Board of Directors Meeting in Public – 13 November 2025

Questions received.

Question from Member of the Public				
	From	***Question***	***Assigned to:***	***Response:***
1	**Mr Taylor**	*Does the trust have a procedure or could the creation of one be considered, whereby patients can bypass the A&E login procedure and consequent waiting time, when responding to the outcome of a previous A&E appointment?*	*Chief Operating Officer*	*We would like to thank Mr Taylor for his question and the information he provided about his experiences which enabled to better understand the question asked.* *If a person has previously booked into the Emergency Department and has been referred to another speciality, it will be that speciality service who will provide the follow-up, treatment, advice etc. In some cases these services may only be available until 5pm on a weekday, this being the case for Worthing where Mr Taylor attended our Emergency Department.* *If someone who is already being looked after by a speciality service comes to the ED outside of these hours and therefore are unable to be seen by that speciality directly, then they will need to book into the ED and this will unfortunately, as in the case of Mr Taylor, see them wait again in order to be assessed and treated according to their clinical needs. Emergency Departments are required, from a safety perspective, to fulfil this requirement, as clinical needs may have changed since the first visit and a different treatment plan may be needed.* *The Emergency Department will refer to a speciality service where appropriate and if that service is not available then they could send a patient to Brighton for further treatment if the clinical need is indicated. If the case is less urgent, the Emergency Department staff will refer the person to the speciality and advise the patient to await contact from that speciality in order to be followed up and report back direct to them thus removing the need to attend via the Emergency Department.* *In respect of the query raised in the question, about the Trust to look at its procedures, we can confirm that we do look at ways of using assessment units which seek to reduce the person needing to return to an Emergency Department as the assessment would be made and the appropriate speciality referral made and if those are not available at that time the patient will be provided with information to aid*

				their return to the speciality without a need to return back to the Emergency Department, and then having to be reassessed when substantially the clinical circumstances have not changed. We have invested in the development of these types of alternatives including the opening of a (SDEC) unit at St Richards on 31 October. *We wish to thank Mr Taylor for his question asking if we can improve things for our patients, and we would add our apologies that his experience which drove him to ask the question of us was not a good as it should have been, and would like to assure Mr Taylor that we have listened to his experience and used this to speak to the respective clinical teams about how better patient communication could have saved Mr Taylor a return visit to ED.*
2	**Ms Craig**	*Thank you Ms Craig for your question however the question contains specific comments about a case along with more general questions regarding our processes, as we have said previously when we have received patient specific questions we can't answer these at a Board meeting in public. Therefore. we kindly ask Ms Craig contact our Patient and Liaison Service who are there to help. However, we are very happy to respond to the question about our processes. For that part of the question, it was asked what is the process by which the Board and thus the public are assured that the Trust's clinical services are safe especially where sadly a person dies whilst in the care of the Trust, and how is accountability for safe care upheld in the Trust? Linked to this what is the process should failings be identified what is the process that ensures swift action is taken.*	*Chief Nurse* *Chief Medical Officer*	*Thank you for the question.* *Patient safety incidents are raised using our Datix IQ system by our teams and they are reviewed and graded against potential and any actual harm. This determines the level of investigation to be undertaken and the Trust follows the national patient safety incident framework which includes having candours conversations with families.* *Following investigations, we look at the learning from incidents and how this learning is shared into our governance processes. In terms of a learning culture, we have seen an improvement in the number of incidents measured here by 1,000 bed days where we are around 60 per 1,000. This is a good improvement in staff raising safety concerns and promotes the learning culture in the Trust.* *If safety investigations identify any professional conduct issues these are referred to the CNO or CMO for review and where necessary referrals to professional bodies are made. Where a person sadly dies then these are subject to independent review investigations which are managed through the Mortality and Learning from Deaths framework which also include family involvement.*