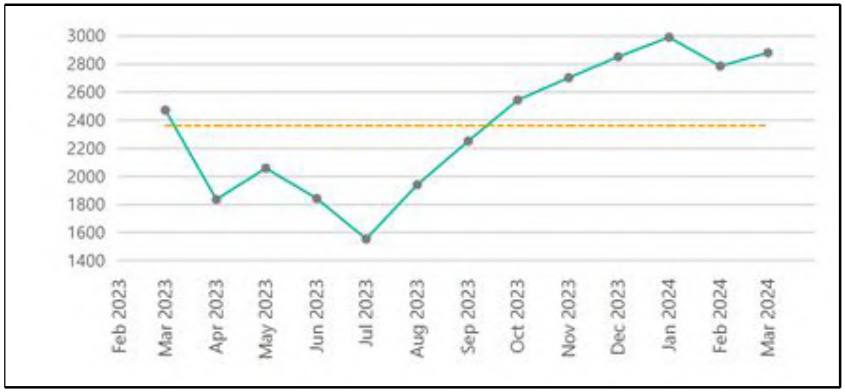
## True North

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2472 | 1836 | 2059 | 1843 | 1555 | 1941 | 2252 | 2544 | 2703 | 2852 | 2991 | 2786 | 2881 |

### Overview

The number of 12 hour breaches decreased through the summer months last year and started to rise again as we moved through Winter. There was a decrease starting to happen in January and February but this number rose again in March. The numbers at WGH and SRH have risen proportionally more than at RSCH and PRH.




### What the chart tells us

The Charts tell us that this March we are holding a greater percentage of patients in our ED for more than 12 hrs than we did in March '23
From Sept 23 the Trust has held more people in ED than the mean with no signs of recovery.

### Intervention and Planned Impact

The UEC recovery plan contains hospital flow schemes which will release hospital capacity earlier to enable movement out of ED and decrease the number of 12 hr breaches.
This includes the Breakthrough Objective Improving the MHD and the LoS Corporate Project.
Work at each site aims to increase the usage of the discharge lounge and to ensure that flow from the acute floors to the wards is efficient thereby releasing capacity to move patients from ED

### Risks/Mitigations

A risk is that discharge planning processes are not applied consistently across the wards.
This leads to a delay in patients being discharged in timely way and increases the length of time patients reside in ED whilst waiting for a bed.
Mitigation work includes operationalising the BO and the CP with the divisional teams on the wards. Maximising the discharge processes which includes discharging pts earlier in the day will allow hospital flow to be released earlier in the day.

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## True North

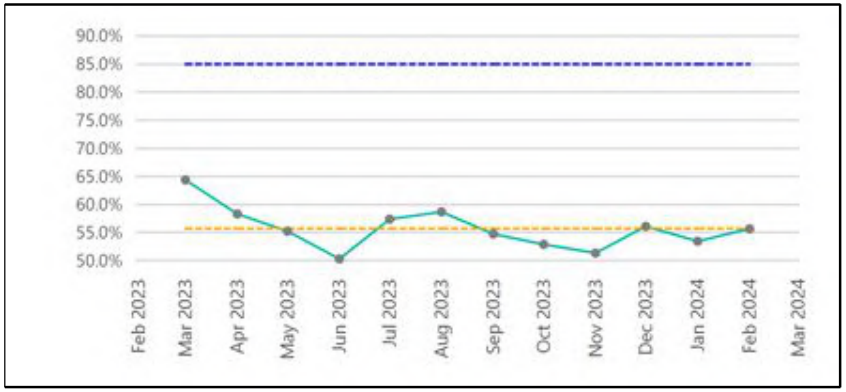
Metric: Cancer - To achieve the 62 day standard
(All referrals - National standard revised Oct 2023)

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 64.38% | 58.32% | 55.26% | 50.32% | 57.40% | 58.68% | 54.75% | 52.91% | 51.37% | 56.11% | 53.48% | 55.68% |

### 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.
UHSX has committed to improving performance to 70% by Mar-25, in line with national planning guidance.




### 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.
Feb-24 performance was 55.7%, compared to 53.4% in Jan-24 and national standard of 85%. Improved performance will only be achieved if reduced backlog is sustained going forward.

### 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.

| Risks/Mitigations |
| --- |
| Risks to deliver of the 62-day standard include:<br>Diagnostic capacity challenge - mitigated by securing funding from the cancer alliance for extra capacity<br>Navigator roles to ensure pathways are closely observed - alliance funding for high-risk pathways now secured so that detailed navigator overview is in place.<br>Industrial Action - mitigated by careful forward planning when dates are announced, with cancer activities being prrioritised for protection. |

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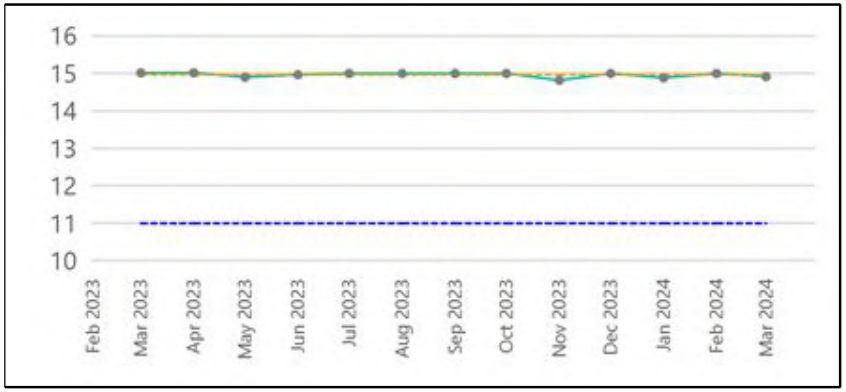
## Breakthrough

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15:01 | 15:01 | 14:54 | 14:58 | 15:00 | 15:00 | 15:00 | 15:00 | 14:49 | 15:00 | 14:53 | 15:00 | 14:55 |

### Overview

The Trust MHD position has not moved significantly since March 23.
The metrics which sit behind this do show improvement in the in scope wards but because these wards had a later MHD than the other wards, then the improvement is masked.




### What the chart tells us

The Chart tells us the Trust MHD position and does not show the difference between the divisional positions.
It does quantify how far away the Trust is from the target MHD time which is 11am and currently we are sitting at 14:54. There has been very little movement across the year and any change could be down to natural variation.

### Intervention and Planned Impact

The MHD BO continues with a focus on improving the MHD and there has been a renewed governance structure and a divisionally led improvement focus.
MHD BO aims for UHSx MHD of 10:00 - 10:59. This will only be achieved by improved communication and the medical and nursing leads to take accountability for ward level improvements.

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| **Risks/Mitigations** |
| --- |
| *Risks:*<br>Medical colleague engagement to influence the main improvement focus which is twice daily board rounds and timely completion of discharge summaries and TTOs<br>Delay in achieving target<br>Ward level communication is not as robust as is needed<br>*Mitigations*<br>SRO led improvement group and direct work with Chiefs of Divisions to establish barriers to increasing the board rounds<br>Nursing and Medical leads for in scope wards identified to increase communication and awareness of requirements to achieve the MHD target time |

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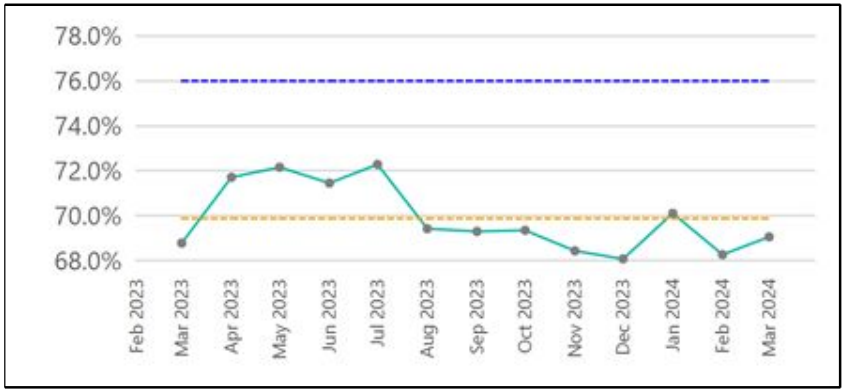
## Driver

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 68.8% | 71.7% | 72.2% | 71.5% | 72.3% | 69.4% | 69.3% | 69.4% | 68.4% | 68.1% | 70.1% | 68.3% | 69.1% |

### Overview

UHSx did not achieve the year end target of 76% discharged from ED within 4 hours.
There has been a very slight improvement at RSCH and PRH when compared to last March but performance against the 4 hour target has deteriorated at SRH and WGH since March '23




### What the chart tells us

Performance is variable across the sites with the Sussex Eye Hospital, The Alex and the walk in centres pulling up performance. Over the past 2 months, the Eye Hospital has struggled with performance and this has pulled the position down more than would be the case.
The was a small improvement in performance in January and this was due to the contribution made by RSCH and PRH. The Trust achieved a month end position of 70% which was the England average.
However the gains seen in January have not been maintained in February and March. This has been mainly due to constraints in flow across the hospitals as well as increased sickness in the EDs at WH and SRH.

### Intervention and Planned Impact

Revised trajectory for the Trust and each site has been produced and shared with the Teams.
A high level UEC improvement plan has been produced looking at different areas across the organisation:

1. Front door
2. ED flow
3. Hospital flow
4. System partners

This will be described in more delatil across each site with plans which are tracked agianst the trajectory

| **Risks/Mitigations** |
| --- |
| *Risks*<br>Increased attendances<br>Lack of whole hospital accountability<br>System partner work does not have the required outputs<br>*Mitigations*<br>Improved pathways to triage to UTC and admission avoidance<br>UEC improvement plan will involve a whole hospital approach<br>Work with system partners together to find solutions to teh complex discharge patient cohort |

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## Driver

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.1% | 1.9% | 2.7% | 3.4% | 2.0% | 2.8% | 3.2% | 5.9% | 4.8% | 7.9% | 7.8% | 8.3% | 6.7% |

### Overview

Ambulance to hospital handovers above 60 mins have deteriorated from October 23
This has a kncok on effect on how quickly crews can be released to go back into the comuncity to repsnd to 999 calls


### What the chart tells us

The poor handover position is being driven by delays at RSCH although the delays being experienced at PRH have increased significantly since December '23
The position deteriorated across all EDs as we moved through the winter months but the position in March '24 is worse than March '23 with a significant proportion of teh deterioration coming from the delays at RSCH

### Intervention and Planned Impact

Work is being concentrated mainly at RSCH as this is where the majority of the delays happen and this site is consistently has the worst handover delays in the region.
Improvement schemes include:

- Improved streaming to UTC to decrease number of patients in majors
- Increase fit to sit area in majors
- Increased usage of CDU

### Risks/Mitigations

*Risks*
Effective use of different areas within ED are not used to maximin to decrease the corridor pressure
Lack of appreciation of the pressures in Secamb by ED staff
*Mitigation*
ED flow is part of the UEC improvement plan
ED RNs to spend a day with paramedic crews during their induction

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## Driver

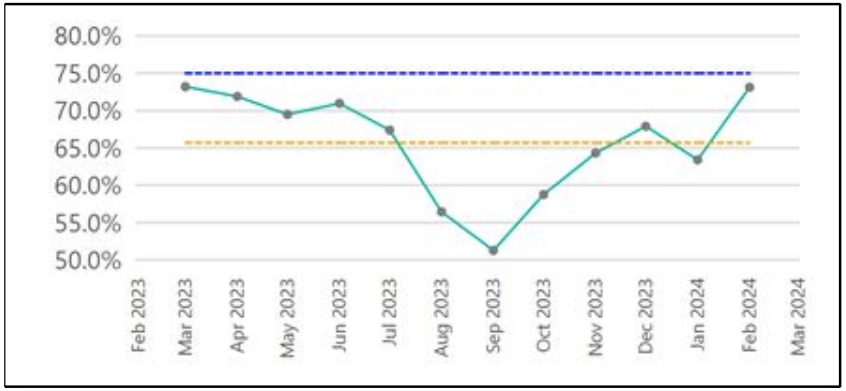
Metric: Cancer - 28 day faster diagnosis standard

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 73.21% | 71.90% | 69.48% | 70.97% | 67.40% | 56.46% | 51.29% | 58.78% | 64.31% | 67.91% | 63.42% | 73.13% |

### 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 for 2023/24.

UHSX has committed to achievement of 77% by March 2025, in line with national planning guidance ask.




### What the chart tells us

FDS performance improved in Feb-24 to 73.1% against the 75% target (from 63.4% in Jan-24). This is the best performance since Mar-23.

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| **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 developed recovery plans for each of these tumour sites, with enhanced oversight and governance in place led by COO and MD (planned care & cancer) to drive improvement.<br><br>Summary of improvement actions and expected percentage point impact:<br>• Breast (WH/SRH) – Increased breast one-stop capacity (now in place) **[expected to improve performance by 6.4%]**<br>• 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%]**<br>• 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%]**<br>• 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%]**<br><br>The collective impact of these actions are expected to achieve compliance with the 75% target by Mar-24. Feb-24 performance is on trajectory for delivering this.<br><br>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.<br><br>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:<br>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.<br>Diagnostic capacity challenge - mitigated by securing funding from the cancer alliance for extra capacity<br>Navigator roles to ensure pathways are closely observed - alliance funding for high-risk pathways now secured so that detailed navigator overview is in place.<br>Industrial Action - mitigated by careful forward planning when dates are announced, with cancer activities being prrioritised for protection. |

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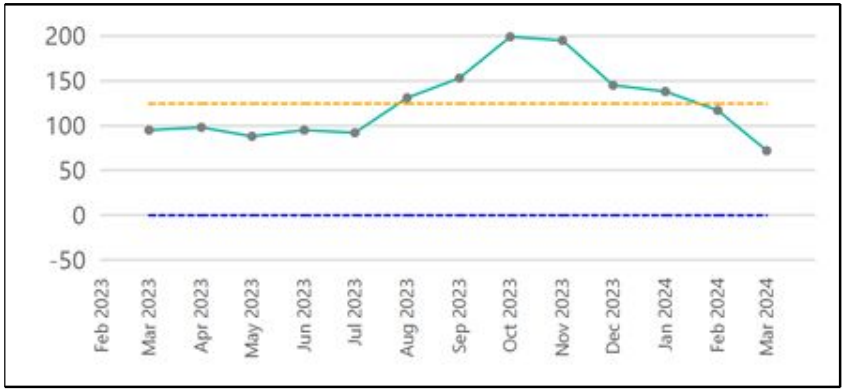
## Driver

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 95 | 98 | 88 | 95 | 92 | 131 | 153 | 199 | 195 | 145 | 138 | 117 | 72 |

### Overview

The NHS operating framework 23/24 required 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 aimed to reduce longest waits over 104 days this year to 75 by Mar-24.
Both these objectives were met, and UHSX now needs to sustain the improved position through 2024/25.




### What the chart tells us

There has been a decrease in over 104 day prospective waits from 117 in Feb-24 to 72 in Mar-24. The Trust met the objective to reduce to below 75 pathways.

### 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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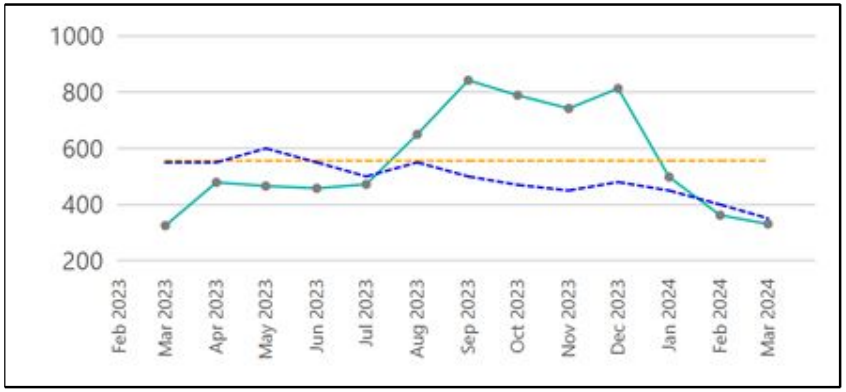
## Driver

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 325 | 479 | 466 | 458 | 472 | 650 | 842 | 789 | 742 | 813 | 498 | 362 | 331 |

## 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 was 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

62-day prospective waits decreased in Mar-23, to 331 meaning UHSX met the 62-day backlog target.

**Intervention and Planned Impact**

Increase in the 62-day backlog was driven by increases in Skin, Colorectal, Gynae, Breast and Head & Neck. The Trust 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. The scale and pace of recovery has been commended by NHS England

**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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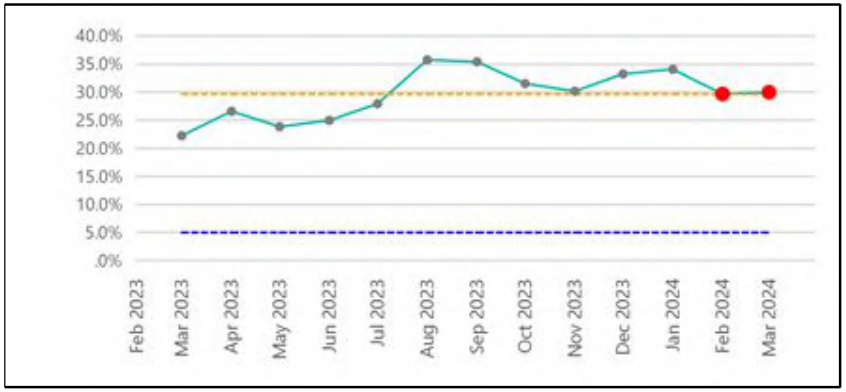
## Driver

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 22.3% | 26.6% | 23.9% | 25.0% | 27.9% | 35.8% | 35.4% | 31.5% | 30.2% | 33.2% | 34.1% | 29.7% | 30.0% |

### Overview

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




### What the chart tells us

UHSX achieved 30.0% in Mar-24 against the diagnostic patients over 6 week target of <5%. This was in line with Feb-24 performance (29.7%).

**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 has been exacerbated by industrial action and the Junior Doctor dispute remains unresolved. 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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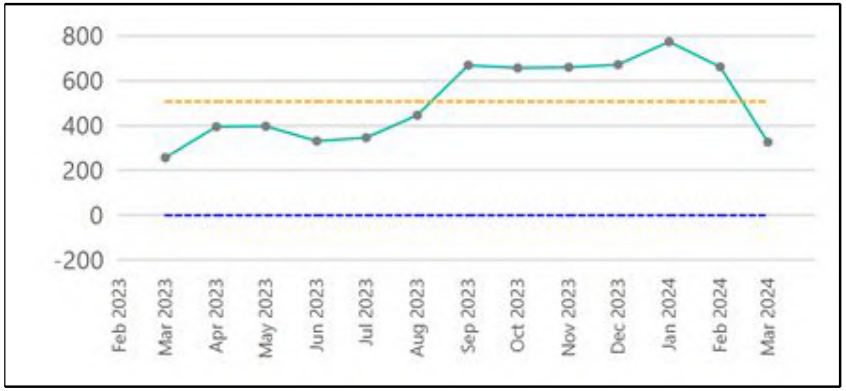
## Driver

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 257 | 395 | 397 | 331 | 346 | 446 | 669 | 657 | 660 | 672 | 774 | 662 | 326 |

### 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. UHSX agreed a Mar-24 target of 298 78-week waits through the Tier 1 process.
UHSX has committed to eliminating waits of 78 weeks by the end of Q1 2024/25.




### 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 Mar-24 there were 326 patients waiting over 78 weeks. This is a significant improvement compared to February (662) and the best position since Mar-23. However, the Trust narrowly missed the 298 objective set through Tier 1 process.

### 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.
These interventions will continue as the Trust works to deliver zero 78-week waits by Jun-24.

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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.<br>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.<br>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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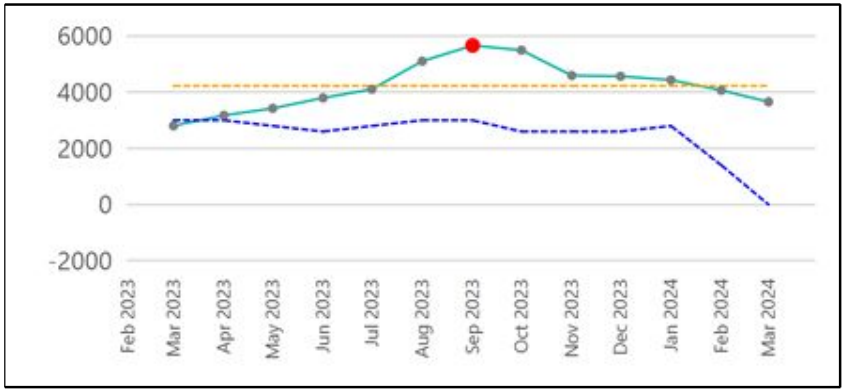
## Driver

Metric: RTT Elective care - >=65 Weeks

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2804 | 3175 | 3424 | 3796 | 4105 | 5103 | 5664 | 5495 | 4594 | 4566 | 4434 | 4067 | 3658 |

### Overview

Elective waiting times are a key constitutional target. Elective Waiting times materially increased as a result of the covid pandemic. The 2024/25 target is to reduce the number of 65-week waits to zero by the end Sep-24. Due to challenges with 65 week performance, the Trust has been placed in Tier 1 level support by NHSE.




### What the chart tells us

There has been a decrease in the number of patients waiting over 65 weeks at the end of Mar-24, to 3,658. This is the lowest position since May-23.

### Intervention and Planned Impact

UHSX has developed recovery plans by specialty to deliver the required reduction of the 65 week waits by Sep-24.
The Trust is being supported by system working to facilitate the full pathway transfer of patients still awaiting first outpatient appointment to capacity in the Independent Sector and at other NHS providers.
The Trust has enhanced governance arrangements led by deputy CEO and COO in place to oversee delivery. The Trust also has fortnightly meetings with CEO and NHS executive to oversee progress as part of Tier 1 process.

### 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.
UHSX is reliant on system working and capacity being available at other providers (both independent sector and NHS) in order to deliver this objective.

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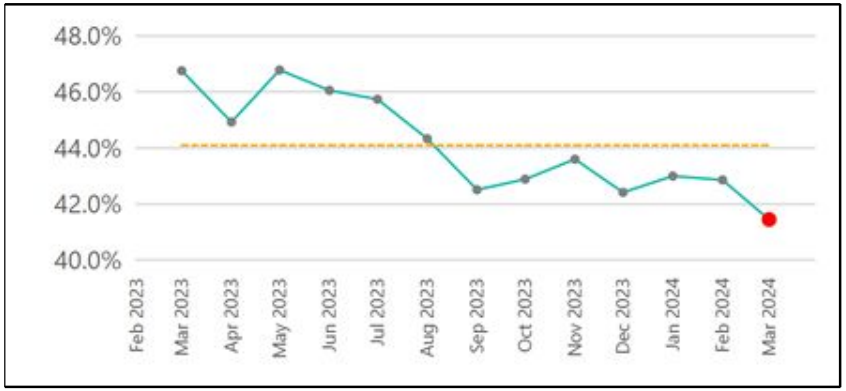
## Driver

Metric: RTT Elective care - 18 Week Performance

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 46.76% | 44.93% | 46.78% | 46.06% | 45.74% | 44.33% | 42.51% | 42.89% | 43.60% | 42.42% | 43.00% | 42.86% | 41.45% |

### 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 (104+,78+ and 65+ week waits) has superseded the 18 week target as acute Trusts look to tackle the very longest waits as part of staged recovery to reduced waits for elective care. It remains part of the constitutional targets, and system oversight framework however.




### What the chart tells us

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

### Intervention and Planned Impact

Key actions include:

1. Increasing activity delivered, through:
   - improved productivity and pathway redesign. 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

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| **Risks/Mitigations** |
| --- |
| Industrial action and emergency pressures have exacerbated risk associated with 18 week performance. There are also some highly complex pathways, and specialist capacity constraints particularly in neurosurgery/spinal care for example, which have created risk in minimising longest waits. Increases in urgent or 2WR demand which take precedence in terms of clinical priority order can also constrain residual routine waiters capacity. 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 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A&E and Emergency flow - % Patients with a 21+ day length of stay | 8.9% | 8.8% | 8.9% | 8.1% | 8.2% | 7.6% | 8.0% | 8.2% | 7.9% | 8.4% | 9.2% | 9.0% | 8.2% |
| A&E and Emergency flow - A&E 4 Hour Breaches | 10607 | 9087 | 10012 | 10122 | 9799 | 10536 | 10752 | 10927 | 11024 | 11285 | 10592 | 10884 | 11761 |
| A&E and Emergency flow - A&E Attendances | 33981 | 32125 | 35961 | 35460 | 35358 | 34460 | 35026 | 35655 | 34930 | 35356 | 35435 | 34304 | 37782 |
| A&E and Emergency flow - Ambulance Handovers | 7339 | 7079 | 7637 | 7328 | 7387 | 7413 | 7200 | 7544 | 7335 | 7733 | 7933 | 7193 | 7697 |
| A&E and Emergency flow - Ambulance Handovers - % Under 15 mins | 46.8% | 55.2% | 55.8% | 60.5% | 67.6% | 63.8% | 59.5% | 56.1% | 56.1% | 49.8% | 52.0% | 52.4% | 52.9% |
| A&E and Emergency flow - Average LOS (Excl LOS 0) | 7.6 | 7.4 | 7.8 | 7.4 | 7.5 | 7.3 | 7.2 | 7.4 | 7.3 | 7.5 | 7.9 | 7.8 | 7.2 |
| A&E and Emergency flow - Bed Occupancy | 1643 | 1624 | 1638 | 1594 | 1571 | 1628 | 1645 | 1676 | 1729 | 1753 | 1799 | 1799 | 1818 |
| A&E and Emergency flow - Emergency Admissions > 1 LOS | 5704 | 5341 | 5575 | 5471 | 5623 | 5621 | 5580 | 5789 | 5704 | 5796 | 5704 | 5315 | 5831 |
| A&E and Emergency flow - Mean Waiting Time | 314 | 288 | 290 | 293 | 281 | 299 | 314 | 320 | 337 | 338 | 337 | 336 | 326 |
| A&E and Emergency flow - Time to treatment in ED (Median time to treatment mins) | 77 | 70 | 77 | 77 | 72 | 78 | 79 | 69 | 70 | 69 | 68 | 71 | 69 |
| A&E and Emergency flow - Time to Triage in ED - % seen within 15 mins | 52.3% | 64.5% | 64.5% | 59.7% | 74.7% | 70.5% | 64.8% | 64.5% | 63.1% | 58.9% | 60.9% | 60.1% | 59.9% |
| Cancer - Two week rule performance | 87.5% | 76.7% | 79.8% | 65.3% | 66.2% | 51.2% | 43.5% | 58.9% | 62.8% | 72.0% | 69.5% | 74.1% | |
| Diagnostics - 6 week backlog | 4591 | 5126 | 4946 | 5268 | 6272 | 8393 | 8541 | 7226 | 6336 | 6829 | 7219 | 6427 | 6491 |
| Diagnostics - Activity | 35348 | 34345 | 36425 | 34682 | 32370 | 32809 | 34481 | 37145 | 39803 | 31927 | 48976 | 35138 | 36092 |
| Diagnostics - Waiting List size | 19634 | 18293 | 19768 | 20081 | 21039 | 22171 | 22550 | 21201 | 19823 | 19436 | 19874 | 20448 | 20320 |
| Elective care - Activity compared to 2019/20 | | 106.7% | 114.3% | 105.5% | 98.7% | 98.7% | 94.3% | 97.6% | 98.5% | 101.6% | 95.6% | 96.2% | 142.4% |
| RTT Elective care - >= 52 Weeks | 10497 | 11539 | 12770 | 13937 | 15132 | 16265 | 16922 | 16379 | 14441 | 13673 | 13790 | 14218 | 15824 |
| RTT Elective care - >104 Weeks (NHSi Criteria) | 18 | 19 | 13 | 5 | 3 | 0 | 0 | 0 | 3 | 4 | 3 | 4 | 0 |
| RTT Elective care - Clock Starts | 20858 | 16381 | 19690 | 21668 | 21975 | 21872 | 20956 | 22845 | 23179 | 17246 | 22556 | 21484 | 19448 |
| RTT Elective care - Clock Stops | 20325 | 15321 | 17754 | 19396 | 17906 | 19361 | 20542 | 23996 | 28246 | 18437 | 22931 | 21460 | 19925 |
| RTT Elective care - Waiting list size | 128876 | 131877 | 138882 | 145339 | 152152 | 154143 | 155091 | 152018 | 145668 | 143841 | 142481 | 141662 | 141173 |

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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.
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 significantly above target (which is to increase by 10% from a base of October 2021 to September 2023) with a year-end position of 7460 recruits. The increase is largely driven by high performance for the GBS3 study in the women's and children's division, and highly active specialties such as cancer, cardiology, infectious diseases and renal.

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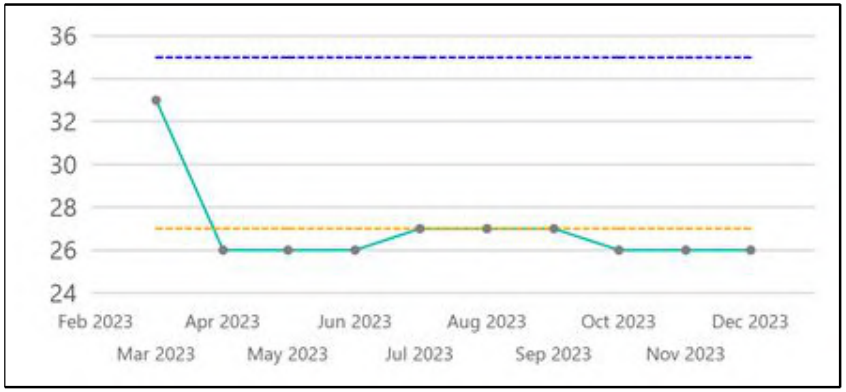
## True North

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

| Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 |
|---|---|---|---|---|---|---|---|---|---|
| 33 | 26 | 26 | 26 | 27 | 27 | 27 | 26 | 26 | 26 |

### Overview

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




### What the chart tells us

The chart shows the relative Trust rank in terms of study participation compared to other acute Trusts on a quarterly basis from national statistics from the NIHR website. Data for Q4 2023/24 shows 26th highest ranked trust.
This information is subject to change in retrospect, and is finalised on an annual basis, due to data lag for either UHSx or other trusts which can influence benchmark.

### Intervention and Planned Impact

The Trust has a new R&I Strategy.
We have appointed Divisional Research Directors to support the embedding of research. These roles will help to promote research in the division through divisional targeted research growth plans, reviews of workforce with research PAs or similar, and reviews of capacity to support research.
The development of divisional growth plans will be a key activity for Q1.
Prioritised work is underway to secure estates for the reprovision of the Clinical Research Facility on RSCH site which is essential to the growth in delivery of commercial clinical research.
Research activity data is now available to all through a dashboard.
R&I strategic workstream are also developing research communication and engagement approaches, research training and education and a programme supporting UHSx research groups and clinical academic career opportunities.
Partnership working is essential to the development of research collaborations and shared infrastructure. The Trust is a key partner in the Brighton and Sussex Health Research Partnership.

### Risks/Mitigations

No Data

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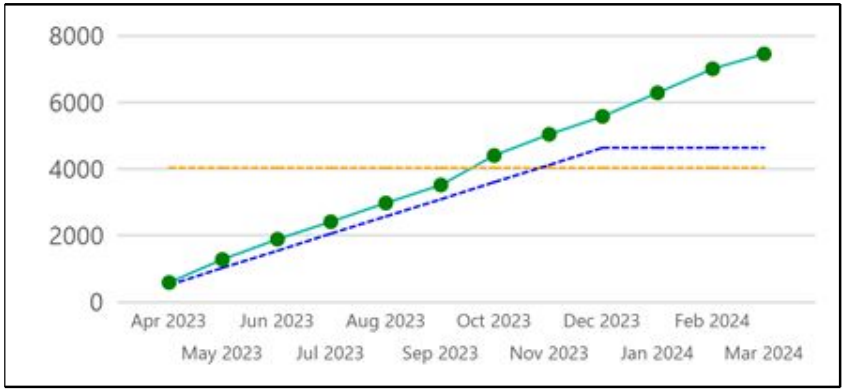
## Breakthrough

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 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 591 | 1284 | 1892 | 2417 | 2979 | 3521 | 4407 | 5043 | 5582 | 6290 | 7012 | 7460 |

### 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.

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R&I strategic workstream are also developing research communication and engagement approaches, research training and education and a programme supporting UHSx research groups and clinical academic career opportunities.

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| **Risks/Mitigations** |
| --- |
| Securing estates for the reprovision of the Clinical Research Facility to a high quality and accreditable standard is the key risk to delivering the Trusts R&I ambition. This is in the estates mater planning process and under Executive discussion – no final plan has been secured at this stage.<br>Workforce and service department capacity to deliver research is also a risk to the delivery of the Trust's research ambition – detailed work with Divisional Directors for Research will help to better clarify the risks and mitigations for each division and support services in Q1. |

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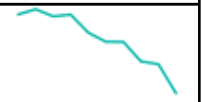
Watch Metrics for

Metric

| Oversight Metrics | | | | |
|---|---|---|---|---|
| Patient First Domain | Metric | Value | Target | Trend |
| People | Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score | 7.28 | 7.06 |  |
| Sustainability | Agency Spending - Agency Costs as a % of staff costs (3.7% target YTD) | 3.1% | 3.7% |  |
| Sustainability | Financial Stability - Variance from breakeven plan YTD | -14,952k | 0k |  |
| Sustainability | Financial efficiency - Variance from efficiency plan YTD | -9,130k | 0k |  |
| Quality | Clinical outcomes/effectiveness - SHMI equal to or less than 100 | 104.7 | 100.0 |  |
| Quality | HCAI - Number of hospital attributable C.diff cases (HOHA/COHA) | 20 | 3 |  |
| Quality | HCAI - Number of hospital attributable E.coli cases (HOHA/COHA) | 14 | 4 |  |
| Quality | HCAI - Number of hospital attributable MRSA cases (HOHA/COHA) | 2 | 0 |  |
| Quality | Safety - Reduction of 5% in preventable harm - UHSx approved | 758 | |  |

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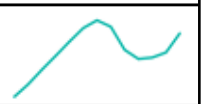
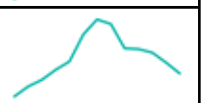
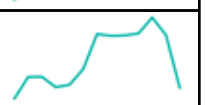
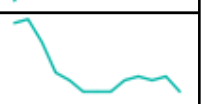
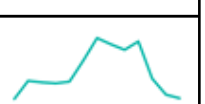
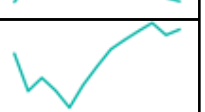
|---|---|---|---|---|
| Systems & Partnerships | Cancer - 28 day faster diagnosis standard | 73.13% | 75.00% |  |
| Systems & Partnerships | RTT Elective care - >= 52 Weeks | 15824 | 10573 |  |
| Systems & Partnerships | RTT Elective care - >=65 Weeks | 3658 | 3000 |  |
| Systems & Partnerships | Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment. | 326 | 0 |  |
| Systems & Partnerships | RTT Elective care - >104 Weeks (NHSi Criteria) | 0 | 0 |  |
| Systems & Partnerships | Cancer - Number of patients waiting over 62 days for treatment | 331 | 600 |  |
| Systems & Partnerships | A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments | 2881 | |  |

**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 oversight processes.
The lead for the oversight of the Trust's performance remains with the ICB (not NHSE) and the Trust provides assurance on its delivery of its annual plan.

**Drivers of the segmentation**
During Q4 the Trust has made significant progress in improving its cancer and RTT waiting list position and the Trust received a congratulatory letter from the National Director for Cancer Services. However, there was a deterioration in urgent and emergency care performance and the financial deficit was slightly more than planned.
The Trust remains in 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.
The Trust's Quality and Safety Improvement Programme (QSIP) includes teh development of the detailed improvement plans to deliver the undertakings which the Trust entered into with NHS England. Delivery of QSIP will contribute to an improved NOF segmentation.
The Board Assurance Framework reflects the continuing level of elevated risk across the delivery of the Trust's strategic objectives, including the domains of quality, people, performance and finance for quarter 4.

**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. This programme captures the specific concerns highlighted by the CQC, as reflected in the undertakings with NHSE. The undertakings in respect of operational performance and finance are overseen by the Trust's Finance and Performance Committee and are reported through the national Tiering meetings with NHS England (in respect of planned and cancer care).
To exit segment 3, the Trust will need to deliver its operating plan for 2024/225 along with delivery of QSIP.
Noting the continuation of the elevated levels of strategic risk the Trust does not anticipate exiting segment 3 over the next quarter (quarter 1 in 2024/25).

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| **Agenda Item:** | 7. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 02 May 2024 |
| **Report Title:** | NHSE Undertakings Progress Report | | | | |
| **Sponsoring Executive Director:** | Chief Governance Officer | | | | |
| **Author(s):** | Chief Governance Officer | | | | |
| **Report previously considered by and date:** | N/A | | | | |

| **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 | 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 | |
| People | Yes | |
| Patient & 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**

Yes

**Communication and Consultation:**

N/A

**Executive Summary:**

In the autumn of 2023, the Board entered into Undertakings on its licence with NHSE. The undertakings are focussed on a range of areas and required the Trust to have a comprehensive improvement plan.

The purpose of this paper is to confirm progress on developing that plan and identify how each element is assured through Trust governance.

The Trust has developed a Quality and Safety Improvement Programme (QSIP) that brings together its work to address the Undertakings and drive sustainable improvement. QSIP has the following workstreams:

- Improving Quality Governance, Risk Management and assurance
- Improving Access to Surgery
- Improving Safety Culture
- Well-Led
- Communications and Engagement (enabling workstream)

QSIP and each of its workstreams has an Executive Sponsor and a Director Senior Responsible Officer with Programme Management Office support. In addition, each workstream has developed its Key Performance

Indicators and delivery plans. The Chief Executive chairs the monthly Steering Group that oversees the progress of the programme.

The Trust has recently received feedback from NHSE and the ICB on its approach to the Undertakings is refining its approach appropriately. The Trust will also produce a document that sets out its approach and the progress being made in a readily accessible form.

External assurance and oversight are provided through the Quality Review Process led by the ICB and attended by NHSE.

To assure QSIP the Board has established a dedicated committee which meets each month.
The following table sets out where each element of the Undertakings is assured noting that the QSIP committee will draw on the assurances from the other committees so that it can assure progress against the Undertakings as a whole.

| **Undertaking** | **Committee for Assurance** |
|---|---|
| Development and delivery of a comprehensive improvement plan with Board level accountabilities, incorporating feedback from NHSE and any external reviews commissioned as part of its improvement work | Quality and Safety Improvement Programme |
| Delivery and assurance of priorities and actions in relation to all previous CQC inspection reports | Patient and Quality |
| Delivery improvement to four-hour performance and planned care | Finance and Performance |
| Engage and support staff in the improvement plan | Quality and Safety Improvement Programme |
| Transparent internal processes and reporting is available to provide staff with confidence to raise concerns | People |
| Ensure effective mechanisms for all staff to provide feedback and respond effectively to this feedback including staff survey, complaints, grievances, and whistleblowing concerns | People |
| Ongoing triangulation of the impact of improvement actions with wider quality metrics including patient and staff feedback, incidents and complaints | Patient and Quality |

| **Key Recommendation(s):** |
| --- |
| The Board is asked to note this report. |

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| **Agenda Item:** | 9. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 2 May 2024 |
| **Report Title:** | Quarter 4 BAF | | | | |
| **Sponsoring Executive Director:** | Chief Governance Officer | | | | |
| **Author(s):** | Company Secretary | | | | |
| **Report previously considered by and date:** | The Quarter 4 opening BAF risks were agreed by the Board at its meeting on 8 February 2024<br>Reported to the Audit Committee 18 April 2024<br>Reported to the respective oversight Committees in the week of the 23 to 25 April 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 the 2023/24 year.

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.

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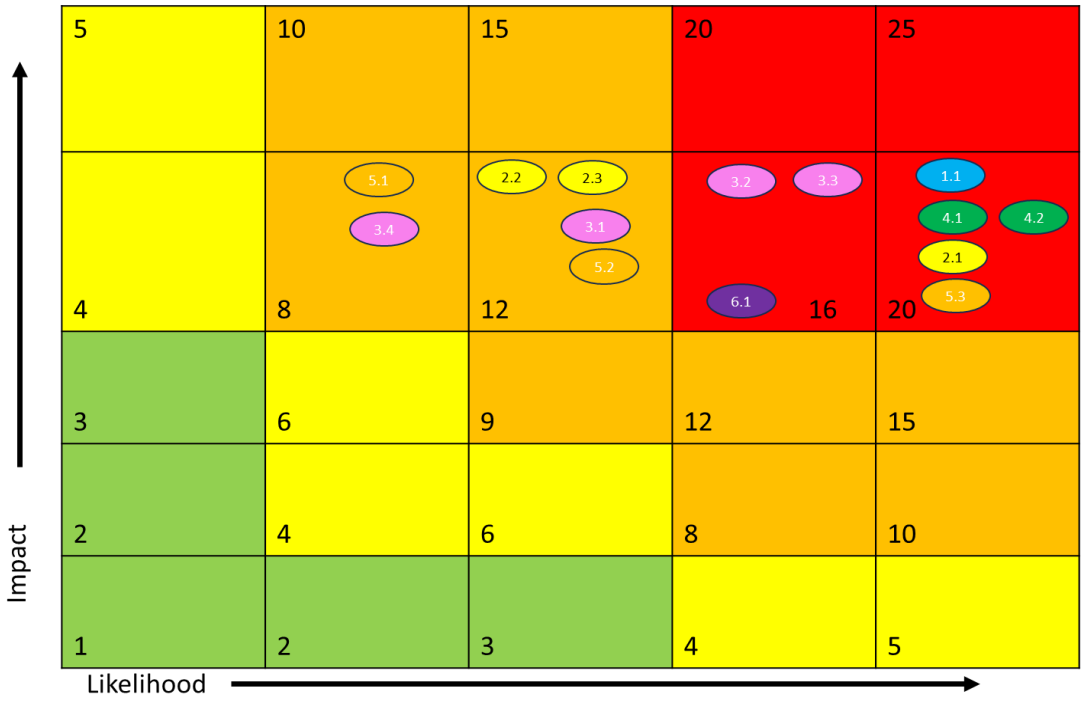
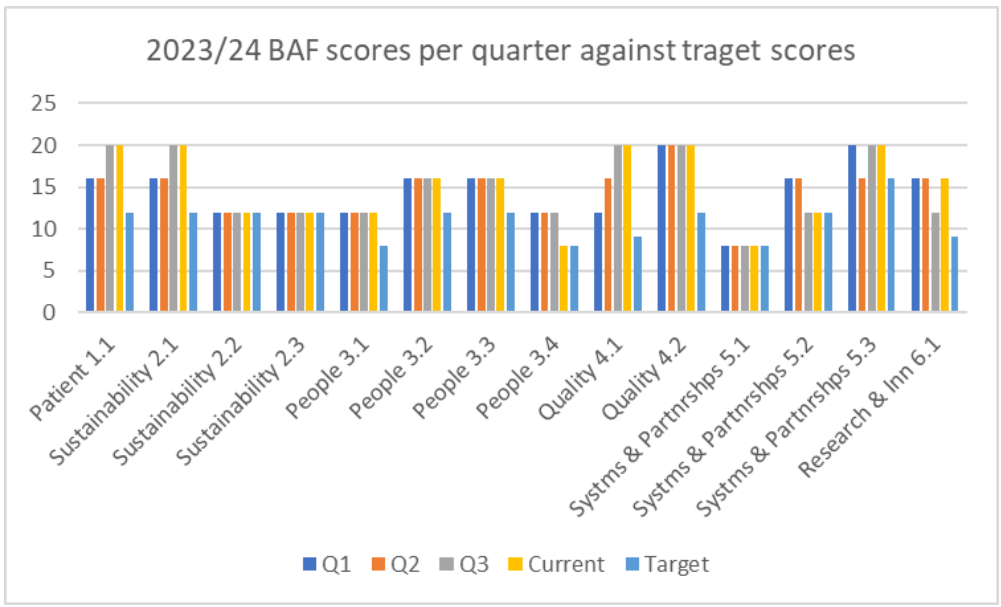
**For each of the 14 strategic risks the expected assurances have been received over the period of quarter 4 enabling a determination to be made as to the quarter 4 score.**




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

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




**Quarter 4 BAF risks**

**Overview**

The review of the BAF has shown that across quarter 4 the following:

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**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 and remained at that score for quarter 4,
- Sustainability risk 2.1 which increased in quarter 3 and remained at that score for quarter 4,
- People risks 3.1, 3.2 and 3.3 have not changed during the year,
- Quality risk 4.1 which increased in quarter 3 and remained at that score for quarter 4,
- 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 and remained at that score for quarter 4.
- Research and Innovation risk 6. reduced to its target score in quarter 3 but then increased for quarter 4.

**Across the year the Trust has seen an overall increase in the highest scored risks (scoring 20) by 3 across to five for the year and one risk scoring 16 reduce across the year. Across the year 6 risks did not record any change in their scores, 3 of which were at their target score for the year.**

The Trust has reviewed its strategic priorities and determined these remain valid and the Trust has approved its 2024/25 operational plan. Having undertaken these tasks a Board session is being planned for early May to review and agree the 2024/25 Strategic Risks which will then flow into an updated Board Assurance Framework document.

## Recommendations

The Board is asked to **NOTE** that the Board Assurance Framework processes including the requisite oversight by the allocated lead Board Committee have been applied across the year.

The Board is asked to **AGREE** the BAF risk scores for the year end, noting that none of the strategic risks have changed during this quarter as has been acknowledged by each respective Committee's review of their assigned strategic risks.

The Board is asked to **NOTE** that a session is planned for May to consider the 2024/25 strategic risks in the context of the recent review of the Trust's priorities and the approval of the Trust operational plan.

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.

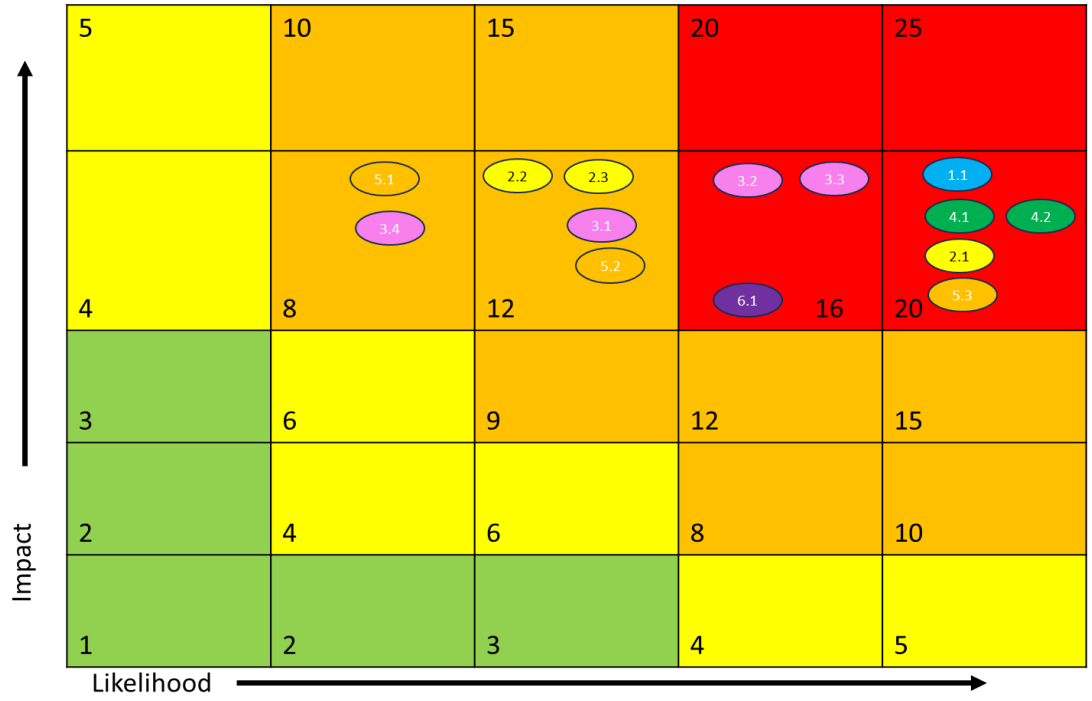
1.2 As in prior years each Strategic Risk has an Executive lead and is grouped within one of the Trust's six strategic domains with each domain being aligned to their respective allocated oversight Committee.

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

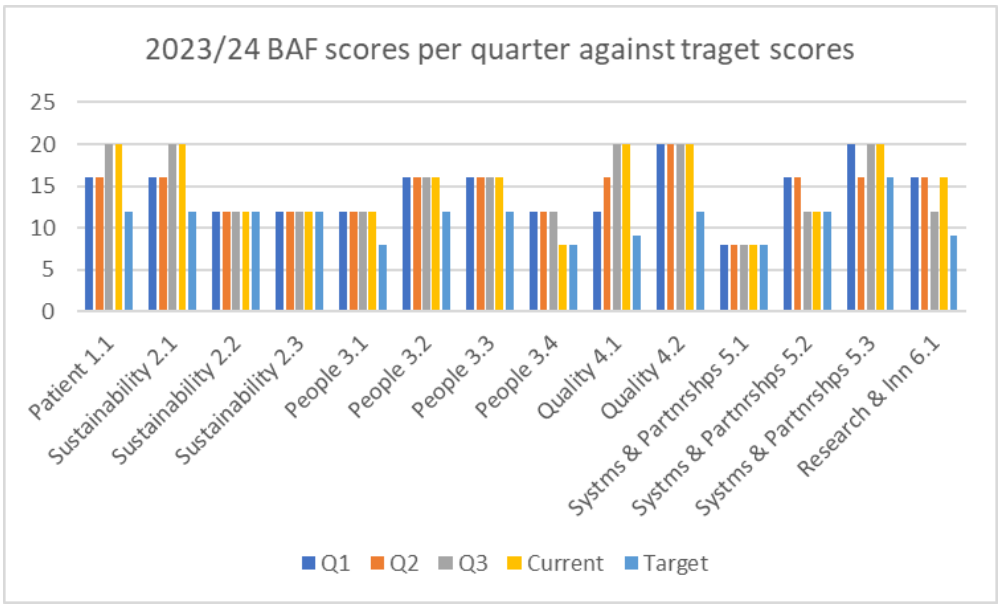
2.1 For each segment of the BAF the respective lead executive has considered their risks along with the supporting highly scored and corporate risks when determining the quarter 4 score, which have then been scrutinised by the respective oversight committee.

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




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

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 Movements across the year**

2.3.1 In Quarter 2, one risk increased in score and one risk reduced in score, these were:

- Quality – Risk 4.1 **increased from 12 to 16.** *We are unable to deliver safe and harm free care to reduce mortality and morbidity.* The Quality Committee considered the gap in assurance over the Trust's Clinical Effectiveness and Outcome processes and felt that given this gap in assurance it was prudent to increase this risk until robust systems of assurance are established.

- **Systems and Partnerships – Risk 5.3, reduced from 20 to 16.** *We are unable to deliver and demonstrate consistent compliance with the 23/24 operational plan and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties and the Trust's reputation*. Following a discussion at the Systems and Partnerships Committee the score was noted as reducing but that given any continuation of industrial action then there would be a low level of confidence that this risk will remain reduced.

2.3.2 In Quarter 3, four risks increased in score and two risks reduced in score, these were:

- **Patient – Risk 1.1 increased from 16 to 20**. *We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact, and poorer patient experience.* The Quarter 3 score increased to 20 and despite planned actions the delivery of the 2023/24 target score of 12 is at risk.

- **Sustainability – Risk 2.1 increased from 16 to 20**. *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*. As had been reported in quarter 2 there was low level of confidence that this risk will achieve its target score by the end of 2023/24 given the continuing significant number of external factors impacting this risk.

- **Quality – Risk 4.1 increased from 16 to 20**. *We are unable to deliver safe and harm free care to reduce mortality and morbidity*. This risk also increased in Quarter 2 and with the quarter 3 increase scored 20. Despite planned actions the risk is not going to meet its 2023/24 target score, this is the same for the other quality risk 4.2 which will not meet its 2023/24 target score.

- **Systems and partnerships – Risk 5.2 reduced from 16 to 12**. *We are unable to define and deliver the strategic intentions, plans and optimal configuration that will enable our services to be sustainable, leading to an adverse impact on their future viability.* Following the approval of the Clinical Strategy the development of the implementation plan is progressing to prioritise the delivery of the strategic intentions as laid out in the Strategy and therefore the risk reduced to 12 which saw the risk at its target score for 23/24.

- **Systems and Partnerships – Risk 5.3 increased from 16 to 20.** *We are unable to deliver and demonstrate consistent compliance with the 23/24 operational plan and NHS constitutional standards resulting in an adverse impact on patient care and financial penalties and the Trust's reputation.* Whilst ED improvement has been sustained at Worthing, Princess Royal and Royal Alex Children's Hospital sites but remains challenges at the Royal Sussex County and St Richard's Hospitals, RTT performance remained challenged as did delivery of the cancer recover trajectory.

- **Research and Innovation – Risk 6.1 reduced from 16 to 12**. *We are unable to fully harness research and innovation capacity and capabilities thus being unable to meet the Trust's stated ambition of being a high-class research organisation. This may impact on our ability to attract and retain staff and provide the highest quality of intervention for patients*. The risk has reduced to 12 as the R&I Strategy was approved and launched.

2.3.3 In quarter 4, one risk increased in score and one risk reduced in score, these were

- **People – Risk 3.4 reduced from 12 to 8.** *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.

- **Research and Innovation – Risk 6.1 increased from 12 to 16.** *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 Board supported by a recommendation at the Research and Innovation Committee 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.

**2.3.4 Across the year the Trust has seen an overall increase in the highest scored risks (scoring 20) by 3 across to five for the year and one risk scoring 16 reduce across**

**the year. Across the year 6 risks did not record any change in their scores, 3 of which were at their target score for the year.**

**2.4 FIVE risks achieved their 2023/24 target score, but it should be noted that all of these are above their longer term goal score, these were**

- **Sustainability – Risk 2.2** remained at its target score of 12 for the year, with assurance over the internal financial control provided to the Audit Committee over the year.

- **Sustainability – Risk 2.3** remained at its target score of 12 for the year, the planned assurance was provided through the Sustainability Committee. The target score of 12 was set recognising that work remains to develop deliverable trajectories for the required the carbon reduction targets.

- **People – Risk 3.4** work delivered across the year enabled the score to reduce in quarter 4 to its target score of 8. As was discussed at the Board and People Committee whilst assurance over the well being actions had been received there remain areas of the Trust where more work is needed to meet the staff wellbeing needs.

- **Systems and Partnerships – Risk 5.1** the score was reduced during quarter 2 to its target score of 8 reflecting the way the Trust has engaged with the system. The Board noted further work is needed to support the system to meet its aspirations.

- **Systems and Partnerships – Risk 5.2**. Following the approval of the Clinical Strategy and with the development of the implementation plan is progressing to prioritise the delivery of the strategic intentions the score was reduced in quarter 3 to its target score of 12. The target score recognised that further work would be needed through 2024/25 to realise the Clinical Strategy.

**2.4.1 Reduction in risk scores to meet their target score or oversight of assurance that target scores are maintained gives confidence that that the oversight of actions in respect of strategic risks is being applied.**

**2.5 NINE risks that exceeded their 2023/24 target score, with five of these scoring 20., these were**

- **Patient - Risk 1.1** this risk increased in score from quarter 3 where it was reported to the Patient and Quality Committee and accepted by the Board that the target score would not be achieved in the year.

- **Sustainability- Risk 2.1** this risk increased in score from quarter 3 where it was reported to the Sustainability Committee and accepted by the Board that a reduction in score would not occur during the remaining part of 2023/24 recognsing the level of level of external factors driving this risk.

- **People - Risks 3.1, 3.2 and 3.3** remained at the same scores, just above their target score all year. Regular reporting to the People Committee over actions being taken showed these where insufficient to reduce these risks.

- **Quality - Risk 4.1** this risk increased in quarter 3 where it was reported to the

Patient and Quality Committee and accepted by the Board that the target score would not be achieved in the year.

- **Quality - Risk 4.2** this risk score did not change during the year and during quarter 3 where it was reported to the Patient and Quality Committee and accepted by the Board that the target score would not be achieved in the year.

- **Systems and Partnerships - Risk 5.3** this score increased from its target score in quarter 3 reflecting the impact of continuation of industrial action was having on performance. Despite progress being made to mitigate reduced capacity during these periods it was accepted by the Board that the performance targets would not be achieved.

- **Research and Innovation - Risk 6.1** whilst reduced in quarter 3 to 12 it increased to 16 for recommendation by the R&I Committee to the Board recognsing the lack of an identified dedicated research facility may have on fulfilling the Trust's R&I strategy.

2.5.1 Where risks are exceeding their target score the respective oversight committee has sought information on the quality of the actions being taken and have in their report to the Board provided used this information when giving their view on the appropriateness of the risk score.

**3. Committee Review**

3.1 Each of the Board Committees during their meeting across 2023/24 considered the risks for which they have allocated oversight and provided a recommendation to the Board as to their relevant scores. Both the People Committee and Research and Innovation Committees recommended to the Board changes to the presented risks scores based on the discussions at the meeting.

3.2 The Sustainability, Systems and Partnerships and latterly the Finance and Performance Committee along with the Patient and Quality and Research and Innovation and here latterly the Research, Innovation and Digital Committees in receiving their routine reports have used these to agree that a number of strategy risks for which they have oversight not only increased during the year but were not likely to reduce during the latter part of the year. The Board agreed with these views.

3.3 The Audit Committee has within each of its quarterly meetings received and challenged this information to validate that the Board Assurance Framework processes have been applied appropriately.

3.4 **The oversight and reporting to the Board gives confidence that the oversight and review of strategic risks is dynamic along with that the effectiveness of the Committee focus on action delivery coupled with the receipt and review of assurances.**

3.5 Within the respective Committee meetings in April whilst reviewing the Strategic Risk scores to the end of the year they considered that the opening 2024/25 strategic risks scores as whole would still show areas of significant risk.

## 4 BAF Strategic Risk Summary

Below is a summary of the strategic risk reviews undertaken by the Executives, Risk Oversight Group and relevant Board Committees:

| Risk | Score | Assurance reports and dates last received | Supporting highly scored risks | Actions | Target Score (risk) |
|---|---|---|---|---|---|
| 1.1 | 20 | All expected sources of assurance have been provided to the Patient and Quality Committee.<br><br>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 across the year, latest assurance provided in April 2024 except for national surveys which were received in October 2023 and March 2024)***<br><br>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).<br><br>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 | 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 the issue of cold temperatures in certain wards lead to a reported poorer experience.<br><br>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 would not be achieved by the 31 March 2024. In quarter 4 this level of risk remained and therefore the risk was accepted by the Board as remaining significantly elevated and away from the target score. |

| Risk | Score | Assurance reports and dates last received | Supporting highly scored risks | Actions | Target Score (risk) |
|---|---|---|---|---|---|
| | | department at RSCH will also support improved experience. | | | |
| 2.1 | 20 | All expected sources of assurance have been provided to the Sustainability Committee and in April to the Finance and Performance Committe. 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 across the year with the latest assurance provided in April)***<br><br>This has been a mix of operational and executive assurance.<br><br>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 would not be achieved by the 31 March 2024. In quarter 4 this level of risk remained and therefore the risk was accepted by the Board as remaining significantly elevated and away from the target score. |
| 2.2 | 12 | All expected sources of assurance have been provided to the Audit Committee. T**he latest assurance was provided to the Audit Committee in it April meeting.**<br><br>These included; Tender waivers, losses and | There are a number of highly scored supporting risks covering operational pressures which are impacting on the consistent delivery of the Trust's established control. | Actions planned have been delivered to maintain the risk at it target score.<br><br>Improvement to the control environment continues including | The risk continued to meet its target score across the year. |

| Risk | Score | Assurance reports and dates last received | 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*<br><br>This has been a mix of operational, executive and through Internal Audit / LCFS external assurance. | Work is overseen at the Sustainability Committee and the People Committee for enhanced workforce development controls. | 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 | All expected sources of assurance have been provided to the Sustainability Committee and in April to the Finance and Performance Committee<br><br>These included the Environmental Sustainability SI report. ***(received across the year with the latest assurance provided to the Committee in April)***<br><br>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 continued to meet its target score across the year. |
| 3.1 | 12 | All expected sources of assurance have been provided to the People Committee over year.<br><br>These included, the People scorecard, the LCD reporting, the FTSU and guardian of safe working reports and HEE reports. ***(the latest assurance was received at the committee re LCD, FTSU and Guardian of Safe working in April and HEE reports received in Nov)*** | 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.<br><br>Assurance over the actions being taken to reduce the impact | Actions continue as improvements in capability and capacity take time and therefore the risk score has not yet reduced.<br><br>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 | 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 and the difficulties |

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| Risk | Score | Assurance reports and dates last received | Supporting highly scored risks | Actions | Target Score (risk) |
|---|---|---|---|---|---|
| | | The Trust has recruited to its senior leadership roles and reporting has been provided to the People Committee attention has turned to the delivery of training and development the senior leadership team.<br><br>This has been a mix of operational and executive assurance. | of these risks has been reported through the People Committee. | work through the Corporate Project enhancing leadership capacity and developing leaders' capabilities. | 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 | Expected sources of assurance have been provided to 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.<br><br>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 staff survey results. ***(the latest assurance was received in April relating to Staff Survey and People Scorecard, and those regarding WRES and WDES in January)*** | There are a number of highly scored supporting risks covering the stretch on staffing and staff capacity impacting of their engagement.<br><br>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.<br><br>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 would not achieved by the 31 March 2024. At quarter 4 this level of risk remains and therefore the risk did not achieve its target score. |
| 3.3 | 16 | Expected sources of assurance have been provided to the People Committee over year.<br><br>The Trust has strengthened the controls and visibility on the use of staffing using HeathRoster for the Agenda for Change | There are a number of highly scored supporting risks reflecting the divisional challenges in recruiting staff, aligning staff to increasing service demands and the | There are plans to deploy systems to allow similar central oversight of the medical workforce, improvements are being delivered under the respective corporate project | As reported at quarter 3 there was an elevated risk that the 2023/24 target score of 12 would not be achieved by the 31 |

| Risk | Score | Assurance reports and dates last received | Supporting highly scored risks | Actions | Target Score (risk) |
|---|---|---|---|---|---|
| | | workforce.<br><br>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. ***(the latest assurance was received in relating to Staff Survey and People Scorecard, in April and regarding WRES and WDES in January)*** | 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).<br><br>Assurance over the actions being taken to reduce the impact of these risks has been reported through the People Committee. | 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.<br><br>The Trust is also seeking to tackle retention with its activities to improve staff experience. Further international recruitment is underway.<br><br>Through the electronic workforce deployment project their a number of to enhance the central oversight of the medical workforce. | March 2024. At quarter 4 this level of risk remains and therefore the risk did not achieve its target score. |
| 3.4 | 8 | The expected sources of assurance have been provided to 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 staff survey results show improvement in the staff's view of the Trust's support offerings. . ***(the latest assurance was received at the committee re Staff*** | 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. Improvements in basic systems for rostering and supporting | Acton has been taken to improve health and wellbeing activities for staff and there was confidence from the reports received and the improvements made to the established systems of |

| Risk | Score | Assurance reports and dates last received | Supporting highly scored risks | Actions | Target Score (risk) |
|---|---|---|---|---|---|
| | | ***Survey in March, EDI, FTSU and Guardian of Safe working in April and HEE reports received in Nov)***<br><br>These have been a mix of operational and executive assurance. | | 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. | internal control that enabled the risk to reduce in quarter 4 to its target score. |
| 4.1 | 20 | Expected sources of assurance have been provided to the Patient and Quality Committee over year.<br><br>These included, Safe Staffing report (nursing), Incident reports, DoC compliance reporting, QIA reporting, Quality Scorecard, Quality risk reporting, Clinical Coding review and Harm reviews. ***(the latest assurance was received at the committee in April, the clinical coding review which was in March / April 23. Safer staffing was reported to the Board directly in February. There was a gap in assurance in relation to harm reviews and SJRs supporting the learning from deaths process which was taken into account when considering the assurance and confidence regarding the risk score )***<br><br>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 | 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.<br><br>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 would not be achieved by the 31 March 2024. In quarter 4 this level of risk remained and therefore the risk was accepted by the Board as remaining significantly elevated and away from the target score. |

| Risk | Score | Assurance reports and dates last received | Supporting highly scored risks | Actions | Target Score (risk) |
|---|---|---|---|---|---|
| | | 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 patients with primary mental health care requirements.<br><br>These have been a mix of operational, executive and via the CQC external assurance. | | | |
| 4.2 | 20 | Expected sources of assurance have been provided to the Patient and Quality Committee over year.<br><br>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. ***(the latest assurance was received at the committee in April, except MSSP which was in April 2023. Safer staffing was reported to the Board directly in February. There was a gap in assurance in relation to harm reviews and SJRs supporting the learning from deaths process which was taken into account when considering the assurance and confidence regarding the risk score )*** | 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 | 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.<br><br>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 would not be achieved by the 31 March 2024. In quarter 4 this level of risk remained and therefore the risk was accepted by the Board as remaining significantly elevated and away from the target score. |

| Risk | Score | Assurance reports and dates last received | Supporting highly scored risks | Actions | Target Score (risk) |
|---|---|---|---|---|---|
| | | These have been a mix of operational, executive and via the CQC external assurance.<br><br>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. | to CTs within ED at RSCH and meeting the NHS E standards for dealing with aortic aneurysms.<br><br>Assurance over the actions being taken to reduce the impact of these risks is reported through the e Patient and Quality Committee and the Trust's operational Quality and Safety Steering Group. | | |
| 5.1 | 8 | Sources of assurance has been primarily provided to the Systems and Partnerships Committee and in April to the Finance and Performance Committee, but each Board Committee also received reports on the work of the Trust within the ICS.<br><br>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. ***(the latest assurance was received at the committee in April with the clinical strategy reported 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 continued to meet its target score. |
| 5.2 | 12 | Sources of assurance has been provided to the Systems and Partnerships Committee and in April to the Finance and Performance Committee and the Patient and Quality Committee on the Trust's clinical strategy development and impact on its delivery on performance. ***(the latest assurance was*** | 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.<br><br>There are a series of actions being taken to deliver the | The risk continued to meet its target score. |

| Risk | Score | Assurance reports and dates last received | Supporting highly scored risks | Actions | Target Score (risk) |
|---|---|---|---|---|---|
| | | ***received at the committee in April with the clinical strategy reported via quality committee)***<br><br>This assurance was provided by executive reports. | | intentions defined within the Strategy to meet the longer term goal score. | |
| 5.3 | 20 | Sources of assurance were provided to the Sustainability Committee and Systems and Partnerships Committee and in April to the Finance and Performance Committee 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 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.<br><br>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. ***(the latest assurance was received at the committee in April regarding operational performance delivery, with the ICS update at January and the 2024/15 operational planning challenges at the Board in March)*** | 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 along with the impact of industrial action on capacity and increased backlogs for treatment.<br><br>Assurance over the actions being taken to reduce the impact of these risks has been reported through the Systems and Partnerships Committee. | The Trust has entered tier 1 (national) oversight for both elective and cancer performance and has developed the corresponding action plans. The delivery of 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. | The ability to achieve the target score was impacted by the resumption of industrial action and remained elevated in quarter 4 therefore this is risk did not achieve its target score by the end of 23/24. |
| 6.1 | 16 | Sources of assurance has been provided to the R&I Committee which had oversight of the Research and Innovation breakthrough | There are risks to divisional capacity to develop the strategy delivery plan to grow the | Through the R&I Committee assurance will be secured over the development of the strategy | This risk for quarter 4 has increased back to 16 based on the |

| Risk | Score | Assurance reports and dates last received | Supporting highly scored risks | Actions | Target Score (risk) |
|---|---|---|---|---|---|
| | | objective to increase research participation which has reflected that this has been sustained above the Trust's established target<br><br>There has been a mix of operational and executive assurance, including that through the R&I Programme reporting processes. ***(the latest assurance was received at the committee in April)*** | capacity for research growth, along with the ability to develop the Trust estate to support research. | 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. | Research and Innovation Committee's view of the potential impact on the delivery of the R&I strategy by not having a dedicated research space. |

## 5 Conclusion

5.1 The BAF across 2023/24 continued 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) also included assurances from external sources, including FFT, internal and external audit and an external coding audit.

5.2 The respective Board Committees and the Executives continued to oversee their allocated strategic (BAF) key risks aligned to their patient first domain and provided reports to the Board providing their recommendations on the risk score.

5.3 The reporting through the Committees and to the Board provide confidence that the Trust processes have remained effective with dynamic review of these risks across the year, evidenced in part by the movements during the year.

5.4 The Board received at it workshop in March 2024 an update on the review of the 2024/25 strategic priorities where it was agreed these would remain unchanged with a fuller review being undertaken during 2024/25. Following the approval of the 2024/25 operational plan, a Board session is being planned for early May to review and agree the 2024/25 Strategic Risks which will then flow into an updated Board Assurance Framework document.

## 6 Recommendation to the Board

6.1 The Board is asked to **NOTE** the Trust's BAF processes have been applied as intended across 2023/24 with reporting to the oversight Committees at each of their main quarterly meetings and with the Committee chairs reports to Board providing assurance of their oversight and a recommendation in respect of the scores for each of their allocated risks.

6.2 The Board is asked to **NOTE** that NINE risks did not achieve their target score and for the FIVE risks that did achieve their target scores none of these were achieving their longer term goal score.

6.3 The Board is asked to **AGREE** the BAF risk scores for the end of the year 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.

6.4 The Board is asked to **NOTE** that a session is planned for May to consider the 2024/25 strategic risks in the context of the recent review of the Trust's priorities and the approval of the Trust operational plan.

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## APPENDIX 1

### BAF Summary

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

| BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total) | Risk Scores | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2023/24 Q1 | | | 2023/24 Q2 | | | 2023/24 Q3 | | | 2023/24 Q4 | | | 2023/24 Target | | |
| | I | L | T | I | L | T | I | L | T | I | L | T | I | L | T |
| **1 Patient** ***(Oversight provided by the Patient & Quality Committee)*** | | | | | | | | | | | | | | | |
| 1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in adverse reputational impact, and poorer patient experience | 4 | 4 | **16** | 4 | 4 | **16** ⟷ | 4 | 5 | **20** ↑ | 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 in Public | **Meeting Date:** | 2 May 2024 |
| **Report Title:** | **Annual Plan Submission 2024 to 25** | | | | |
| **Sponsoring Executive Director:** | Roxanne Smith, Chief Strategy Officer | | | | |
| **Author(s):** | Oliver Phillips, Director of Strategy & Planning | | | | |
| **Report previously considered by and date:** | Trust Board 25 April<br>Finance & Performance Committee 25 April | | | | |

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

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

| **Link to ICB / Trust Annual Plan** | | | |
|---|---|---|---|
| Link to ICB Annual Plan | Yes | Link to Trust Annual Plan | Yes |

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

| **Link to CQC Domains:** | | | |
|---|---|---|---|
| Safe | Yes / N/A | Effective | Yes / N/A |
| Caring | Yes / N/A | Responsive | Yes / N/A |
| Well-led | Yes / N/A | Use of Resources | Yes / N/A |

**Regulatory / Statutory reporting requirement**

Board sign off required of our submission to statutory ICB Annual Plan.

**Communication and Consultation:**

Developed with input from across the Trust. Final plan will be presented to Public Board 2nd May.

**Executive Summary:**

2024/25 will be an important and challenging year for UHSussex as we continue to improve performance, quality and our estate across the Trust, while working within limited budgets and workforce constraints.

The Board is asked to approve our Capital Plan for 2024/25 to the Board, representing c£64m of investment in digital, our estate, and medical equipment.

The Board is asked to note our contribution to the NHS Sussex submission to NHSE for revenue, activity and workforce. We are working within nationally-set timescales and constraints. We expect final approval in May/June.

Our plans for 2024/5 are ambitious for the difference we will make to patients, including:

- Reducing the waiting time for non-urgent patients down to a maximum of 65 weeks
- Ensuring that at least 78% of patients attending our A&E departments are seen within 4 hours of arrival

- Opening phase 2 of the successful Community Diagnostic Centre at Southlands Hospital
- Developing a new Urgent Treatment Centre at Worthing Hospital
- Continuing the redevelopment of the Emergency Department at the Royal Sussex County Hospital
- Starting construction of a Hyper-Acute Stroke Unit at St. Richard's Hospital

**Key Recommendation(s):**

The Board is asked:

1. To approve the UHSussex Capital investment plan for 2024/25.
2. To note the UHSussex contribution to the NHS Sussex operational plan, and associated risks and actions. The Trust submission to the ICB was approved by the Board on 25 April 2024. The full Sussex system plan will now be reviewed by NHS England.

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# Trust Capital Plan 2024/5

# Trust Operational Planning and NHS Sussex System Plan – Update

**2nd May 2024, Trust Board**

**Karen Geoghegan, CFO**
**Oliver Phillips, Director of Strategy and Planning**

# Purpose of paper

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The Board is asked:

1. To approve the UHSussex Capital investment plan for 2024/25.
2. To note the UHSussex contribution to the NHS Sussex operational plan, and associated risks and actions. The Trust submission to the ICB was approved by the Board on 25 April 2024. The full Sussex system plan will now be reviewed by NHS England.

# Summary

University Hospitals Sussex NHS Foundation Trust

- 2024/25 will be an important and challenging year for UHSussex as we continue to improve performance, quality and our estate across the Trust, while working within limited budgets and workforce constraints.
- Today, the Board is asked to approve our Capital Plan for 2024/25 to the Board, representing c£64m of investment in digital, our estate, and medical equipment.
- The Board is asked to note our contribution to the NHS Sussex submission to NHSE for revenue, activity and workforce. Here we are working within nationally-set timescales and constraints. We expect final approval in May/June.
- Our plans for 2024/5 are ambitious for the difference we will make to patients, including:
  - Reducing the waiting time for non-urgent patients down to a maximum of 65 weeks
  - Ensuring that at least 78% of patients attending our A&E departments are seen within 4 hours of arrival
  - Opening phase 2 of the successful Community Diagnostic Centre at Southlands Hospital
  - Developing a new Urgent Treatment Centre at Worthing Hospital
  - Continuing the redevelopment of the Emergency Department at the Royal Sussex County Hospital
  - Starting construction of a Hyper-Acute Stroke Unit at St. Richard's Hospital

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# UHSussex Capital Plan 2024/25

To approve

## Development and Governance

The Capital plan has been developed in partnership with clinical and operational colleagues as well as director leads for Estates and Digital.

The prioritisation of limited capital resources has been undertaken to reflect the Trust's key risks, prior year commitments and key deliverables for the operational plan.

The plan is designed to be dynamic and respond to any emerging priorities in year as well as to be able to respond to opportunities to secure additional capital funding for specific schemes.

The plan is currently over-programmed by £12m (20%) to reflect normal expectations of slippage in year in order to ensure meeting the capital resource limit which has been set.

The Capital Plan has been presented and approved at the following cross trust governance meetings:

- Capital Investment Group (CIG) – 15th April
- Trust Management Committee – 18th April
- Finance and Performance Committee – 25th April

New projects for the Capital Plan will be required to go through the appropriate level of governance, including production of a business case where appropriate.

Oversight and accountability for delivery of the capital programme is governed by the Capital Investment Group chaired by the CFO.

# Source of funds

Total secured/unsecured funds is **£63,964k**, including:

- Operational capital (**£48,399k**): including Internally generated capital resources (net of loan repayments), and ring-fenced funding for the RSCH Acute Floor;
- PFI life cycle funding (**£2,277k**);
- Unsecured strategic capital (**£6,393k**) associated with the delivery of Stages 2 and 3 of the 3T's new hospital programme;
- Digital Schemes (**£6,660k**) associated with prioritised investments, including Electronic Patient Records (EPR), Order Comms, and LIMS;
- Unsecured charitable funding (**£235k**) mainly associated with the procurement of medical devices.

| Source of Funds | Trust Board Plan £'000 |
|---|---|
| *Operational Capital funding (ICS CDEL)* | |
| Depreciation (Excl 3Ts) | 49,707 |
| Capital Loan Repayments | (3,740) |
| ED Floor RSCH | 13,000 |
| CDEL Allocation Adjustment | (10,818) |
| Additional brokered CDEL | 250 |
| ICS CDEL Sub-total: | 48,399 |
| PFI funding | 2,277 |
| ICB CDEL Total: | 50,676 |
| *Strategic capital (Secured)* | |
| *Strategic capital (Not Secured)* | |
| 3Ts Stage 2 - PCSA and Site Clearance Works | 6,393 |
| 3Ts Stage 2 - Construction | - |
| Strategic Capital Total: | 6,393 |
| *PDC Ringfenced Funding Sources (Secured)* | |
| Electronic Patient Records (EPR) - deferred from 2023/24 | 445 |
| Electronic Patient Records (EPR) | 3,575 |
| Order Comms | 1,657 |
| LIMS programme delivery | 983 |
| *PDC Ringfenced Funding Sources (Not Secured)* | |
| PDC Ringfenced Total: | 6,660 |
| *Charitable Funding (Secured)* | |
| Trust Charity and Hypothecated Funds | |
| Partner Charities | |
| *Charitable Funding (Not Secured)* | |
| Trust Charity and Hypothecated Funds | 235 |
| Partner Charities | |
| Charitable Funds Total: | 235 |
| Total Sources of Funds PLAN | 63,964 |
| *In-Year Adjustments* | |
| Sub Total: | - |
| Total Source of Funds: | 63,964 |

# Application of funds

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The corporate teams have worked closely with clinical colleague in determining priorities given the limited resources. Divisions were asked to focused on mission critical investments such as required for statutory or regulatory compliance.

With respect to medical devices, each clinical division has worked within an affordability envelope. Medical equipment priorities have been reviewed and approved by the Trust's clinically led Medical Devices Group (MDG) and including key stakeholders such as Infection Prevention and Control and EBME.

The methodology for assessing and prioritising estates investment follows that described by NHS Estates "A Risk Based Methodology for Establishing and Managing Backlog". This approach follows a tried and tested method in use by many NHS organisations.

IM&T investments were prioritised by the CIO and senior leadership team. The investments reflect the commitments agreed in the EPR business case approved by the Board in 2023. Additional schemes reflect associated digital priorities and management of risk against cybersecurity and data centre resilience.

All projects will require a business case approved at the appropriate level of governance to progress.

| 2024/25 Capital Plan (by workstream) | No of Investments | Investments £'000 |
|---|---|---|
| Strategic capital (3T's Stages 2 and 3) | 1 | (6,393) |
| Ring-fenced Digital investments (PDC) | 4 | (6,660) |
| Previously approved investments (c/f from 2023/24) | 10 | (28,812) |
| Costed divisional priorities (incl. service developments) | 13 | (6,391) |
| Medical equipment (incl. £1.0m contingency) | 100 | (5,996) |
| Critical Estates infrastructure (incl. £0.75m contingency) | 55 | (10,470) |
| IM&T infrastructure and systems | 22 | (8,966) |
| Charitable funded investments | 7 | (235) |
| Capitalised Salaries | 1 | (500) |
| PFI | 1 | (2,277) |
| Capital Programme Total: | 223 | **(76,700)** |
| Source of Funds: | | 63,647 |

# Key investments 24/25

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Key Capital investments planned for 2024/25 include.

| | |
|---|---|
| - Digital Schemes | £15.6m |
| - Urgent Treatment Centre (and SDEC Unit) WGH | £5.4m |
| - Acute Floor Redevelopment (£48.0m over 4-years) RSCH | £13.0m |
| - Hyper Acute Stoke Ward at SRH | £4.6m |
| - Community Diagnostics Centre (Phase 2) at Southlands | £3.5m |
| - Bi-Plane Suite (LMB theatre 6)  RSCH | £0.8m |
| - Dispensing Pharmacy (Pharm @Sea)  PRH | £0.5m |
| - Worthing Heat Network (£2.0m over 2-years)  WGH | £0.5m |
| - Critical Estates Infrastructure | £10.5m |

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# Trust Operational Planning and NHS Sussex System Plan – Update

- To note
- Approved by Trust Board, 25 April 2024

# Introduction

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- The Trust's operational budget and targets for 2024/25 will be set as part of the **NHS Sussex operational plan** for the Sussex Integrated Care System.
- We are working to nationally set timelines, and to NHSE's National Planning Guidance for 2024/5, which was published on 27 March 2024.
- 2024/25 will be an important and challenging year for UHSussex and the wider Sussex system, as we continue improve performance while working within the significant recovery targets and constrained finance and workforce position set by national Government.
- We have been working with partners across the system, and within the Trust, to contribute to the NHS Sussex plan. Our submission balances the need to continue to improve performance and quality across the Trust, while working within limited budgets and workforce constraints.
- System plans are now to be reviewed by NHSE, and we will update the Board on the final position when available. It is possible that we may be asked to make further changes, particularly to reduce the Sussex system deficit, by national government
- **This updates summarises the key elements of our submission, and the actions we are taking to ensure that our commitments are deliverable in 2024/25.**

# NHS Sussex Planning Priorities

***A detailed review of the performance and outcomes delivered by the Sussex system was undertaken across a range of measures in order to identify those areas we should prioritise as a system when faced with making choices about use of constrained resources. This have been used to guide decision making through the planning round***

## National Must dos for 24/25

1. Maintaining and building upon the increase in and **optimisation of core UEC capacity** established in 2023/24;
2. Complete agreed investment plans to increase **diagnostic and elective activity, reduce waiting times and PTL size;**
3. Maximise the gain from the investment in **primary care in improving access for patients;**
4. Focus on recovering our core service delivery and **productivity;**
5. Target a reduction in the cost of **temporary staffing**;

## Population Priorities

6. **Growing and ageing population** - As a proportion of the Sussex population, the aged 65+ cohort is forecast to rise from 23.2% in 2023 to 29.5% by 2043Lower % of population healthy/well, **higher % LTCs an higher % frailty**
7. Health Inequalities – significant difference in life expectancy between least and most deprived. 2,709 excess deaths due to **deprivation** (2020 to 2021)
8. Higher than England average prevalence for **hypertension, Cancer and CHD.**

## Health Inequalities

9. Address areas for clinical improvement (Adul**t)**

**a) Cardiovascular Health** Hypertension and Lipid management.

**b) Respiratory Health** – smoking cessation and TDT and

**c) Early Diagnosis**: cancer screening uptake

10. Address areas for clinical improvement: Children**:**

**a) asthma, diabetes, epilepsy, mental health and oral health.**

**b) CYP elective waiting times.**

**11) Embed personalised care:** Enabling ICTs to support patients cope with the wider determinants which impact health. (Older people key recipients)

## Performance Outliers

12. Total patients waiting more than **65 weeks** to start consultant-led treatment
13. Proportion of patients meeting the **faster cancer diagnosis** standard
14. **Access rates to community mental health** services for adult and older adults with severe mental illness
15. **Physical Health Checks** for SMI
16. Adult general and acute type 1 **bed occupancy** (adjusted for void beds)
17. Percentage of beds occupied by patients who **no longer meet the criteria to reside**
18. **Length of stay –** bed days per weighted pop**.**

## Quality and Clinical Outliers

19. % of patients identified as having 20% or greater 10-year risk of developing **CVD** are treated with statins (S053c)
20. Methicillin-resistant Staphylococcus aureus (**MRSA)** bacteraemia infection rate
21. **E. coli** bloodstream infection rate
22. **% of patients (between the age of 12-55yrs) prescribed valproate where that prescribing is in accordance with the Pregnancy Prevention Programme**

*Quality and clinical areas contained in the other pillars have not been repeated here.*

# Performance and Access Targets

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- National Planning Guidance was published on 27 March 2024, which set out the National expectations for the NHS across a range of quality and access targets.
- The Trust has been working closely withing the Integrated Care Board, and with other Providers in Sussex to develop plans which achieve these targets within our financial allocation
- The headline targets which most impact on UHSussex are in the table below

| Area | National Targets for 2024/25 |
|---|---|
| **Elective Care** | Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties) |
| **Cancer** | Improve performance against the headline 62-day standard to 70% by March 2025 |
| | Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026 |
| **Diagnostics** | Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% |
| **Urgent & Emergency Care** | Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025 |

# Performance and Access Targets: How UHSussex will deliver these targets

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| Area | Our Plans |
|---|---|
| **Elective Care** | • The Trust has submitted a plan which achieves a maximum wait of 65 weeks, to be achieved by September 2024<br>• Our plans make improved use of plain time theatre and outpatient capacity to reduce waiting times<br>• There will also need to be system wide support from other Providers, including the independent sector, to achieve this target. |
| **Cancer** | • The Trust has submitted a plan which:<br>  • increases the percentage of patients seen within 28 days of diagnosis to 77% by March 2025 (currently 73.2%)<br>  • increases the percentage of patients seen within 62-days to 70% by March 2025 (currently 55.6%)<br>• This will be achieved through targeted interventions for Breast care, Dermatology, Urology, and Gynaecology |
| **Diagnostics** | • The Trust will seek to ensure that 92% of patients wait under 6 weeks for diagnostic tests, up from the current performance of 70%<br>• The Trust has developed plans to improve performance, including using increased capacity through the Community Diagnostic Centres, to help achieve this.<br>• However, there will also need to be system wide support from other Providers, including the independent sector, to achieve this target |
| **Urgent & Emergency Care** | • The Trust will seek to ensure that at least 78% of patients are seen at our A&E departments within 4 hours of arrival by March 2025<br>• Significant improvements can be achieved through planned improvements in internal hospital flow.<br>• There is a need to improve our flow in and out of the hospital in order to significantly reduce our bed occupancy to achieve this target, working with our Mental Health, Community and Social Care partners. This will require system action, including a reduction in the number of patients who are in acute beds but are medically ready for discharge |

# Quality Improvement

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**In 2024/5 our Quality and Safety Improvement Programme will continue to be core to our Operational Plan. This:**

- Makes clear and understood all the standards and expectations, including those required by our regulators – across all the domain of standards, policy, performance, practice, measurement, risk management and assurance
- Understands the extent to which our policy framework reflects the regulations and standards we are required to uphold, the extent to which we are compliant with those standards, and the evidence
- Enables assurance and oversight – making clear who is expected to do what, when and to create the means through which this is reported, overseen and assured
- Will deliver new capabilities to enable quality and safety delivery and compliance.

**Examples of what we are doing**:

- A new clinical dashboard including audits of falls, pressure damage, nutrition, IPC and more
- A compliance and assurance framework identifying by division the level of compliance with the new CQC framework
- A programme of clinical assurance visits led by senior clinical teams to appraise quality practice against expected standards
- Improvements in surgical pathways and access, including response to Royal College of Surgeons' report
- Patient safety incident response framework implementation

# Trust submission – Finance and Efficiency

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- The Trust currently forecasts a **deficit** for 2024/25 of **£39.9m.**
- This includes work to identify **5% efficiencies across the total** Trust cost base; equating to £75m. A full programme of work is in place to identify these efficiencies whilst maintaining quality and patient care.
- A significant increase in productivity is assumed in order for the efficiency programme to be achieved and to ensure delivery of performance targets.
- An enhanced control environment is in place and further strengthening of control measures may be required.

# Final Core Gap (as at 19/04/2024)

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| | £m | £m |
|---|---|---|
| **Core Gap Do Nothing (surplus) / deficit** | | 188.766 |
| LMB income | (24.00) | |
| Capacity Funding Grant | (7.35) | |
| MRD Funding | (6.14) | |
| | | (37.483) |
| ERF Fixed income | (12.00) | |
| ERF variable - uplift to 105% | (10.00) | |
| NR element of COVID PCR test funding | (0.57) | |
| | | (22.567) |
| Income Mitigations | | (60.050) |
| **Core Gap Do Something (surplus) / deficit pre-efficiency** | | **128.716** |
| Efficiency target in MTFP | | (60.019) |
| Additional efficiency | | (15.000) |
| Remove general excess inflation | | (8.758) |
| CNST allocation change | | (0.049) |
| Non-recurrent ERF benefit 23/24 | | (5.000) |
| **Final Plan** | | **39.890** |

**The final core gap is a Trust deficit of £39.9m** (System £79m deficit).

- The £5m improvement is non-recurrent ERF income earned in 23/24, but not yet secured, is allocated and used to support an improvement in the deficit plan.
- This approach has been agreed with the ICB but remains a risk until NHSE confirm treatment in 24/25 baselines / targets.

**Key drivers of the deficit**

- underlying deficit – excess cost of inflation 22/23 and 23/24, premium rate card, shortfall on pay award funding, recurrent efficiency shortfall, LMB income support shortfall, extended bed base, MH specialling and increase in block drugs costs.
- tariff impact is an overall net deflator (£5.2m); coupled with a minimum expectation 1.1% efficiency (£12.7m) and an updated convergence factor (£12.0m).

# Workforce

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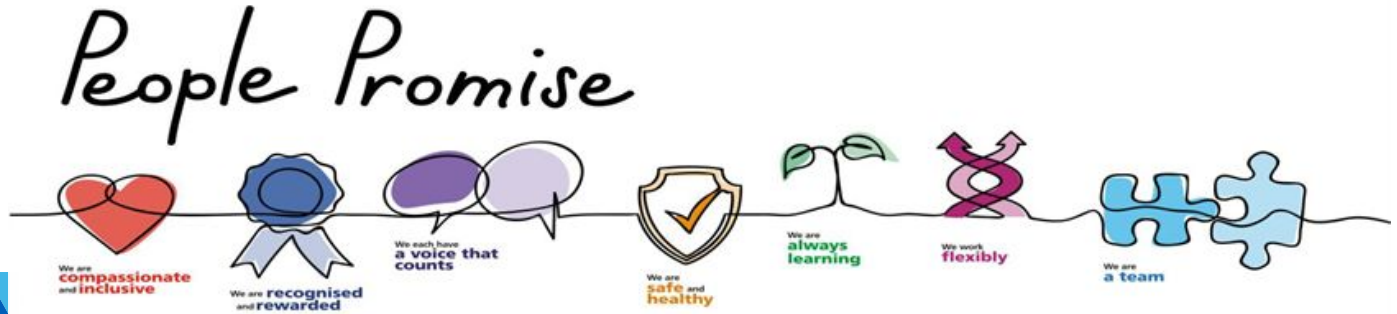
- The Trust is committed to the NHS People promise and to supporting our workforce and their development. Our workforce plan for 2024/25 maintains this commitment, notwithstanding a requirement for reduction in workforce spend.

- An efficiency saving of 5-6% of current staffing costs would release c£58m (the remainder of the Trust's overall £75m efficiency target being from reducing non-pay costs). We propose to make these savings principally by reducing spend on high-cost agency staffing, less need for escalation staffing through improved patient flow, reducing sickness absence and establishment/staffing reviews.

- Divisional workforce plans to support this are in development and include 10 key lines of enquiry including sickness and turnover, workforce diversification, expanding trainee doctor capacity, roster optimisation, and culture and values.



# Annual Plan: High-level Risks and Mitigations

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| There is a risk that.. | Impact of risk occurring | How the Trust is planning to mitigate the risk |
|---|---|---|
| There is insufficient internal and external capacity to achieve a maximum 65 week wait by the end of September | Patients wait for treatment for longer than they should, resulting in sub-optimal care and experience | Continue to work closely with Divisional teams to maximise the capacity available internally in plain time<br>Ensure through the ICB and other providers there is sufficient capacity externally to bridge the capacity gap |
| The Trust does not manage to improve the A&E performance target of 78% by March 2025 | Unwell patients wait longer than they should in our A&E departments, resulting in sub-optimal care and experience | Implement the key actions on improving flow internally<br>Ensure through the system that there is a sufficient reduction in MFD and Mental Health patients in the Trust |
| The Trust does not deliver improvements in the quality of care it provides due to financial constraints | Patient experience and outcomes may be affected should key quality improvements in services not be made | Focus resources as much as possible on those areas which will have the greatest quality impact<br>Ensure oversight of key quality issues through the QSIP programme |
| Delivery of the full £75m Efficiency programme is unachievable and the Trust is unable to achieve its financial target | The Trust is unable to meet its statutory duty to meet its financial target and may need to make reductions in services | Continued development at a granular level of the Trust's Efficiency Programme<br>Increase in activity through productivity to maximise income to the Trust |
| We are unable to reduce our agency use and headcount where targeted | Quality of care may be impacted and an increased risk to the Trust's financial target | Maximise direct substantive recruitment opportunities, apply robust workforce management controls, review the effectiveness of rota management and staff deployment |

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# Next steps

- The Trust will continue to work with NHS Sussex and NHSE, and across the organisation, to finalise our operational plans for 2024/25. The NHS Sussex plan is due to be submitted to NHSE on 2nd May.
- It is possible that we may be asked to make further changes, particularly to reduce the Sussex system deficit, by national government
- We have been advised to expect approval of plans by central government in May/June.
- Within UHSussex we are now working to this plan, with an extensive programme of finalising divisional, workforce and efficiency plans to secure delivery.
- Operationally we will continue to progress steps to improve hospital flow, reduce waiting lists, identify waste and efficiencies, support our workforce, and work across the system to ensure that there is Community, Mental Health and Social Care support for patients who do not have medical need for acute beds.
- As we mark our third birthday as UHSussex, we are also commencing a refresh of the UHSussex Strategy, taking stock of our current position, strengths and opportunities, setting a road map for our development to 2030.

# Recommendations

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The Board is asked:

1. To approve, the UHSussex Capital investment plan for 2024/25.
2. To note the UHSussex contribution to the NHS Sussex operational plan. The Trust submission to the ICB was approved by the Board on 25 April 2024. The full plan will now be considered and approved by NHS England.

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| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 11. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 2 May 2024 |
| **Report Title:** | Research, Innovation and Digital Committee Chair Report to Board | | | | |
| **Sponsoring Non-Executive:** | Jackie Cassell, Non-Executive and Committee Chair | | | | |
| **Author(s):** | Jackie Cassell, Non-Executive and Committee Chair | | | | |
| **Report previously considered by:** | | | | | |

| **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, Innovation and Digital Committee met on the 23 April 2024 and was quorate, as it was attended by two Non-Executive Directors including the Chair and at least two executives, the Chief Medical Officer, and the Chief Strategy Officer with the Chief People 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 (workforce), and Cancer and Company Secretary. The Chief Nurse gave apologies that they could not attend for the meeting.

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

- **Digital Steering Group Chair's report** The Committee welcomed the report which included the Annual Plan setting out relative Digital priorities and noted the Terms of Reference. The Committee welcomed the work toward a Digital maturity assessment against 'what good looks like' which would underpin outline a framework and enable benchmarking opportunities. The committee was advised on discussions following the Data centre incident last June consideration about reinstatement arrangement and an update on readiness. The initial work on the Electronic Patient Record was **noted** and the significance and timelines of the longer-term programme including the process toward business case approval. The report updated on the Data Security Protection Toolkit and the annual

process to ensure data handling is fit for purpose, including internal audit and inviting NHSE audit. The Committee was assured on processes and by the clinical/operational representation at the group.

- **Digital Data Governance Overview Report.** The Committee received a helpful outline of the governance arrangements that oversee both technical design authority (looking forward) and the change advisory board (protecting the IT environment) to ensure a coherent strategy in investments. The Committee **noted** work in progress to ensure linkages between reporting groups and also the significance of ensuring robust technical foundations necessary for the important digital opportunities. The report also outlined the approach to testing and assessing Cyber security annually and the proactive and extensive multifactor authentication rollout for Trust email and systems.

- The Committee requested a report bringing together external perspectives in the Digital arena. It discussed the importance of clear prioritisation over time of what is possible aligned to Trust strategy, which can be delivered well, taking into account wider implications including behaviours and impacts for staff,

- **Research Strategy Steering Group (RSSG) Chair's Report** set out a fully developed assurance and risk and escalations approach building on previous reports. The Committee received the minutes of the RSSG monthly meetings and noted the February meeting had not been quorate. The Committee discussed the risk previously escalated to Sustainability Committee around the Clinical Research Facility and was advised that the current building is due to close by May 2025 with the delivery of the research agenda being threatened if a solution is not found. The Committee welcomes the appointment of Divisional Directors of Research connecting academic interest with NHS colleagues.

A future Chair's report will set out f the financial elements of Research activity and how these are integrated.

- **Research Activity Report and dashboard**. The Committee **noted** the developed KPIs since the last meeting and the work on development of performance targets at a divisional and service level. The considerable increase on last year's participation was welcome and places the Trust in the upper quartile of peers. The Committee noted the improved visibility of the studies taking place at speciality level and some considerable increase in recruitment in some emerging areas, particularly respiratory and paediatrics. A need to reduce the setup time was noted to be important as an enabler for the Trust's ambitions of attracting commercial research as well as optimal delivery of the wider portfolio.

- **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 a more strategic approach to 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. However, it recognised that creating capacity for staff to take part remained a limiting factor as does the ability for the Trust to m a dedicated clinical research facility, if the Trust is 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 and reach of patent participation.

- **A report on Research & innovation Workstream Updates** which provided the Committee with information on the development of an innovation group that is dedicated to supporting staff to progress bids for external innovation funding. The Committee **noted** this report and the value of having a dedicated group to support innovation. The Committee also welcomed the advancement with PowerBI reporting giving visibility on the agreed metrics for performance.

- **The Innovation Report** set out learning from innovation projects and illustrated the support to our entrepreneurial clinicians. Peer learning and innovation training development on the Trust Intranet

was noted. The Committee noted the active work taking place and confidence that the 20% increased adoption target can be met.

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 **noted** the developing Sussex-wide Strategy to be finalised in year that sets which aspects are owned and delivered by partners while overseen by the ICB, and also the Specific actions that the partners all agree to take as individual organisations / contribute to through the HRP which will underpin their shared success.

The Committee was assured that the Clinical Research Facility has allocated funding in the capital budget, and there is currently a process under way to identify the appropriate site and scale of the facility aligned to other developments. In the meantime the Committee was assured that the Trust will aim to optimise everything else we can do to be attractive to commercial approach and this will be monitored through the action log for a future update.

The Committee reviewed the BAF risk for which it has oversight of, and **agreed**, that having regard to both the BAF summary, the Research and Innovation Strategy Delivery risks and the reports considered during the meeting, that the strategic risk score did not change by the end of quarter 4 2023/24.

**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 recommendation that the BAF risk 6.1 is maintained at a score of 16 and that this risk remains fairly stated at the end of quarter 4 2023/24.

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# RESEARCH AND INNOVATION COMMITTEE CHAIR'S HIGHLIGHTS REPORT TO BOARD

| **Meeting Details** | | | | | |
|---|---|---|---|---|---|
| **Meeting Date** | **24 April 2024** | **Chair** | Jackie Cassell | **Quorate** | Yes |
| **Declarations of Interest** | No declarations were raised | | | | |

| **Items received at the Committee meeting** | | | |
|---|---|---|---|
| **Digital** | | | |
| Digital Steering Group Chair's Report<br>*To include Terms of Reference for information*<br>To note | **Presenter** Clinical Research Director | **Purpose**<br>For information and assurance | **Outcome /Action taken**<br>Noted |
| Digital and Data Governance Overview | **Presenter** Clinical Research Director | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Digital Discussion | **Presenter** Clinical Research Director | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| **Research and Innovation Strategy Delivery** | | | |
| Research & Innovation Strategy Steering Group: Chair's Report | **Presenter** Clinical Research Director | **Purpose**<br>To note | **Outcome /Action taken**<br>Noted |
| Research Activity<br>To include<br>- Research Activity Report<br>- SDR Scorecard | **Presenter** Clinical Research Director | **Purpose**<br>To note | **Outcome /Action taken**<br>Noted |
| Research & Innovation Workstream Updates | **Presenter** Clinical Research Director | **Purpose**<br>To note | **Outcome /Action taken**<br>Noted |
| Brighton & Sussex Health Research Partnership<br>a) HRP Sussex Health and Care Research Strategy | **Presenter** Clinical Research Director | **Purpose**<br>To note | **Outcome /Action taken**<br>Noted |
| Innovation update | **Presenter**<br>Clinical Research Director / Associate Commercial Director | **Purpose**<br>To Note | **Outcome /Action taken**<br>Noted |
| ***Risk*** | | | |
| R&I Extract of Board Assurance Framework for Quarter 4 | **Presenter**<br>Company Secretary | **Purpose**<br>For agreement | **Outcome /Action taken**<br>The Committee noted there were no changes to the R&I Strategic Risk during quarter 4 so it remained at 16 for quarter 4 Increased at the start of the quarter). |

| Actions taken by the Committee within its Terms of Reference | |
|---|---|
| The Committee received its expected reports and the assurance these reports provided as summarised above. | |
| **Items to come back to Committee / Group (Items Committee / Group keeping an eye on)** | |
| Digital maturity assessment Report to come to the Committee for July 2024. | |
| **Items referred to the Board or another Committee for decision or action** | |
| **Item** | **Who / when** |
| The Committee agreed to recommend to the Board that the BAF risk score of 16 at the end of Q4 for the Research and Innovation Strategic Risk 6.1 remains fairly stated. | Board<br>2nd May 2024 |

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| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 12. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 02 May 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 February, March and April 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 Chief Nurse, 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. 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, medicines management, 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.

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. There has been a steady improvement in the quality of these summaries and notable in the last meeting was the inclusion of harm review data. 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 particularly medical leadership through divisional Chiefs. The report recognised considerable pressure on staff shortages and the Committee acknowledged particular pressures for staffs dealing with the effects of Cancer treatment delays and surgery, radiotherapy and SACT (chemotherapy). An emerging theme from Divisional reports and elsewhere in the committee is medical equipment and devices and building issues in clinical settings and the Committee has asked for assurance around the arrangements for the impact assessment on quality and clinical delivery within management decisions for maintenance and investment prioritisation.

The Quality Scorecard continued to be work in progress. Progress that had been made was recognised but a few challenges remain on data collection affecting the accuracy of certain measures. The Director of Performance has been asked to work with Divisions and Domain leads to ensure appropriate and accurate report and to come to a future meeting of the Committee to discuss the work to address these issues and future developments.

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 Q4 were satisfied that they have a good or very good experience, which was comparable to Q3 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 discussed that 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 Q4 Patient Experience Report was received**.** The number of new complaints had increased considerably (18.5%) compared to Q3 and are more complex. The volume of complaints, complexity and resource pressure on the patient experience and divisional teams is resulting in overdue complaints which continues the poor experience. The Committee heard that the resourcing is being reviewed as part of the Quality Improvement and Safety Programme.

**Patient Safety:** The committee the rate of incident reporting per 1000 bed days but noted this is still below the national average the bedding in of DatixIQ after its Q4 go-live. The Committee discussed the issues attributed to differential reporting cultures on different sites and the actions to address this. The Committee 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 one Never Event in the reporting Quarter (Q3). The Committee received updates on 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 positivity and engagement with this approach and the associated training was heard by the Committee.

The Committee also received a report on Inquests and discussed the support required for these given both the complexity and the number including medico-legal and how the learning is fed back into Divisions.

The Q3 Duty of Candour Report was received by the Committee and audits demonstrated the Trust is not fully compliant with the Duty of Candour in all areas. While there had been improvement in the timely sharing of investigation findings, this remained less than 100% overall but both Medicine Divisions had achieved 100% compliance which represented positive progress. The Committee noted that the new DCIQ incident module going live on 6th February 2023 had revised the data collection tools and process to assist compliance.

**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 compliance remains across these domains, the Committee is **assured** that suitably prioritised plans are being developed or are in place to rectify this and that progress is being made. The Committee received an update on the comprehensive work to consolidate clinical documentation across the Trust.

The committee received a report on the suggested approach to harm reviews, which is to focus on areas where harm from waiting 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. The Committee expects an initial report on this in May and I will update the Board on this in my next report.

<u>Medicines Management</u>

The committee received a comprehensive Pharmacy and Medicines Governance Q4 Report which identified gaps in compliance and assurance. The committee noted the update on medication incidents and the learnings and themes identified. This report showed positive progress in developing plans and action taken to address issues and a broad focus to improve medicines security and storage. Staffing pressures were recognised as a particular challenge.

<u>Learning from Deaths</u>

The Committee received the Q3 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 3 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 Q4 report which includes reporting on the Trust's arrangements. The Committee heard there had been improved 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.

The Resuscitation Group report was not received and the committee has asked that this should be included in the next report in July 2024 meeting including the annual workplan.

Safeguarding

The Committee **received** the Q4, 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 CQC report published in February 2024 highlighted two areas of concern relating to safeguarding: to review safeguarding arrangements in line with the intercollegiate guidance for safeguarding to ensure staff training is suitable for frontline staff, and to ensure the consistent completion of Deprivation of Liberty Standard (DoLS) paperwork that matches patient's need. The Committee noted the work to better align safeguarding training levels with staff roles, a training needs analysis (TNA) has been reviewed and the training system IRIS will be updated to reflect these changes. The committee also noted the focus on specialised Level 3 training and anticipated requirement to broaden uptake of this training as well to meet the 90% compliance target. The success of CAIT training in reducing instances of aggression was noted and the Committee received the Dementia strategy at the April meeting. The continued resource challenge associated with high demand on 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.

Addressing the CQC concerns, the April meeting of the Committee also heard the Mental Capacity Act MCA and DoLS working group has been established to develop, plan and implement an audit programme for 2024/25 and will look to receive its assurances around the quality of documentation in relation to MCA assessments and best interest decision making and DoLS, and the development of improvement actions plans. Policies for Domestic Abuse, Safeguarding Supervision and policies on Separation at Birth. The good work being achieved in Maternity was noted.

Mental Health

The Committee heard about the continuing 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 UH Sussex Mental Health Strategy and Quality Group continued to be held and the minutes and action plans from these meetings are received by the Committee. 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. The enhanced care team led by the Head Nurse post for Mental Health started in November with a focus to review our processes with the Mental Health Act and 26 of the planned 30 Enhanced Care Support Workers were in post were working in the clinical areas by the end of March. The committee were assured of the support in place as well as the careful monitoring of the impact patient experience as well as registered mental health nurse (RMN) use.

Care Quality Commission (CQC) action plans

The Committee reviewed the outstanding actions from previous CQC reports and further discussed the approach to the appropriate status recording. Additional executive oversight given to this area was **noted** and the evolution of monitoring through the establishment of a Quality & Safety Improvement Programme (QSIP) Committee which will report to the Board.

Infection Prevention and Control Quarterly Report

The Committee welcomed the Q4 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.

Surgical site infection (SSI) rates are high in some areas and the Committee received updates on 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. Given the challenge represented by sub-optimal theatre size, the Committee heard about the preparations being made to utilize space in the new Louisa Martindale Building for cardiac theatre. The committee also asked if additional areas should be included in the SSI reporting and the tools in place to monitor this.

Following on from my previous report and the above there are a number of concerns relating to ventilation and water and the Committee has asked for the Estates and Facilities Director to present the report findings from the ventilation audit tool at the May 2024 meeting and water management at the next committee.

Human Tissue Authority Compliance

Following an inspection from the HTA where improvement actions were identified, the Committee received Compliance updates and an action plan that were reported to the Committee and escalated to the Board in February. By the April meeting the committee received an updating confirming all but two actions were complete and reassurance from the Chief Medical Officer that the HRA were very content with progress. I would like to share my thanks with the Mortuary Team management and staff who worked hard to respond swiftly to the checks and assurances needed. A full report with a breakdown of longer-term recommendations and phasing of remedial works will be received at a future meeting. There are broader learnings for the Trust on the governance and timeliness of escalation and this is linked to ensuring Board oversight of the Health and Safety Committee and its connection with other areas.

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. A pilot for additional theatre capacity in RSCH had commenced in February and from positive initial findings with respect to both safety and experience alongside heard the Division have sought for the arrangement to continue once the pilot ends in April. Acute shortages in midwifery teams through sickness and maternity/paternity leave as well as challenges in being able to attract new staff were noted to coincide with difficult inquest and media experiences to cause concerningly low morale. The committee were updated on the trajectory to improve staffing in neo-natal and especially PRH which has experienced significant challenges.

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 the year 5 declaration against the Maternity Incentive Scheme (MIS) operated by NHS Resolution at the April 2024 meeting it was confirmed that the Trust's compliance had been accepted and awarded. The risks to the Trust's year 6 position have been acknowledged in particular meeting monitoring requirements in light of the capacity challenges on Scanning (sonography)

The committee noted further reduction in peri-natal mortality rates which are below both regional and national rates. 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 a continued positive impact 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 risks 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.

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 was confirmed not to have been achieved.

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. There was an initial discussion about how the risks may be worded for 2024/25 that differentiate the areas where the tangible impact of actions will be able to be seen.

Referrals to other Committees

There were no referrals made to other Committees.

**RECOMMENDATION:**

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 the end of quarter 4 are fairly represented.

## COMMITTEE HIGHLIGHTS REPORT TO BOARD

| Meeting Details | | | | | |
|---|---|---|---|---|---|
| **Meeting Date** | **27 February 2024** | **Chair** | Lucy Bloem | **Quorate** | Yes |
| **Meeting Date** | **26 March 2024** | **Chair** | Lucy Bloem | **Quorate** | Yes |
| **Meeting Date** | **23 April 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 | **Feb** | **Mar** | **Apr** | **Presenter** Chief Medical Officer | **Purpose** For information | **Outcome /Action taken** Noted. Action to come back on: connecting the clinical quality Implications from estate/maintenance issues |
| Quality Dashboard (excluding Maternity) Safety, Effectiveness, Experience, Mortality | **Feb** | **Mar** | **Apr** | **Presenter** Chief Medical Officer/ Chief Nurse | **Purpose** For information | **Outcome /Action taken** Noted. |
| Mortality - Counter Measure Summary | **Feb** | **Mar** | **Apr** | **Presenter** Chief Medical Officer | **Purpose** For information | **Outcome /Action taken** Noted |
| Learning from Deaths Assurance Report Q3 2023/24 | | **Mar** | | **Presenter** Director of Clinical Outcomes & Effectiveness | **Purpose** For assurance | **Outcome /Action taken** Noted |
| Structured Judgement Review Backlog Project – Progress Report | | | | **Presenter** Chief Medical Officer | **Purpose** For information | **Outcome /Action taken** Noted |
| Patient Experience Assurance Report | **Feb** | **Mar** | **Apr** | **Presenter** Director Patient Experience & Engagement | **Purpose** For information | **Outcome /Action taken** Noted |
| Strategic Initiative – Patient First Q4 | | | **Apr** | **Presenter** Chief Operating Officer | **Purpose** For information | **Outcome /Action taken** To receive Q4 Report – Apr 2024 |
| Perinatal Quality Surveillance Report and Dashboards | **Feb** | **Mar** | **Apr** | **Presenter** Director of Midwifery / Chief of Women & Children Service | **Purpose** For information | **Outcome /Action taken** Noted |

| | | | | | | |
|---|---|---|---|---|---|---|
| Perinatal Mortality Review Tool Q4 | **Feb** | **Mar** | **Apr** | **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 Q4 2023/24 | | | **Apr** | **Presenter** Director of Midwifery | **Purpose** For information | **Outcome /Action taken** Noted |
| Saving Babies Lives Review Quarterly Report | | | **Apr** | **Presenter** CNO/ Chief of Women & Children Service | **Purpose** For information | **Outcome /Action taken** Noted |
| Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) | **Feb** | **Mar** | **Apr** | **Presenter** CNO/ Chief of Women & Children Service | **Purpose** For information | **Outcome /Action taken** March Report to Board |
| ***Safe, Effective, Caring, Well Led and Responsive*** | | | | | | |
| Patient Safety Assurance Report<br>- Harm free care Report Counter Measure Summary<br>- Harm Reduction Report<br>- Inquest Monthly Report (Jan) | **Feb** | **Mar** | **Apr** | **Presenter** Chief Nurse / Deputy Director Patient Safety & Learning | **Purpose** For information | **Outcome /Action taken** Noted |
| Infection Prevention & Control Q4 Report | | | **Apr** | **Presenter** Director Infection Prevention & Control | **Purpose** For assurance | **Outcome /Action taken** Noted |
| Infection Prevention and Control Assurance on Water Quality | | | **Apr** | **Presenter** Director Infection Prevention & Control | **Purpose** For assurance | **Outcome /Action taken** Noted |
| CQC Update / Action Plans | **Feb** | **Mar** | **Apr** | **Presenter** Chief Medical Officer/ Chief Nurse | **Purpose** For information | **Outcome /Action taken** Noted |
| Safeguarding Adults and Children Quarterly Reports | | | **Apr** | **Presenter** Chief Nurse/ Head of Safeguarding | **Purpose** For assurance | **Outcome /Action taken** Noted |
| Quality Assurance Report Including Clinical Outcomes & Effectiveness Group Reports | **Feb** | **Mar** | **Apr** | **Presenter** Chief Medical Officer / Director of Clinical Outcomes & Effectiveness | **Purpose** For assurance | **Outcome /Action taken** Noted,<br>Action: Gap analysis and progress update on improvement workstreams |
| Supportive-End of Life Care & Resuscitation Group Report Quarter 4 2023/24 | | | **Apr** | **Presenter** Chief Medical Officer / Lead Nurse EOLC | **Purpose** For information | **Outcome /Action taken** Noted |

| | | | | | | |
|---|---|---|---|---|---|---|
| Human Tissue Authority Inspection and Improvement Actions | **Feb** | **Mar** | **Apr** | **Presenter** Chief Medical Officer | **Purpose** For information | **Outcome /Action taken** Noted Escalated to Board. Full report to come back |
| ***Risk*** | | | | | | |
| Trust Risk Register relating to Patient & Quality (Summary changes between Quarterly meetings) | **Feb** | **Mar** | **Apr** | **Presenter** Chief Medical Officer / Chief Nurse | **Purpose** For information | **Outcome /Action taken** Noted |
| Board Assurance Framework | | | **Apr** | **Presenter** Company Secretary | **Purpose** For agreement | **Outcome /Action taken** Agreed risks fairly stated |

| **Actions taken by the Committee within its Terms of Reference** |
|---|
| The Committee **AGREED** to recommend the risk score for BAF risks 1.1, 4.1 and 4.2 to the Board for the end of quarter 4 2023/24.<br>The Committee received Patient Experience Quarterly Reports<br>The Committee received the Adult Safeguarding and Child Safeguarding Quarterly Reports<br>The Committee received the Infection Prevention and Control quarterly report<br>The Committee received the Learning from Deaths Quarterly Report |
| **Items to come back to Committee / Group (Items Committee / Group keeping an eye on)** |
| ▪ Report from 2023/24 from Resuscitation team (by July 2024)<br>▪ Harm Reviews Report<br>▪ Clarity on arrangements for the clinical and quality Impact consideration within estate and maintenance issue management and prioritisation<br>▪ Assurances around Technology Appraisals<br>▪ Water and Ventilation Reports in relation to Infection Prevention & Control presented by Director of Estates.<br>▪ Further detail on Infection Prevention and Control surveillance arrangement in relation to surgical site infections. |
| **Items referred to the Board or another Committee for decision or action** |

| **Item** | **Date** |
|---|---|
| The Quality Committee invites the Board to **NOTE** the following:<br>- the Learning from Deaths Quarterly Reports<br>- 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 the end of quarter 4 are fairly represented. | **May 2024** |

University Hospitals Sussex
NHS Foundation Trust

# Mortality & Learning from Deaths Report

# Quarter 3

1st October – 31st December 2023

# Contents

# Learning from Death

## Introduction

This report provides details of the activity across the Learning from Deaths workstream during quarter three of 2023/24. It covers the period of 1st October to 31st December 2023.

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

Quarter 2 report provided 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).

Quarter 3 report continues to provide details of activity across the Learning from Deaths workstream and progress towards the aims and objectives for the reporting period (1st October – 31st December 2023).

## Recap from Quarter 2 (1st July – 30th September 2023)

This quarter provides the first complete outputs using the new pathway for referring and processing Structured Judgement Reviews on Panda.

## Highlights from Quarter 3

### 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) was successfully appointed and is due to commence in post 1st January 2024
- 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 took occupancy of the new larger space in October 2023. This office space is shared with the bereavement team. Office equipment has been sourced for the current new space and good working relationships across teams is positively impacting working environments
- **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. An action is currently addressing the backlog of 374 SJRs.

### 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 enables 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.

Trust wide mortality meetings 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 reviews 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 trigger the patient safety pathways and allow triangulation with end of life care, patient safety and patient/relative experience learning.

### 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 are held twice weekly during the process of backlog management and is led by the Senior SJR reviewer.
- Thematic reviews being undertaken 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 where DoC applies.

- 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 is a significant piece of work for Divisional leads and is being communicated sensitively 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 will be reviewed at the weekly Trust wide Mortality Panel along with WGH and SRH SJRs.

Delivery of a UHSussex fully aligned Learning from Deaths service continues to progress as a priority.

Successful recruitment of a Mortality and Learning from Deaths Manager along with a Learning from Deaths Project Manager and two part time administrators, with all candidates expected in post at the end of April 2024.

# UHSussex Mortality Data & Metrics Quarter 3 (1st October – 31st December 2023)

## All Adult Deaths

### 1. Mortality Reviews

**Table 1**: Number of hospital deaths by setting and site

| Total Adult Deaths | | | | |
|---|---|---|---|---|
| | Oct 23 | Nov 23 | Dec 23 | Total for Quarter |
| WGH | 92 | 87 | 118 | **297** |
| SRH | 68 | 90 | 88 | **246** |
| RSCH | 98 | 95 | 124 | **317** |
| PRH | 38 | 32 | 25 | **95** |
| **Total** | **296** | **304** | **355** | **955** |

**Table 2:** Number of inpatient deaths

| Total Adult Inpatient Deaths | | | | |
|---|---|---|---|---|
| | Oct 23 | Nov 23 | Dec 23 | Total for Quarter |
| WGH | 89 | 84 | 114 | **287** |
| SRH | 67 | 87 | 84 | **238** |
| RSCH | 94 | 87 | 106 | **287** |
| PRH | 36 | 29 | 24 | **89** |
| **Total** | 286 | 287 | 328 | **901** |

**Table 3:** Number of ED deaths

| Total Adult ED Deaths | | | | |
|---|---|---|---|---|
| | Oct 23 | Nov 23 | Dec 23 | Total for Quarter |
| WGH | 3 | 3 | 4 | **10** |
| SRH | 1 | 3 | 4 | **8** |
| RSCH | 4 | 8 | 18 | **30** |
| PRH | 2 | 3 | 1 | **6** |
| **Total** | 10 | 17 | 27 | **54** |

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 2 / 3 – Data provided is the most up to date available.

| Table 4 | WGH | SRH | RSCH | PRH | UHXs |
|---|---|---|---|---|---|
| August (Q2) | 38 | 43 | 33 | 8 | 122 |
| September (Q2) | 35 | 51 | 23 | 17 | 126 |
| October(Q3) | 36 | 35 | 26 | 16 | 113 |
| November (Q3) | Available March 24 | | | | |
| **Total** | **109** | **129** | **82** | **41** | **361** |

**Table 5:** SHMI (12 Month Rolling)

| Table 5 | WGH | SRH | RSCH | PRH | UHXs |
|---|---|---|---|---|---|
| August (Q2) | 106.42 | 102.86 | 115.44 | 93.45 | 106.07 |
| September (Q2) | 106.11 | 104.03 | 115.76 | 93.12 | 106.35 |
| October(Q3) | 105.33 | 102.95 | 114.26 | 92.95 | 105.39 |
| November (Q3) | Available March 24 | | | | |

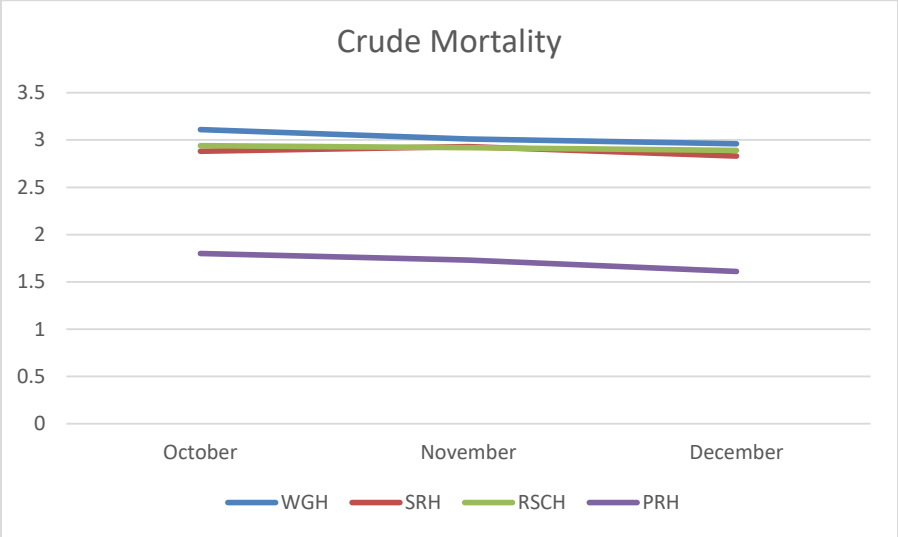
1.2 **Table 6:** HSMR (12 Month Rolling)

| Table 6 | WGH | SRH | RSCH | PRH | UHXs |
|---|---|---|---|---|---|
| September (Q2) | 101.81 | 99.96 | 100.8 | 83.93 | 98.88 |
| October (Q3) | 101.35 | 97.65 | 100.42 | 81.65 | 97.78 |
| November (Q3) | 101.64 | 98.91 | 100.13 | 82.18 | 98.13 |
| December (Q3) | Available March 24 | | | | |

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

| Table 7 | WGH | SRH | RSCH | PRH | UHXs |
|---|---|---|---|---|---|
| October | 3.11 | 2.88 | 2.94 | 1.8 | 2.8 |
| November | 3.01 | 2.93 | 2.92 | 1.73 | 2.77 |
| December | 2.96 | 2.83 | 2.89 | 1.61 | 2.69 |

**Graph 1**: Q3 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 |
|---|---|---|---|---|---|
| October | 100% | 100% | 100% | 100% | 100% |
| November | 100% | 100% | 98.95% | 100% | 99.74% |
| December | 100% | 100% | 99.19% | 96% | 98.8% |
| **Total** | **100%** | **100%** | **99.38%** | **98.67%** | **99.51%** |

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

| Table 9 | WGH | SRH | RSCH | PRH | UHXs |
|---|---|---|---|---|---|
| October | 47.83% | 48.53% | 24.49% | 23.68% | **36.13%** |
| November | 33.33% | 25.56% | 25.26% | 21.88% | **26.51%** |
| December | 37.29% | 32.95% | 24.19% | 44% | **34.61%** |
| **Total** | **39.48%** | **35.68%** | **24.65%** | **29.85%** | **32.42%** |

## 1.6 Referral to Coroner

**Table 10**: Number of deaths referred to the coroner.

| Table 10 | WGH | SRH | RSCH | PRH | UHXs | Percentage |
|---|---|---|---|---|---|---|
| October | 21 | 18 | 51 | 10 | 100 | **33.78%** |
| November | 22 | 19 | 35 | 8 | 84 | **27.63%** |
| December | 17 | 14 | 36 | 4 | 71 | **20%** |
| **Total** | **60** | **51** | **122** | **22** | **255** | **26.7%** |
| **Percentage Referred to Coroner** | **20.84%** | **21.16%** | **39.31%** | **19.22%** | **26.7%** | |

## 1.7 Investigated by Coroner

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

| Table 11 | WGH | SRH | RSCH | PRH | UHXs | Percentage |
|---|---|---|---|---|---|---|
| October | 12 | 5 | 26 | 7 | 50 | **50%** |
| November | 9 | 13 | 18 | 4 | 44 | **52%** |
| December | 8 | 8 | 21 | 0 | 37 | **52.11%** |
| **Total** | **29** | **26** | **65** | **11** | **131** | **51.37%** |
| **% investigated by Coroner** | **48.33%** | **50.98%** | **53.28%** | **50%** | **51.37** | |

## 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 |
|---|---|---|---|---|---|---|
| October | 24 | 9 | 18 | 3 | 54 | **18.24%** |
| November | 19 | 11 | 10 | 2 | 42 | **13.82%** |
| December | 16 | 3 | 25 | 3 | 47 | **13.24%** |
| **Total** | **59** | **23** | **53** | **8** | **143** | **14.97%** |
| **% of all Deaths referred for SJR** | **19.87%** | **9.35%** | **16.72%** | **8.42%** | **14.97%** | **9.35%** |

## 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 to merge a Trust wide Mortality Panel.

| Table 13 | SRH | WGH | Total |
|---|---|---|---|
| October | 4 | 7 | 11 |
| November | 3 | 6 | 9 |
| December | 1 | 4 | 5 |
| **Total** | **8** | **17** | **25** |

### 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 (excludes 2nd SJRs (2))

| Outcome Score | WGH | SRH | RSCH | PRH |
|---|---|---|---|---|
| 5 - Excellent | 1 | | | 1 |
| 4 - Good | | 2 | | |
| 3 - Adequate | 2 | 1 | | |
| 2 - Poor | 6 | 5 | 2 | |
| 1 - Very Poor | 3 | | | |
| **Total** | **12** | **8** | **2** | **1** |

## SJR Activity and Outcomes

All SJRs outstanding up to and including 31st October 2023 were considered as part of the backlog project. Therefore details of SJR activity can be found in the backlog progress report (Appendix A).

## 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.

There was one SJR referral in Q3 were patients with Learning Disabilities. The SJR is currently in progress.

SJRs Referred in Q3 for patients with a learning disability and/or autistic people:

| Table 21 | WGH | SRH | RSCH | PRH | UHXs |
|---|---|---|---|---|---|
| October | | | | | |
| November | | | 1 | | 1 |
| December | | | | | |
| **Total** | | | **1** | | **1** |

11 | Learning from Deaths

## 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.

### Poor Care

- ✗ Failed discharge, re-admission 4 days later. No package of care was provided. Failed discharge
- ✗ Patient under wrong team (under Ortho instead of DOME for both admissions).
- ✗ Lack of ASC involvement
- ✗ Issues around package of care (poor PoC, and then delay to PoC)
- ✗ Delay to recognising deteriorating patient
- ✗ Family raised significant concerns/complaint
- ✗ Lack of senior input
- ✗ No medical reviews over weekend and BH
- ✗ Poor discharge planning
- ✗ Delay to recognising deteriorating patient
- ✗ Interventions and treatment continued despite EoLC pathway
- ✗ No ReSPECT/DNACPR
- ✗ TEP form was not revised
- ✗ Lack of senior involvement
- ✗ CPR decision of family/NoK upheld despite medically futile judgment.
- ✗ Inappropriate use of MET calls
- ✗ Patient under wrong team (under Ortho instead of DOME)
- ✗ Poor medical records
- ✗ Prolonged ITU stay in frail patient
- ✗ No learning points on M&M discussion form
- ✗ Delay to antibiotics (6 hours)
- ✗ Delay to TEP and DNACPR
- ✗ CPR decision of family/NoK upheld despite medically futile judgment.
- ✗ CPR commenced 35 minutes after the patient was found dead.
- ✗ Investigations continued in a deteriorating patient

### Good / Excellent Care

- ✓ Early recognition of deteriorating patient
- ✓ Good senior input
- ✓ Good junior reviews

## Medical Examiner Feedback

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

## WGH

**21 families shared positive feedback during Quarter 3**

Respectful; considerate; happy with care; wonderful; fantastic; amazing; couldn't have got better care if paid for.

Couldn't fault care despite how busy.

Kind considerate, respectful, compassionate, caring understanding, second to none; well informed; good comm; involved; grateful for time and space to be with family

**Concerns**

Incorrect information on records re: dates and NOK details; poor planning, poor access to medical team; not happy about previous decision making no Package of Care; not informed of death; DNACPR not signed even though family were told it had been.

## SRH

**31 families shared positive feedback during Quarter 3**

Impressed with care; helpful; compassionate; caring; sensitive; excellent communication; fantastic; kept informed; grateful for efforts; mother was well looked after and so were whole family; good care; lovely compassionate staff.

**Concerns**

Questions about decision making; taken off palliative care then restarted causing family distress, not supported with eating and drinking; not sat up; delay in diagnosis and referral for cancer; delay in coroner referral due to miscommunication about treatment vs palliative care; not informed of DNACPR; problems with pre hospital care/ other hospital; symptom control; poor access to medical team; concerns raised about decision to operate; concerns over medications; pain management.

## RSCH

**36 families shared positive feedback during Quarter 3**

36 both good quality care & communication, 19 good quality care. 5 mixed experiences of good quality care/communication but with issues alongside.

**Concerns**

5 issues of poor communication/access to team. 8 incidents of A&E feedback about poor environment in December - 'awful' 'dirty' above capacity, long stay.

## PRH

**24 families shared positive feedback during Quarter 3**

Good quality care; eight good quality and other positive feedback provided. Could not fault the service; amazing; attentive; lovely and kind; 'absolutely wonderful' excellent care even though there was a doctor's strike

**Concerns**

4 issues of poor communication/access to team

## Progress toward Statutory service (Community Roll Out)

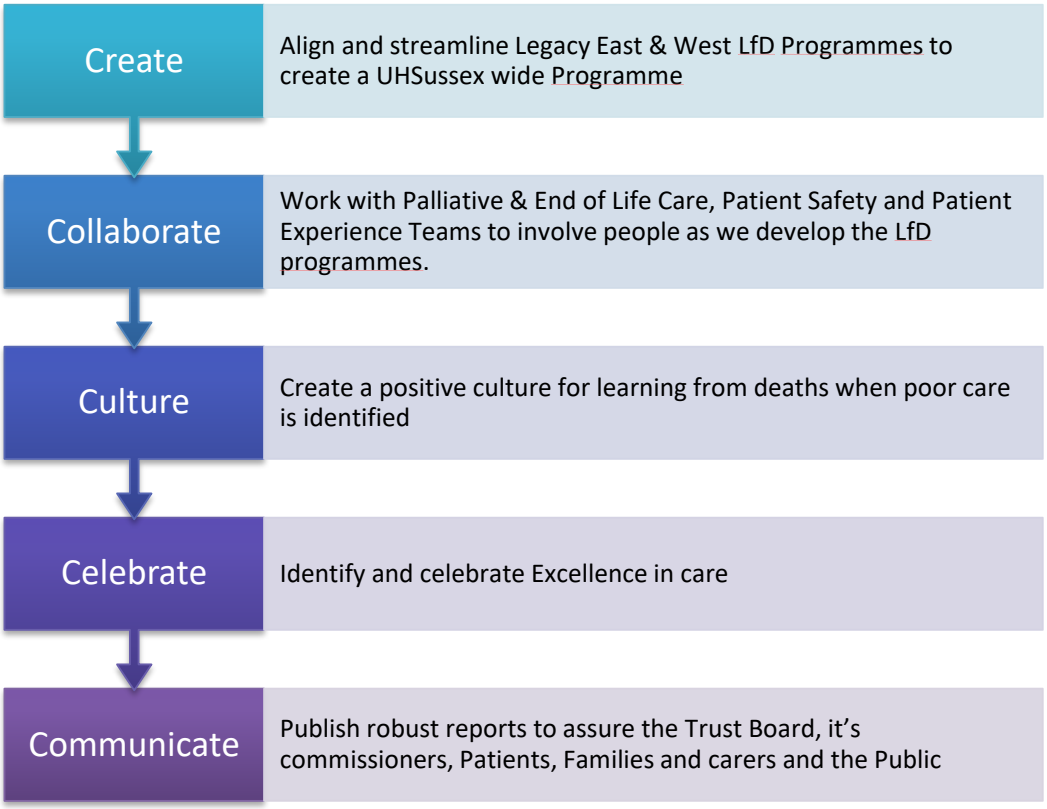
Good progress continues across both Medical Examiner Services and are on track to meet the statutory deadline of April 2024

- Drop in feedback sessions with practices are continuing across the community,
- Good increase in scrutiny of number of community deaths
- Work continues towards community Panda module
- Discussions with coroner regarding community referrals and how we provide input to the coroner are proceeding.

### In progress

- Increased space is required for PRH to provide a community hub (additional phone line, desks and computers are required)
- MEO admin workload increased until Panda module is complete for community deaths.
- Resource intensive with providing training and support to GP surgeries.
- Waiting confirmation of new death certification process. Pathway and clarification regarding ME involvement in coroner referrals

# 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 | **Complete** |
| **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 | **Complete** |
| **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** |

## Appendix A

SJR Backlog Project Progress Feb 24.docx

SJR Backlog Project Progress Jan 24.docx

University Hospitals Sussex
NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 13. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 2 May 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 27 March 2024 and as the People & Culture Committee on 23 April 2024 and was quorate at both meetings as it was attended by two Non-Executive Directors and Executives including the Chief People Officer and the Chief Culture and Organisational Development Officer. The Chief Operating Officer was also present. In attendance were the; Director of Workforce Planning & Deployment; Director of Integrated Education; Director of Medical Education the Associate Director of Leadership, Culture and Development, Deputy Chief Nurse – Workforce and Professional Standards; the Guardian of Safe Working Hours. and the Company Secretary. The Trust Chair was in attendance at the March meeting.

Apologies for absence were received from the Director of Human Resource Management

At the April Meeting the Committee approved updated terms of reference and a schedule of expected business including annual assurance reports. The updated terms of reference make clear the committee's role around culture, encompassing leadership, behaviours and related matters.

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 at the end of this paper.

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. The report emphasised the need to recognise the stress and strain on the organisation in the month of March, when staff were being asked to focus on the drive to meet the 2023/24 year-end financial and operational positions whilst also planning for the significant efficiencies required for 2024/25. This position also meant that had sometimes not been sufficient opportunities to reflect and celebrate successes over the last year.

In 2024/25 planning, the Committee **NOTED** the Trust's plans would increasingly use the national objectives (7 people promises) and support of the People Promise Exemplar Programme both to help focus but also raise awareness of progress in improving staff's working lives within organisation.

Staff engagement measured by a Pulse Survey had shown improvement over 2023/24 and especially markedly in March 2024. 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 although not all areas were at target, Mandatory Training compliance had continued to improve. While there had been a slight drop in non-clinical appraisal levels this had been sustained above 80%. The Committee **RECEIVED** a report on the arrangements for medical appraisals and approach to revalidation and acknowledged the work of Dr Neil Cripps for the work to understand the issues and address the shortage in appraisers. The Committee was sighted on the arrangements overseen by the new Deputy Chief Medical Officer and the prioritising work and approach to clearing the backlog of overdue medical appraisals. This is anticipated to be addressed through medical supervision in light of the associated revalidation requirement.

The Trusts success in recruitment and reducing vacancies was **NOTED** to have been achieved against a growth in the budgeted establishment. However, despite this the Trust has continued to utilise more additional staffing resource (through bank and agency usage) than it can afford. The overall statistics also mask that some areas of recruitment remain challenging, including registered nursing staff, medical staff and some specialist roles notably in radiography and pharmacy.

Payroll Service Update

Following the implementation of a new Payroll Hub in 2022, the Committee received an update of the performance of the payroll hub against its KPIs for the 12 months to January 2024 in advance of the 18 month break point review available to the Trust in May 2024, under the contract. The report also provided an update of the automation actions implemented in the first year of operation and of the actions still in progress.

The Trust was broadly achieving expected performance against high level priorities. However, overpayments remained an issue. The Committee were advised that issues with overpayments were as a result of the Trust's failure to send the required information in a timeline required. Significant further, targeted improvement work planned with the ICB and the Trust had offered to support this nationally. The volume of queries to the Trust's Finance and HR Leaders and number of complaints through the payroll hub triage had significantly reduced over the last year and average call times had significantly improved.

The arrangements for Overpayments as losses and their accounting was discussed at Audit Committee.

Education & Training Opportunities

The Committee **RECEIVED** and **NOTED** a proposal of a training needs analysis approach from a hybrid of training and learning needs analysis of the people's aligned to the organisation's needs. The proposal was to build a collaborative relationship with Divisions to support them to take ownership of staff training and governance, that would support the ongoing Quality and Safety Improvement Programme work. Matrices were introduced in March and further provided in April to illustrate training requirements for staff outside their typical areas of expertise (e.g., the care of mental health patients).

True North, Staff Engagement

The Committee noted embargoed National Staff Survey results have been received and considered the findings. A report on the latest National Staff Survey Data is provided behind this report

The Committee were **ASSURED** staff have routes for speaking up and that there have been additional tools and resources for managers including listening events that some Divisions have continued to use.

The Committee welcomed the presentation from the Freedom to Speak Up Guardian service providing their report for Quarter 4 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 on EDI maturity from Internal Audit, the work of the Inclusive Recruitment Working Group, and the six high impact actions of the NHS England EDI Improvement Plan.

At the April 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 been 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 coinciding with the Launch of the new incident reporting system in February and the post-incident staff support survey.

The Committee heard about the focussed work to identify and address the clinical ward areas of concern, ie. with high reported levels of physical violence, bullying, abuse or discrimination from patients and/or notable worsening reported in 2023. Similarly the Committee welcomed the focus on identified areas with reported high levels of harassment, bullying, abuse, physical violence or discrimination from managers, team leader or colleagues. The areas of overlap represent the highest priority for support and intervention.

The Committee also welcomed the example of 'upstream' preventative measures, the Head of Nursing for Dementia & Learning Disabilities and team report significant benefits of CAIT (Communication and Intervention) training for dementia care staff on the subsequent incidence of Violence & Aggression.

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.

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 the updates received in April on how this was embedded and sustained noting its significance to the Trust in multiple areas reviewed by the Committee including the improvement for Junior Doctors in Training hours and reduced breaches since Health Rota was introduced. The Committee noted the current state of doctors currently on an e-rostering platform with implementation work continuing to ensure all doctors are e-rostered. The Corporate Project will run until October 2024 when it will move to business as usual. The Committee had taken interest in the development of a suitably skilled implementation team. A Deputy Chief Medical Officer was NOTED to lead the work to ensure job plans are being refreshed and renewed. While a majority of consultants have an e-job plan, only small proportion had been reviewed in the last year but this is in the process of being addressed and the Committee heard about the work to tackle the backlog.

The Committee has asked for a detailed and realistic projection of the state of reviews of job planning and rostering by the scheduled Corporate Project close in October 2025. Advice from the Chief Medical Officer was that clearing the backlog to ensure up to date job Planning is expected to take a full year – 70-80% by autumn and the last 20% by this time next year. The Committee NOTED the trajectory of when to have discussions with consultants was under consideration and looks forward to receiving this at a future meeting. The Committee NOTED the significance of this work and that a realistic trajectory for completing the work is required and acknowledged the considerable effort undertaken to reach the current position.

Cost of Living Update

The Committee welcomed that the Charitable Funds Committee had agreed to extend the period to use the agreed funding for the hardship fund and projections on longevity of its availability based on current run rate. An extended period for the Financial Support officer role, currently outsourced. These extensions provide time to properly evaluate both the support fund and the financial adviser roles, and to consider and decide whether either or both are required on an ongoing basis, or whether either or both could be provided in a different way, such as at an ICB or local level. Other support schemes would also be considered, such as the salary advance option, for which some firms would also provide financial advice to employees. In process and work required.

The Committee welcomed the positive impact for staff at lower pay scales and the team's efforts to evaluate overall impact on staff's stress and wellbeing and, the diversity of applicants. The Committee also sought to understand the basis for applications turned down which were cases that had not met the stated criteria.

Culture Programme Update

At the April meeting the Chief Culture and Organisation Development (OD) officer introduced the programme that built on the diagnostic work introduced to the Committee in January. The Programme forms the basis of a Board workshop so is not summarised further here.

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.

Annual People Plan / people promise priorities 2024/25

The Committee NOTED a paper that provided an update on the development of a comprehensive people plan for 2024-25 in light of the significant challenges facing the NHS and Trust but building on improvements made in 2023-24. The Trust is using the seven NHS people promises as the framework for supporting its True North goal of achieving the most satisfied and engaged staff in the NHS. The intent is to identify the programmes of work and their link to those people promises.

The Committee NOTED There is further work to do to align priorities across the Directorate and with the cultural needs identified by the Chief Culture and OD Officer and to determine the resourcing and priorities. Much of the work builds on existing programmes of work already well defined and that will continue (eg the Trust's EDI plan). The people plan will support the Trust through 24-25 while wider work on the Trust's overall strategy takes place. The Committee look forward to receiving the final plan that will form the Trust's people promise aligned Exemplar Programme work by May 2024.

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 as at the end of quarter 4.

## COMMITTEE HIGHLIGHTS REPORT TO BOARD

| Meeting Details | | | | | |
|---|---|---|---|---|---|
| **Meeting Date** | **23 April 2024** | **Chair** | Paul Layzell | **Quorate** | Yes |
| **Meeting Date** | **27 March 2024** | **Chair** | Claire Keatinge | **Quorate** | Yes |
| **Declarations of Interest** | No declarations were raised | | | | |

| Items received at the Committee meeting | | | | | |
|---|---|---|---|---|---|
| True North –<br>Staff Survey update on 2023 Survey National Comparator results | **Mar** | | **Presenter**<br>Chief People Officer | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted. Staff Survey Report to Board (May 2024) |
| Breakthrough Objective –<br>Staff Voice that Counts Summary Report (Mar) / Closure Report (Apr) | **Mar** | **Apr** | **Presenter**<br>Chief People Officer | **Purpose**<br>For information | **Outcome /Action taken** Noted – Transition to BAU |
| Freedom to Speak Up Update Q4 | | **Apr** | **Presenter**<br>Freedom to Speak Up Guardian Service | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Strategic Initiative –<br>Leadership Culture and Development update and KPIs | **Mar** | **Apr** | **Presenter**<br>Chief People Officer / AD Leadership, OD & Engagement | **Purpose**<br>For approval | **Outcome /Action taken**<br>Noted |
| Violence Prevention & Reduction Update | **Mar** | **Apr** | **Presenter**<br>Chief Culture & OD Officer/ AD Leadership, OD & Engagement | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Equalities Diversity & Inclusion Update | **Mar** | **Apr** | **Presenter**<br>Chief Culture & OD Officer/ AD Leadership, OD & Engagement | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Medical Workforce Systems, Update | **Mar** | **Apr** | **Presenter**<br>Director of Workforce Planning | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| People Performance Overview Report | **Mar** | **Apr** | **Presenter**<br>Director of Workforce Planning (Mar/Apr) | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Guardian for Safe Working Report Annual Report 2023/24 | | **Apr** | **Presenter**<br>Guardian of Safe Working) | **Purpose**<br>For assurance | **Outcome /Action taken**<br>Noted & approved |
| Culture Programme | **Mar** | **Apr** | **Presenter**<br>Chief Culture & OD Officer | **Purpose**<br>To approve | **Outcome /Action taken**<br>Approved |
| Integrated Education Update | | **Apr** | **Presenter**<br>Director of Integrated Education | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Updates from Reporting Groups<br>- Education & Workforce Group<br>- Diversity Matters Steering Group<br>- Health & Wellbeing Steering Group | | **Apr** | **Presenter**<br>AD Leadership, OD & Engagement,<br>Chief People Officer | **Purpose**<br>For information | **Outcome /Action taken**<br>Updates Noted |

| | | | | | |
|---|---|---|---|---|---|
| - Joint Negotiation & Consultation Committee<br>- Nursing & Midwifery Group | | | Deputy Chief Nurse (Workforce) | | |
| Patient First Improvement Programme Update | | **Apr** | **Presenter**<br>Chief Operating Officer | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| People Promise Exemplar Programme | **Mar** | | **Presenter**<br>Chief Operating Officer | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Quarterly Education and Training Opportunities, including:<br>- Training Needs Analysis | **Mar** | | **Presenter**<br>Chief People Officer<br>Director of Integrated Education | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Payroll Service Update | **Mar** | | **Presenter**<br>Director of Finance / Director of Workforce Planning | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Annual Medical Appraisal and Revalidation Update –<br>Including fitness to practice review | **Mar** | | **Presenter**<br>Chief Medical Officer | **Purpose**<br>For information / Endorse Actions | **Outcome /Action taken** Noted. Actions Endorsed to enable Apr. s.4 Board submission |
| Medical Workforce Systems | | **Apr** | **Presenter**<br>Director of Workforce Planning | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Equality Workforce Data – Key lines of Enquiry | **Mar** | | **Presenter**<br>AD Leadership, OD & Engagement,<br>Chief People Officer | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Divisional Update –<br>Facilities and Estates | **Mar** | | **Presenter**<br>Director of Estates & Facilities / Deputy Dir. | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Updates on Integrated Care System | **Mar** | **Apr** | **Presenter**<br>Chief People Officer | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Risk Report | | **Apr** | **Presenter**<br>Chief People Officer | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted |
| Board Assurance Framework | | **Apr** | **Presenter**<br>Company Secretary | **Purpose**<br>To agree | **Outcome /Action taken** Agreed risks fairly stated |
| People & Culture Committee - Terms of Reference (Mar and Apr)<br>Annual Cycle of Business (Apr) | **Mar** | **Apr** | **Presenter**<br>Chief People Officer / Company Secretary | **Purpose**<br>For approval | **Outcome /Action taken**<br>Approved |

| **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 end 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**:<br><br>A report on the latest National Staff Survey Data is provided behind this report<br><br>The BAF risks 3.1 to 3.4 are considered fairly stated for the end of quarter 4 2023/24. . | <br><br>**May 2024**<br><br>**May 2024** |

University Hospitals Sussex
NHS Foundation Trust

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|---|---|---|---|---|---|
| **Agenda Item:** | 13a. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 02 May 2024 |
| **Report Title:** | NHS Staff Survey 2023: National Comparator Results | | | | |
| **Sponsoring Executive Director:** | David Grantham, Chief People Officer | | | | |
| **Author(s):** | Nick Groves, Associate Director, Leadership, OD & Engagement<br>Elea Drews Windeck, Data & Reporting Analyst (Inclusion, Engagement & Wellbeing)<br>Faye Heffernan, Health, Wellbeing & Engagement Programme Manager | | | | |
| **Report previously considered by and date:** | • Trust Executive Team (presentation only) – 6th March 2024<br>• Initial results (benchmarked against Quality Health rather than all NHS Trusts) presented to People Committee on 31st 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 | 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** | | |
|---|---|---|
| Sustainability | Yes | |
| People | Yes | The annual NHS Staff Survey is the Trust's largest single staff engagement activity. It provides a year-on-year comparison of results, and nationally-benchmarked data against 122 other NHS Acute and Acute & Community Trusts. This informs the Trust's Staff Engagement (People True North) metric, but also provides data across the range of Patient First domains. |
| Patient & 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**

All NHS Trusts are required to participate in the NHS Staff Survey (NHS Standard Contract 2023/24).

**Communication and Consultation:**

No consultation required.

The national embargo on NHS Staff Survey results was lifted on 7th March 2024. Results data have been made available to Trust managers through the PowerBI data visualisation tool, which enables local analysis of results. Results are also available to the public via a national online interactive dashboard.

**Executive Summary:**

**Background**

1. The annual NHS Staff Survey (NSS) is one of the largest workforce surveys in the world. The NSS describes how NHS staff experience their working lives and provides national sector and ICS (Integrated Care System) benchmarking alongside local data. The NSS is intended to enable staff voice, to provide data organisations need to improve staff engagement and experience, and to track progress towards achieving the NHS People Promise. The People Promise sets out the expectations staff should have of the NHS as an employer, following consultation with NHS staff, and which the Trust is committed to meeting as best it possibly can. The survey, which is structured around those people promises, is open from September to November each year. 2023 marked the survey's 20th year. The People Committee has considered the survey results and draft people plan for 24-25.

**2023 Response Rate**

2. In 2022, 45% of Trust staff completed the NSS (vs 44% benchmark median). In 2023, the Trust met its target of increasing this to 50% (8,453 staff). This was better than the national median (45%).

**2023 Results Summary**

3. Overall, the Trust remains below the NHS average for the majority (83%) of questions. However, it scored better than average for 17% of questions, is showing improvements in almost all areas since 2022 (8/9 People Promises/Themes were significantly higher than 2022), and the gap between the Trust position and NHS average is narrowing for most (77%) People Promise elements.

4. Key headlines:-
   - Of the 9 People Promises, 8/9 of the Trust's 2023 scores were worse than NHS average. However, 8/9 of the Trust's scores were significantly improved from 2022 (1/9 was the same).
   - Of the 22 People Promise elements, UHSussex results were better than NHS average for 2/22 (Flexible working, Inclusion) but poorer for 20/22.
   - However, UHSussex closed the gap with NHS average for 17/22 (77%) of People Promise elements, and maintained the same gap for 2/22 (9%).
   - 3/4 WRES (Workforce Race Equality) metrics indicate an improvement in score from 2022. 3/4 WRES metrics indicate better results compared to the national average.
   - WDES (Workforce Disability Equality) metrics indicate mixed results – 2/9 better compared to 2022, and 3/9 WDES metrics better compared to the 2023 national average.
   - Further analysis of the experience of staff from minoritized backgrounds is available at Divisional and team level via the PowerBI (interactive data visualisation) tool.

**Trust Results 2023: Questions with Greatest Improvement vs 2022**

| | 2022 | 2023 | Change | NHS Avg. | Gap | Good? |
|---|---|---|---|---|---|---|
| Q3i Enough staff | 19.53 | 25.54 | 6.01 | 31.75 | -6.21 | High |
| Q3g Able to meet time conflicts | 38.58 | 43.82 | 5.24 | 46.63 | -2.81 | High |
| Q3h Have adequate materials/equipment | 46.44 | 51.20 | 4.76 | 56.88 | -5.68 | High |
| Q4c Level of pay | 21.53 | 26.22 | 4.69 | 30.61 | -4.39 | High |
| Q25c Recommend as place to work | 49.11 | 53.77 | 4.66 | 60.52 | -6.75 | High |
| Q24e Able to access right learning when needed | 53.56 | 58.03 | 4.47 | 59.52 | -1.49 | High |
| Q6b Organisation committed to work-home balance | 42.21 | 46.42 | 4.21 | 48.43 | -2.01 | High |
| Q23c Appraisal helped me agree objectives | 25.24 | 29.43 | 4.19 | 36.02 | -6.59 | High |
| | | | | | | |
| Q12e Worn out at end of work | 52.49 | 47.50 | -4.99 | 43.17 | 4.33 | Low |
| Q26a Often think about leaving | 36.66 | 31.83 | -4.83 | 28.89 | 2.94 | Low |
| Q12b Feel burnt out | 37.81 | 33.59 | -4.22 | 31.12 | 2.47 | Low |
| Q12a Work often emotionally exhausting | 41.77 | 37.58 | -4.19 | 34.03 | 3.55 | Low |
| Q11c Work related stress in last 12 mths | 49.37 | 45.18 | -4.19 | 41.57 | 3.61 | Low |

5. Even where UHSussex scored poorest against the NHS average, 2023 scores were better than in 2022 in most areas, and the gap is closing.

### Trust Results 2023: Questions with Poorer Scores than 2022

| | 2022 | 2023 | Change | NHS Avg. | Gap | Good? |
|---|---|---|---|---|---|---|
| Q20a Feel secure to raise unsafe practice | 68.61 | 66.53 | -2.08 | 70.24 | -3.71 | High |
| Q19c When errors/n-misses happen, organisation takes action | 60.81 | 60.09 | -0.72 | 68.30 | -8.21 | High |
| Q24a Challenging work | 68.91 | 68.42 | -0.49 | 69.12 | -0.70 | High |
| Q19e Organisation treats staff involved in incidents fairly | 56.95 | 56.49 | -0.46 | 59.36 | -2.87 | High |
| Q23a Appraisal in last 12 mths | 83.30 | 82.98 | -0.32 | 83.12 | -0.14 | High |
| Q20b Confident organisation would address (clinical) concerns | 48.70 | 48.44 | -0.26 | 55.90 | -7.46 | High |
| Q5b Choice in how to do work | 51.71 | 51.46 | -0.25 | 52.55 | -1.09 | High |
| Q19d Get feedback following reported errors | 53.10 | 52.95 | -0.15 | 60.53 | -7.58 | High |
| Q25b Acts on concerns from patients | 61.55 | 61.44 | -0.11 | 69.78 | -8.34 | High |
| Q31b Employer made Reasonable Adjustments | 73.78 | 73.76 | -0.02 | 73.19 | 0.57 | High |
| | | | | | | |
| Q16a Personally experienced discrimination (patients) 12 mths | 10.01 | 10.23 | 0.22 | 7.99 | 2.24 | Low |
| Q13b Physical violence (managers) last 12 mths | 0.67 | 0.83 | 0.16 | 0.67 | 0.16 | Low |
| Q13c Physical violence (colleagues) last 12 mths | 1.91 | 2.04 | 0.13 | 1.75 | 0.29 | Low |
| Q13a Physical violence (patients) in last 12 mths | 17.51 | 17.52 | 0.01 | 13.32 | 4.20 | Low |

6. By People Promise Element, UHSussex improved its results in 21/22 (95%) elements compared to 2022. The position worsened for only 1/22 (5%): Raising Concerns. This saw a 3% fall vs 2022, compared to a national 3% improvement).

7. However, in a few areas the UHSussex score worsened in 2023 and the gap with NHS average is greatest:
   - Confident organisation would act on clinical concerns (Q25f)
   - Feedback following reported errors (Q19d)
   - Action following errors/near-misses (Q19c)
   - Acting on patient concerns (Q25b)
   - Physical violence (from patients) (Q13a)

### Trust Results 2023: Questions with Worsening Scores and Biggest Gap vs National Average

| | 2022 | 2023 | Change | NHS Avg. | Gap | Good? |
|---|---|---|---|---|---|---|
| Q19c When errors/n-misses happen, organisation takes action | 60.81 | 60.09 | -0.72 | 68.30 | -8.21 | High |
| Q20b Confident organisation would address (clinical) concerns | 48.70 | 48.44 | -0.26 | 55.90 | -7.46 | High |
| Q19d Get feedback following reported errors | 53.10 | 52.95 | -0.15 | 60.53 | -7.58 | High |
| Q25b Acts on concerns from patients | 61.55 | 61.44 | -0.11 | 69.78 | -8.34 | High |
| | | | | | | |
| Q13a Physical violence (patients) in last 12 mths | 17.51 | 17.52 | 0.01 | 13.32 | 4.20 | Low |

8. Divisions show broadly the same pattern of results across all People Promises, ie. scoring best against Compassionate & Inclusive and poorest against Morale and Always Learning. However there is wide variation in scores:-
   - By Division, Facilities & Estates and Corporate reported best results, and Women's & Children's and Central Support Services (CSS) the poorest.
   - By Staff Group, Additional Clinical Services and Estates & Ancillary reported the best scores, and Healthcare Scientists and Medical & Dental the poorest.
   - By Band/grade, FY2, Specialist Registrar and FY1 doctors report the poorest results (and Band 9s and Very Senior Managers the best).

**Summary**

9. The Board and People Committee may take some assurance from the 2023 NHS Staff Survey results. The Trust met its target for response rate, and again achieved a higher rate than nationally (50% vs 45%). The Trust improved its scores vs 2022 for 21/22 People Promise Elements, and narrowed the gap with NHS average in 17/22 (77%) of elements (and widened the gap in only 2/22 – 9%).

10. However, there is wide variation within the Trust between Divisions and Staff Groups. This analysis therefore provides an opportunity for appreciative enquiry in those areas scoring best, and for targeted support in teams that are reporting a less positive (less improved) workforce experience.

11. The questions/areas in which the Trust scored poorest against the NHS average and worsened its scores since 2022 (largely relating to patient Quality & Safety, raising and acting on concerns, and physical violence from patients) will require a particular focus in 2024/25.

12a. The NHS Staff Survey also provides a calibration of resource/effort vs improvement. The most notable improvements against 2022 were:
- Enough staff (Q3i) – 6.0% point improvement
- Able to meet time conflicts (Q3g) – 5.2% point improvement
- Worn out at the end of each work day/shift (Q12e) – 5.0% point improvement
- Often think about leaving (Q26a) – 4.8% point improvement
- Adequate materials/equipment (Q3h) – 4.8% point improvement

12b. The areas of worsening position:
- Feel secure to raise unsafe clinical practice (Q20a) – 2.0% point worse
- When errors/near-misses happen, organisation takes action (Q19c) – 0.7% points worse
- Challenging/developmental work (Q24a) – 0.5% points worse (higher challenge considered positive)
- Discrimination from patients (Q16a) – 0.2% points worse

13. It should also be noted that in the new NSS questions, Trust staff are reporting notably higher levels of unwanted sexual behaviour from colleagues (5.32% vs 3.82% national average), unwanted sexual behaviour from patients (11.25% vs 7.33% national average). The Trust is a signatory to the national NHSE Sexual Safety in Healthcare Organisational Charter.

**Next Steps**

14. The national embargo on the 2023 NHS Staff Survey results lifted on 7th March 2024. A template Action Plan has been created by HR Business Partners and circulated to Divisions. The Workforce Business Intelligence (Performance & Information Team) has designed a PowerBI tool and uploaded the national and Trust results. Local managers will therefore be able to analyse their own comparative data (at Cost Centre and Team as well as Divisional and Trust level).

15. Where work is encompassed within a Corporate Project or Strategic Initiative (eg. Violence, Prevention & Reduction within the Leadership, Culture & Development Strategic Initiative), the 2023 NSS results will be reviewed alongside the 2024/25 planning refresh and Charter Renewal.

16. The Trust's ambition remains to be above average (and eg. in the top quartile for Staff Engagement). While the 2023 NHS Staff Survey shows significant improvements against the 2022 position and NHS average, this further step-up in performance would require an associated step-up in resourcing and activity. The 2024 NHS Staff Survey opens in September 2024 (ie. in five months' time), which presents a relatively small window for further improvement in staff experience.

| **Key Recommendation(s):** |
| --- |
| 17. The Board is invited to:<br>i) **note** the staff survey presentation and analysis and areas of improvement and concern<br>ii) **take assurance** from the results that work following the 2022 NHS Staff Survey results and in conducting the 2023 NHS Staff Survey has yielded improvement, and<br>iii) **note** that the People Committee has discussed the 2024-25 People Plan and challenges in achieving a significant step-change in performance in the 2024 NHS Staff Survey to progress towards the Trust's ambition of being in the Top Quartile of NHS Acute / Acute & Community Trusts for Staff Engagement as it seeks to balance quality, performance and resources (issues the Board will consider as part of the assurance framework review). |

University Hospitals Sussex
NHS Foundation Trust

# National NHS Staff Survey 2023

## Results summary

7th March 2024

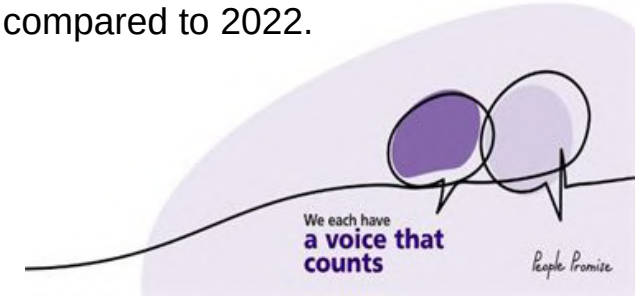
# Executive Summary

NHS
University Hospitals Sussex
NHS Foundation Trust

- The 2023 NHS Staff Survey ran from Sept to Nov 2023. UHSussex met its target of >= 50% responses (8,453 staff) – better than NHS median 45%
- The updated results benchmark against NHS sector (122 Trusts) – rather than only Quality Health Trusts in previous data
- National results embargo lifts on 7th March 2024

- Of the 9 People Promises, 8/9 of the Trust's 2023 scores were worse than NHS average. However, 8/9 of the Trust's scores were *significantly* improved from 2022 (1/9 was the same)
- Of the 22 People Promise elements, UHSussex results were better than NHS average for 2/22 (Flexible working, Inclusion) but poorer for 20/22
- However, UHSussex closed the gap with NHS average for 17/22 (77%) of elements, and retained the same gap for 2/22 (9%)

- 3/4 WRES (Workforce Race Equality) metrics indicate an improvement in score from 2022. 3/4 WRES metrics indicate better results compared to the national average.
- WDES (Workforce Disability Equality) metrics indicate mixed results – 2/9 better compared to 2022. 3/9 WDES metrics indicate better compared to the national average



# Summary: People Promise

University Hospitals Sussex
NHS Foundation Trust

| People Promises | UHSussex | Nat Avg | |
|---|---|---|---|
| Engagement | 6.66 | 6.91 | -0.25 |
| Morale | 5.69 | 5.91 | -0.22 |
| Voice that Counts | 6.48 | 6.70 | -0.22 |
| Always Learning | 5.40 | 5.61 | -0.21 |
| Safe & Healthy | 5.85 | 6.06 | -0.21 |
| Recognised & Rewarded | 5.75 | 5.94 | -0.19 |
| Compassionate & Inclusive | 7.12 | 7.24 | -0.12 |
| Teamwork | 6.64 | 6.75 | -0.11 |
| Work Flexibly | 6.20 | 6.20 | 0.00 |

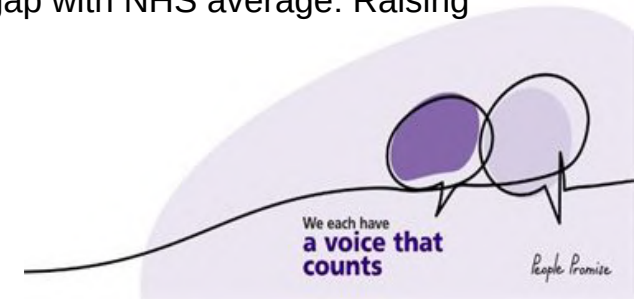
- At overall People Promise level, the Trust is on average for one (We Work Flexibly) and below average for eight
- However, this high-level aggregation summarises a wide range of variations – by People Promise element, question, and at Divisional, Staff Group and Band levels

# Summary: People Promise Element

NHS
University Hospitals Sussex
NHS Foundation Trust

| People Promise Element | UHSussex | | | NHS Average 2023 | |
|---|---|---|---|---|---|
| | 2022 | 2023 | Change | 2023 | Gap |
| | | | | | |
| Flexible working | 5.98 | 6.19 | 0.21 | 6.15 | 0.04 |
| Inclusion | 6.83 | 6.87 | 0.04 | 6.86 | 0.01 |
| Supporting work-life balance | 5.96 | 6.21 | 0.25 | 6.25 | -0.04 |
| Development | 6.22 | 6.36 | 0.14 | 6.44 | -0.08 |
| Team working | 6.50 | 6.60 | 0.10 | 6.68 | -0.08 |
| Stressors | 6.19 | 6.29 | 0.10 | 6.38 | -0.09 |
| Autonomy & Control | 6.81 | 6.88 | 0.07 | 6.99 | -0.11 |
| Compassionate leadership | 6.72 | 6.85 | 0.13 | 6.96 | -0.11 |
| Line management | 6.55 | 6.68 | 0.13 | 6.80 | -0.12 |
| Diversity & Equality | 7.95 | 7.99 | 0.04 | 8.12 | -0.13 |
| Negative experiences | 7.45 | 7.62 | 0.17 | 7.75 | -0.13 |
| Involvement * | 6.62 | 6.71 | 0.09 | 6.86 | -0.15 |
| Thinking about leaving | 5.61 | 5.90 | 0.29 | 6.06 | -0.16 |
| Recognised & Rewarded | 5.55 | 5.75 | 0.20 | 5.94 | -0.19 |
| Burnout | 4.60 | 4.80 | 0.20 | 5.00 | -0.20 |
| Motivation * | 6.71 | 6.84 | 0.13 | 7.04 | -0.20 |
| Appraisals | 4.15 | 4.44 | 0.29 | 4.74 | -0.30 |
| Compassionate culture | 6.65 | 6.76 | 0.11 | 7.06 | -0.30 |
| Advocacy * | 6.27 | 6.43 | 0.16 | 6.74 | -0.31 |
| Health & Safety climate | 4.81 | 5.14 | 0.33 | 5.45 | -0.31 |
| Raising concerns | 6.10 | 6.08 | -0.02 | 6.41 | -0.33 |
| Work pressure | 4.48 | 4.88 | 0.40 | 5.31 | -0.43 |
| | | | | | |
| * Staff Engagement (People TN) | | | | | |

- There are 22 People Promise elements. Of these, UHSussex is above NHS average for two (9%): Flexible Working and Inclusion. It is below average for 20/22 (91%)
- However, UHSussex improved its scores in 2023 for 21/22 elements (95%). Only one element worsened slightly: Raising Concerns
- In 2023, UHSussex closed the gap with NHS average in 17/22 (77%) of elements, and retained the same gap for 2/22 (9%)
- UHSussex increased its scores in 2023 for two elements but still saw a worsening gap with NHS average: Appraisals, and Recognised & Rewarded
- In only one element did the UHSussex score worsen in 2023 and widen the gap with NHS average: Raising Concerns



# Summary: Question Level

University Hospitals Sussex
NHS Foundation Trust

High scores better:

| | 2022 | 2023 | Change | NHS Avg. | Gap |
|---|---|---|---|---|---|
| Q8b Colleagues are understanding and kind | 70.28 | 71.56 | 1.28 | 69.73 | 1.83 |
| Q8d Colleagues show appreciation | 67.47 | 68.09 | 0.62 | 66.91 | 1.18 |
| Q7c Receive respect from colleagues | 70.77 | 71.95 | 1.18 | 70.96 | 0.99 |
| Q8c Coleagues are polite and respectful | 71.44 | 71.93 | 0.49 | 70.95 | 0.98 |
| Q7h Valued by team | 69.72 | 70.98 | 1.26 | 70.12 | 0.86 |
| Q4d Satisfied with opportunities for flexible working | 53.25 | 56.56 | 3.31 | 55.70 | 0.86 |
| Q6c Can achieve good work-home balance | 51.81 | 55.67 | 3.86 | 55.04 | 0.63 |
| Q31b Employer made Reasonable Adjustments | 73.78 | 73.76 | -0.02 | 73.19 | 0.57 |
| Q7i Personally attached to team | 64.34 | 64.88 | 0.54 | 64.32 | 0.56 |
| Q7e Enjoy working with colleagues | 80.57 | 81.71 | 1.14 | 81.23 | 0.48 |
| Q9d Manager takes positive interest in health/wellbeing | 66.77 | 69.22 | 2.45 | 69.10 | 0.12 |
| Q6d Can approach manager re flexible working | 66.50 | 69.27 | 2.77 | 69.22 | 0.05 |
| Q7a Team has shared objectives | 72.29 | 73.38 | 1.09 | 73.34 | 0.04 |

Low scores better:

| | | | | | |
|---|---|---|---|---|---|
| Q11e Pressure from manager to work | 23.46 | 21.95 | -1.51 | 22.57 | -0.62 |
| Q14c Harassment/bullying (colleagues) in last 12 mths | 20.48 | 18.66 | -1.82 | 19.25 | -0.59 |
| Q14b Harassment/bullying (managers) in last 12 mths | 11.95 | 10.19 | -1.76 | 10.49 | -0.30 |

- At question level, UHSussex is better than NHS average for 16/94 (17%)
- UHSussex results were improved for 15/16 of those questions, falling back on only 1/16 vs 2022: Employer made Reasonable Adjustments

# Summary: Question Level

University Hospitals Sussex NHS Foundation Trust

High scores better:

| | | | | | |
|---|---|---|---|---|---|
| Q3i Enough staff | 19.53 | 25.54 | 6.01 | 31.75 | -6.21 |
| Q23c Appraisal helped me agree objectives | 25.24 | 29.43 | 4.19 | 36.02 | -6.59 |
| Q25c Recommend as place to work | 49.11 | 53.77 | 4.66 | 60.52 | -6.75 |
| Q25f Confident organisation would address concern (anything) | 40.64 | 41.49 | 0.85 | 48.65 | -7.16 |
| Q20b Confident organisation would address (clinical) concerns | 48.70 | 48.44 | -0.26 | 55.90 | -7.46 |
| Q19d Get feedback following reported errors | 53.10 | 52.95 | -0.15 | 60.53 | -7.58 |
| Q19c When errors/n-misses happen, organisation takes action | 60.81 | 60.09 | -0.72 | 68.30 | -8.21 |
| Q25b Acts on concerns from patients | 61.55 | 61.44 | -0.11 | 69.78 | -8.34 |

Low scores better:

| | | | | | |
|---|---|---|---|---|---|
| Q14a Harassment/bullying (patients) in last 12 mths | 32.03 | 29.33 | -2.70 | 25.82 | 3.51 |
| Q12a Work often emotionally exhausting | 41.77 | 37.58 | -4.19 | 34.03 | 3.55 |
| Q11c Work related stress in last 12 mths | 49.37 | 45.18 | -4.19 | 41.57 | 3.61 |
| Q12d Exhausted at the thought of work | 35.71 | 32.10 | -3.61 | 28.22 | 3.88 |
| Q17a Unwanted sexual behaviour (patients) in last 12 mths | | 11.25 | | 7.33 | 3.92 |
| Q11b MKS problems in last 12 mths | 36.45 | 33.55 | -2.90 | 29.36 | 4.19 |
| Q13a Physical violence (patients) in last 12 mths | 17.51 | 17.52 | 0.01 | 13.32 | 4.20 |
| Q12e Worn out at end of work | 52.49 | 47.50 | -4.99 | 43.17 | 4.33 |
| Q12c Work frustrates me | 45.19 | 41.33 | -3.86 | 36.71 | 4.62 |

- Even where UHSussex scored poorest against NHS average, 2023 scores were better than 2022 in most areas, and the gap is closing
- However, in a few areas the UHSussex score worsened in 2023 and the gap with NHS average is greatest:
  - Confident organisation would act on clinical concerns
  - Feedback following reported errors
  - Action following errors/near-misses
  - Acting on patient concerns
  - Physical violence (from patients)

# Summary: Variation – Division

University Hospitals Sussex NHS Foundation Trust

- Within UHSussex, there are wide variations by **Division**

| | | Compassionate & Inclusive | Engagement | Teamwork | Voice that Counts | Work Flexibly | Safe & Healthy | Recognised & Rewarded | Morale | Always Learning |
|---|---|---|---|---|---|---|---|---|---|---|
| 57.77 | Facilities & Estates | 7.14 | 6.89 | 6.50 | 6.63 | 6.40 | 6.63 | 6.14 | 6.31 | 5.13 |
| 57.11 | Corporate | 7.16 | 6.66 | 6.72 | 6.46 | 6.59 | 6.35 | 6.03 | 5.96 | 5.18 |
| 56.84 | Medicine (WOR & SRH) | 7.27 | 6.85 | 6.91 | 6.72 | 6.33 | 5.38 | 5.74 | 5.63 | 6.01 |
| 56.48 | Specialist | 7.18 | 6.81 | 6.73 | 6.55 | 6.32 | 5.72 | 5.79 | 5.75 | 5.63 |
| 56.21 | Medicine (RSCH & PRH) | 7.11 | 6.65 | 6.91 | 6.56 | 6.57 | 5.37 | 5.76 | 5.53 | 5.75 |
| 55.71 | Surgery (WOR & SRH) | 7.06 | 6.72 | 6.57 | 6.45 | 5.98 | 5.89 | 5.61 | 5.83 | 5.60 |
| 55.70 | Cancer | 7.13 | 6.67 | 6.61 | 6.60 | 6.08 | 5.80 | 5.84 | 5.62 | 5.35 |
| 55.44 | Surgery (RSCH & PRH) | 7.00 | 6.51 | 6.65 | 6.40 | 6.15 | 5.73 | 5.58 | 5.66 | 5.76 |
| 54.47 | Womens & Childrens | 7.19 | 6.68 | 6.49 | 6.49 | 5.72 | 5.64 | 5.60 | 5.46 | 5.20 |
| 53.62 | CSS | 7.03 | 6.46 | 6.49 | 6.31 | 5.80 | 5.64 | 5.46 | 5.29 | 5.14 |
| | | | | | | | | | | |
| 55.92 | Trust overall | 7.12 | 6.68 | 6.65 | 6.50 | 6.20 | 5.85 | 5.76 | 5.71 | 5.45 |

# Summary: Variation – Staff Group

NHS
University Hospitals Sussex
NHS Foundation Trust

- Within UHSussex, there are wide variations by **Staff Group**

| | | Compassionate & Inclusive | Morale | Recognised & Rewarded | Teamwork | Safe & Healthy | Voice that Counts | Engagement | Always Learning | Work Flexibly |
|---|---|---|---|---|---|---|---|---|---|---|
| 57.64 | Additional Clinical Services | 7.29 | 6.90 | 6.78 | 6.69 | 6.47 | 6.02 | 5.74 | 6.04 | 5.71 |
| 57.64 | Estates and Ancillary | 7.13 | 6.89 | 6.46 | 6.62 | 6.37 | 6.64 | 6.11 | 6.32 | 5.10 |
| 57.16 | Administrative and Clerical | 7.20 | 6.67 | 6.71 | 6.50 | 6.63 | 6.33 | 6.04 | 5.97 | 5.11 |
| 56.14 | Nursing and Midwifery Registered | 7.16 | 6.79 | 6.82 | 6.65 | 6.16 | 5.46 | 5.65 | 5.52 | 5.93 |
| 54.45 | Allied Health Professionals | 7.15 | 6.60 | 6.61 | 6.43 | 5.90 | 5.52 | 5.63 | 5.29 | 5.32 |
| 52.32 | Add Prof Scientific and Technic | 6.91 | 6.28 | 6.43 | 6.20 | 5.49 | 5.48 | 5.42 | 5.16 | 4.95 |
| 51.09 | Healthcare Scientists | 6.66 | 6.30 | 6.00 | 6.05 | 5.43 | 5.47 | 5.38 | 5.00 | 4.80 |
| 50.37 | Medical and Dental | 6.67 | 5.93 | 6.17 | 5.72 | 5.27 | 5.31 | 5.37 | 5.11 | 4.82 |
| | | | | | | | | | | |
| | Trust (sum): | 56.17 | 52.36 | 51.98 | 50.86 | 47.72 | 46.23 | 45.34 | 44.41 | 41.74 |

# Summary: Variation – Band

University Hospitals Sussex NHS Foundation Trust

| Pay Band Heatmap | Compassionate & Inclusive | Engagement | Teamwork | Voice that Counts | Recognised & Rewarded | Work Flexibly | Safe & Healthy | Morale | Always Learning |
|---|---|---|---|---|---|---|---|---|---|
| Band 9 | 8.05 | 7.96 | 7.84 | 8.05 | 7.57 | 7.17 | 6.72 | 6.53 | 6.57 |
| VSM | 7.92 | 7.94 | 7.85 | 8.03 | 7.37 | 6.75 | 6.42 | 6.24 | 7.16 |
| Band 8 - Range D | 7.51 | 7.57 | 7.19 | 7.29 | 6.50 | 6.73 | 5.76 | 5.72 | 5.90 |
| Band 8 - Range C | 7.33 | 6.97 | 7.07 | 6.84 | 6.59 | 7.03 | 5.92 | 5.68 | 5.58 |
| Band 2 | 7.28 | 6.89 | 6.70 | 6.66 | 6.01 | 6.53 | 6.40 | 6.28 | 5.36 |
| Band 5 | 7.17 | 6.79 | 6.86 | 6.64 | 5.70 | 6.29 | 5.70 | 5.70 | 6.09 |
| Band 8 - Range A | 7.16 | 6.81 | 6.65 | 6.69 | 6.11 | 6.51 | 5.69 | 5.32 | 5.33 |
| Band 4 | 7.15 | 6.61 | 6.60 | 6.48 | 5.73 | 6.20 | 6.06 | 5.79 | 5.14 |
| Band 8 - Range B | 7.14 | 6.97 | 6.51 | 6.70 | 6.08 | 6.54 | 5.72 | 5.41 | 5.18 |
| Band 7 | 7.12 | 6.67 | 6.69 | 6.53 | 5.75 | 6.10 | 5.53 | 5.39 | 5.36 |
| Band 3 | 7.11 | 6.69 | 6.56 | 6.49 | 5.64 | 6.32 | 6.32 | 6.09 | 5.29 |
| Band 6 | 7.07 | 6.57 | 6.65 | 6.42 | 5.55 | 5.98 | 5.45 | 5.37 | 5.57 |
| Specialty Doctor | 6.76 | 6.40 | 6.44 | 5.88 | 5.54 | 5.94 | 5.76 | 5.54 | 5.38 |
| Consultant | 6.71 | 5.91 | 6.15 | 5.85 | 5.49 | 5.52 | 5.33 | 5.14 | 4.70 |
| Band 1 | 6.64 | 6.16 | 5.83 | 5.89 | 5.67 | 6.22 | 6.11 | 5.90 | 4.26 |
| Foundation Doctor Year 1 | 6.86 | 6.15 | 6.00 | 5.44 | 5.14 | 4.75 | 5.10 | 5.31 | 4.14 |
| Specialty Registrar | 6.56 | 5.87 | 6.24 | 5.40 | 5.15 | 4.77 | 5.22 | 4.91 | 5.07 |
| Foundation Doctor Year 2 | 6.28 | 5.71 | 5.63 | 5.44 | 4.50 | 3.31 | 4.74 | 4.81 | 4.94 |

- FY2 Doctors, Speciality Registrars and FY1 Doctors reported the lowest scores across all PPs and Themes
- Always Learning, Morale and Safe & Healthy were identified as the lowest scoring Promises Themes across all bands
- The lowest score overall was by FY2 Doctors for We Work Flexibly

# Participation Summary 2023

NHS
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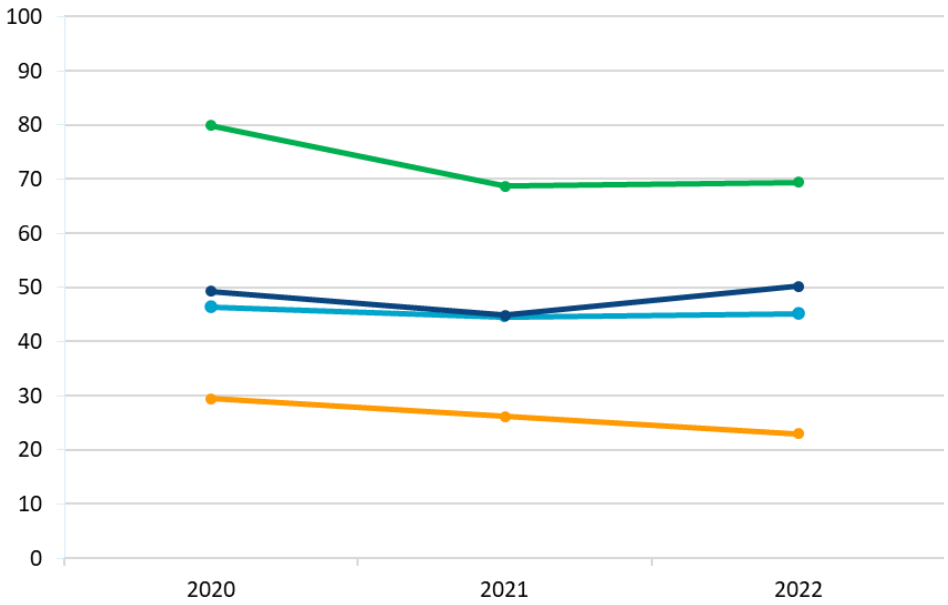
NHS Foundation Trust




| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Your org | 49.29% | 44.87% | 50.18% |
| Highest | 79.95% | 68.69% | 69.45% |
| Average | 46.38% | 44.46% | 45.23% |
| Lowest | 29.47% | 26.17% | 23.03% |
| Responses | 8076 | 7388 | 8453 |

## University Hospitals Sussex NHS Foundation Trust

### Organisation details

Completed questionnaires **8453**

2023 response rate **50%**

### This organisation is benchmarked against:

**Acute and Acute & Community Trusts**

### 2023 benchmarking group details

Organisations in group: 122

Median response rate: 45%

No. of completed questionnaires: 477643

# People Promise / Themes

University Hospitals Sussex NHS Foundation Trust

- 7 People Promises and 2 Themes which are made up of key staff survey questions and scored out of 10 (10 being the highest)

## 7 People Promises

**PP1: We are compassionate and inclusive**

| | |
|---|---|
| PP1_1 | Compassionate culture |
| PP1_2 | Compassionate leadership |
| PP1_3 | Diversity and equality |
| PP1_4 | Inclusion |

**PP2: We are recognised and rewarded**

**PP3: We each have a voice that counts**

| | |
|---|---|
| PP3_1 | Autonomy and control |
| PP3_2 | Raising concerns |

**PP4: We are safe and healthy**

| | |
|---|---|
| PP4_1 | Health and safety climate |
| PP4_2 | Burnout |
| PP4_3 | Negative experiences e |

**PP5: We are always learning**

| | |
|---|---|
| PP5_1 | Development |
| PP5_2 | Appraisals |

**PP6: We work flexibly**

| | |
|---|---|
| PP6_1 | Support for work-life balance |
| PP6_2 | Flexible working |

**PP7: We are a team**

| | |
|---|---|
| PP7_1 | Teamworking |
| PP7_2 | Line management |

## 2 Themes

**E: Engagement**

| | |
|---|---|
| E_1 | Motivation |
| E_2 | Involvement |
| E_3 | Advocacy |

**M: Morale**

| | |
|---|---|
| M_1 | Thinking about leaving |
| M_2 | Work pressure |
| M_3 | Stressors |

# Historical changes – UH Sussex

NHS
University Hospitals Sussex
NHS Foundation Trust

- 8/9 people promises/themes were *significantly* higher than in 2022
- 'We each have a voice that counts' scored similar to 2022 and was not found significant

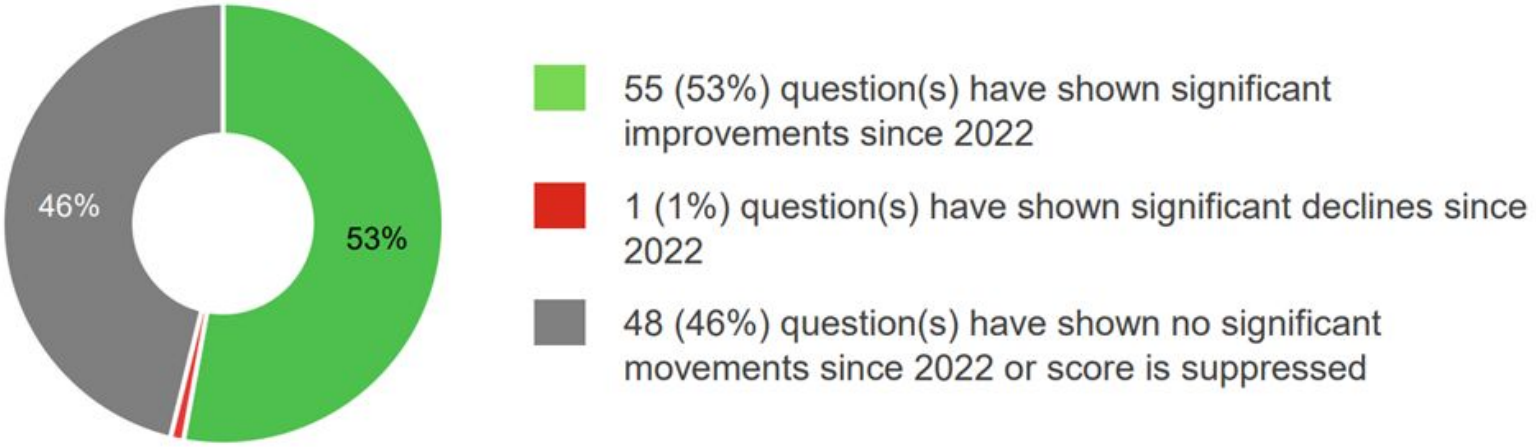
| People Promise elements | 2022 score | 2022 respondents | 2023 score | 2023 respondents | Statistically significant change? |
|---|---|---|---|---|---|
| We are compassionate and inclusive | 7.04 | 7339 | 7.12 | 8406 | Significantly higher |
| We are recognised and rewarded | 5.55 | 7330 | 5.75 | 8419 | Significantly higher |
| We each have a voice that counts | 6.45 | 7272 | 6.48 | 8319 | Not significant |
| We are safe and healthy | 5.62 | 7310 | 5.85 | 8334 | Significantly higher |
| We are always learning | 5.19 | 6972 | 5.40 | 7927 | Significantly higher |
| We work flexibly | 5.97 | 7286 | 6.20 | 8347 | Significantly higher |
| We are a team | 6.52 | 7321 | 6.64 | 8383 | Significantly higher |
| **Themes** | | | | | |
| Staff Engagement | 6.54 | 7358 | 6.66 | 8416 | Significantly higher |
| Morale | 5.42 | 7352 | 5.69 | 8422 | Significantly higher |

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

# Significant Questions

University Hospitals Sussex NHS Foundation Trust

- UH Sussex question scores compared to 2022.
- Summarises questions that have shown statistically significant improvements or declines since the 2022 National Staff Survey (Quality Health significance testing)
- Of the 104 comparable evaluative core questions (3 non-comparable to 2022), 53% of questions have improved since 2022, 1% have declined, and 46% show no significant movement. This shows that 99% of the individual question scores have increased or remained stable since 2022.

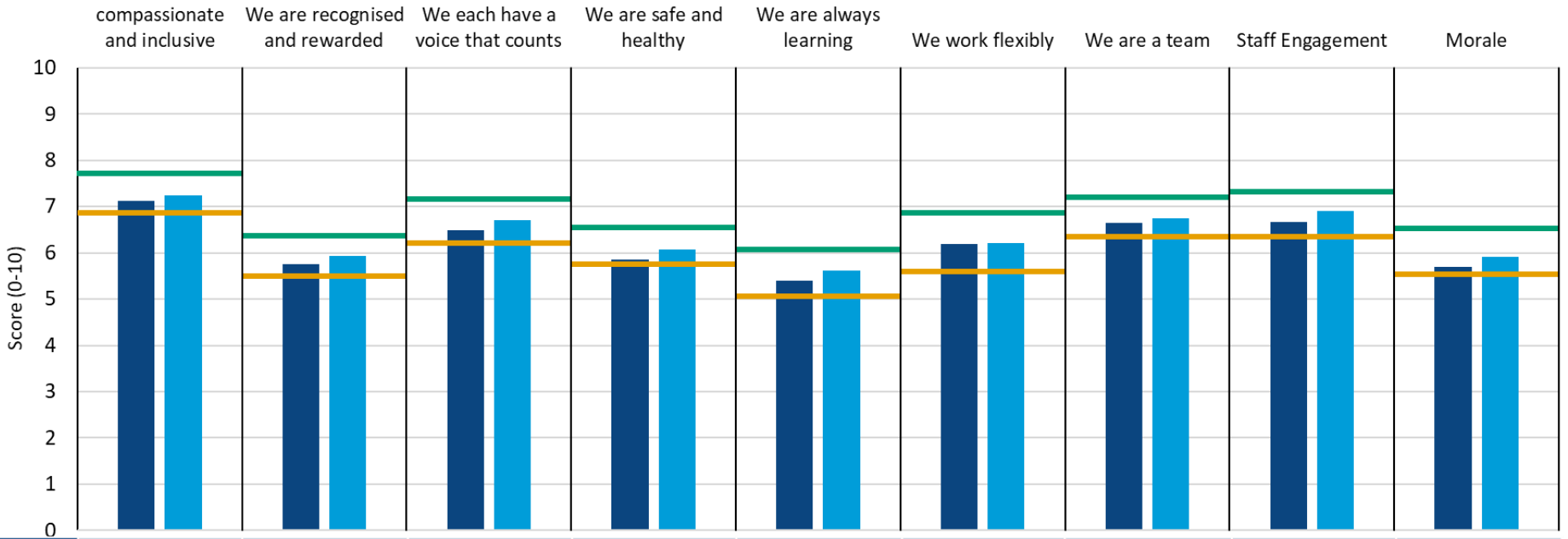



The approach of significance testing on individual items taken here by quality Health is not recommended by statisticians/ our in-house data analyst, and is subject to inaccuracies. Therefore, please apply caution when interpreting these results

# People Promise / Theme Summary

University Hospitals Sussex
NHS Foundation Trust

- UHSussex scored lower than the national average on all PPs/Themes except 'We work flexibly'
- UHSussex scored close to the worst national result for 'We are safe and healthy' and 'Morale'



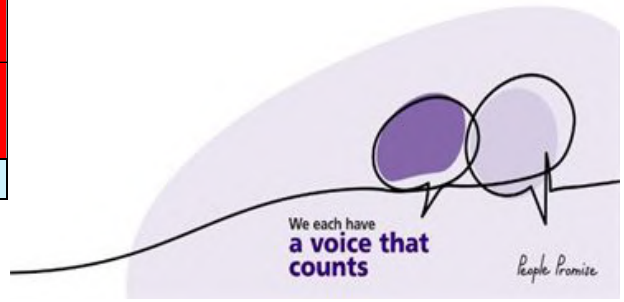

| | compassionate and inclusive | We are recognised and rewarded | We each have a voice that counts | We are safe and healthy | We are always learning | We work flexibly | We are a team | Staff Engagement | Morale |
|---|---|---|---|---|---|---|---|---|---|
| Your org | 7.12 | 5.75 | 6.48 | 5.85 | 5.40 | 6.20 | 6.64 | 6.66 | 5.69 |
| Best result | 7.71 | 6.37 | 7.16 | 6.55 | 6.07 | 6.87 | 7.19 | 7.32 | 6.52 |
| Average result | 7.24 | 5.94 | 6.70 | 6.06 | 5.61 | 6.20 | 6.75 | 6.91 | 5.91 |
| Worst result | 6.85 | 5.50 | 6.21 | 5.75 | 5.05 | 5.60 | 6.35 | 6.34 | 5.54 |
| Responses | 8406 | 8419 | 8319 | 8334 | 7927 | 8347 | 8383 | 8416 | 8422 |

# Staff Engagement

University Hospitals Sussex NHS Foundation Trust

| | | | Staff Engagement Questions | UHSx 2020 % | UHSx 2021 % | UHSx 2022 % | UHSx 2023 % | variance 2022 vs 2023 | National Sector (n126) Avg 2020 | National Sector (n126) Avg 2021 | National Sector (n126) Avg 2022 | National Sector (n122) Avg 2023 | Variance UHSx vs National 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff Engagement Theme | Subscore 1: Motivation | 2a | I look forward to going to work (Often/Always). | 58% | 47% | 47% | 50% | 3.0% | 59% | 52% | 52% | 55% | -4.6% |
| | | 2b | I am enthusiastic about my job (Often/Always). | 72% | 62% | 62% | 65% | 2.9% | 73% | 68% | 67% | 69% | -4.4% |
| | | 2c | Time passes quickly when I am working (Often/Always). | 75% | 71% | 70% | 71% | 1.8% | 76% | 73% | 73% | 72% | -0.9% |
| | Subscore 2: Improvement | 3c | There are frequent opportunities for me to show initiative in my role (Agree/Strongly agree). | 72% | 70% | 70% | 72% | 1.8% | 72% | 73% | 73% | 74% | -1.7% |
| | | 3d | I am able to make suggestions to improve the work of my team / department (Agree/Strongly agree). | 74% | 70% | 70% | 71% | 0.8% | 73% | 70% | 71% | 71% | -0.3% |
| | | 3f | I am able to make improvements happen in my area of work (Agree/Strongly agree). | 57% | 51% | 52% | 54% | 2.1% | 55% | 53% | 55% | 56% | -2.2% |
| | Subscore 3: Staff Advocacy | 25a | Care of patients / service users is my organisation's top priority (Agree/Strongly agree). | 79% | 72% | 70% | 71% | 0.8% | 79% | 76% | 74% | 75% | -4.3% |
| | | 25c | I would recommend my organisation as a place to work (Agree/Strongly agree). | 67% | 54% | 49% | 54% | 4.7% | 67% | 58% | 56% | 61% | -6.8% |
| | | 25d | If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree). | 75% | 65% | 57% | 60% | 2.1% | 74% | 67% | 62% | 63% | -3.7% |
| | | | Staff Engagement Score (True North) | 7.0 | 6.6 | 6.5 | 6.7 | - | 7.0 | 6.8 | 6.8 | 6.9 | - |

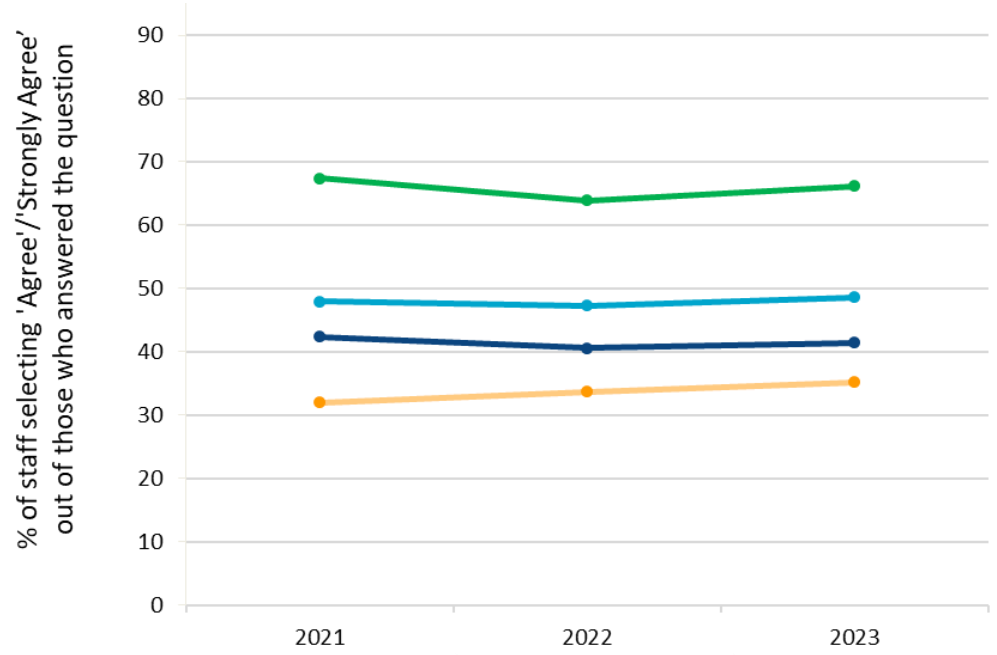
- UHSussex scored higher than in 2022 on all questions within the staff engagement theme, 4 questions substantially increased (green)
- UHSussex scored lower than the national average on all questions within staff engagement, 5 questions substantially lower (red)



# Breakthrough Objective

University Hospitals Sussex NHS Foundation Trust

**Q25f If I spoke up about something that concerned me, I am confident my organisation would address my concern**



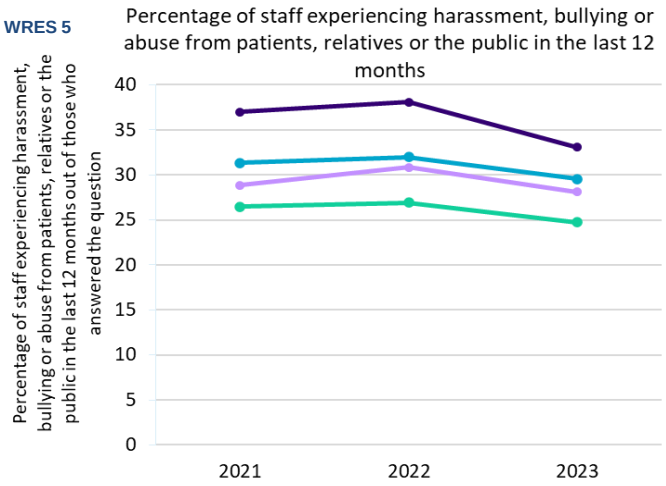

| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Your org | 42.25% | 40.64% | 41.49% |
| Best result | 67.43% | 63.87% | 66.13% |
| Average result | 47.97% | 47.28% | 48.65% |
| Worst result | 32.02% | 33.68% | 35.26% |
| Responses | 7992 | 7304 | 8358 |

- UHSussex has consistently scored lower than the national average for the breakthrough objective question
- UHSussex breakthrough objective score remains close to the lowest scoring Trust
- UHSussex breakthrough objective score has increased only minimally from 2022

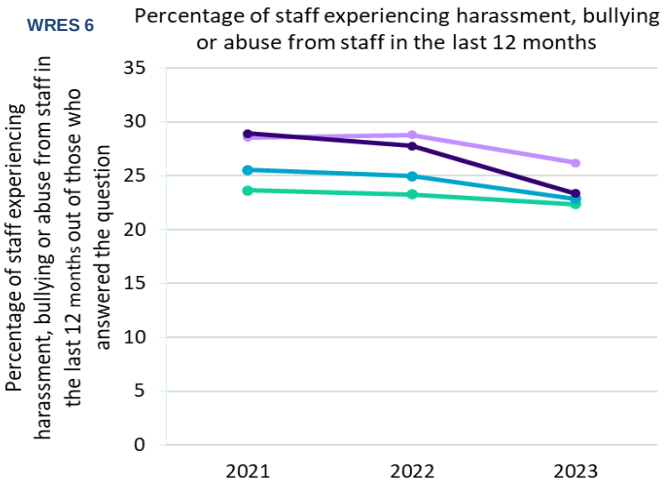
# Workforce Race Equality Standard

University Hospitals Sussex
NHS Foundation Trust

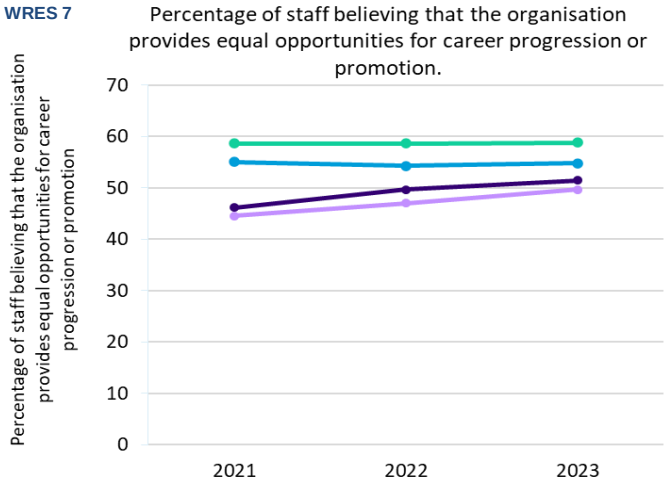
**WRES 5**



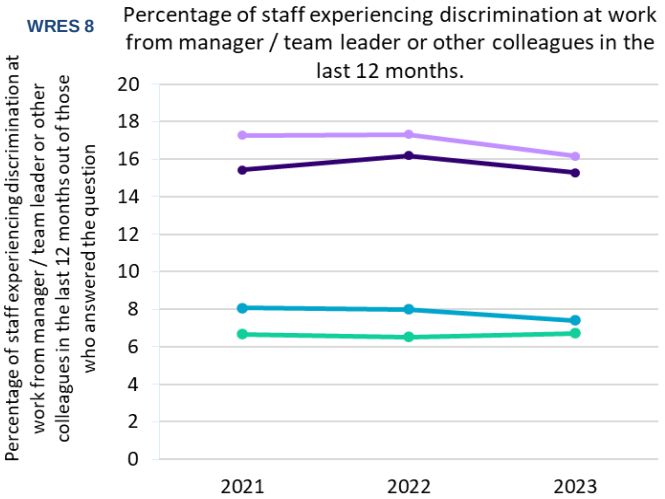

**WRES 6**




**WRES 7**




**WRES 8**



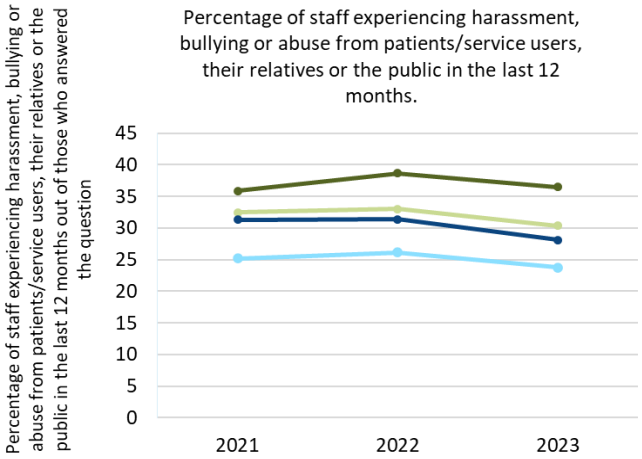

- WRES 6, 7 & 8 indicate less difference in results between minority ethnic and white staff (better) than the national average
- WRES 5, 6 & 7 indicate a narrowing gap in score between minority ethnic and white staff (improvement) from 2022

White staff: **UHSussex**
All other ethnic groups*: **UHSussex**
White staff: National Average
All other ethnic groups*: National Average

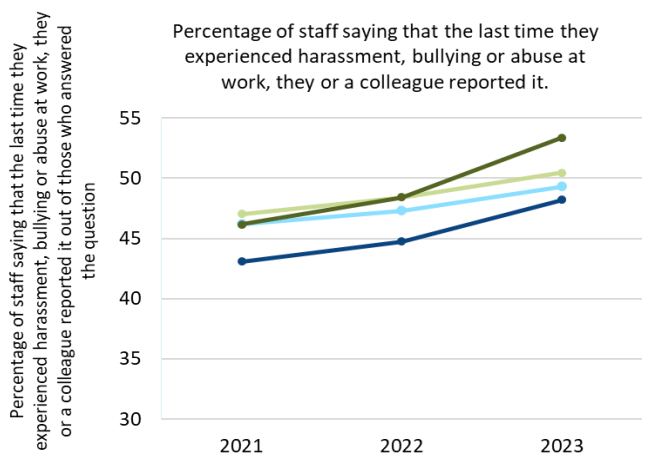
# Workforce Disability Equality Standard

University Hospitals Sussex NHS Foundation Trust

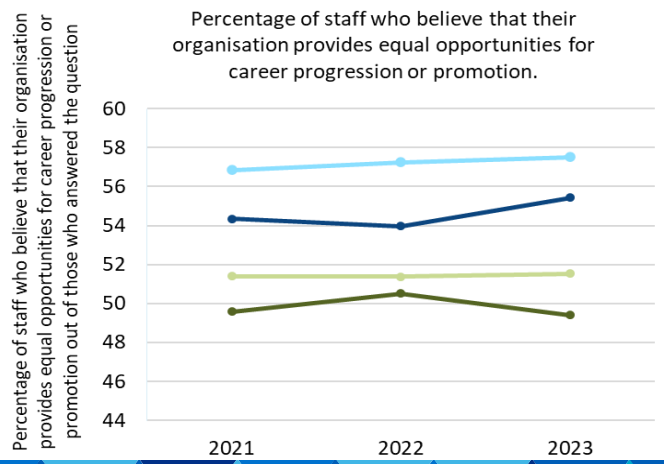
**WDES 4.1**



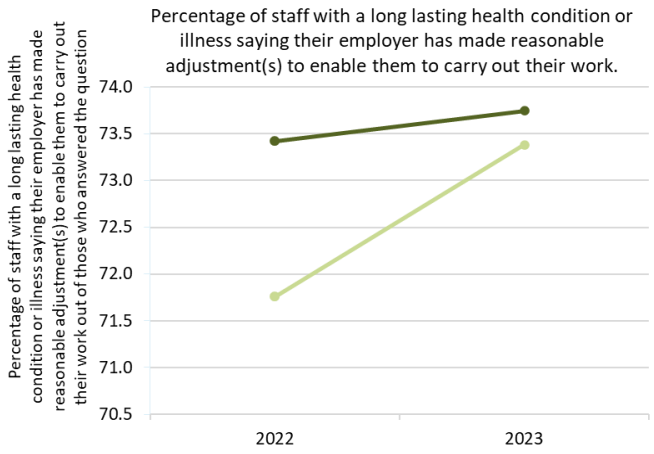

**WDES 4.4**




**WDES 5**




**WDES 8**




- WDES 4.1 and 4.4 indicated a larger difference in scores (worse) than the national average, all other indicated similar or better scores
- WDES 5 indicated the largest increase in disparity between scores (worse) from 2022
- WDES 8 a larger percentage of reasonable adjustments

| |
|---|
| **Staff with a LTC or illness: UHSussex** |
| Staff without a LTC or illness: **UHSussex** |
| Staff with a LTC or illness: National Average |
| Staff without a LTC or illness: National Average |

# Action Plan

University Hospitals Sussex NHS Foundation Trust

| Action | When | Lead | Status |
|---|---|---|---|
| Analyse NHS staff survey results | March 2024 | Engagement, Health and Wellbeing Manager<br>Data & Reporting Analyst | Completed March 2024 |
| Share Trust wide results with staff (embargo lifted) | March 2024 | Engagement, Health and Wellbeing Manager<br>Communication Team | In progress - Launch 7 March 2024 |
| Divisions to share results with Teams (limited access) | March 2024 | Divisional leadership Team<br>HRBP | Completed March 2024 |
| Create a bespoke analytical tool to enable divisional results to be interrogated at a cost centre, site, protected characteristic level | March - April 2024 | BI Team<br>Data & Reporting Analyst | Restricted view – Completed Feb 2024<br>Available to all - 7 March 2024 |
| OD training, Culture and Values enquiry | Feb- April 24 | Chief OD and Culture Officer<br>Culture Advisory Group<br>Values enquiry volunteers | In progress |
| Divisions to analyse data, determine areas of Success and improvement, share in posters and Divisional Newsletters | March 2024 | Divisional leadership Team<br>HRBP | In progress – completed by 15 March 2024 |
| Hold Divisional focus groups | March-May 2024 | Divisional leadership Team<br>HRBP | In progress – completed by 3 May 2024 |

# Action Plan

NHS
University Hospitals Sussex
NHS Foundation Trust

| Action | When | Lead | Status |
|---|---|---|---|
| Implement Divisional Action plans. Consideration given to actions on protected characteristics and link to Culture work. | Mid-May 2024 | Divisional leadership Team<br>HRBP | Commence May 2024 |
| Implementation of Divisional Action plans to be monitored through Divisional SDR and Trust SDR | May 2024 onwards | Divisional leadership Team | Commence May 2024 |
| Develop corporate workstreams to support Culture and values enquiry workstream and Divisional Action plan themes | May 2024 | Chief OD and Culture Officer<br>Director of HRM<br>Director of Communications | In progress |
| Report to People Committee detailing Divisional and corporate action plans | May 2024 | Chief OD and Culture Officer<br>Director of HRM | Commence May 2024 |
| Planning commence for 2024 Staff Survey (delivery and communication plan) | July 2024 | Engagement, Health and Wellbeing Manager | Launch September 2024 (date TBC) |
| Implement ongoing Trust and Divisional “You Said, We Heard, We did” communications | July-August 2024 | Director of HRM<br>Director of Communications | Commence July 2024 |

University Hospitals Sussex
NHS Foundation Trust

| | | | | | |
|---|---|---|---|---|---|
| **Agenda Item:** | 14. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 2 May 2024 |
| **Report Title:** | Finance & Performance Committee Chair's report to Board | | | | |
| **Sponsoring Director:** | Philip Hogan, Committee Non-Executive Chair | | | | |
| **Author(s):** | Philip Hogan, Committee Non-Executive Chair | | | | |
| **Report previously considered by:** | | | | | |
| **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 | 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 Finance & Performance Committee met for the first time on 25 April 2024. The Committee brings together oversight of matters that were previously received by the Sustainability and the Systems & Partnerships Committees. Both committees met in February and March covering their focused monthly meetings.

This meeting was a full quarterly Committee and covered all areas within the Committee's remit and received, discussed ad noted papers covering:
Sustainability True North, Breakthrough Objective (productivity), Strategic Initiative (environmental sustainability) and Corporate Projects (median hour of discharge, reducing length of stay, and patient access transformation), a Quarter 4 finance report, the Efficiency Programme, the Capital Programme, Operational Performance including the performance against constitutional standards, the Corporate Projects for Commercial team activities including procurement, an ICS finance update and a risk paper and the Board Assurance Framework. The Committee also received a 3Ts progress report and stage 1 post project evaluation.

**Sustainability Committee Chair's report to Board**
May 2024

The committee reviewed and endorsed for Board approval the 24/25 Capital Plan and 24/25 Operating plan for submission to the ICB.

Investment decisions were also considered and approved (subject to the Committee's delegated limits) that concerned:

- The Medical Assessment Unit on the Royal Sussex County Hospital site; and
- Waste Management Contracts.

<u>True North Financial Performance Report</u>
Quarter 4 2023/24 Financial position

The Committee received the report on the financial position 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. At Month 12 the agency expenditure had been lower than Month 11 and excluded the cost of direct engagement.

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 had an in year revised forecast outturn deficit position. The actual deficit for the year exceeded the revised forecast outturn due to the amount relating to value of activity expected when compared to the application of NHSE's default methodology. The Committee noted the ongoing discussion around the way the quarter 4 activity improvement would be reflected in quarter 1 2024/25.

The Committee **NOTED** drivers of the deficit position included 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 had not been achieved. The Committee **NOTED** the tactical actions to underpin improvement on exit run rate.

The Committee **NOTED** the risks to the 2024/25 financial year given the adverse run rate that had been significantly ahead of expectation in month 12. While there had been no one issue, divisional expenditure on agency, use of the independent sector, clinical supplies costs and private sector patient income shortfall. The Committee heard that work was taking place to understand the issues through finance business partners and communicate the measures to be taken including stratified training for all budget managers.

The Committee **NOTED** that work on efficiencies had made positive impact on the position but had not fully delivered at the necessary pace and was adverse to plan in month and cumulatively.

The Committee received information on the risks to the 2023/24 position and the implications for the 2024/25 plan, the actions planned and had assurance these have been shared and are understood by the Integrated Care System.

<u>ICS Finance Update</u>

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

The Strategy Committees in Common meeting with ICS partners had not yet held a formal meeting but was scheduled and the Committee would receive an update at the May meeting.

Productivity Breakthrough Objective

The Committee discussed the productivity breakthrough objective. In the April meeting the Committee **RECEIVED** an update from Managing Director for Planned Care and Cancer for the position at Month 12. The Committee **NOTED** that the Trust significantly outperformed the baseline year at Month 12. The internal delivery excluding use of the independent sector exceeded the baseline year.

The Committee welcomed the positive updates on Outpatient productivity noting significant opportunities remain. The Committee heard about the particular benefits to improve clinic lists lists and the initiatives to advance this approach further.

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 into 2024/25, trajectories having been reported and agreed.

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 Trust had delivered 86% of the in year CO2 reduction target for 2023/24.

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 and was anticipated through the negotiated waste management contract that were expected to bring cultural benefits for active staff engagement in the Strategic Initiative.

Efficiency and Transformation Programme Quarter 4

The Committee **NOTED** the current level of delivery of the year's efficiency programme which was adverse to plan at month 12. 2024/25 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 as there was low confidence that the risk will achieve its target risk score in year.

Capital Investment Progress Report Quarter 4

The Committee **RECEIVED** the Q4 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 outturn was an underspend at Month 12 due to external factors outside the Trust control. The approach taken had been supported by the Integrated Care System and supported system partners.

The Committee **NOTED** that work to reduce over-programming had shown considerable success. Although the capital programme remained over committed. Learning from the 2023/24 experience was discussed including the importance of clarity on deliverables and benefits on projects so that opportunities are properly

assessed. The Committee discussed that 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). The considerable patient benefit through the investments delivered in 2023/24 were **NOTED**.

Commercial Activities Update

The Committee **NOTED** the update on the activities of the Commercial Directorate over quarter 4 that were wide ranging. The innovation work-stream now reports as part of the Research and Innovation strategy. Progress on this is reported to the Research & Innovation and Digital Committee.

The Committee **RECEIVED** an update on procurement and supply chain projects and deliverables and **ENDORSED** the approved Procurement Strategy.

Operational Plan 2024/25

The Committee **NOTED** the draft Operational Plan to support further engagement with the Board at their meeting at the end of April 2024. The Plan looks at the approach bring compliance with performance and access targets together with workforce and financial targets. The Committee **NOTED** the arrangements for development of the plans and submission dates to go to the Integrated Care Board to be incorporated into their plan. The plan outlined the arrangements to deliver performance measures, a challenging financial plan and significant savings on workforce spend through efficiencies. It was noted that the national guidance on the annual plan had been considerably delayed but was broadly as anticipated. A change had been the requirement to deliver 78% 4-hour A&E waiting compliance slightly higher than earlier iterations.

The plan contains Workforce plans as seen by the Board at the meeting in March. In respect of the Finance plan the Committee **NOTED** ongoing discussion on where costs would fall in year 2024/25. The Committee **NOTED** that Performance and Access Targets had been given RAG ratings that reflected confidence in the plans. The Committee recognised that the Workforce plan delivers on the numbers asked for and the conversion of bank spend and to reduce spending on medical workforce. The Committee **NOTED** that the delivering of planned care targets eliminating 65week waits in year given the financial position predicated on Elective Recovery Funding achievement without spend above tariff rates or use of the Independent Sector so would be a considerable challenge.

The Operational Plan included the Final Core Gap that had been outlined at the February and March meetings of the Sustainability Committee but for 2024/25 outlined the high-level risks and mitigations. The Committee **NOTED** the work to develop the plan into robust delivery plans with Divisions as the basis for a coherent and well communicated plan for the maintenance and improvement of services.
The Committee **AGREED** to **ENDORSE** the Operational Plan to the Board.

Risks and Board Assurance Framework (BAF)

The Committee **NOTED** the quarter 4 Sustainability Risks and quarter 4 Systems & Partnerships performance risks paper on the programme risks which may impact the delivery of the Sustainability and Systems and Partnerships True Norths along with the overarching risks from the respective Strategic Initiative and Corporate Projects. 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 4 2023/24 scores for Sustainability risks 2.1, 2.2 and 2.3 and in relation to risk 5.1, 5.2 and 5.3 for which it has oversight, are fairly represented as at the end of quarter and remained unchanged.

Focus meetings of the Sustainability Committee and Systems and Partnership Committee outside the quarterly meeting.

This report also covers those meetings of Sustainability Committee and Systems & Partnerships Committee meetings in February and March 2024 through further tables at the end of this report.
The meetings of the Sustainability Committee 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 and the Managing Director, Planned Care & Cancer. The Director of Improvement and Delivery had given apologies and was represented by the Chief Finance Officer at each meeting.

The February and March meetings of the Systems & Partnership Committee were quorate attended by at least two Non-Executive Directors and at least two Executives present one of which being the Chief Operating Officer or the Chief Financial Officer. The February meeting was fully attended by Executive members. At the March meeting there were apologies of absence from the Chief Strategy Officer and the Chief Finance Officer was present for part of the meeting.
Also in attendance were the Managing Directors of Planned Care & Cancer and for Urgent & Emergency Care. The Director of Performance and Information was present at the March meeting of the Systems & Partnerships Committee

Corporate Projects Systems & Partnerships

The Committee received updates from the Senior Responsible Officers for the Corporate Projects of Median Hour of Discharge and **NOTED** the slowly progressing but impactful work to discharge patients earlier in the day creating specialty headroom for handovers and reducing the challenges of outlying patients while reducing crowding on the emergency floor. The Committee took assurance through the positive impact the projects are having and heard about the transformative impact of the Louisa Martindale Building discharge lounge. The Committee heard that the project remained in the Improve state and in addition to targeted standards for every in-scope ward, during 2024/25 supportive work will be undertaken with three focus wards per Division to establish the changes in the current cultural working pattern of the wards that are potentially blocking improvements thus patient flow. The Reducing Length of Stay project was similarly making improvements but had not reached pre-pandemic levels. The Committee heard about the improved discharge protocols and work with the NHS Sussex Peer review for managing longer length of stay cohorts. To note the proposed next phase of the project and its synergy to the Discharge Peer Review work.

Around Patient Access Transformation, the Committee also **NOTED** the advancements made with the booking team including the use of robotics to speed up appointment scheduling to optimise theatre lists. While absences in the team had delayed implementation the Committee was assured that there is a skilled team in place with coherent plans for making impactful improvements.

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.<br><br>The Board is asked to **NOTE** the Committee recommendation that the BAF risks 2.1, 2.2 and 2.3, and in relation to risk 5.1, 5.2 and 5.3 for which it has oversight, are fairly represented as at the end of quarter 4. |

## FINANCE & PERFORMANCE COMMITTEE HIGHLIGHTS REPORT TO BOARD

| Meeting Details | | | | | |
|---|---|---|---|---|---|
| **Meeting Date** | **25 April 2023** | **Chair** | Philip Hogan | **Quorate** | Yes |
| **Declarations of Interest** | No declarations were raised | | | | |

| Items received at the Committee meeting | | | | |
|---|---|---|---|---|
| Sustainability True North<br><br>Financial Performance Report Quarter 4 2023/24 -Updates Provided in April on Month 12 | **Apr** | **Presenter**<br>Director of Finance | **Purpose**<br>For assurance | **Outcome /Action taken**<br>Noted position and significant key risks. |
| ICS Financial Report | **Apr** | **Presenter** Chief Finance Officer | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted system work on financial gap, and national context and the implications for the Trust. |
| Sustainability Breakthrough Objective<br>Productivity<br>Updates on delivery of associated Systems & Partnership Corporate Projects<br>▪ Median Hour of Discharge<br>▪ Reducing Length of Stay<br>▪ Patient Access Transformation | **Apr** | **Presenter**<br>Chief Finance Officer / Managing Director Planned Care | **Purpose**<br>To inform the Committee of the productivity against 2019/20 activity at 2019/20 cost | **Outcome /Action taken**<br>Noted positive performance and continued risks to delivery. The Committee took assurance from the positive impact the projects are having though fragile. The improved alignment through other Trust developments including job planning supports medical leaders getting behind the cultural change needed for these interrelated priority action |
| Sustainability Strategic Initiative<br>Environmental Sustainability | **Apr** | **Presenter**<br>Director of Estates and Facilities | **Purpose**<br>To inform the Committee on the progress being made to reduce the Trust's environmental impact | **Outcome / Action taken**<br>Noted considerable progress. However, energy usage increased compared to 2022/23 so means CO2 target continues to require a significant step change to delivery |

| | | | | |
|---|---|---|---|---|
| Efficiency & Transformation Programme.<br>Updates provided on Month 12 | **Apr** | **Presenter** Chief Finance Officer in absence of Director of Improvement and Delivery | **Purpose**<br>To inform the committee on the update on the 2023/24 plan delivery | **Outcome /Action taken**<br>Noted the update on the 2023/24 plan delivery, development of the 2024/25 plan and associated risks for the 2024/25 plans |
| Capital Investment Progress Report Q4 2023/24<br><br>Capital Plan for 2024/25 | **Apr** | **Presenter**<br>Director of Capital Planning | **Purpose**<br>To update on the implementation of the 2023/24 capital plan and set out the actual position at Q4 end and revised full-year outturn position and plan for 2024/25. | **Outcome /Action taken**<br>Noted the source of funds secured. Noted agreed overprogrammed capital plan has been mitigated significantly |
| Commercial Progress Report Q4 2023/24<br><br>Procurement Strategy to April 2024 meeting | **Apr** | **Presenter**<br>Commercial Director | **Purpose**<br>To inform the Committee of activities undertaken by the commercial directorate and upcoming areas of opportunity | **Outcome /Action taken**<br>Endorsed Procurement Strategy<br>Noted the wide-ranging procurement and commercial activities in Q4 and how these align to our Trust strategy. |
| Systems & Partnership True North<br>Operational Performance<br><br>▪ Report on Developing Performance Scorecard<br>▪ Report on Constitutional Standards | **Apr** | **Presenters** Chief Operating Officer. MD Planned Care / MD Urgent & Emergency Care Director of Performance & Information | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted and recognised the performance challenges which support the strategic risk score remaining at 20 |
| Operating Plan 2024/25 | **Apr** | **Presenter** Chief Strategy Officer | **Purpose**<br>To endorse | **Outcome /Action taken**<br>Endorsed. |
| Waste Management Contract | **Apr** | **Presenter**<br>Director of Estates and Facilities | **Purpose**<br>To endorse | **Outcome /Action taken**<br>Noted financial impacts, benefits and risks.<br>Agreed to support recommendations.<br>**APPROVED** Contract awards |
| Medical Assessment Unit Business Case<br>(Part of RSCH Emergency Department Reconfiguration) | **Apr** | **Presenter** Chief Finance Officer / Divisional Director of Operations (Medicines) | **Purpose**<br>To endorse | **Outcome /Action taken**<br>Noted financial impacts, of revised schemes, benefits and risks,<br>Agreed to support recommendations.<br>To Board for approval. |
| Trust Risk Register relating to Sustainability & Systems & Partnerships | **Apr** | **Presenter** Chief Finance Officer for Sustainability<br><br>Chief Operating Officer for Systems & | **Purpose**<br>For information | **Outcome /Action taken**<br>Noted and discussed.<br>Confirmed the risks and scores across individual areas in the Sustainability & Systems & Partnership domains were scored |

| | | | | |
|---|---|---|---|---|
| | | Partnership Risks | | appropriately given the risks and issues set out in the papers presented at the meeting. |
| Board Assurance Framework | **Apr** | **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 4 score for BAF risks 2.1, 2.2 and 2.3, and in relation to risk 5.1, 5.2 and 5.3 for which it has oversight, are fairly represented as at the end of 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** |
| The proposals for the following are referred to the Board meeting in Private for **APPROVAL**:<br>- Medical Assessment Unit Full Business Case Programme | **May 2024** |

## SUSTAINABILITY COMMITTEE HIGHLIGHTS REPORT TO BOARD

| **Meeting Details** | | | | | |
|---|---|---|---|---|---|
| **Meeting Date** | **28 March 2024** | **Chair** | Philip Hogan | **Quorate** | Yes |
| **Meeting Date** | **29 February 2024** | **Chair** | Lizzie Peers | **Quorate** | Yes |
| **Declarations of Interest** | No declarations were raised | | | | |

**Items received at the Committee meeting**

| | | | | | |
|---|---|---|---|---|---|
| Sustainability True North<br>Financial Performance Report -Updates Provided in February on Month 10 March on Month 11 | **Feb** | **Mar** | **Presenter**<br>Director of Finance | **Purpose**<br>For assurance | **Outcome /Action taken**<br>Noted position and significant key risks. |
| Financial Forecast. Roadmap for 2023/24 | **Feb** | **Mar** | **Presenter**<br>Director of Finance | **Purpose**<br>For information | **Outcome /Action taken** Noted. Reviewed mitigated forecast outturn key risks |
| Sustainability Breakthrough Objective<br>Productivity<br>- Updates Provided in February on Month 10 March on Month 11 | **Feb** | **Mar** | **Presenter**<br>Chief Finance Officer / Managing Director-Planned Care | **Purpose**<br>To inform the Committee of the productivity against 2019/20 activity at 2019/20 cost | **Outcome /Action taken**<br>Noted positive performance and continued risks to delivery and the impact of industrial action. |
| Efficiency & Transformation Programme.<br>Updates provided in February on Month 10 March on Month 11 | **Feb** | **Mar** | **Presenter**<br>Chief Finance Officer in absence of Director of Improvement and Delivery | **Purpose**<br>To inform the committee on the update on the 2023/24 plan delivery | **Outcome /Action taken**<br>Noted the update on the 2023/24 plan delivery and associated risk |
| Draft Financial Plan 2024/25 | **Feb** | **Mar** | **Presenter**<br>Director of Finance | **Purpose**<br>To inform the committee on the development of a plan for 2024/25 to Board approval | **Outcome /Action taken**<br>Noted risk. Escalation to Board (Mar) on Risk Appetite and Strategy determining bed base |
| Electronic Patient Record Programme<br>- Update on building specifications | **Feb** | | **Presenter**<br>Chief Information Officer | **Purpose**<br>To endorse | **Outcome /Action taken**<br>Noted use of time since decision taken to review specification. Agreed sign-off approach |
| Full Business Case – OrderComms | | **Mar** | **Presenter**<br>Chief Operating Officer | **Purpose**<br>To endorse | **Outcome /Action taken**<br>Ratified Committee Chair's action to endorse contracting by Sussex Pathology Network. Escalated learning points to Board |

## SYSTEMS AND PARTNERSHIPS COMMITTEE HIGHLIGHTS REPORT TO BOARD

| **Meeting Details** | | | | | |
|---|---|---|---|---|---|
| **Meeting Date** | **28 March 2024** | **Chair** | Bindesh Shah | **Quorate** | Yes |
| **Meeting Date** | **29 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<br>-Emergency Access<br>-Tier 1 RTT Recovery<br>-Tier 1 Cancer Recovery<br>-Diagnostics | **Presenter**<br>Managing Director of Unscheduled Care / Managing Director of Planned Care and Cancer / Chief Operating Officer | **Purpose** For information. | **Outcome /Action taken**<br>Noted and recognised the performance challenges which support the strategic risk score remaining at 20 |
| Strategic Initiative – 3Ts (March only) | **Presenter**<br>Chief Financial Officer | **Purpose** For information and assurance | **Outcome /Action taken**<br>Noted – Updates on Stages 2&3 Affordability Challenge & trust response |

University Hospitals Sussex
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|---|---|---|---|---|---|
| **Agenda Item:** | 15. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 02 May 2024 |
| **Report Title:** | Report from Quality and Safety Improvement Programme Committee meeting held on 24 April 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 April which supported the reporting to this Committee.

**Report:**

The Committee met on the 24 April 2024 and was quorate as it was attended by three non-executives, the Trust Chair and eight executives and programme SRO.

The meeting received its scheduled updates from each of the delivery and enabling workstreams along with the programme risk register, the programme delivery scorecard and an update from the programme executive lead and SRO.

The Committee focused its attention on the development of the overarching single plan against the Trust's undertakings recognising that the Quality and Safety Improvement Programme is just one element. The Committee heard about the Trust's engagement with the NHS E regional team and the ICB on what they wish to see, and would value receiving assurance reporting against, to ensure that the Trust can develop one detailed plan that supports the assurance requirements of the Board and the external regulators in an efficient way.

The Committee agreed that having one detailed plan will be efficient and remove duplicative effort in tracking and reporting improvements. The meeting agreed that this single plan would give clearer visibility and assurance flowing through to the Board via the key oversight route of this Committee. The Committee reflected that whilst a single plan would report to the Committee the document should be clear where matters are covered and reviewed in detail at other forums such as the CQC recommendation delivery through the Patient and Quality Committee. The Committee also endorsed the action being taken to produce an accessible summary of the plan which would be maintained to provide a snapshot of improvements and where gaps remain.

The Committee received the progress update for each of the programme's four workstreams, noting for each of these appropriate governance and oversight of delivery continues including their reporting to the Quality and Safety Improvement Programme Steering Group led by the Chief Executive. The Committee noted that each programme continues with their delivery and noted the work undertaken to remove duplication between the improving surgery access and the safety culture workstreams.

The Committee received a report from the Director of Communications and Engagement which provided assurance over the delivery of the communications work that is supporting each of the workstreams. The Committee noted the development of a programme and project communications toolkit and the wider work undertaken to promote this programme and its value in supporting the delivery of the Trust's ambition to provide excellent care every time.

The Committee received and noted the programme risk register that this has been reviewed at the Programme Steering Group.

## Recommendations

The Board is recommended to:-

**NOTE** the progress being made by each workstreams against their improvement delivery plans.

**NOTE** the development of an overarching undertakings action tracking plan and the endorsement of the Committee that a single plan needs to efficient and not replicative of work being undertaken in other forums.

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|---|---|---|---|---|---|
| **Agenda Item:** | 16. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 2 May 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 18 April 2024 and was quorate as it was attended by six Non-Executive Directors. In attendance were the Chief Financial Officer, the Chief Strategy Officer, the Trust's Director of Finance, 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, the Chief Information Office attend to present the Information Governance reports and the Chief Operating Officer attended in respect of one of the Internal Audit Reviews undertaken in respect of Outpatient Clinic Management.

<u>Risk Register and BAF reports.</u>

The Committee considered, reviewed, discussed, and confirmed the operation of the Trust's Board Assurance Framework process across the year and specifically how this supported the quarter 4 strategic risk scores.

The Committee recognised that the quarter 4 scores had not changed from those agreed by the Board at the start of the Quarter. The Committee reflected on the supporting process of Committee's oversight in particular that undertaken by the People Committee that scrutinised the reduction in score for risk 3.4 from the end of quarter 3 to the start of quarter 4 seeing the risk achieve its 2024/25 target score with this movement.

The Committee reflected on the complementary oversight role and the value of undertaking a deep dive of risks that have not moved for several quarters and are away from their target score.

The Committee noted the continued positive impact the risk oversight group is having on the level of risk reviews being undertaken by the respective risk owners with the divisional focus being directed to the highest scored risks. The Committee noted that there remains work to be undertaken to continue to mature the Trust's risk management processes to improve overall compliance with the Trust risk management policy. The Committee also noted the developing business partnering approach to support the divisions to improve the regularity of the risk oversight, review and datix update processes.

Internal Audit activity

The Committee noted the positive opinion on the Trust's RTT Data Quality processes and whilst significant improvements were identified within the Outpatient Clinic Management the Committee noted that Internal Audit had been proactively used to enable a structure to be applied to the Trust's improvements.

The Committee noted the Internal Auditors follow up report continued to show good levels of engagement with Internal Audit enabling evidence to be provided against prior recommendations. The Committee noted the auditors continued to reflect 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.

The Committee received the draft annual report and noted that the Head of Internal Audit was providing an overall positive opinion of moderate assurance over the Trusts systems of internal control based on their activity across the year. The Committee agreed that directing Internal Audit activity to support the Trust realise improvement should continue into the shaping of the 2024/25 internal audit plan.

Local Counter Fraud

The Committee considered the Local Counter Fraud progress report for Quarter 4 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 Declaration of Interests Processes. The Committee received assurance from this work that the design and application of Trust's process are robust, noting that this complemented the report later on the agenda from the Company Secretary.

The Committee received the annual report from the Local Counter Fraud services and noted the overall positive conclusion based on the work undertaken across the year and through their work their assess overall fraud risk reduction. The Committee also received and approved the submission of the assessment against the Counter Fraud Functional Standards and that 11 of the 12 standards were fully met and in respect of the standard on training this was measured as having an opportunity to improve. The Committee endorsed the Local Counter Fraud's proposed actions to enhance the content and to improve the ways this training is delivered.

The Committee approved the 2024/25 Local Counter Fraud activity plan and its alignment to the Trust's fraud risk assessment.

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Annual Report and Accounts

The Committee considered the Trust's assessment that the financial statements should be prepared on a going concern basis and endorsed this assessment.

The Committee considered the draft Annual Governance Statement and provided a small number of changes to sharpen the text used to describe the Trust's process and to include to aid the reader prior year comparative information where relevant. The Committee agreed post the changes being made that the draft be submitted as part of the Trust's annual report for external audit comment.

Health and Safety Committee chairs report

The Committee noted the update provided and the reduction in risks based on assurances received at the Committee along with an elevated risk identified linked to the delivery of required improvements identified from recent HSE inspections at a laboratory at RSCH and a laboratory at St Richards.

The Committee asked that the outstanding risk assessment in respect of the risk of falling from height at the RACH be undertaken swiftly and that the Board through the QSIP CQC recommendation delivery workstream be informed of the tactical mitigations being taken to reduce the risk whilst longer term risk mitigations are agreed and implemented.

The Committee agreed that the review of the governance reporting route for the Health and Safety Committee needs to be completed swiftly as it was felt that whilst there is a compliance element to this reporting there is also a significant element of the reporting that overlaps with the operational risk of the Trust and if the reporting to QGSG is sufficient to support acting on reported elevated risks.

Declarations of Interests report

The Committee received the report showing compliance with the Trust management of interests' policy, noting that a 100% of senior decision makers have provided their required declaration recognising that a number provide a nil return. The report also provided a view of the register extract that is published on the Trust's website and referred to in the Trust's annual report. The Committee noted the complementary assurance provided by the work of the Local Counter Fraud Specialist over the Trust declaration of interest processes.

Terms of Reference

The Committee reviewed its Terms of Reference and agreed these remained valid with the understanding that the requested review of the reporting route for the Health and Safety Committee may bring a change and move this away from the routine reporting to the Audit Committee.

**Key Recommendation(s):**

The Board is asked to **NOTE**

- the assurances received including those from Internal Audit especially the draft Head of Internal Audit opinion and the Local Counter Fraud Specialist.
- the Audit Committee decisions to endorse that the Trust's Financial Statement be prepared on a going concern basis, that post the minor adjustments the draft Annual Governance Statement be submitted to External Audit for comment as part of the external audit of the Trust's annual report and accounts and the agreement that the Committee's terms of reference remain appropriate subject to the review of the Health and Safety Committee reporting.
- the Audit Committee request for the review of the Health and Safety Committee reporting route be concluded swiftly.

- the Audit Committee request that the outstanding risk assessment be concluded swiftly and its outcome be reported to the Board.

**COMMITTEE HIGHLIGHTS REPORT TO BOARD**

| Meeting | Meeting Date | Chair | Quorate |
|---|---|---|---|
| Audit Committee | 18 April 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 processes supporting the maintenance of the Trust BAF.<br><br>The Committee recognised that the strategic risk scores had not changed across quarter 4.<br><br>The Committee reflected on the complementary oversight role and the value of undertaking a deep dive of risks that have not moved for several quarters and are away from their target score. |
| 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. |
| Internal Audit Reports<br>- Activity Progress Report<br>- Recommendation Follow Up Report<br>- Draft annual report and draft Head of Internal Audit Opinion (annual statement of assurance) | BDO (Internal Auditors) | For assurance over respective areas of internal control | The Committee noted the positive opinion on the Trust's RTT Data Quality processes and whilst significant improvements were identified within the Outpatient Clinic Management the Committee noted that Internal Audit had been proactively used to enable a structure to be applied to the Trust's improvements.<br><br>The Committee noted the Internal Auditors follow up report continued to |

| | | | |
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| | | | show good levels of engagement with Internal Audit to provide evidence of action delivery or a sound rationale for any date changes.<br><br>The Committee received the draft annual report included the draft Head of Internal Audit opinion which provided an overall positive opinion of moderate assurance over the Trusts systems of internal control based on their activity across the year. |
| Counter Fraud Reports<br>- Annual Report<br>- 2024/25 workplan<br>- Reactive work update<br>- Declaration of Interest (routine 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<br><br>To agree the submission against the Counter Fraud Functional Standards | The Committee noted the work undertaken by the counter fraud team reported within its Annual Report and Reactive Work progress report and the conclusion that there were no elevated fraud risks.<br><br>The Committee noted the proactive work undertaken by the local counter fraud team in respect of the Trust's Declaration of Interests Processes. The Committee received assurance from this work that the design and application of Trust's process are robust, noting that this complemented the report by the Company Secretary.<br><br>The Committee also received and approved the submission of the assessment against the Counter Fraud Functional Standards. |
| External Audit Update | GT (External Audit) | To note status of the External Audit work | The Committee noted that the audit update. |
| Annual Accounts Preparation Update | Director of Finance | To note the Trust's position and take assurance that the accounts will be submitted on time | The Committee noted the update |
| Going Concern Assessment | Director of Finance | To agree the Trust's assertion. | The Committee agreed with the Trust's assessment that the financial statements should be prepared on a going concern basis. |
| Draft Annual Governance Statement | Company Secretary | | The Committee considered the draft Annual Governance Statement and |

| | | | |
|---|---|---|---|
| | | | provided a small number of changes to sharpen the text used to describe the Trust's process and to include to aid the reader prior year comparative information where relevant. The Committee agreed post the changes being made that the draft be submitted as part of the Trust's annual report for external audit comment. |
| 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. |
| Tender Waiver Report | Commercial Director | To note the report and the assurance it provides over the Trust's processes. | The Committee noted the continued oversight and approval processes applied to these. |
| Cyber Security Update including Data Protection Toolkit update | 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 progress against the 2023/24 toolkit self-assessment that is due to be submitted by June 2024<br><br>The Committee noted the update from the CIO in respect of the Trust's data centre. |
| 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.<br><br>The Committee requested that the review of the reporting route for the Health and Safety Committee be concluded swifty. |
| Annual Declarations of Interest Report | Company Secretary | To provide assurance over the application of the Trust's policy. | The Committee noted the high compliance rates with the declaration of interest policy and that 100% of senior decision makers have provided their required declaration recognising that a number provide a nil return. |
| Committee Terms of Reference and Cycle of Business | Company Secretary | To agree these for 2024/25 | The Committee reviewed these and agreed they remained appropriate for 2024/25 subject to the conclusion of the H&S Committee reporting review. |

**Actions taken by the Committee within its Terms of Reference**

University Hospitals Sussex NHS Foundation Trust

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|---|
| The Committee **approved:**<br>- LCFS annal plan for 2024/25<br>- The submission of the assessment against the Counter Fraud Functional Standards<br>- That the Trust's financial statements should be prepared on a going concern basis<br>- The inclusion of the draft AGS in the Trust Annual Report follow the small adjustments recommended by the committee. |
| **Items to come back to Committee (Items the Committee keeping an eye on outside its routine business cycle)** |
| The Committee would as it receives the 2024/25 BAF will consider the value of undertaking complementary deep dives into the strategic risks that whilst exceeding their target score do not move over several quarters. |
| **Items referred to the Board or another Committee for decision or action** |

| Item | Referred to |
|---|---|
| The review of the Health and Safety Committee reporting route be concluded swiftly. | Director of Governance |
| The outstanding risk assessment be concluded swiftly and its outcome be reported to the Board through the QSIP CQC recommendation delivery workstream. | Director of Governance |

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|---|---|---|---|---|---|
| **Agenda Item:** | 18. | **Meeting:** | Trust Board in Public | **Meeting Date:** | 2 May 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:**

**Committee in Common**

Following the Board decision to establish a Committee in Common which would look to meet with similar Committees in Common with other Sussex NHS Providers and NHS Sussex the terms of reference was adjusted to reflect the Board's feedback. These terms of reference are attached as Appendix 1.

The purpose of these Committees is to support system performance and collaboration. The first meeting for the respective Committees in Common is being arranged for early May and is expected to have a focus on establishing a common forward workplan for the Committee.

**New Chair**

The Council of Governors approved the appointment of Philippa Slinger as Trust Chair from 1 July 2024. The Trust has concluded the pre appointment checks and is now working with Philippa on a programme of orientation which is designed to support the transition of Trust Chair to Philippa when Alan McCarthy retires on the 30 June.

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**Governor elections**

As was reported at the last meeting a number of governors terms of office end in 2024/25, these positions are those with terms of office that end on the 30 June, these being for 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 St Richards Hospital staff governor from 31 October.

The nomination process opened on the 18 April with a deadline for the submission of a nomination by 17 May 2024. During this period the Trust is offering a number of briefing sessions allowing those interested to understand the role of a governor, these are taking place, by MS Team, with the Company Secretary on Tuesday 30 April at 17.00, Wednesday 8 May at 13.00 and Monday 13 May at 17.00. Places at these sessions can be booked by e-mailing uhsussex.governors@nhs.net Also there is information on the Trust's website about the role of a Governor and the election process which can be located at https://www.uhsussex.nhs.uk/about/governors/

Should any of the vacant seats be contested, then a notice of the poll will be published on 10 June 2024, with voting packs dispatched on 11 June seeing the closure of the elections on the 4 July 2024.

We are taking the opportunity during the election process to review our Governor Induction Handbook with support from recently recruitment governors.

**Recommendations**

The Board is recommended to:

**NOTE** the adjustments have been made to Committee in Common terms of reference based on prior Board discussions (appendix 1).

**NOTE** the commencement of the orientation of the Trust Chair designate ahead of their formal commencement on the 1 July 2024.

**NOTE** that the Trust governor elections process has commenced, and the Trust is continuing to support those members interested in applying to be a Governor through drop-in briefing sessions to enable those interested to better understand the governor role.

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**Sussex NHS Committees in Common**

# TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER ORGANISATIONS

*TOR designed by the ICB to ensure consistency for each provider*

NHS
University Hospitals Sussex
NHS Foundation Trust

# TERMS OF REFERENCE

## 1 Introduction

1.1 NHS organisations in Sussex are establishing a new governance structure – via a set of Committees in Common (CiC) - to enable collaborative working to drive delivery of our shared strategy 'Improving Lives Together'.

1.2 The organisations establishing committees to meet in common will be the NHS Sussex Integrated Care Board, East Sussex NHS Healthcare Trust, Queen Victoria Hospital NHS Foundation Trust, South East Coast Ambulance Service NHS Foundation Trust, Surrey and Sussex Healthcare NHS Trust, Sussex Community NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, University Hospitals Sussex NHS Foundation Trust and the Sussex Primary Care Collaborative.

1.3 Each organisation has agreed to establish a committee which shall work in common with the other CiCs, but which will each take its decisions independently on behalf of its own organisation.

1.4 While this governance model permits a committee to meet separately, it is expected that they will usually only meet in common and assurance and escalations will go to sovereign organisations' Boards.

1.5 Each organisation has decided to adopt terms of reference in substantially the same form to other organisations, except that the membership of each committee will be different.

## 2 Aims and Objectives of the [insert organisation name] CiC

2.1 The aims and objectives of the CiC are to work with the other CiCs to:

- Work together to improve the population health outcomes, reduce the health inequalities and enhance the productivity of the NHS services in Sussex
- Collectively lead the NHS contribution to the Sussex Integrated Care System strategy 'Improving Lives Together' and delivery of the in-year aims of the Shared Delivery Plan (Joint Forward Plan under the Health and Care Act 2022)
- Collectively lead the clinical and financial transformation of the NHS in Sussex to deliver new, integrated and affordable models of care over the next 5 years

## 3 Specific Functions

3.1 The functions of the committee will be carried out via powers delegated to the committee members by University Hospitals Sussex NHS Foundation Trust Board.

3.2 **Data-led oversight of NHS contribution to shared strategy and delivery plan**

Each year a Shared Delivery Plan will be agreed (Joint Forward Plan as per the Health and Care Act 2022) in line with the system's strategy. The CiCs will collectively take decisions to:

- Agree a schedule of work to review each component of the plan and progress of the plan as a whole.
- Review a standard routine set of insight and analytical information on progress against objectives.
- Recommend and steer deep-dive analyses to identify issues and agree actions for ICB and system delivery partners to resolve delivery problems
- Work with other governance fora to ensure actions can be taken forward by the right organisations
- Review the annual refresh of the delivery plan and make recommendations on the associated targets, trajectories and oversight approaches

3.3 **Establish a shared NHS Medium Term Financial Plan in Sussex over next 5 years**

The NHS in Sussex will agree a shared set of financial goals to operate within a finite funding envelope and work to meet our medium-term plans. In this context the committee will:

- Assess the population and demographic growth to forecast the demand for all key NHS services in each Integrated Community Team footprint
- Assess the cost growth of delivering these NHS services in each Integrated Community Team footprint against the forecasted financial allocations from NHS England
- Assess the clinical effectiveness and financial productivity of existing service models to identify the greatest opportunities for improvement across Sussex
- Collectively assess data and insight to form a shared view of the major opportunities, challenges, risks, barriers and mitigations to the delivery of the Medium Term Financial Plan
- Define the programmes, project management resources and leadership accountabilities to achieve the Medium Term Financial Plan goals

3.4 **Collective leadership of clinical and financial transformation of NHS in Sussex**

The CiC will empower clinical and subject matter experts to lead the development of new, integrated and affordable models of NHS care in Sussex over the next 5 years to deliver the biggest health benefits to the greatest number of patients and service users by:

- Engaging and involving clinical leaders from all levels within the system on the prioritisation and development of new models of care and integrated patient pathways across different providers
- Seeking national expert advice to learn from the experience of other systems in transforming clinical and integrated care pathways
- Engaging and involving digital health and process improvement experts to support the digitisation and automation of new integrated care pathways
- Agreeing Senior Responsible Officers with appropriate delegated authority to create specific, measurable, realistic and timebound plans to deliver the specific clinical and financial transformations with the required individuals, organisations and collaboratives
- Tracking actions to ensure implementation, follow up and support where needed

3.5 **Review effectiveness and terms of reference of the committee on annual basis**

The CiC will assess its own effectiveness and terms of reference on an annual basis to ensure that its aims, objectives and specific functions are still relevant so that recommendations for improvement can be made to the Board of each member organisation for review and approval.

## 4 Establishment

4.1 The University Hospitals Sussex NHS Foundation Trust CiC is a committee of University Hospitals Sussex NHS Foundation Trust Board and therefore can only make decisions binding University Hospitals Sussex NHS Foundation Trust. None of the organisations other than University Hospitals Sussex NHS Foundation Trust can be bound by a decision taken by University Hospitals Sussex NHS Foundation Trust CiC.

## 5 Membership

5.1 The University Hospitals Sussex NHS Foundation Trust CiC shall be constituted of directors and non-executive directors of [*insert organisation name*]. Namely:

5.1.1 University Hospitals Sussex NHS Foundation Trust Chair; and

5.1.2 University Hospitals Sussex NHS Foundation Trust Chief Executive,

5.1.3 University Hospitals Sussex NHS Foundation Trust Non-executive director with skills relevant to the CiC's functions, being the Chair of the University Hospitals Sussex NHS Foundation Trust Finance and Performance Committee

and each shall be referred to as a "Member".

5.2 Each University Hospitals Sussex NHS Foundation Trust CiC Member shall nominate a deputy to attend University Hospitals Sussex NHS Foundation Trust CiC meetings on their behalf when necessary.

5.3 The Nominated Deputy for University Hospitals Sussex NHS Foundation Trust] CiC's Chair shall be a Non-Executive Director of University Hospitals Sussex NHS Foundation Trust and the Nominated Deputy for University Hospitals Sussex NHS Foundation Trust Chief Executive shall be an Executive Director of University Hospitals Sussex NHS Foundation Trust.

5.4 In the absence of the University Hospitals Sussex NHS Foundation Trust CiC Chair Member and/or the University Hospitals Sussex NHS Foundation Trust Chief Executive Member, a Nominated Deputy shall be entitled to:

5.4.1 attend University Hospitals Sussex NHS Foundation Trust CiC's meetings;

5.4.2 be counted towards the quorum of a meeting of University Hospitals Sussex NHS Foundation Trust CiC's; and

5.4.3 exercise Member voting rights subject to delegated authority.

## 6 Non-voting attendees

6.1 Only members of the committee in common have the right to attend meetings, however all meetings of the committee will also be attended any other attendees that the committee considers have expertise that would be relevant to the responsibilities of the committee or specific agenda items.

6.2 Other individuals may be invited to attend all or part of any meeting as and when

appropriate to assist it with its discussions on any particular matter.

6.3 The Chair may ask any or all of those who are in attendance, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

## 7 Meetings

7.1 Subject to section 10 below meetings in common shall take place every other month.

7.2 Meetings of the University Hospitals Sussex NHS Foundation Trust CiC shall be held in public.

7.3 Meetings in common will be chaired by the NHS Sussex Chair and supported by a secretariat from NHS Sussex (see section 12 below).

7.4 A vice-chair should be nominated and appointed by the respective CiCs. In the absence of the NHS Sussex Chair the Nominated vice-chair shall chair the meeting.

7.5 Any CiC Chair may request an extraordinary meeting of the CiCs (working in common) on the basis of urgency etc. via the secretariat, with timings agreed by mutual consent.

7.6 When there is an urgent matter where a decision is required outside of the meeting (which cannot wait for the next scheduled meeting), the Chair of Committee may make a decision after conferring with at least two other members ("Chair's Action").

7.7 When Chair's Action has been taken then the next quorate meeting of the Committee must ratify it. Urgent decisions will only be taken when there is insufficient time available for the decision to be delayed until the next meeting.

## 8 Quorum and Voting

8.1 Each Member of the University Hospitals Sussex NHS Foundation Trust CiC shall have one vote. The University Hospitals Sussex NHS Foundation Trust CiC shall reach decisions by consensus of the Members present.

8.2 The quorum for an individual CiC shall be two (2) Members.

8.3 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

## 9 Conflicts of Interest

9.1 Members of the University Hospitals Sussex NHS Foundation Trust CiC shall comply with the provisions on conflicts of interest contained in University Hospitals Sussex NHS Foundation Trust Constitution/Standing Orders, and NHS Conflicts of Interest guidance.

9.2 All Members of the University Hospitals Sussex NHS Foundation Trust CiC shall declare any new interest at the beginning of any University Hospitals Sussex NHS Foundation Trust CiC meeting and at any point during a University Hospitals Sussex NHS Foundation Trust CiC meeting if relevant.

## 10 Attendance at meetings

10.1 University Hospitals Sussex NHS Foundation Trust shall ensure that, except for urgent or unavoidable reasons, University Hospitals Sussex NHS Foundation Trust CiC Members (or their Nominated Deputy) shall attend University Hospitals Sussex NHS Foundation Trust CiC meetings (in person or virtually) and fully participate in all University Hospitals Sussex NHS Foundation Trust CiC meetings.

## 11 Behaviours and conduct

11.1 Members will be expected to conduct business in line with their organisation's values and objectives.

11.2 Members of and those attending the committee shall behave in accordance with their organisational constitution, Standing Orders, Standards of Business Conduct Policy

11.3 Members have a duty to demonstrate leadership in the observation of the NHS code of conduct and to work to the Nolan Principles which are selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

11.4 The committee will apply best practice in its deliberations and in decision-making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct.

11.5 All members are expected to comply with relevant policies and procedures regarding confidentiality and information governance, noting the sensitivity of information to be discussed when committees meet individually or in common.

## 12 Secretariat

12.1 The Committees, when meeting in common, shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive leads;
- Attendance of those invited to each meeting is monitored and highlighted to the Chair those that do not meet the minimum requirements;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The committee is updated on pertinent issues, areas of interest and policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored; and
- Committee papers will be stored and archived.

12.2 The secretariat shall be responsible circulation of a committee report and minutes to members within a week of the meeting for agreement

12.3 Where a CiC meets individually (not in common) an individual organisation will be responsible for secretariat arrangements.

**APPROVED BY University Hospitals Sussex NHS Foundation Trust Board**