Brighton & Hove City Council

Health Overview & Scrutiny Committee

Date:	**12 July 2023**
Time:	**4.00pm**
Venue	**Council Chamber, Brighton Town Hall**
Members:	**Councillors:** Fowler (Chair), Baghoth (Deputy Chair), Asaduzzaman, Evans, Hill, Lyons, McLeay, Robins, Simon and Wilkinson **Invitee:** Nora Mzaoui (CVS), Michael Whitty (OPC) and Geoffrey Bowden (Healthwatch)
Contact:	**Giles Rossington** Policy, Partnerships & Scrutiny Team Manager 01273 295514 giles.rossington@brighton-hove.gov.uk

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AGENDA

PART ONE **Page**

1 PROCEDURAL BUSINESS

(a) **Declaration of Substitutes:** Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

(b) **Declarations of Interest:**

(a) Disclosable pecuniary interests;
(b) Any other interests required to be registered under the local code;
(c) Any other general interest as a result of which a decision on the matter might reasonably be regarded as affecting you or a partner more than a majority of other people or businesses in the ward/s affected by the decision.

In each case, you need to declare:
(i) the item on the agenda the interest relates to;
(ii) the nature of the interest; and
(iii) whether it is a disclosable pecuniary interest or some other interest.

If unsure, Members should seek advice from the committee lawyer or administrator preferably before the meeting.

(c) **Exclusion of Press and Public:** To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: *Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.*

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls and on-line in the Constitution at part 7.1.

2 MINUTES **7 - 12**

To consider the minutes of the previous Health Overview & Scrutiny Committee meeting held on 12 April 2023 (copy attached).

3 CHAIR'S COMMUNICATIONS

4 PUBLIC INVOLVEMENT

To consider the following items raised by members of the public:

(a) **Petitions:** To receive any petitions presented by members of the public to the full Council or to the meeting itself;
(b) **Written Questions:** To receive any questions submitted by the due date of 12noon on the 6th July 2023;
(c) **Deputations:** To receive any deputations submitted by the due date of 12 noon on the 6th July 2023.

5 MEMBER INVOLVEMENT

To consider the following matters raised by Members:

(a) **Petitions:** To receive any petitions submitted to the full Council or to the meeting itself.
(b) **Written Questions:** A list of written questions submitted by Members has been included in the agenda papers (copy attached).
(c) **Letters:** To consider any letters submitted by Members.
(d) **Notices of Motion:** To consider any Notices of Motion.

6 RECONFIGURATION OF SPECIALIST CHILDREN'S CANCER SERVICES — 13 - 62

Report of the Executive Director, Governance, People & Resources (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

7 CARE QUALITY COMMISSION INSPECTION REPORT: UNIVERSITY HOSPITALS SUSSEX (MAY 2023) — 63 - 128

Report of the Executive Director, Governance, People & Resources (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

8 UNIVERSITY HOSPITALS SUSSEX: CAPITAL INVESTMENT PROGRAMME — 129 - 150

Report of the Executive Director, Governance, People & Resources (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

9 WINTER PRESSURES 2022/23: UPDATE — 151 - 170

Report of the Executive Director, Governance, People & Resources (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

10 HEALTHWATCH BRIGHTON & HOVE ANNUAL REPORT **171 - 220**

Presentation from Healthwatch on their latest annual report (copy attached)

Date of Publication - Tuesday, 4 July 2023

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FURTHER INFORMATION
For further details and general enquiries about this meeting contact Giles Rossington, (01273 295514, email giles.rossington@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

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Agenda Item 2

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 12 APRIL 2023

COUNCIL CHAMBER, BRIGHTON TOWN HALL

MINUTES

Present: Councillor Moonan (Chair)

Also in attendance: Councillor West (Group Spokesperson), Grimshaw, John, O'Quinn and Rainey

Other Members present: Geoffrey Bowden (Healthwatch), Michael Whitty (Older People's Council), Nora Mzaoui (CVS Representative)

PART ONE

43 PROCEDURAL BUSINESS

43.1 There were no substitutes. Clls Barnett and Lewry sent apologies for the meeting.

43.2 There were no declarations of interest.

43.3 RESOLVED – that the press and public be no excluded from the meeting.

44 MINUTES

44.1 RESOLVED – that the minutes of the 15 March 2023 special meeting be agreed.

44.2 Cllr John noted that at point 33.16 of the draft minutes of the 25 January 2023 meeting, it stated that Cllr John has suggested to Southern Water that it might wish to assume some responsibility for collecting dog waste from beaches. This suggestion had in fact been made by Cllr O'Quinn. It was agreed to amend this error.

44.3 RESOLVED – that the minutes of the 25 January meeting be agreed (subject to the amendments detailed above).

45 CHAIR'S COMMUNICATIONS

45.1 The Chair gave the following communications:

Firstly, I wanted to give you a quick update on planning for the JHOSC on children's cancer. At our March special meeting, the HOSC agreed that it wanted to scrutinise NHS England plans, and this was subsequently approved at March 30 Full Council. HOSCs in East and West Sussex and Kent have decided that they don't want to scrutinise this issue, but the standing South West London & Surrey HOSC does. We'll consequently probably seek to temporarily join the SW London JHOSC. However, it's not yet clear whether the standing South East London JHOSC wants to scrutinise. In any case, I think we're looking at early summer before anything formal happens.

Also, Anyone aged 75 or over or who has a weakened immune system will be eligible for a Spring booster vaccination to top up their protection against becoming seriously unwell from Covid. Anyone eligible can book now for appointments from next week. www.nhs.uk/covid-booster

From next week there will be free and low cost events running across the city until the end of April to help older people improve their strength and balance to prevent falls. You can pick up a Stay Strong, Stay Steady Stay Independent programme at libraries and other venues across the city or you can view the programme on the council or Ageing Well website. www.brighton-hove.gov.uk/stay-strong-events

46 PUBLIC INVOLVEMENT

46.1 There were no public questions.

47 MEMBER INVOLVEMENT

47.1 There were no member questions.

48 TRANS HEALTH CARE: SPECIALIST SERVICES

48.1 This item was presented by Jeremy Glyde (NHS England: NHSE); Dr Derek Glidden (Clinical Director at the Nottingham Centre for Transgender Health/NHS England National Speciality Adviser for Gender Dysphoria Services); Hugo Luck (NHS Sussex Primary Care Commissioning); and by Claire Newman (Sussex Partnership NHS Foundation Trust: SPFT Service Director). Gray Hutchins from the Clare Project was also in attendance. The Chair explained that The Clare Project were in attendance as Sussex's largest trans/TNBI-led VCSO who throughout their 23 years have witnessed and informed the development of gender affirming care within our locality. The charity has led on various NHS Sussex commissioned engagement pieces and continues to deliver Trans LCS training. Over the past 2 years alone, TCP has consulted over 1000 Brighton-based community members on navigating gender dysphoria treatment pathways. They currently host the postholder of VCSO TNBI Rep for Community Works, Chair the Trans Equip Sub-group, organise Sussex TNBI Organisers' Network and hold a seat at Trans Health Improvement Board.

48.2 In response to a question from Cllr O'Quinn about oversight/scrutiny of the new Sussex gender service, Mr Glyde told members that the contract would be managed in the usual way by the NHSE regional team. The Sussex gender service is one of a number of national pilots, and is the fifth pilot to go live, so there is already considerable learning which will be used to inform the Sussex model. The evaluation framework for the

Sussex pilot will be co-designed by local stakeholders to ensure that it reflects local needs. Ms Newman added that SPFT would apply its usual governance arrangements to the Sussex pilot. The pilot will sit within the Trust's Brighton & Hove division for governance purposes, although the service is Sussex-wide. Mr Luck told the committee that NHS Sussex would have oversight of the pilot via its Trans Healthcare Board.

48.3 In response to a question from the Chair as to where these different governance strands joined up, Mr Glyde responded that there is no formal join-up. However, NHSE has a national group on which each of the Regional Directors of Specialised Commissioning sit, so there will be national NHSE oversight of the progression of all the regional pilots.

48.4 Cllr John thanked Cllrs Powell and Allbrooke for bringing this issue to the attention of the HOSC, and also expressed her solidarity with all those who have been waiting for years for gender reassignment. Cllr John noted that it was good to see that people with lived experience had been involved in the design of the Sussex pilot and asked for more information about engagement. Ms Newman responded that SPFT had worked with many NHS organisations, with the Clare Project and with LGBT Switchboard. This included a survey of the Trans, Non-Binary and Intersex Community (TNBI), managed by The Clare Project, which had gained over 700 responses in a very short period of time. SPFT is in the early stages of developing an engagement plan, working together with the TNBI community and with the Sussex Integrated Care Board (ICB). This has been a learning journey for SPFT, and the Trust is grateful to the community for its support. Gray Hutchins added that there has been lots of community engagement to date. However, there are no formal plans in place for future engagement and this is a concern. Claire Newman responded that there are resources to do further engagement and that community organisations will be commissioned to manage this.

48.5 Cllr John highlighted some of the terminology used in the report, querying whether it might be deemed offensive. Dr Glidden explained that there is a lag between the language used by the TNBI community, which evolves quite quickly and the language used in formal diagnostic classifications, which remains fixed for several years. This is unfortunate, but unavoidable.

48.6 In response to a question from Cllr John on how success of the pilot will be measured, Jeremy Glyde told members that KPIs are yet to be agreed with SPFT as part of the contract mobilisation period. However, waiting times will be a key factor; there is likely to be a focus on ensuring that services are inclusive and respectful; on developing and maintaining a good relationship with primary care services; and on ensuring that there is a focus on training staff. Claire Newman agreed, noting that workforce training and links with primary care will be vital. Hugo Luck added that the Locally Commissioned Service (LCS) that is being rolled out across GP practices is unique to Sussex, and integrating with and learning from the LCS (particularly in terms of its staff training offer, supported by The Clare Project) will be key to the success of the pilot. Dr Glidden added that the Nottingham centre will provide support for the Sussex pilot: e.g. in terms of clinical supervision.

48.7 Cllr Grimshaw welcomed the report and the launch of a Sussex pilot. Cllr Grimshaw asked how the current positive community engagement can be continued into the future. Gray Hutchins told the committee that the TNBI community needs to feel safe and valued. This will require a formal commitment around engagement from NHS partners,

with adequate budget and a timeline. The HOSC could also play a role in ensuring that engagement continues as the contract is rolled out: e.g. an update to the HOSC a year after the pilot starts. Claire Newman responded that SPFT had not initially fully appreciated how much engagement was required. However, the Trust is committed to future engagement and recognises that this requires community organisations to be commissioned to deliver an engagement plan, with appropriate funding in place.

48.8 Cllr West welcomed the pilot and noted that he was particularly glad to see The Clare Project's involvement, as he had worked closely with them in his time as Mayor since they were one of the mayoral charities he had chosen. He also drew members' attention to the pioneering work of the 2012 BHCC Scrutiny Panel, which had included Cllrs Mac Cafferty and Morgan. Cllr West noted that he had concerns about primary care training and support and about potential gaps in primary care cover and would welcome an update report to cover these issues. The Chair agreed, suggesting an update after the pilot had been in operation for 12 months (autumn 24).

48.9 The Chair asked a question about young people services and the transition to adult services. Gray Hutchins added that it was important that services honour the time young people have spent on waiting lists when they transfer to adult services. Dr Glidden responded that the pilots are focused on adult services, but that the East of England pilot is exploring taking some clients from young people waiting lists. The time spent on young people waiting lists will be honoured when people transfer to adult waiting lists.

48.10 Gray Hutchins told the committee that a figure of 8-900 hundred adults on the Sussex waiting list was often quoted, but that this is a gross underestimate of the actual number of people requiring services. Dr Glidden responded that NHSE acknowledges that this number will inevitably rise; this has happened in other pilots and NHSE are open to discussing how to cope with larger numbers of clients: the service has to be able to see people in a timely manner and to provide ongoing care. Claire Newman agreed, telling members that SPFT does not want to run a service that is not adequate to meet demand.

48.11 The Chair thanked everyone for their contributions, noting that there has been considerable progress in the provision of TNBI services over recent years, but that much more still needs to be done. She would recommend to the incoming HOSC Chair that an update be scheduled for autumn 2024.

48.12 RESOLVED – that the report be noted.

49 GP SERVICES IN BRIGHTON & HOVE

49.1 This item was presented by Hugo Luck (NHS Sussex primary care commissioning); by Liz Davis (NHS Sussex Director of Primary Care: Brighton & Hove); by Lola Banjoko (NHS Sussex Managing Director: Brighton & Hove); and by Rob Persey (BHCC Executive Director, Health & Adult Social Care).

49.2 Mr Luck outlined some of the challenges facing general practice in the city, including the GP/patient ratio, variance in performance across practices, recruitment and resilience, and access. Recent measures taken to improve performance have included additional winter funding for all practices, the development of a locum workforce bank, and the

introduction of Respiratory Hubs. There are currently more GP appointments taking place than pre-pandemic. The city GP workforce is fairly static, but there has been an increase in non-GP clinical staff at practices. All city practices are part of a Primary Care Network (PCN), with all PCNS offering enhanced services, later appointments etc. The Sussex Integrated Care Strategy has priorities for improving GP access and availability.

49.3 In response to a question from Cllr West on demand pressures, Mr Luck responded that demand has increased. However, commissioners have a much better understanding of capacity data than they do demand data, and work is under way to improve the data extraction of demand information from practices. Ms Davis added that work is planned to better communicate to residents the range of services available from GP surgeries in addition to GPs.

49.4 Cllr West noted that he would value input at future meetings from practitioners: e.g. current or former GPs, community pharmacists etc. The Chair agreed, noting that she had originally asked for the GP update to reference other aspects of primary care, but had been advised that the breadth of the topics meant it was more sensible to have a further update on other aspects of primary care at a later HOSC.

49.5 Cllr O'Quinn raised concerns about digitally excluded people. Mr Luck and Mr Persey both agreed that this is a significant issue, particularly amongst older people. The council has a digital workstream which seeks to address exclusion, and there is also Public Health funding support for older people.

49.6 Michael Whitty (Older People's Council) expressed concerns about the GP/patient ratio and about the loss of a number of practices in recent years, asking whether the system was in crisis. Mr Luck responded that the reduction in practices needs to be seen in context: the main reason for the reduction is because practices have merged, but this does not necessarily mean that there are fewer GPs or premises. Ms Davis added that recruitment is challenging, but that there is an active push to recruit and retain GPs. Ms Banjoko told members that the GP/patient ratio has improved in recent years. Long term workforce planning is key here – e.g. knowing when GPs may retire and planning accordingly. A focus on neighbourhood working is also critical, and there will be a stakeholder workshop on this on 15 May.

49.7 Nora Mzaoui (CVS representative) asked a question about the role of PCNs. Ms Davis replied that PCN development is a priority. She would be happy to come back to a future HOSC to talk in more depth about PCNs. Mr Luck added that there are different challenges for different PCNs, so while there are commonalities, all PCNs need to be supported to develop systems that suit their particular circumstances.

49.8 Geoffrey Bowden (Healthwatch) noted that digital exclusion can be just as much about people not being able to afford technology as having problems operating it; and also noted that financial pressures exacerbate access problems. Ms Banjoko agreed with this, and told members that there is lots of work with the VCS to target specific communities which are experiencing inequalities.

49.9 Cllr Rainey asked a question about recruitment of GPs. Mr Luck responded that this was a national issue, although there may be specific issues with Brighton & Hove given the

relatively high cost of living. There are steps to be taken to make the city more attractive: e.g. by investing in estates; and by encouraging trainee GP posts.

49.10 In response to a query from the Chair about the process for complaining about GP services, Mr Luck told members that there is a formal process, but that Councillors also have the option to reach out directly to him or to Lola. Cllr Grimshaw noted that she had had occasion to escalate issues to Lola and Hugo and had always been impressed at how quick and thorough their responses were.

49.11 RESOLVED – that the report be noted.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item 6

Subject: **Children's Cancer Services: NHS England Change Plans**

Date of meeting: **12 July 2023**

Report of: **Executive Director, Governance, People & Resources**

Contact Officer: **Name: Giles Rossington**
Tel: 01273 295514
Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: **All**

For general release

1. Purpose of the report and policy context

1.1 NHS England (NHSE) are consulting with relevant Health & Overview Scrutiny Committees, or 'HOSCs', on plans to reconfigure specialist children's cancer services for South London and South East England.

1.2 At a special meeting in March 2023, Brighton & Hove HOSC agreed that it considered the plans to constitute a significant variation in service (a 'SViS'), and wished to be formally consulted on these plans.

1.3 This report formally presents NHSE's plans to improve specialist children's cancer services, and invites HOSC to scrutinize the proposals before considering the recommendations below.

2. Recommendations

2.1 That Committee reviews the plans described here to reconfigure specialist children's cancer services and determines that it does not wish to make specific comments or require additional responses, as it considers that on balance the changes mooted will not be detrimental to the health of city residents; and

2.2 That Committee formally agrees that it does not wish to undertake further formal scrutiny of these plans, but asks officers to indicate to NHSE its desire to be kept informed of their progress.

3. Context and background information

3.1 NHS England (NHSE) commissions specialist health services – e.g. services for relatively rare conditions that need to be delivered on a regional or a national footprint. This includes children's cancer services. All children and young people England who are diagnosed with cancer are treated in one of 13 Principal Treatment Centres (PTCs) which are responsible for coordinating and delivering care. For many city families, most cancer services will be delivered locally, at the Royal Alexandra Children's Hospital, Brighton, but the most specialist services are delivered at a PTC in London.

3.2 Currently in South West London, the Royal Marsden NHS Foundation Trust (RMH) and St George's University Hospitals NHS Foundation Trust (SGUH) provide a joint PTC over their two sites which covers the catchment area of Sussex, Kent & Medway, Surrey, South East London and South West London. Following the publication of a new national service specification for PTCs in November 2021, the RMH/SGUH service is not compliant with the requirement to provide a paediatric intensive care unit (PICU) on the same site as the PTC, and for joint site services this means a PICU on each site thus avoiding the need to transfer critically sick children. While the current specialist children's cancer service is high quality and safe, the Royal Marsden has confirmed that it would not be sustainable clinically or financially to provide a PICU on its Sutton site. The current service provider therefore does not meet this new requirement, and a compliant single site is needed for this service going forward.

3.3 NHSE has identified two potential providers for this single site PTC: either SGUH or Guy's & St Thomas' NHS Foundation Trust (at the Evelina Children's Hospital) (GSTH). NHSE will not make a final choice of provider until it has consulted with the public and stakeholders, including HOSCs, but its initial scoring identifies GSTH as the preferred option.

3.4 When planning to make substantial changes to services, NHS bodies are required to contact all affected HOSCs at an early stage in their planning. If HOSCs consider that the plans constitute a Substantial Variation in Services (SViS) then they have the option to be formally consulted. Where a change plan impacts multiple HOSC areas and two or more HOSCs agree that the plan is an SViS, then HOSCs are required to form a single Joint HOSC (JHOSC) for the purpose of scrutinising the change plan.

3.5 NHSE contacted the HOSC about its plans to reconfigure children's cancer services in 2022, and the HOSC held a special meeting in March 2023 to consider whether the plans constituted an SViS. The HOSC resolved that the plans were an SViS and the committee referred the matter to April 2023 full Council with a request that Council agree to establish a JHOSC with other interested local authorities. Council agreed this.

3.6 At the time of the March 2023 special HOSC meeting and of April 2023 Council, it was not clear which other local authorities in the region had determined that the NHSE plans were an SViS as not all had considered the issue. They now have, and formal scrutiny will be undertaken by Brighton & Hove City Council, by the Standing JHOSC for South East London and by the Standing JHOSC for South West London & Surrey. (Standing JHOSCs

are permanent JHOSCs established by local authorities within in a geographical footprint. They are typically instituted in places where NHS change plans regularly cross local authority boundaries, London being an obvious instance, and they enable a number of local authorities to come together quickly to scrutinise service change plans.)

3.7 In normal circumstances, BHCC and the standing South East London and South West London JHOSCs would have established a single JHOSC to scrutinise children's cancer plans. However, both of the standing JHOSCs have told NHSE that it would take them until at least autumn to establish a combined JHOSC, as they would need to have any decision ratified by the full Councils of their constituent local authorities. (The standing JHOSCs have no agreed process to combine to scrutinise plans that impact the entirety of South London, hence the need to refer back to their constituent members.) NHSE wants to progress its cancer plans this summer, so has agreed to consult separately with each of the standing JHOSCs and with BHCC. Although this was not what Brighton & Hove HOSC and Council initially agreed, being consulted separately has obvious advantages: e.g. the HOSC is able to consider NHSE's in terms of their impact on city residents rather than their impact on the entirety of the JHOSC area.

3.8 At its March 2023 special meeting, the HOSC heard from NHSE about the change plans. In general, members were assured that the changes would maintain or improve the current excellent clinical services on offer. Members were also assured that the bulk of local children's cancer treatment would continue to be provided at the Royal Alexandra Children's Hospital, Brighton (a tier of services which is not included in the change process, which focuses only on the most specialist services which are required to be provided at a regional tertiary centre).

3.9 At the March special meeting, member questioning focused particularly on:

- **Patient and family transport.** Members were informed that patient journeys to the PTC after reconfiguration will be similar to current journeys, as both of the potential sites are in London as is the current provision. Means tested support is available for families, and both potential providers have well-funded charities which offer additional support. However, members may wish to further explore the issue of travel support, and facilities for overnight family stays.
- **Continuity of care.** Members were told that current PTC staff would be offered employment at the new provider, but that there was no guarantee that staff would choose to transfer. Members may wish to seek further assurances around measures to ensure that there is continuity of care for families who have developed a trusting relationship with the current services.
- **Consultation and engagement.** Members may wish to learn more about NHSE's plans to engage with local service users.

3.10 The minutes of the March 2023 special meeting are included for reference as Appendix 1 to this report. Additional information on consultation and engagement, provided by NHSE, is included as Appendix 2.

3.11 The stated aim of NHSE's reconfiguration plans is to deliver a safer service, with both options providing a single-site specialist cancer centre with an on-site PICU. There is in any case no option to retain the current configuration as it no longer meets national service specifications. For Brighton & Hove residents, there is considered to be relatively little difference in terms of accessibility between the two options; and NHSE have provided assurances that there will be comprehensive support for travel expenses, overnight accommodation etc. with either option. NHSE have also provided assurances that they will do all they can to ensure continuity of staffing. NHSE have outlined their plans to involve local service users in the reconfiguration process. Given this, it is recommended that the HOSC agrees that it does not need to undertake additional formal scrutiny of this issue. This would not preclude the HOSC receiving informal updates, presentations to committee etc. as the reconfiguration plans progress (and NHSE have confirmed they are happy to support the HOSC in this way).

4. Analysis and consideration of alternative options

4.1 If members are not satisfied that they have received sufficient assurance about the reconfiguration plans, they can choose to continue formal scrutiny of this issue. Given reconfiguration timelines, this would require one or more special meetings to be held in summer 2023.

5. Community engagement and consultation

5.1 None directly in relation to this report, but members may wish to note NHSE consultation and engagement plans (Appendix 2).

6. Conclusion

6.1 Members are asked to consider NHSE plans to reconfigure specialist children's cancer services and to agree that no further local formal scrutiny of these plans is required.

7. Financial implications

7.1 There are no financial implications for Brighton & Hove City Council as a direct result of the recommendations of this report.

Name of finance officer consulted: David Ellis Date consulted (16/06/23):

8. Legal implications

8.1 As described in the legal implications to the last Report on this topic, HOSCs have powers to scrutinise significant NHS plans for service change (Substantial Variation in Service, or SViS). Following the decision of a previous meeting of HOSC that the changes described here did constitute a significant variation, NHSE has indicated that it will accept responses outside of a Joint Health & Overview Scrutiny Committee.

It now remains for Brighton City Council's HOSC (as the delegated body with relevant expertise) to review the changes described in accordance with its powers under the Health & Social Care Act (2001) and related legislation and to consider whether it wishes to approve the recommendations to this Report or to make some other response to the proposals.

Name of lawyer consulted: Victoria Simpson Date consulted 19.06.23

9. Equalities implications

9.1 Children with cancer have protected characteristics in terms of their age and of disabilities (as the Equality Act considers a diagnosis of cancer as a disability). Both of these have been taken into account in NHSE's planning, which is for a dedicated service for children delivered by specialist paediatric clinicians. Members may be interested to explore what measures NHSE will adopt to ensure that its consultation and engagement reaches and is accessible to all communities in the city, including for example, families where English is not the primary language. Members may also wish to seek additional assurances that there is financial support for travel and accommodation costs for families.

10. Sustainability implications

10.1 Many children's cancer services for Brighton & Hove families are delivered locally at the Royal Alex. However, the most specialist services need to be delivered on a regional basis, which does necessitate travel to London. NHSE's plans NHSE's plans will enable easier to access via public transport to either of the potential future PTC providers, compared to the Royal Marsden.

Supporting Documentation

1. Appendices

1. Minutes from the 15 March 2023 special HOSC meeting
2. Information provided by NHS England on their consultation and engagement plans

Appendix 1

BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

11.00am 15 MARCH 2023

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Moonan (Chair)

Also in attendance: Councillor West (Group Spokesperson), Grimshaw, O'Quinn and Rainey

Other Members present: Nora Mzaoui (Community & Voluntary Sector representative), Michael Whitty (Older People's Council)

PART ONE

38 PROCEDURAL BUSINESS

38A Substitutes and Apologies

38.1 Cllr Hugh-Jones attended as substitute for Cllr John.

38.2 Apologies were received from Cllrs Lewry, Barnett and John, and from Geoffrey Bowden (Healthwatch representative).

38B Declarations of Interest

38.3 There were none.

38C Exclusion of Press & Public

28.4 Resolved – that the press & public be not excluded from the meeting.

39 CHAIR'S COMMUNICATIONS

39.1 The Chair gave the following communications:

I have called a special meeting of the HOSC today to look at NHS England plans to make changes to specialist cancer services for children.

Unfortunately, it wasn't possible to wait until the scheduled April meeting for this item. The formal scrutiny of regional change plans needs to be via a Joint HOSC, and for Brighton & Hove the final decision as to whether to join a Joint HOSC is resolved for full Council – we needed to schedule this meeting to potentially feed into 30 March full Council or we would have needed to wait until Annual Council on 25 May, which would have been a significant delay.

I apologise for the inconvenience and appreciate those who have been able to attend today. I think if it hadn't been for the school strike, we would have had several more with us today.

I also want to be clear about the purpose of today's meeting. Today's meeting is for HOSC members to decide whether they think these plans are of sufficient local importance that the represent a 'substantial service variation' for our residents, and that the city council should therefor join a Joint HOSC.

We do have colleagues from NHS England here today; I will ask them to present on their plans, and they will be available to answer questions. However, in-depth scrutiny of these plans, and questions about which provider offers the best option, are really matters that are reserved for a Joint HOSC. Therefore, please ask questions that will help you come to a view about a substantial variation of service and the needs of our local population affected, rather than the commissioning decision itself.

If the committee agree the recommendation today, then we will link up with other HOSCs across the region which have expressed an interest in scrutinising the plans. We don't yet know definitively which HOSCs this may be involve, although we do know that several have decided not to formally scrutinise this issue. If we decide not to take part in the joint HOSC, then NHSE will keep us updated on the progress of the plans, but we won't be formally involved in any scrutiny. I do need to be clear that the options are for formal scrutiny via a Joint HOSC or for no formal scrutiny. Under health scrutiny legislation we do not have the option to formally scrutinise regional change plans as individual HOSCs.

My personal view is that, although the number of children involved are small, the nature of these serious cancers mean that the whole family is heavily affected. The illness and care pathway can lead to life changing consequences for the siblings, parents and extended family, as well as the child with cancer. My personal view is that this therefore represents a substantial variation of service, which we should scrutinise for our B&H residents affected. It is of course up to the committee this morning to decide if they agree.

There is an additional factor that influenced me in coming to the view that we should take part in joint HOSC. As we now have much larger ICPs across the southeast there are likely to be many more service changes that cross local authority borders. As BHCC has not taken part in a joint HOSC for more than a decade, this will be an opportunity for the new HOSC chair and committee to learn about the process and make link with other HOSCs across the region. This should stand us in good stead when much larger service changes are proposed in the future.

Finally, I would like to add in the interests of openness, that on the request of St Georges University Hospitals NHS Foundation Trust I met their chair and some senior clinicians last week. I was briefed about their service and their views on future service models. This was an informal meeting and did not influence my view that we should take part in the JOSC. And if we do decide to proceed, I will of course offer the same opportunity to meet Guy's & St Thomas' NHS Foundation Trust in order to be fully briefed by all parties prior to formal scrutiny at the joint HOSC.

40 PUBLIC INVOLVEMENT

40.1 There were no public engagement items.

41 MEMBER INVOLVEMENT

41.1 There were no member involvement items.

42 CHILDREN'S CANCER SPECIALIST SERVICES: PLANS FOR SERVICE CHANGE

42.1 This item was presented by Dr Chris Streather, NHS England South East Medical Director. Chris Tibbs (NHS England South East Medical Director, Specialised Commissioning), Sabahat Hassan (NHS England Head of Partnerships & Engagement, South East Commissioning Directorate), and Hazel Fisher, NHS England, also attended the meeting via teams.

42.2 Dr Streather outlined the reasons for making changes to services, noting that there is a new National Service Specification for Paediatric Treatment Centres (PTC) requiring the bulk of services to be provided on a single site. There are currently two PTCs for London and South East England: Great Ormond Street Hospital for Children (GOSH) covers North London and counties to the north of London; St George's University Hospitals NHS Foundation Trust (St George's) and the Royal Marsden NHS Foundation Trust (RM) jointly cover South London, Kent, Sussex and Surrey. Since the southern service currently operates across two sites, a consolidated alternative will need to be identified.

42.3 There are two options for a single-site PTC: St George's or Guy's & St Thomas' NHS Foundation Trust/Evelina Hospital for Children (GSHT). NHS England (NHSE) is the commissioner of specialist children's cancer services, and as such is leading the search for a new PTC. NHSE has scored both potential providers, and has a narrow preference for GSHT. However, NHSE will engage with stakeholders and the public, taking their views into account before a final decision is reached. This will include consultation with any of the Health Overview & Scrutiny Committees in the footprint via a Joint HOSC (JHOSC). As part of its decision-making process, NHSE will conduct a full Health Inequalities Assessment.

42.4 In response to a question from Cllr O'Quinn, Mr Streather confirmed that wherever possible, children's cancer services are provided locally. For Brighton & Hove residents this will be at the Royal Alexandra Children's Hospital, Brighton. Some services may have to be provided at the PTC, typically in the early stages of treatment. There will be means-tested support for families who need to travel to the PTC.

42.5 In answer to a query from Cllr O'Quinn, Dr Streather stressed that the quality of patient and family experience was of paramount importance. There is learning here from the current joint PTC, but also from GOSH which has been operating an excellent single-site PTC in central London for some time.

42.6 Cllr West challenged the data on deprivation that had been shared with members, noting that a focus on Brighton & Hove as a whole could be misleading, as the relative wealth of parts of the city tends to obscure, but does nothing to alleviate, very real issues of deprivation. Dr Streather responded that NHSE works with more granular data than was represented on the deprivation map shared with members, and a more granular approach will be followed in preparing the Health Inequalities Impact Assessment.

42.7 In response to a question from Cllr West on journey modelling, Dr Streather told the committee that modelling had been undertaken on a number of scenarios (e.g. on both a 50/50 split of journeys by private car/public transport and on a 70/30 split), and he was confident that patient traffic can be managed.

42.8 In answer to a question from Cllr Rainey on the benefits of change Vs the risks of disruption, Dr Streather told members that discontinuity in transition is a significant risk. Commissioners will work closely with the current and future providers, both to identify high performing elements of the current service which must be maintained, and to ensure a smooth handover.

42.9 Cllr Grimshaw asked questions about means-testing and about support for people who don't meet the criteria for receiving support but who may nonetheless be struggling financially. Dr Streather responded that this is always an issue with means-testing and that NHSE have no control at the levels at which support is provided. However, all the providers involved in this provision have well-funded charities and there is likely to be plenty of support on offer to families. The Chair noted that this was an issue that HOSC members would be likely to wish to focus on should it be agreed that the city council should join a Joint HOSC.

42.10 Cllr Hugh-Jones noted that she would welcome a Joint HOSC focus on transport support. Dr Streather responded that NHSE modelling shows that either future provider will be somewhat easier to access via public transport than the current providers, but that car journeys would be slightly longer. Dr Streather reiterated that NHS will use granular data to fully explore the travel implications of its new model.

42.11 Nora Mzaoui asked a question about facilities for parents staying overnight. Hazel Fisher replied that both potential providers have a mix of options including pull-out beds, some capacity for using adjoining rooms, and nearby family accommodation to support longer term stays (Ronald McDonald house options).

42.12 Cllr O'Quinn asked a question about support for families with London congestion and ULEZ charges. Ms Fisher responded that there is the capacity for hospitals to register with ULEZ which allows families to claim back charges. GOSH PTC is often asked to support families with transport costs, so there is a good practice model for the new provider to draw upon.

42.13 The Chair asked a question about the transfer of workforce to a new provider. Dr Streather replied that staff will be offered the opportunity to transfer to the new provider, although they are under no obligation to do so, so it is not possible to say with certainty what percentage of staff will move across. Under some scenarios surgeons might find themselves working across two sites; however, this is fairly standard practice and one that hospitals are well-used to dealing with.

42.14 In response to a question from the Chair about engagement with a Joint HOSC, Ms Fisher told the committee that this will be negotiated with the Joint HOSC: NHSE are keen to engage as fully as possible, and are also happy to keep HOSCs that do not wish to formally scrutinise the plans informed of progress.

42.15 Members debated whether to recommend that the city council joins a Joint HOSC. They unanimously agreed that the JHOSC option should be pursued.

42.16 RESOLVED – (i) That Committee agrees that the plans to change specialist children's cancer services for South East England outlined in Appendices 1 and 2 do constitute a Substantial Variation in Services requiring the establishment of a Joint HOSC (JHOSC); and (ii) that Committee agrees to recommend to full Council that it formally approve the decision that Brighton & Hove Council forms a JHOSC with other local authorities in the region.

The meeting concluded at 13:05

Signed Chair

Dated this day of

Reconfiguration of Children's Cancer PTC serving south London, Kent and Medway, most of Surrey, East Sussex, Brighton and Hove

Presentation to the Brighton & Hove Health Overview and Scrutiny Committee

12 July 2023

Today we would like to

- Tell you more about plans for the service reconfiguration of the PTC (PTC)
- Share an overview of our work to date including our plans for the forthcoming consultation
- Seek feedback on our plans and on how we work together going forward

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Structure of our presentation

Agenda
1. Background and case for change
2. Options development and evaluation
3. Where are we now
4. Equality and Health Inequality Impact Assessment
5. Consultation plan and document, including stakeholder engagement
Appendix – supporting slides

1. Background and case for change

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Caring for children with cancer

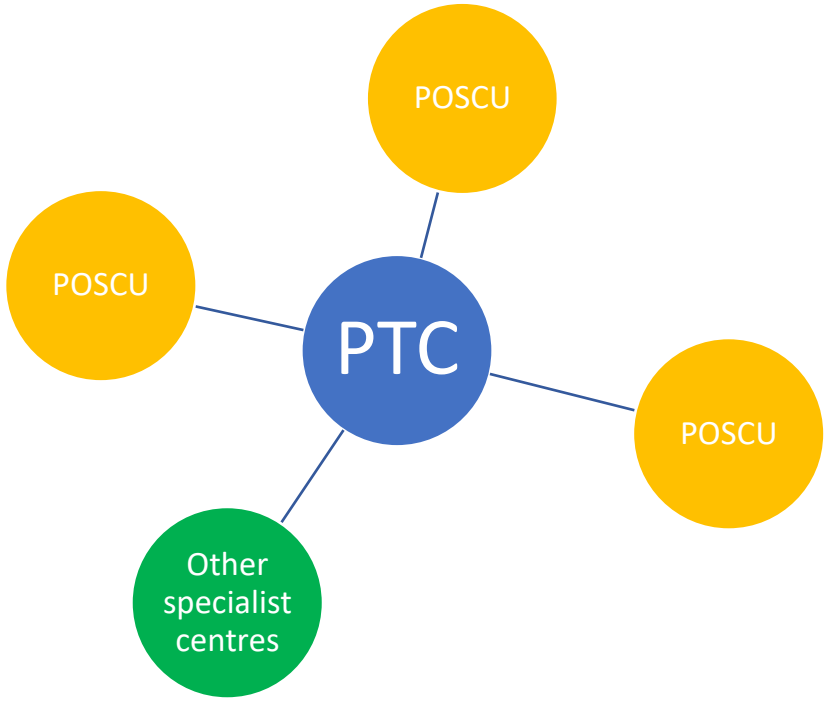
Principal Treatment Centres (PTCs)

Children with cancer in England receive some of the best care in the world, at the forefront of cutting-edge treatments and technology.

Their care is coordinated and led by PTCs, which provide diagnosis, treatment plans, and highly specialised care for children aged 15 and under with cancer.

PTCs are responsible for making sure each child gets the specific expert care they need for their particular cancer, and for coordinating treatment by different hospitals, if needed. Treatments for cancer in children can be complex and intensive and are often delivered as part of a clinical trial. Children can become acutely ill during treatment, requiring a high level of medical support.

There are 13 PTCs across England.



Shared care

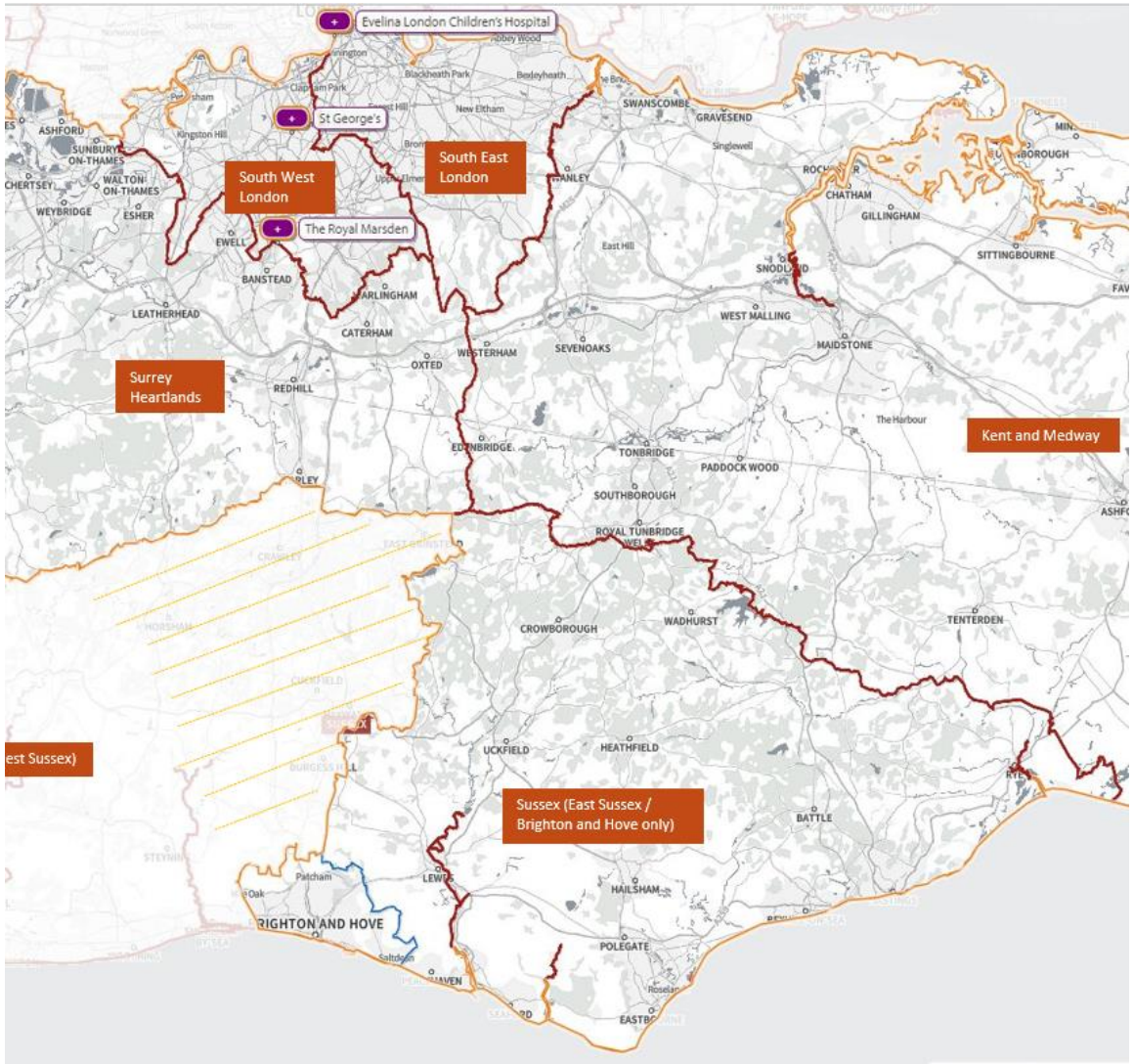
PTCs work in partnership with Paediatric Oncology Shared Care Units (POSCUs) at specified hospitals across their catchment areas, allowing care to be delivered closer to children's homes.

Many children with cancer also receive care in their homes. This can be from staff or 'outreach' services from the PTC, POSCU or staff from children's community nursing teams.

PTCs also coordinate children's care with cancer services that are provided at other specialist centres (if not provided by the PTC), and with national services to ensure children receive the right care at the right time and in the right place.

The PTC for south London, Kent, Medway, most of Surrey, East Sussex, Brighton and Hove

This PTC is one of 13 across the country. It offers care to patients across a wide catchment area and some patients outside the catchment area who choose to access their care at this PTC. The map below shows the locations of The Royal Marsden, St George's Hospital and Evelina London Children's Hospital. **There is one POSCU (Royal Alexandra Children's Hospital) within Brighton and Hove**



Children newly diagnosed with cancer

While a diagnosis of cancer clearly has a huge impact on people's lives, it is relatively rare among children.

The rate of diagnosing new cancers among children across Brighton & Hove and East Sussex combined is around **164 cases per million per year**. This means that around **1 child in every 6,100** are diagnosed with cancer each year.

On average, each year there are 7 children newly diagnosed with cancer from Brighton & Hove.

Children receiving cancer treatment

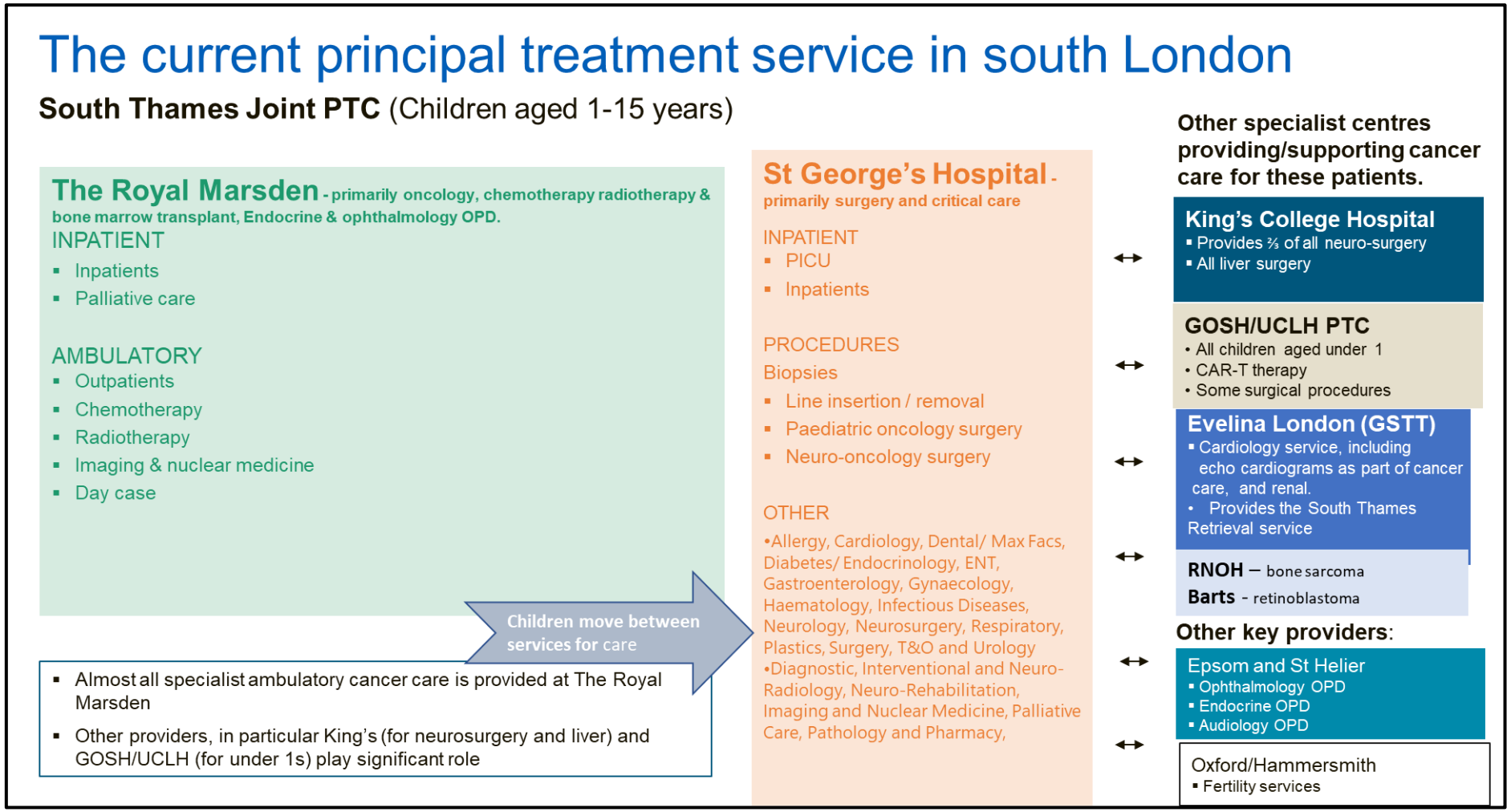
In total, the PTC treats around 1,400 children per year. Of these, in 2019/20, 22 children (2%) came from Brighton & Hove

All children were seen as an outpatient; 45% also had an inpatient stay.

Sources: NDRS new cancer registrations 2015-2019
ONS mid-year population estimates 2021
PTC programme "data lake" 2019/20 data

The current PTC

- The Royal Marsden provides the majority of inpatient and outpatient care for children with cancer in the PTC catchment area. Care is provided at its Sutton site.
- If children require surgery, critical care and some other specialist children's services they are treated at St George's Hospital in Tooting.
- The Royal Marsden works closely with the Institute of Cancer Research, which is based on its Sutton site, on world leading research into children's cancer care.



Some children also travel to other London hospitals for care, this is because of the expertise these hospitals have in specialist areas. This will continue in the future too.

Case for change

Being on the **same site as a children's intensive care unit and cancer surgery** is now a national requirement for all PTCs in England (national specification for PTCs, November 2021).

Locating the future PTC on the **same site as children's intensive care** will mean:

- ✓ no more hospital transfers for children who need intensive care*: very sick children will not need to be transferred eight miles from Sutton to Tooting to receive intensive care. This happens safely but can be very stressful for children, parents, and the staff involved
- ✓ no more hospital transfers for children who the clinical team thinks may need admission to an intensive care unit: pre-emptive transfers to safely manage the inbuilt geographical risk will not be needed
- ✓ fewer admissions to intensive care: some can be avoided if intensive care doctors are able to visit the child on the ward and keep a close eye on progress.

Placing the future PTC on the **same site as children's cancer surgery** will:

- ✓ improve patient experience as patients can get more of their care in a familiar place rather than having to find their way around different sites.

Other **benefits** of relocating specialist services for children with cancer include:

- ✓ the ability to provide a service where all PTCs in England are equipped to give complex new treatments which require children's intensive care services to be on-site (such as CAR-T which uses a child's own treated immune cells to treat their cancer)
- ✓ the potential to further develop multidisciplinary team working and research.

**See Appendix for further detail*

2. Options development and evaluation

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Summary of options appraisal process

We have already run an option appraisal process – consisting of four elements:

Longlist to shortlist	In line with NHS formal reconfiguration guidance, a short list of options was developed from a long list of all potential options by applying **first fixed points** (things that cannot be changed) and then **hurdle criteria** (to determine viability).	Following this stage, **two options remained**: the trusts running St George's and Evelina London Children's hospitals. Both were asked to complete a formal proposal document outlining how they would deliver the service using set criteria.
Evaluation Criteria	Evaluation criteria were developed over 2020/2022, reflecting the requirements of the service specification and incorporating research, patient and carer experience, capacity and resilience.	This resulted in four domains for evaluation: clinical, research, enabling requirements, and patient and carer experience. Measurable sub-criteria were developed for each domain, drawing on expertise from clinicians, parents, and managers from in London and outside London.
Weighting the evaluation criteria	Four expert panels comprised of patient and carer representatives, charities, researchers from outside London, clinicians (medical and nursing) from in and outside London, managers, and experts in various specific fields (e.g. emergency preparedness, human resources) were established to weight and score the criteria within each domain.	In September 2022, the Programme Board finalised the high-level weighting given to each of the domains. Between October and November 2022, the identified panels for each domain undertook a virtual, two-stage exercise to establish the sub-weights for the criteria within their domain.
Scoring the proposals	In November 2022 both Trusts submitted their proposals, aligned with the domains and sub-criteria. During December 2022, the topic-specific expert panels scored the submissions against each of the sub-criteria for their specific domain.	Final scores were calculated for each option using the pre-agreed weighting.

Final weightings

Programme Board members set the domain weights and expert panels weighted the sub-criteria.

Clinical domain

36%

- Interdependencies 35%
- Treatment transfers 27.5%
- Network effectiveness and system benefits 19.5%
- Transition 18%

Patient and carer experience domain

26%

- Quality of facilities 25%
- Patient navigation 23%
- Family support 21%
- Engagement and collaboration 16%
- Service accessibility 15%

Enabling domain

19%

- Capacity 30.5%
- Resilience 25%
- Organisational support for staff 23.5%
- Impact on staff 21%

Research domain

19%

- Performance and capability 39%
- People 32%
- Place 29%

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There are two strong proposals for the relocated PTC

- Although the services which the **current PTC** in south London provides are safe and high quality, they do not and cannot comply with the national service specification. As it is not a children's hospital, The Royal Marsden does not have a Children's ICU or Children's Cancer Surgery on-site. Children's ICUs are always at hospitals that provide many other specialist children's services. In the context of the change in the service specification, the Royal Marsden is actively contributing to the review process to ensure the very best outcome is achieved for children.

- We are fortunate to have **two strong options** for relocating the PTC which we will be consulting on:
  - **Evelina London Children's Hospital**, which is run by Guy's and St Thomas' NHS Foundation Trust and is based on the St Thomas' site in Lambeth
  - **St George's Hospital**, which is run by St George's University Hospitals NHS Foundation Trust (part of St George's, Epsom and St Helier Group) and is based in Tooting.

- In combination with the new specification for POSCUs, this will enable NHS England London to implement the national vision for children's cancer services, driving continued improvement across the network with enhanced levels of care closer to where children live.

Our vision is that the future centre will lead coordinated children's cancer care of the highest standard across the catchment area. We are ambitious about what we can deliver for our patients by providing care in a specially designed environment that also supports the delivery of new treatments as they become available; continuation of ground-breaking research; and access to clinical trials. We know these things are very important to children with cancer, their families, and the staff who deliver the current service.

Things to note:

In setting its clinical model, the Programme Board overseeing this reconfiguration made a number of key decisions including:

- No matter which option is chosen, **children will need travel to other London hospitals for the care**, due to the expertise these hospitals have in these specialist areas – services are not going to move as part of the reconfiguration:

Hospital	Services
Royal London Hospital (RLH), Whitechapel	Eye Cancer
Royal National Orthopaedic Hospital (RNOH), Stanmore	Bone Cancer
Great Ormond Street Hospital for Children (GOSH), Bloomsbury	Babies aged 0 to 12 months (all types of cancer)
King's College Hospital (KCH), Denmark Hill	Liver Cancer
St George's Hospital, Tooting and King's College Hospital, Denmark Hill	Neurosurgery: Cancer of the Brain and Central Nervous System
University College London Hospitals' Grafton Way building (UCL), near Euston	Proton beam radiotherapy (at one of only two proton beam machines in England)

- **Access** - the PTC must be accessible for all service users in terms of journey time and should therefore be based within Greater London.
- **Timeliness -** once a decision has been made, the new service must 'go live' within a 2.5 year implementation timeline
- **Affordability** - so long as both options remain affordable, the cost will not influence the decision. Instead, the decision will focus how to create the best possible service for children with cancer.

Outcome of scoring

- The Evelina London Children's Hospital option received a higher overall score than the St George's option, scoring higher in three of the four key areas.
- Based on the evidence provided by the evaluation, Evelina London is NHS England London's preferred option at this stage in the process.
- Both options scored highly and are viable options for the location of the future centre. We are very much keeping an open mind.
- NHS England London will only make their final decision on the location of the future centre after hearing the views that come forward during the public consultation and taking account of all other relevant factors.

3. Where are we now

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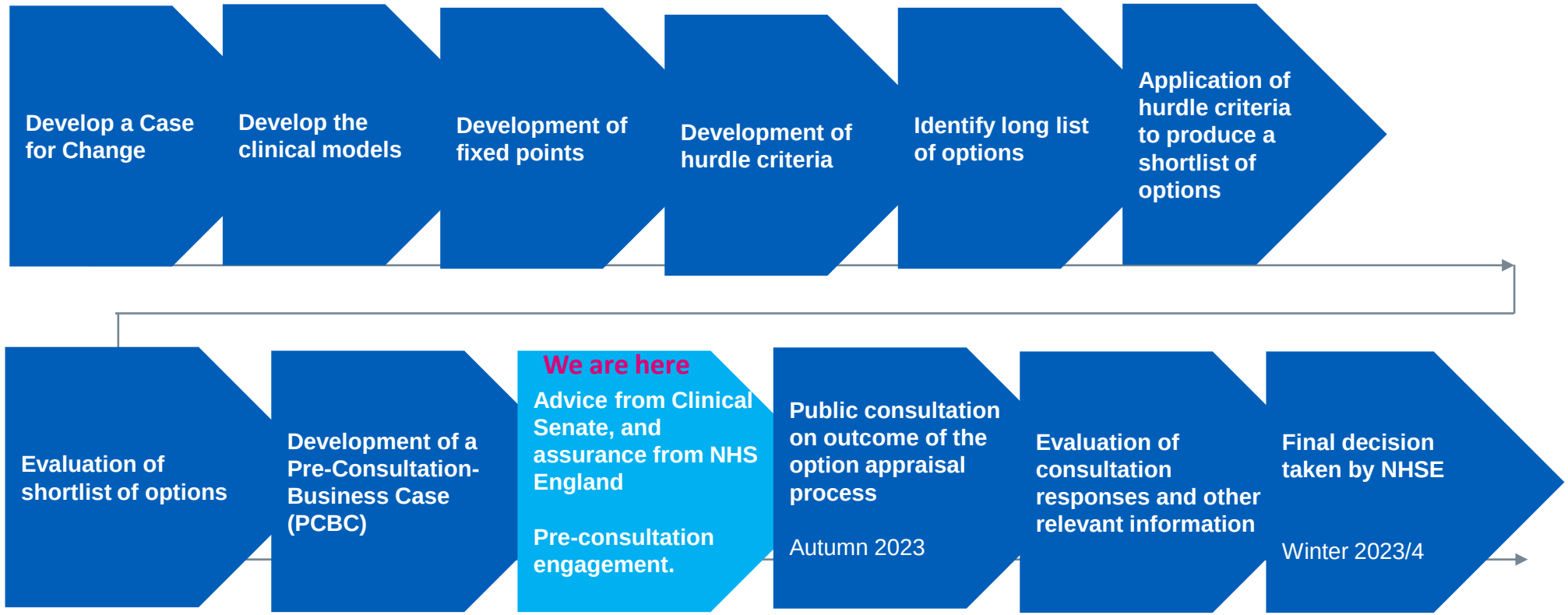
Where we've been and where we are now



A formal reconfiguration process is required when moving a significant service from one site to another to ensure all stakeholders have the opportunity to review and comment on the case for change, clinical model and proposals.

Consultation with Brighton and Hove HOSC will continue in forthcoming months; including during the decision-making phase.

4. Equality and Health Inequality Impact Assessment

Equality and Health Inequality Impact Assessment (EHIA): Process

Purpose of the EHIA
To support meeting legal duties including the Public Sector Equality Duty (Equality Act 2010) and the Health and Social Care Act

What changes are we assessing the impact of?

A change in location of the current PTC and the implications of this change on patient travel arrangements, including travel time; complexity of journey (including parking arrangements); and cost.

Additional considerations:
- the prospect of the service change process itself
- the prospect of a new environment and aspects of onsite accessibility
- other potential benefits

The EHIA takes a non-comparative, population-based approach.

Which population groups were considered in terms of experiencing differential impacts?

Those with a protected characteristic as specified in the Equality Act 2010, or who typically face health inequalities, including those living in deprived areas or families on low incomes (EHIA document contains full list).

For each group, using the information referenced below, plus professional and personal experience, the sub-group assessed any potential differential impacts of the proposed changes in relation to both the Public Sector Equality Duty and inequalities in access to, and outcomes from the service.

Sources of information used:

1. An equalities profile for the PTC catchment population
2. A travel time analysis report
3. Qualitative insight collected through patient engagement activities

Equality and Health Inequality Impact Assessment: overall findings

Impacts of travel time differences on health inequalities (access)
When comparing travel times to the current PTC main site (The Royal Marsden) to either future PTC location, travel time analysis shows:

- there are differential positive impacts for children living in the most deprived areas and rural areas when travelling by public transport.
- there are differential negative impacts for children living outside London or in rural areas when driving.

Other impacts:
Several population groups (full list in EHIA) may experience a differential impact in terms of:

- complexity or cost of their journey
- uncertainty brought on by the prospect of the service change process itself
- on-site accessibility

For example, patients and/or families:

- where a family member is disabled (or has a spectrum disorder)
- who are on a low income/living in more deprived areas
- with poor literacy and/or language barriers
- who experience digital exclusion

The Equalities profile document includes an estimated quantification of the size of each population group within the PTC catchment area.

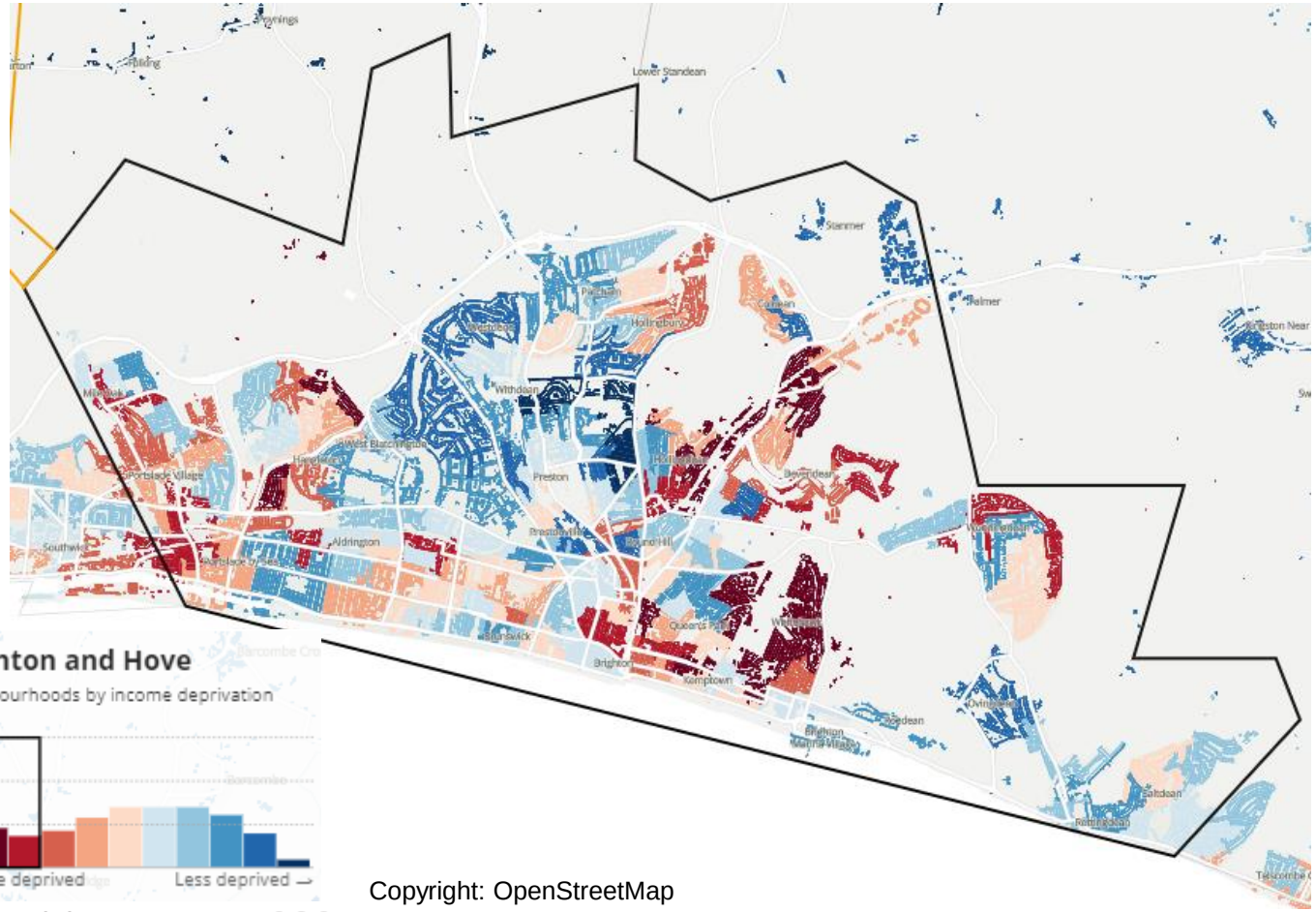
Benefits for improving outcomes and reducing inequalities:
Compliance with the service specification will mean that healthcare related outcomes (in terms of patient experience and safety) are likely to be enhanced through receipt of co-ordinated, holistic care with a reduced requirement for treatment transfers at a time of crisis, and the risk that certain types of transfers involve.

While this will benefit all children attending the PTC, the EHIA sub-group concluded that there may be a differential positive benefit for certain groups who may have a higher need for additional paediatric specialties (e.g. those with complex cancer care needs, co-morbidities, who are disabled or have or other conditions) or with communication difficulties (e.g. language barriers or poor literacy) where the reduced need for treatment transfers/multi-site appointments may be beneficial.

Equality and Health Inequality Impact Assessment: Travel from Brighton & Hove

Travel time modelling confirms that journeys by public transport to Evelina London would be around 14 minutes faster and 8 minutes faster to St. George's (on average).

Journeys by road vehicle would (on average) be around 50 minutes longer to Evelina London and around 30 minutes longer to St. George's.



Copyright: OpenStreetMap

Of the 165 neighbourhoods in Brighton & Hove, 27 were among the 20% most income-deprived in England.

Exploring local income deprivation (ons.gov.uk)

The Interim Equalities and Health Inequalities Impact Assessment (to be released as part of the suite of public consultation documents) contains a range of proposals for mitigating the financial impact of patient journeys that may increase as a result of the change in PTC location. A summary is included on the next slide.

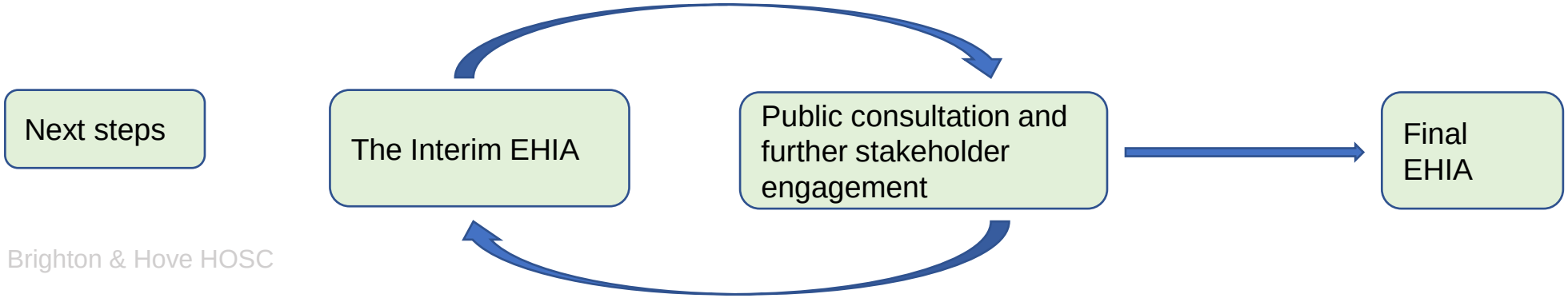
Please see Appendix for travel time analysis methodology

Equality and Health Inequality Impact Assessment: mitigation & next steps

It is important to note that the travel analysis can only capture impacts in terms of travel time. It is not possible to systematically quantify impact in terms of complexity of journey, reliability of transport services and costs. **The most important aspect of the EHIA is the recommendations for mitigation**. The EHIA sub-group has put forward a range of potential systems, processes or programmes that could serve to mitigate the adverse impacts of a longer, more complex, more costly journey.

The main themes include:

1. Systems and processes aimed at helping patients and families plan their journeys to hospital, including provision of inclusive and accessible information and translation services.
2. Systems and processes aimed at reducing the financial impact of travel, such as reimbursement schemes for travel costs (including Ultra Low Emission Zone - ULEZ charges) or supporting patients to access other financial support.
3. Transport services provided directly to patients and their families (with clear eligibility criteria) and family accommodation.
4. High quality onsite accessibility arrangements, including parking and drop-off facilities.
5. Other aspects of care planning including flexibility for appointment times, shared care closer to home, strong communication systems between different health and social care teams, and remote (non face to face) appointments (that take into account aspects of digital capability)
6. An excellent implementation plan for the service change process, to support patients through the transfer period, with high quality continuity of care. Implementation plans should consider meeting NHS duties around health inequalities and take a Core20Plus5 approach.



Other impacts

Alongside the duty to reduce inequalities of outcomes, NHS England – London, have, and will continue to give due regard to:

- The wider impact of the decision made
- The need to contribute towards compliance with the UK net zero emissions target (s. 13NC NHS Act)

5. Consultation plan and document, including stakeholder engagement

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We seek to ensure an inclusive engagement approach

We are:

- Working with **experts in the voluntary and community sector** to include a range of views from within and outside the PTC catchment area
- **Commissioning specialist expert organisations** to ensure we reach EIA groups and children and young people in an effective and appropriate way.
- Learning from Trust and ICB engagement colleagues to develop **relationships** with key stakeholders to be **inclusive of seldom heard**, **minority and deprived population groups**
- **Using intelligence** from the EHIA **to inform engagement plans** to focus on those most affected and impacted groups
- Historic engagement (via both surveys undertaken) has reached a **range of ages, ethnicities and geographies**

Planned engagement (during pre-consultation and consultation) will focus on reaching professionals and different groups:

Current and recent service users and their families and carers	**Voluntary and community organisations** i.e. those supporting children and young people and other communities identified here, including Healthwatch	**Staff** Most intensively with those working in these services but also informing wider staff groups to understand any impacts
Health and care partners i.e. connected services and other nearby Trusts	**Children and young people from Black and other minority ethnic communities**	**Children with physical and/ or learning disabilities or autism**
Scrutiny and assurance bodies i.e. Overview and Scrutiny Committees and both Clinical Senates across south London and the south east region	**Focus on all geographic areas patients currently come from**	**Focus on all age band between 0-15 years**

Feedback has informed our approach to date

Engagement phase	How engagement is influencing the process
Early engagement and options appraisal (March 2020 - January 2023)	Fed into the development of the case for change and options appraisal process.
We are here → **Pre-consultation** (March 2023 – August 2023)	Helping us to plan the consultation and understand what some of the key issues may be.
Consultation (Autumn 2023)	Will help us understand the impact of implementing either proposal and consider mitigations.
Decision- making (Winter 2023/4)	Feedback considered, alongside other evidence, to support the decision-making process.

Stakeholders who have been involved in this process to date:

- Parents/carers and children and young people
- Staff Researchers
- Stakeholder group
- Clinical Advisory Group
- Voluntary and community organisations

Engagement to date – pre-consultation (work in progress)

Pre-consultation (March 2023 – August 2023)
Purpose: Helping us to plan the consultation and understand what some of the key issues may be. **Activities:** ➢**Held/attended 6 feedback sessions** with different groups ➢Attended informal and formal meetings with **local council Overview and Scrutiny Committees** to discuss the programme and our plans ➢**Undertaken 3 ward visits** to speak to parents and families – with further sessions planned •Using **surveys** to capture feedback from staff and current service users – including asking about travel and access ➢Stakeholders are **reviewing and feeding back** on our consultation plan and document **Impact of engagement:** Refining and updating our consultation plan and document. Creating new information and in different formats to meet communication needs. Working with Trusts t

Reach and representativeness
Spoken to over 320 individuals to date via 1:1 basis, via email, through surveys or at meetings – most with direct experience of receiving or providing the service as well as voluntary and community organisations like **specialist children's cancer charities** and **Healthwatch organisations.** • from a range of, but not all, geographies within the PTC catchment area • from a range of ages (both of children, young people and parents/carers) • who have physical or mental health conditions, disabilities, or illnesses other than their cancer (40%) • from black, Asian and other minority communities (40%) • who do not speak English as their first language (23%) • who had had experience of The Royal Marsden Hospital (100%) or St. George's Hospital (53%) and Evelina London (11%)

The appendix contains a high-level summary of feedback received and how we are acting on what we're hearing

Travel and access

Asking staff, children and young people and parents/ carers about travel and access as part of the pre-consultation phase

What we know* is:

- Around 75% of travel to appointments are made by car/taxi, with the remaining 25% by public transport
- Those who use their car/ taxi for transport tend to live outside of London (over 52%)
- Over 30% are already travelling over an hour to get to appointments at The Royal Marsden and over 75% are already travelling over 30 minutes to get to appointments.

We are feeding this data into our travel analysis work

**for CYP and families we spoke to with direct experience of current service (n.b. more data to come following St. Georges site visits)*

Consultation: aims

We have two strong options for the future PTC.

The consultation aims to inform NHS England – London on our decision on which option will offer the best service for children with cancer in the future.

The **purpose of the consultation** is to:

- engage with as many people as possible in the geography affected by this service change and hear their views on the proposals for the future location of the children's cancer PTC
- understand the impact of implementing either proposal and any mitigations or enhancements that could be put in place
- ensure NHS England - London, as decision-maker, is made aware of any information which may help to inform the options and the decision-making process.

Public consultation is not a vote or referendum, and we are asking stakeholders to consider each proposal in its own right.

Outside scope of consultation:

- Shared care units which provide cancer care to children in local hospitals are not affected by this consultation.
- Cancer services for teenagers and young adults (generally for 16 to 25-year-olds but with some flexibility around ages) will continue to be provided at The Royal Marsden.

Consultation document – updated following stakeholder feedback

Our preparations for consultation remain ongoing, this includes ongoing review and assurance of our pre-consultation business case and associated consultation materials as part of NHS England's Stage Two assurance process. In parallel with this, we have received a lot of feedback during the pre-consultation phase, there remains ongoing work to review this and reflect it in our documentation.

Consultation document: proposed content includes

- How people can get involved (including hard copy questionnaire)
- What the consultation is about (and what services won't change
- Why a change is needed and benefits
- Our proposals
- What the proposed changes would mean
- What children, parents and staff have told us about the impacts
- Developing and assessing our shortlist
- The options
- Other impacts (including travel and other services)
- Scoring outcome
- Our preferred option
- Timetable and next steps

Appendices/other supporting documents include:

- Summary consultation document
- Easy read document
- Consultation questions
- Consultation plan
- Early engagement feedback report
- Animation
- Factsheets on development, summary and evaluation of the proposals, financial aspects including costs, getting to the two potential sites, transition offer to teenage and young adult service
- Initial Equalities and Health Inequality Impact Assessment (EHIA)
- Feedback from the Clinical Senate

The appendix contains a high-level summary of feedback received and how we are acting on what we're hearing

Consultation: engagement methodology & key questions

Engagement methodology

- **Writing to current and recent service users and their families/carers**
- **Online events**
- **Targeted sessions** with the **stakeholder group and other charities/ Voluntary and Community Sector (VCS) organisations** already closely involved with us
- **Community outreach to children and young people and their families with specific characteristics** identified in the equalities impact assessment
- **Creative activities on existing sites with children and young people currently accessing services** (through working with a play therapy organisation)
- **1:1 interviews/ survey completion on existing sites with parents/carers**
- **Attending existing meetings** in the community
- **Survey** (including an easy read version)
- **Wide use of simple animation** to raise awareness and encourage feedback
- **Sharing information through existing contacts and networks** including Facebook group for RM parents
- **Posters with QR codes** linking to online materials
- **Briefings**
- **Offering non-digital channels:** completion of surveys by post, interviews by phone, printed documents in wards/given out by Royal Marsden volunteers/in flats used by long-stay parents

Consultation questions will focus on:

- Understanding of the case for change
- Views on key aspects of both proposals such as travel, access and research
- Ideas around how to mitigate or enhance impacts
- Understanding how we could make implementing the change easier for those currently in the service

Appendix: Supporting slides

- Case for Change - references
- Travel time analysis – methodology
- Pre-consultation engagement – who we have contacted
- How stakeholder feedback is influencing our consultation plans and documents

55

Case for change – references used in presentation

Transferring critically unwell patients is associated with a risk of physiological deterioration and adverse events[1] and the emotional and psychological stress for parents should not be underestimated[2]. Although specialist transport services have been shown to enhance safety and quality[3], the 2008 "Safe and Sustainable" framework, produced by clinicians and endorsed by the relevant Medical Royal Colleges, states that paediatric oncology and paediatric intensive care have "absolute dependency, requiring co-location". It is this clinical advice, backed up by subsequent expert reviews[4] that underpins the national service specification requirement.

References:

1. Droogh, J.M., Smit, M., Absalom, A.R. *et al.* Transferring the critically ill patient: are we there yet?. *Crit Care* **19**, 62 (2015). https://doi.org/10.1186/s13054-015-0749-4
2. Harvey, Edmunds, Ghose. Transporting critically ill children. Anaesthesia & Intensive Care Medicine Volume 21, Issue 12, December 2020, Pages 641-648
3. Gilpin Hancock. Referral and transfer of the critically ill child. BJA Education, 16 (8): 253–257 (2016)
4. NHS England board-meeting-item-9-update-on-specialised-services-c-appendix-2.pdf (england.nhs.uk)

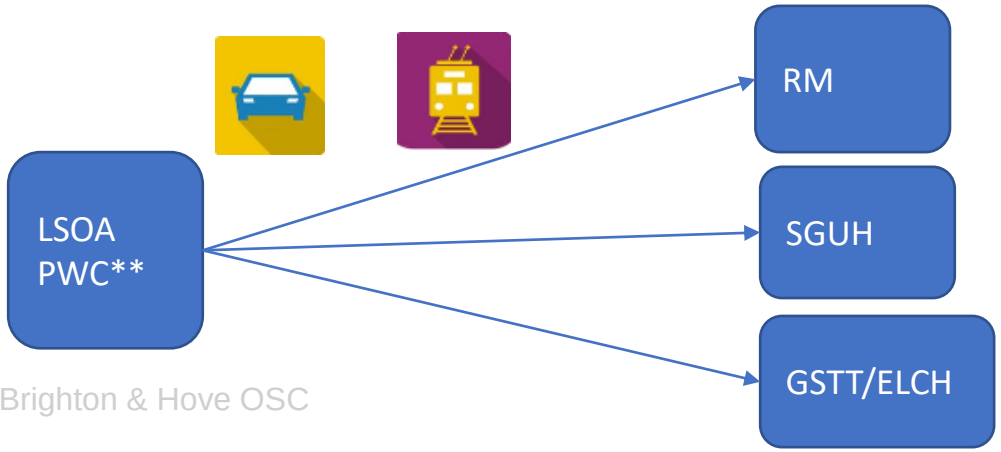
Travel time analysis: methodology

Travel time modelling software was used to generate public transport and car journey travel times for all children (aged 15 and under) living in the PTC catchment to each of the three provider locations, from their "origin" (based on their Lower Super Output Area* (LSOA) of residence). There are 4,000 LSOAs within the PTC catchment area.

Travel times are for the fastest trip departing from resident origin for arrival at midday on a Wednesday. Metrics used in the analysis are median and longest travel times (minutes) and the proportion of the population within a 60 minute journey time of each provider, by public transport and driving.

The modelling uses both road networks and timetabled transport networks. The potential combination of travel modes for each journey by public transport are national rail, tram, light rail, tube, bus, coach, ferry, and walking to and from stops and interchange, and walking alone if quicker. A public transport journey was only measured if a station or stop was reachable within an initial 20 minute walking time (only 0.2% of LSOAs did not meet this criteria).

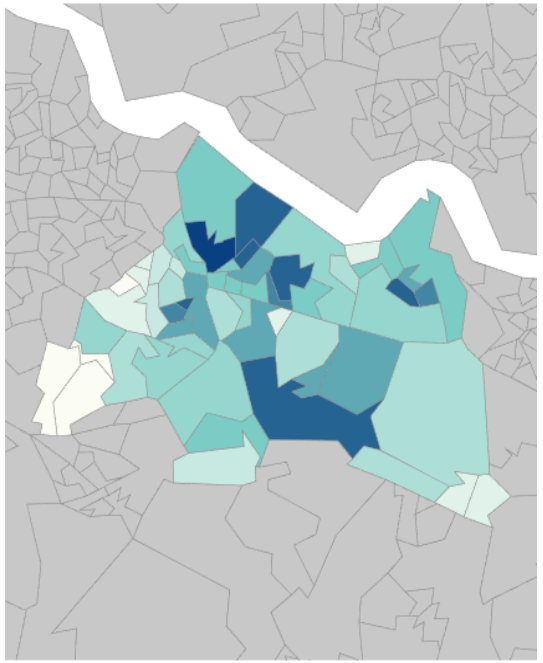
The travel measures are intended to provide a typical indication of the quickest journey from origin to destination for people travelling with no additional requirements. Individual experiences may not completely align with the estimated times.



*** Note: Lower Super Output Areas (LSOAs)** are a small area geography averaging approximately 1,500 people. Each LSOA has a PWC (population weighted centroid) which represents the centre of the distribution of residents across the LSOA.

Population estimates are available at LSOA level and each LSOA is assigned an Index of Multiple Deprivation (IMD) score and an urban/rural classification. This allows for travel time analysis by these classifications. More information on the IMD is in Appendix B

Illustration of Lower Super Output Areas (Dartford)



Early engagement activity (2020-2023)

Early engagement (March 2020- March 2023)	Reach and representativeness
Purpose: Seek early feedback about experiences of the current service and understand important features for a future service **Activities:** ➢**2 surveys –** online and via staff on wards ➢**9 Meetings with our Stakeholder Group** – of parents and charities ➢**Over 60 contacts** (through our independent Chair of the Stakeholder Group) with parents/carers /caregivers – a combination of meetings, individual conversations with parents (telephone or virtual) and email contacts - to support their participation and engagement ➢**Panel of parents** participated in the options appraisal process – scoring aspects of the patient experience domain ➢**2 Parent representatives** involved in reviewing the EHIA **Impact of engagement:** Fed into the development of the case for change and influenced options appraisal criteria and weightings	Through our early engagement work, **we heard from over 250 children, young people and families** through our surveys from: ➢ a broad range of geographies across the PTC catchment area, including in SWL and Surrey ➢ a range of ages of parents and children ➢33% of survey respondents were from Mixed/Multi Ethnic, Asian, Black Ethnic Groups or other Ethnic groups Our future focus has been on reaching a wide range of views – many currently in the service may not be affected in the future. Conversely, some families who currently know nothing about the service may be impacted if they need to use the service in future.

Pre-consultation engagement – who we have contacted

Below is a list of the different types of organisations we have contacted as part of our pre-consultation engagement:

- Specialist Children & Young People (CYP) cancer charities/groups (including parent-led organisations)
- Youth Forums/Councils/ Parliaments
- Healthwatch organisations
- Maternity Voice Partnerships
- Mental health umbrella organisations
- Black and minority ethnic forums/ groups
- Pan-geography organisations supporting; refugees or asylum seekers, addiction and/or substance misuse issues, people involved in the criminal justice system, people experiencing homelessness and gypsies or travellers)
- Learning disability and autism groups
- Groups supporting people with physical impairments
- Carers (young and adult)
- Community groups in the most deprived areas within the catchment

What we are doing as a result of feedback

- **Updating key documents**
  - *Consultation plan*
  - *Consultation document*
  - *Equalities and Health Inequalities Impact Assessment*
  - *Travel Analysis*
- **Creating new documents** to be published at consultation launch
  - *Factsheets*
  - *Updating our FAQ documents*
  - *Posters to enable quick responses to consultation*
- **Strengthening our governance** around patient and public voice
  - *National charity representation on our Programme Board*

What we are doing as a result of feedback

- Working more closely with charities and providers to **help us prepare for consultation**
  - *Offering site visits*
  - *Testing materials to make them children and young people friendly*
  - *Exploring possibilities for creating social media content with children and young people*
  - *Using existing networks like parent groups to reach more people*
- Considering what information can be put in the **public domain**, even **before we launch consultation**
- Seeking **external assurance** around our consultation plans from **The Consultation Institute**
- Producing public **information about how a decision will be made**, what information will be considered and if any weighting will be given to different items

What we are doing as a result of feedback

- **Rewording our case for change** so that it better describes the benefits and reasons for the change
- Working with Trusts to think now about: **how we can mitigate some of the impacts** that are coming through on feedback (specifically around transfers, travel and access and clinical quality), how they would plan to **involve people in implementing the change** and how **transition could be managed**
- **Seeking additional data** from Trusts around the impacts they have identified to their organisations so that this can be considered in the process
- Meeting with **research organisations** to seek feedback
- Working with Trusts to **strengthen mitigations around travel and access**

Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item 7

Subject: **Care Quality Commission (CQC) Inspection of University Hospitals Sussex NHS Foundation Trust: May 2023 Inspection Report**

Date of meeting: **12 July 2023**

Report of: **Executive Director, Governance, People & Resources**

Contact Officer: **Name: Giles Rossington**
Tel: 01273 295514
Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: **All**

For general release

1. Purpose of the report and policy context

1.1 The Care Quality Commission (CQC) is the statutory regulator of NHS services. This report presents information on the recently published CQC inspection report on University Hospitals Sussex NHS Foundation Trust (UHSx), with particular focus on the CQC's findings in relation to the Royal Sussex County Hospital (RSCH).

1.2 The May 2023 CQC Inspection report of RSCH is attached as Appendix 1 to this report. Information from UHSx in response to the CQC's findings is attached as Appendix 2.

2. Recommendations

2.1 That Committee notes the Care Quality Commission's May 2023 report on University Hospitals Sussex NHS Foundation Trust, and the Trust's response to the report.

3. Context and background information

3.1 The Care Quality Commission (CQC) is the statutory regulator of health and care services in England. Part of the CQC's work is to conduct a rolling inspection programme of NHS providers, as well as spot inspections of providers where there are particular grounds for concern. The CQC grades NHS Trusts, individual hospitals and individual services as either *outstanding*, *good*, *requires improvement* or *inadequate*. Trusts and Trust services are evaluated in terms of six domains: *safe*, *effective*, *caring*, *well-led*, *responsive*, and *use of resources.*

3.2 University Hospitals Sussex NHS Foundation Trust (UHSx) is an NHS Trust which runs a number of acute hospitals across Sussex, including St Richards Hospital, Chichester; Worthing Hospital; the Princess Royal Hospital, Hayward's Heath; the Royal Alexandra Children's Hospital, Brighton; and the Royal Sussex County Hospital (RSCH), Brighton.

3.3 The CQC inspected maternity services at all UHSx hospitals in 2021. It also inspected surgery at RSCH at the same time. The CQC published a report in December 2021, downgrading RSCH maternity and surgery from *good* to *inadequate.* The CQC also inspected RSCH urgent & emergency services in 2022, publishing a report in July 2022, downgrading RSCH urgent & emergency from *good* to *requires improvement*.

3.4 UHSx, supported by partners across the local health and care system, developed and implemented action plans in response to the CQC's findings. The HOSC received a progress report on these in October 2022. This showed that the Trust had made good progress in enacting the CQC's recommendations for improvement, although there was still more improvement work to be done, particularly in terms of surgery.

3.5 The CQC has subsequently conducted a further inspection of UHSx, this time focusing on the *well-led* domain. The CQC inspection report, published on May 15th 2023, found significant leadership failings at the Trust, and downgraded the *well-led* domain to *inadequate*. Overall, the Trust is now rated as *Requires Improvement* but *outstanding* in the *effective* and *caring* and domains. The hospital rating for RSCH has been downgraded from *good* to *inadequate*.

4. Analysis and consideration of alternative options

4.1 Not relevant to this report for information.

5. Community engagement and consultation

5.1 None for this information report.

6. Conclusion

6.1 Members are asked to note the publication of the recent CQC inspection report, and to note the measures UHSx is taking to address the CQC's recommendations for improvement.

7. Financial implications

7.1 Not relevant to this report for information.

8. Legal implications

8.1 There are no legal implications to this report.

Name of lawyer consulted: Elizabeth Culbert Date consulted 01.06.2023

9. Equalities implications

9.1 None directly to this report for information.

10. Sustainability implications

10.1 None directly to this report for information.

Supporting Documentation

1. Appendices

1. CQC Inspection Report, Royal Sussex County Hospital, May 2023
2. Presentation in response to the CQC report (provided by University Hospital Sussex NHS Foundation Trust)

University Hospitals Sussex NHS Foundation Trust

Inspection report

Worthing Hospital
Lyndhurst Road
Worthing
BN11 2DH
Tel: 01903205111
www.westernsussexhospitals.nhs.uk

Date of inspection visit: 04 October - 05 October 2022
Date of publication: 15/05/2023

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Outstanding
Are services caring?	Outstanding
Are services responsive?	Requires Improvement
Are services well-led?	Inadequate

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

University Hospitals Sussex NHS Foundation Trust provides clinical services to people in Brighton and Hove, parts of East Sussex and West Sussex. The trust came into existence as a result of an acquisition by Western Sussex Hospitals NHS Foundation Trust of Brighton and Sussex University Hospitals NHS Trust on 1 April 2021.

The trust is now one of the largest organisations in the NHS employing nearly 20.000 staff and serving a population of around 1.8 million people in Sussex. The trust runs 7 hospitals across Brighton and Hove, West and Mid Sussex and parts of East Sussex. The trust provides 24 hour accident and emergency and maternity services on 4 hospital sites, with Royal Sussex County Hospital in Brighton being a centre for major trauma and tertiary specialist services. The trust also provides specialist services for patients from across the wider South East region.

The Care Quality Commission (CQC) carried out 7 core service inspections in the past 18 months at University Hospital Sussex NHS (UHSx) Foundation trust. These included maternity, surgery (general surgery, upper gastrointestinal (UGI) cancer services, neurosurgery), and urgent and emergency care. In September 2021 we carried out focused inspections of the maternity services at St Richards Hospital, Worthing Hospital, Princess Royal Hospital and Royal Sussex County Hospital. These inspections found safety concerns raised by staff to CQC were valid. The ratings for all 4 maternity services went down. CQC took enforcement action by serving a warning notice that asked the trust to make significant improvements. We inspected the maternity services again in April 2022 and found the trust had complied with the terms of the warning notice. However, we asked the trust to make additional improvements by issuing requirement notices.

We also inspected the surgical core service at the Royal Sussex County Hospital in September 2021 because we received safety and leadership concerns from whistle-blowers. This inspection also found the concerns to be valid. The service was rated as inadequate. CQC took enforcement action and asked the trust to make significant improvement. We carried out another inspection to check on the improvements in April 2022. Our findings showed little improvement had been made. We took additional enforcement action and placed conditions on the trust's CQC registration.

Our findings

CQC then received concerns about the UGI surgical service from staff and other stakeholders. We carried out an inspection of the elective UGI surgical service in August 2022 and found serious safety and leadership concerns. This resulted in CQC urgently imposing conditions on the registration of the trust, suspending the UGI elective surgical service to protect patients from the potential risk of harm.

We have continued to receive concerns from staff about the safety of the surgical services at the Royal Sussex County Hospital. We have escalated these concerns to other key stakeholders to ensure there is oversight and support for the trust to make the necessary improvements at pace.

We inspected the emergency and urgent care services at the Royal Sussex County Hospital in April 2022. The rating for this service went down from good to requires improvement. We provided the trust with a list of actions they must and should take to drive the changes needed to improve the service.

Due to the ongoing safety concerns identified by our inspections and the contacts from staff, we carried out a well-led inspection. This was to review our concerns about the quality of the trust's leadership, organisational culture and the lack of progress against the enforcement action taken in the surgical core service at the Royal Sussex County Hospital. At the same time, in response to concerns, we carried out a focused inspection of the neurosurgical service at Royal Sussex County Hospital.

CQC policy details that when a trust acquires or merges with another service or trust to improve the quality and safety of care, we do not aggregate ratings from the previously separate services or providers at trust level for up to two years. However, CQC can aggregate ratings at any time during that 2 year period if it is considered in the best interest of the provider and people using the service.

Following this current inspection, we have aggregated ratings, including core service rating, location/hospital ratings and the well led rating to give an overall rating for the trust. This has resulted in a deterioration in the overall trust rating.

CQC had contact with approximately 120 staff during the well-led inspection. Although this was a small proportion of the trust's total workforce we found consistent trends and themes from these contacts. As part of the inspection process staff 'drop-in' sessions were arranged rather than traditional focus groups to ensure clinical areas were not depleted of high numbers of key staff during a widely recognised period of high demand and staffing pressures. A letter was sent to all staff making them aware of the various ways to contact CQC should they wish to share their experience of working at the trust drop- in sessions across the trust's sites to give staff opportunity to talk to the inspection team. 120 staff took this opportunity to meet with CQC and share their experiences. These themes and trend matched information CQC had received from members of the trusts staff in the 18 months prior to the well led inspection. We spoke with staff from all hospital sites. However, it is worth noting the majority of contacts came from the Royal Sussex County Hospital and Worthing Hospital locations. We continue to have repeated contact from staff who tell us feel unable to raise concerns through the trust's own internal escalation processes.

CQC continues to work with system partners and key stakeholders to support the trust make the necessary improvements for patients and staff.

Trust wide

- Current communication and engagement methods were ineffective.

Our findings

- Staff felt leaders were not visible and felt unsupported by senior leaders.
- Some staff did not feel respected, supported and valued.
- Staff reported low levels of satisfaction and high levels of stress and work overload.
- Not all staff felt they could raise concerns without fear of reprisal. Others experienced 'concern fatigue' from raising the same concerns repeatedly with no action taken.
- We found some examples of bulling and harassment.
- Staff were not able to identify the Freedom to Speak Up Guardian (FTSUG). Staff were unable to tell us how they would access the guardian or raise a concern.
- There was no substantively appointed guardian of safe working hours for the Royal Sussex County hospital and Princess Royal hospital from April 2022.
- Risk, issues and poor performance and behaviours were not always dealt with quickly enough.

However,

- The majority of leaders had the experience, capacity and capability to lead effectively
- There was improved collaborative working between the trust and the Integrated Care System.
- There was good collaborative working between local patient advocacy groups.
- The refreshed trust strategies appeared to be sufficient to improve quality for patients and staff.
- All staff were committed to continually learning and improving services.

Neurosurgery

- The service did not always have enough staff to care for patients and keep them safe. Shortage of radiography staff resulted in delays of surgical procedures.
- Some staff had not completed trust mandated training in key and essential skills. Some staff had not received appraisals.
- Staff did not always work well together for the benefit of patients. Some consultants did not engage with patient discharge processes or with sharing prognoses with patients.
- The environment and availability of equipment did not always support safe and effective patient care and treatment. There were incidents of surgery being delayed due to lack of imaging equipment. Lack of an emergency theatre capacity meant planned surgery was often cancelled to accommodate emergency cases.
- People could not always access the service in a timely manner. Some patients were waiting over a year for their planned surgery.
- Staff did not always feel respected, supported and valued. Some consultants did not demonstrate respectful behaviours.

However:

- Managers used local and national audits and reviews to monitor the effectiveness and safety of the service. They used the results to make changes and improvements to the service. Leaders supported staff to develop their skills. Most staff were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Our findings

- Where safety incidents were reported, the service managed them well and learned lessons from them.

How we carried out the inspection

- We looked at information such as staffing numbers and rotas, staff training, clinical stack management.
- We looked at medicines management, checked equipment, medical devices and consumables.
- We reviewed information provided by the service following the inspection.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Most patients praised the care, treatment and support they received from the service. However, we also saw concerns about waiting times in the emergency departments, long waiting times for access to services and staff attitude.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Trust wide

- The trust must ensure it publicises the Freedom to Speak up function so staff can raise safety concerns safely. (Regulation 17)
- The trust must ensure good quality FTSUG records are kept identifying trend and themes and used for to improve services for patients and staff. (Regulation 17)
- The trust must ensure all staff report incidents via the trust reporting systems. (Regulation 17)
- The trust must ensure the risks associated with reported safety concerns are mitigated promptly. (Regulation 17)
- The trust must ensure it seeks and acts quickly on feedback from staff for the purposes of continually evaluating and improving services. (Regulation 17)
- The trust must ensure it collates staff feedback is used for trend and theme monitoring and used to improve governance and risk oversight. (Regulation 17)
- The trust must ensure it takes account of the Workforce Race Equality Standard and NHS staff survey to ensure staff from ethnic minority groups are not disproportionately disadvantaged by working in the organisation. (Regulation 17)
- The trust must ensure it reviews the current medical staffing levels in the surgery division at the Royal Sussex County hospital to ensure the service can deliver safe and responsive care. (Regulation 12)

Surgery – Neurosurgery services

Our findings

- The trust must ensure that all staff complete training about how to interact with people with a learning disability and with autistic people. (Regulation 18)
- The trust should ensure that staff compliance with mandatory training meets the trust target. (Regulation 12)
- The trust must ensure completion of staff appraisals meets the trust target. (Regulation 18)
- The trust must ensure there are enough neurosurgery theatres to meet the needs of the local population, including availability of theatres for emergency cases. (Regulation 15)
- The trust must ensure leaders and managers have protected time to effectively carry out their role. (Regulation 18)
- The trust must ensure there is enough equipment to manage patient care in a safe and effective manner. (Regulation 15)
- The trust must ensure the culture of the service means that staff are treated with respect by all staff. (Regulation 17)
- The trust must make sure that all staff work together in a manner that promotes the safe and effective care of patients. (Regulation 12)
- The trust must ensure that multidisciplinary meetings are attended by the required number and mix of healthcare professionals. (Regulation 12)

Action the trust SHOULD take to improve:

Trust wide

- The trust should consider reviewing current staff engagement processes to ensure they are effective. (Regulation 17)
- The trust should review how incidents are being graded to ensure the severity levels are graded appropriately. (Regulation 17)
- The trust should ensure staff with long-term health conditions are protected in line with the Disabilities Discrimination Act 1995 and have meaningful personal adaptation plans to ensure they are treated fairly, with dignity and respect they deserve. (Regulation 17)
- The trust should ensure it recruits to the Guardian of safe working hours post to oversees the Royal Sussex County Hospital and Princess Royal. (Regulation 12)
- The trust should ensure the Freedom to Speak up Guardian and the Freedom to Speak up champions have sufficient resources to support staff to raise concerns.

Surgery – Neurosurgery services

- The trust should consider improving the facilities for relatives.

Is this organisation well-led?

Our rating of well-led went down. We rated it as inadequate.

Leadership

Our findings

Leaders understood the priorities and issues the trust had but did not always take appropriate action to resolve them. Some executives were visible and approachable in the service, but most staff reported a disconnect between the board and the floor.

The majority of leaders had the experience, capacity and capability to lead effectively. However, some staff had been promoted into leadership roles but were not provided with the necessary training to do the job. There was a wealth of healthcare knowledge and leadership experience in the executive team, but there were also different challenges that managing one of the country's largest and newly merged teaching trusts entailed. The executive team were consistent in their view of the challenges facing the organisation. The board consisted of a number of experienced executives some of whom were part of the predecessor organisation leadership team and others who were new to the trust. The executives were supported by 10 Non-Executive Directors from a wide range of sectors. There was a significant amount of support available from system partners and key stakeholders to support the trust in delivering the best care possible for patients in Sussex.

Staff were empathetic towards the challenges the executive team faced in leading a trust of its size in the current healthcare economy. However, from the conversations in our drop-in sessions and contacts from staff, they felt the management style, was 'autocratic,' 'bureaucratic' and did not demonstrate commitment and adherence to the trust's own Patient First Quality Improvement methodology. Some staff felt their clinical areas lacked senior leadership and executive oversight and support which left them feeling 'neglected' and 'forgotten.'

While some staff believed they worked in cohesive and dynamic teams at service level that generally managed their own issues this brought its own challenges because these areas felt they were not provided with senior leader/executive support or oversight because of a 'lack of noise'. Consequently, whilst these areas appeared to be self-sufficient, they were not without their challenges which went unaddressed due to the lack of senior support. Clinical and nursing leaders did not have the autonomy to solve all their own issues and a lack of senior support and leadership turnover meant staff felt 'nothing ever got resolved.'

Staff knew who their leaders were. Most staff felt well supported by their immediate line managers and teams at a local level. However, staff said they had concerns about the leadership turnover which left them feeling unsupported and exhausted from telling leaders the same concerns repeatedly without resolution. Some staff described their experiences of bullying and harassment. These staff felt this went largely unaddressed because of the seniority of the staff allegedly carrying out the bullying and because they saw historical working relationships with senior executives as a deterrent to raising their concerns.

The leadership team said decisions were always made in the best interests of patients using the Patients First and True North methodologies. The trust website describes Patient First as their long term approach to transforming services for the better. It describes it as a process of continuing improvement which allows staff to identify opportunities for positive and sustainable change and gives staff the skills and support to make those changes. True North is defined as the very top of the patient first triangle which was is to represent the patient. The patient is set as a constant and must always set the direction of travel for the care delivered.

However, the trends and themes from our conversations with staff indicated they did not believe the leadership team always made decisions in the best interest of patients. Based on our conversations with whistle-blowers and focus groups common themes from these conversations included but were not restricted to: poor communication, fear of speaking truth to power, lack of dedicated time for clinical leads and lack of senior leadership support, senior leadership unable to make decisions, patient first improvement programme in conflict with top-down management style, new ideas resisted rather than implemented, poor business case processes resulting in cases being ignored, not considered

and no feedback, poor Human Resources support and the Freedom to Speak Up Guardian function was unknown. There was also a perception from staff that data was 'made to look better' because the senior leadership team did not like 'bad news'. We raised data quality as a concern with the trust and as a result an independent review was commissioned. Staff felt key decisions were made in an autocratic way which meant their expertise, experience and clinical knowledge was not always considered when developing service improvements and problem-solving. Staff said their senior leaders were not always empowered to make decisions or lead in a progressive or constructive way. They felt frustrated when they were not given the autonomy or support to solve their own problems. Staff were also concerned about the prevalence of racism in the organisation. A number of staff from ethnic minority groups contacted CQC to raise concerns about their experience of bullying harassment and discrimination.

Communication methods were not effective. Whilst the trust used many methods of communication which included but were not restricted to hot topics, topic of the week, staff huddles, emails, newsletters, pc screen savers, staff still felt they were not kept up to date with what was happening within the trust. Staff felt the executive team's communication was not focused on subjects that were meaningful, relevant or reflective of the empathy and support they longed for. Staff felt the current 'all staff' calls lacked authenticity and meaningful dialogue and the 'controlled' question format being used was seen very much as closed communication. Staff expressed a wish for more open, informative and productive forums to have meaningful two-way conversations.

The executive team told CQC they were open, listening and modelling a fair and just culture in the organisation. They felt staff could raise concerns openly and honestly and have these responded to appropriately.

Staff attending drop-in sessions shared their concerns and worries about raising concerns. Their comments described two themes about raising concerns. Some staff some staff said they continuously raised concerns, but no action was taken to address them, and others told us they were afraid to raise concerns because they felt it would be career limiting. It was clear from the trends and themes from contacts with staff during the inspection that their concerns correlated with the issues staff raised with CQC before our recent maternity and surgery inspections. Our recent inspection activity also identified safety concerns that went unaddressed, and that patients were at risk of harm. During our recent inspection activity CQC found the safety concerns raised by staff were legitimate and took enforcement action as a result.

Although leaders were clear about their roles and their accountability for quality, our recent inspection findings showed there may be insufficient challenge and assurance at executive and senior levels. We saw a wide range of committee and subcommittee meeting minutes. Most non-executive directors felt assured that the information they were provided was a true and accurate reflection of the organisation. The trust governors held the executive team in high regard and expressed confidence in the trust assurance processes. However, CQC's recent repeated inspection activities and associated enforcement action showed that trust assurance processes may not be as robust as previously thought, as there were recurring trends and themes in our inspection findings. There findings were also similar to other independent reviews including but not restricted to the Dawson report.

Staff were not always supported to develop. The recent pandemic, staff sickness and vacancies had a significant impact on the trust ability to support staff to train and develop. Many staff were promoted into leadership roles but were not provided with the necessary training to do the job. Some senior leaders were experienced but their individual styles may not be conducive with getting the best out of their workforce. However, mandatory training rates continued to improve, and annual appraisal rates were also within the expected range. The trust recognised the importance of training, development and annual appraisals and were trying to balance this with the current staffing challenges.

Our findings

Leaders were not visible and did not always respond appropriately when staff raised concerns. CQC were aware of the geographical challenges associated with executive visibility in a trust the size of University Hospitals Sussex NHS Foundation Trust. However, staff told us executive and senior leadership teams were not visible and some went as far to say some leaders were not approachable. Many staff described a 'disconnect' between the executive and senior leadership team and the staff delivering care. Others stated the 'churn' of senior leaders was also part of the reasons for poor leadership visibility. Some staff felt raising concerns was futile and would negatively impact their future careers if they continued to bring concerns to the attention of the senior leadership team. CQC were provided with a formal list of executive walkarounds that occurred weekly. This document listed all the clinical areas visited and the named executive. A review of board minutes showed information from some visits, but not all, were shared with members of the executive team.

Some staff contacted CQC to raise concerns about the trust's human resources department. Staff concerns were about pay and the general support from the human resources department. Some staff had received incorrect pay, with some receiving more and some less than they should have done. The trust explained this had occurred during a change of payroll system. The hospitals on the east side of the trust (Royal Sussex County Hospital and Princess Royal Hospital) had moved from a paper-based payroll payment system to a more advanced IT system. The trust said it was during this transfer of systems that the errors had occurred. The trust said the salary issues had now been resolved. However, some staff said they were still receiving an incorrect salary. There was a perception from the senior leaders that the pay issues only affected junior doctors, however this was not the case. Staff felt the trust had not acknowledged the emotional and financial impact this had had on them. Many staff told us about additional concerns with HR which included a lack of consistent support and responsiveness.

Fit and Proper Person

We reviewed the personnel files of 4 members of the executive team. Appropriate checks had been carried out in accordance with 'Fit and Proper Person' requirements. The executive team had an appropriate range of skills, knowledge and experience.

Vision and Strategy

The trust had a clear set of values and had refreshed all the key strategies in September 2022. The trust had also implemented a clinical operating model to aid the consistent delivery and high standards in the services it provided.

The trust values were Compassion, Communication, Teamwork, Respect, Professionalism and Inclusion. Staff we spoke with were aware of and felt aligned to the trust values. The values were underpinned by the trust mission statement which was 'Excellent care, every time, where better never stops'.

The trust had undertaken a detailed strategy refresh during June-July 2022. The project resulted in in an updated set of strategic aims including the trust True North goals and targets, breakthrough objectives, strategic Initiatives and corporate projects.

The executive team agreed there would be no significant change to the strategic themes or initiatives. The trust had six strategic themes in total: Patient, Sustainability, People, Quality, System and Partnerships, Research and Innovation. Each theme was aligned to a strategic initiative.

For example: 'Patient' was aligned to the strategic vision Patient First Improvement Programme with a vision to providing outstanding compassionate care for patients and their families every time. The trust's strategic goal was to ensure all patients have a positive experience of the care they receive. The trust theme had a current target to be in the top quartile nationally for patients rating their experience as good or very good for all touchpoints.

'Sustainability' was aligned to the strategic vision of living within our means and providing high quality accessible services to patients and staff through optimising the use of trust resources. This theme had a strategic goal to consistently live within the resources available.

'People' was aligned to the strategic vision of being the employer of choice and have the most highly engaged staff within the NHS, passionate about delivering the best care. This theme had a current target to be the top acute trust for staff engagement within 3 years.

'Quality' was aligned to the strategic vision of excellent outcomes ensuring no patient comes to harm and no patient dies who should not have. This theme had a current target which included a reduction of 5% in preventable harms and a Summary Hospital Mortality Indicator (SHMI) equally to or less than 100 for the test and individual hospital sites.

'Systems & Partnerships' was aligned to the strategic vision of delivering timely, appropriate access to high quality planned, cancer and emergency acute care as University Hospital Sussex and part of the wider integrated care systems. This theme had a current target to achieve the constitutional standards for planned, cancer and emergency care.

Research and innovation were aligned to all patients and staff having the opportunity and equality of access to high quality researchable innovation which was relevant to them. This theme had a current target to be in the top 10% of acute trusts nationally for the total numbers of patients contributing to portfolio research.

The trust aimed to deliver their strategic objectives in a 12-18 month timeframe, alongside a suite of longer term strategic initiatives to ensure the delivery of a quality, patient focused service.

The Clinical Operating Model used at the trust was also newly implemented. It was introduced just before our well-led inspection. Therefore, CQC were unable to assess its effectiveness or how well it was embedded in practice. Despite it being in its infancy the new operating model appeared to provide clear structures and evidenced multi-disciplinary leadership both across hospital sites and divisions through a consistent triumvirate model. Whilst there were still some outstanding vacancies and interim posts that the trust was trying to recruit to, the vacancies could be a potential risk to the overall implementation of the model.

The new clinical operating model appeared to be designed and based on best practice from other multi-site trusts and with engagement from stakeholders. The key principles of the trust model included the triumvirate structure, consistency in roles and bandings across divisions and sites. The model ensured clear clinical leadership within the divisions through the triumvirate structure, with clinical leads having accountable lines to both the Chief Medical Officer and Chief Nursing Officer and Managing Directors as required. The triumvirate structure was replicated throughout divisions into directorates and services which ensures appropriate multi-disciplinary representation across the trust.

The new patient experience strategy's aim was to achieve a 95% good or very good experiences for the majority of patients who used the trust services. The strategy had 8 principles: Data and Insight led, Patient-centred, Active listening, Place-orientated, Fairness and equality, Solution focused, Prevention and early action, Accountable. Each of these aims was underpinned by three main ambitions: Better engagement – nothing about me without me, addressing

inequality - voice and influence for the least heard, learning and action on patient experience. This strategy had eight measurable outcomes to assess success which included but were not restricted to: Improved Friends and Family scores and improved engagement scores, complaints, reduced discharge time, improvement in the number of staff recommending the trust as a good place to work.

CQC reviewed a draft copy of the trust winter plan which outlined the capacity objectives for 2022 - 2023. The plan had five main objectives, safely avoid admissions, safely create more capacity, safely reduce the length of stay, maintain operational grip and control and participate in the system wider plan of development and implementation. The plan also included 3 enhanced system workstreams for out of hospital response, frailty, respiratory pathways and discharge. Each workstream had a clinical lead responsible for the delivery of workstreams. Many staff told us during the inspection they were not aware of the trust winter plan. It was widely circulated with staff when it was approved at the trust board meeting after our inspection.

There was a significant investment in the trust laundry services at St Richard's Hospital. This included a five million pound investment to ensure new equipment to provide sustainable green benefits. These include minimising electricity and gas by using new efficient equipment, cutting water use by using improved technology to recycle and re-use water, reduction in the use of chemical and detergent usages and reducing and eventually eliminating the use of plastic packaging through the use of washable reusable canvas or water soluble bags. The key initiatives for the green strategy for the next three years focused on the reduction of Desflurane and Nitrous Oxide (anaesthetic gases), trialling reusable surgical instruments that could be re-sterilised on site.

We also reviewed the trust's updated five year digital strategy which was in draft form at the time of inspection. The aim of this strategy was to improve access and continuity of care for patients through collaboration with a wider range of acute NHS and community services. It aimed to improve recruitment and retention for staff creating greater scope and flexibility to deploy staff. The size of the trust was an opportunity to make significant improvement to the environment using economies of scale and to offer a wider range of services across Sussex. The strategy also noted improved quality by ensuring people get the right care, in the right place, at the right time through improved innovation and specialist support. The fifth aim focused on systems and partnerships, greater flexibility and improved information flow.

CQC requested the trust's mental health strategy for review. We received two documents, a commentary of the service level agreement between University Hospital Sussex NHS Foundation Trust and a local mental health trust and the terms of reference for the strategy group. The trust had set up a multi trust bimonthly Mental Health Strategy and Quality Group. This document described the acute trust mental health strategy, operational delivery and service development, workforce, and quality. It also outlined the governance arrangements to manage incidents and risks and the process the strategy group followed to report to the board. The group was set up in response to the local challenges to provide care for patients with mental health care needs experiencing long waits for acute adult and children's mental health beds.

The trust had developed a green strategy in line with the NHS commitment to deliver the first net zero carbon health services. The strategy was developed in line with the patient first improvement methodology. To date the trust had achieved a 37% reduction in its carbon footprint since 2010, reduced anaesthetic emissions by 87% since 2014, undertaken 1500 remote consultations in 2022, had joined a green travel network and recruited over 300 green ambassadors trust wide. The trust was continuing to deliver on the strategy by providing a £3million investment plan to improve food and drink for patients and reduce food miles, a new menu with more plant-based options, using electronic

devices instead of paper to capture individual food preferences, reduce energy efficient kitchen equipment and food delivery trolleys. The trust strategies were rightfully ambitious and focused on the delivery of high-quality care. However, it was clear from our repeated contact with staff, our inspection activity and enforcement action, quality, safely and culture improvements were required at pace to realistically achieve the organisational strategic ambitions.

Culture

Not all staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care. Not all staff felt they could raise concerns without fear of reprisal. The organisation needed an improved focus to fully embrace the equality and diversity agenda.

The executive team told us there was a fair and just culture at the trust. Executives felt they role modelled a compassionate leadership style. The executive team described the culture of the organisation as 'good' with some local areas that required additional oversight and support to improve.

We spoke to over 120 staff during the well-led inspection. A total of 118 staff raised a concern and 2 provided positive feedback. However, it is important to note CQC continued to receive ongoing contact from staff wishing to raise concerns after the inspection. There were trends and themes identified from contact with staff that indicated their perception of the organisation was different to the executive team. Some staff feared reprisal for raising concerns and others had simply given up because of 'concern fatigue.' This group of staff felt there was little point raising concerns because no action was taken when they did. When we asked staff to describe the culture of the trust, the feedback was mostly negative. Staff also felt the trust was a 'hierarchical' organisation which made it hard to get their voice heard.' However, most staff remained very committed to their patients, their colleagues and their purpose in the organisation. Some described that their family members received good care from the trust. They told us they were very proud to work at the trust and wanted to be part of the new trust legacy. During the well-led inspection, 2 staff provided positive feedback about working at the trust, the support from senior leaders and their positive perception of the leadership team.

Conversations with the executive team indicated they believed that most staff who attend the drop-in sessions and spoke with CQC inspectors worked at the Royal Sussex County Hospital. However, this was not the case. An equal number of staff from Worthing Hospital also came forward. The number of contacts from St Richard's, the Royal Alexandra Children's Hospital, Southlands and Princess Royal Hospital were small in comparison. However, this did not make their concerns any less significant. The themes of concerns expressed by staff were the same across all the hospitals.

There were low levels of staff satisfaction and high levels of stress and work overload. Much of this related to the burn out from the pandemic and the current staffing crisis. However, staff also felt it related to the challenges they felt when trying to raise concerns. Staff spoke about their frustration and disappointment when potentially serious concerns went unheard and unaddressed. Staff also told us about the fatigue they felt from escalating their concerns repeatedly to senior leaders who then left the organisation or moved division. The lack of continuity and consistency at senior leader level compounded the perception that concerns went unresolved. Staff provided CQC with email trails to evidence they had raised concerns. This was felt more significantly at the Royal Sussex County Hospital, Worthing Hospital and Royal Alexandra Hospital.

Although the trust had responded to the cultural concerns in surgery at the Royal Sussex County Hospital, it has had a limited impact. There was poor medical engagement and some consultants continued to display poor behaviours which meant a lot of staff felt undervalued, unsafe, and unsupported. This view was supported by our conversations with staff during our well led inspection.

Our findings

Most staff did not know who the Freedom to Speak Up Guardian was, or how to contact them. The guardian had been an interim post for a considerable time. The trust had only recently recruited a full-time guardian and identified a large number of freedom to speak up champions. However, the trust employed in excess of 20,000 staff but only had one full time Freedom to Speak up Guardian. The trust had recently appointed 200 FTSU champions. There was no assurance that the FTSUG and champions had enough resource and time and support to deliver their role. We were concerned there was not enough resource to meet the needs of staff given the number of trust employees and the significant culture concerns raised with CQC over the last 18 months. The last three Freedom To Speak Up Guardian reports were of a poor quality with an inconsistent format, with little evidence that trends and themes were monitored, or actions taken to address specific concerns. The 2021 NHS staff survey asked if the organisation acted on concerns raised by patients/ service users'. The scores for this question showed results were worse than the 2020 survey.

Staff believed there was a culture of bullying and harassment which pressured staff towards unsafe decision making. We asked staff at what level they felt this culture existed. Staff perceived this was being driven from the top down and there was a concern that poor behaviour was role modelled at a senior leadership level and went unaddressed. They felt a lack of skilled senior management meant good engagement and driving change was a challenge. National engagement scores have decreased across England. However, the trust scores had declined more than the national average for every question. The national average decrease for each Engagement question was 4%, whilst for the trust it was a decrease of 7%. CQC recognised that the national average included both acute and community trusts and that this impacted on the average score. It is also acknowledged that there was a potential impact of the recent merger. However, it is important to note the trust staff survey data was broken down into the historic Western Sussex location and Brighton and Sussex University hospital location levels, so a trend and themes analysis was possible when reviewing this data. Staff also provided positive feedback about some senior leaders who were viewed as 'excellent, hardworking and effective' role models who demonstrated compassion and actively listened and addressed concerns.

CQC continued to receive contact from whistle blowers which indicated ongoing concerns about the safety and culture of the organisation. The ongoing contacts raised questions about reasons why staff felt unable to use the trust's own internal escalations processes. There was evidence that senior clinicians continued to raise patient safety concerns to senior members of the organisation. However, there was lack of evidence to show how these concerns were acted upon. CQC continues to be concerned about a potential culture of 'normalising' safety concerns and conflating these with individual poor behaviours.

The 2021 staff survey asked staff 'if they felt safe to speak up about anything that concerns them in this organisation,'. The results declined by 8% since 2020. The questions asking staff 'If they were able to make improvements happen in their area of work,' also declined by 6% since 2020. These were both driven by higher decreases in staff responses from the East Sussex hospitals versus the West Sussex hospitals locations. The trust also saw a reduction by 6% to the question asking staff about 'their level of confidence the organisation would address their concern, which' was lower than average score by 5%. The question asking 'If I spoke up about something that concerned me, I am confident my organisation would address my concern,' also saw a deterioration that was 6% lower than the baseline score for the comparative sector. The staff survey showed a continued decline.

Two staff staff contacted us to share their stories of how the organisation supported them to continue working whilst having a long-term health condition. There was evidence of three trust employees who would have benefited from a more personalised approach around their long term health condition. However, data from the 2021 staff survey showed disabled staff scored lower on all questions (between 5-8 per cent lower) compared to non-disabled staff. The largest negative disparity related to the question 'During the last 12 months have you felt unwell as a result of work related

stress? Non-disabled staff scored 47%, whilst 20% more disabled staff (67%) reported they felt unwell as a result of work related stress. When staff were asked if they felt valued by their teams, non-disabled scored 70% but disabled staff scored 10% lower at 60%. When staff were asked if people they worked with showed appreciation to one another, non-disabled scored 86% while disabled staff scored 28% lower (58%).

However, 72% of disabled staff believed the trust supported them with adjustments. This was 1% above the average sector score for this question. A health passport to aid those with a long term health conditions move around the organisation easily was introduced in 2020, raising awareness and training of reasonable adjustments. However, the staff we spoke with did not have a health passport.

The trust recognised the increased risk of violence towards staff particularly those working in the emergency departments. The trust took a zero-tolerance stance to violence and aggression towards staff. Additional training was provided to security staff, (including but not restricted to restraint, dementia, mental health) and bodycams were worn. Security staff were now included in incident debriefs and provided with trauma counselling.

The trust's Equality, Diversity and Inclusion policy was in draft form at the time of inspection. There was ongoing work required to ensure the trust met all its requirements and priorities to ensure alignment with the NHS 2022/23 Priorities & Operational Planning Guidance, NHSE/I Six National Actions for Closing the Gap in Recruitment and the Health Inequalities Leadership Framework – Board Assurance Tool (2022) and the NHSE Equality Delivery System 2022 (August 2022) – 'Implementation of the EDS' was a requirement on both NHS commissioners and NHS providers.

The 2021 staff survey showed poor engagement scores for staff with particular equality characteristics and staff with a long-term disabilities. The trust had identified five areas it needed to work on to improve the experiences of marginalised staff groups. This included debiased recruitment, improve workplace experience, enable career development, equitable patient care, community engagement and reputation. The plan had identified measurable metrics to assess its success. The plan was developed in collaboration with the integrated care systems. As the plan was in its infancy, we were unable to judge its effectiveness.

The Annual Gender Pay Gap Report for 2021, which summarised the legacy East and West Gender Pay Gap (GPG) as of 31 March 2021, demonstrating the difference in average hourly pay and bonus payments between men and women. As documented in the people committee minutes, the trust was aware there was more work to do to harmonise the various elements of pay across the trust, and this would be undertaken as part of the pay strategy workstream.

A number of staff from ethnic minority groups contacted CQC to raise concerns about their experience of bullying harassment and discrimination. We were aware of a number of current legal challenges on the grounds of racial discrimination. The NHS survey suggested 22% of staff at the trust identified as being from an ethnic minority group. A total of 17% of staff identified as being from an ethnic minority group on the 2021 staff survey.

Workforce Race Equality Standard (WRES) data from the 2022 report showed there was a higher than expected representation of ethnic minority staff in Bands 2-5 and all medical grades. However, within bands 6-9 and very senior management group there was a lower than an expected representation of staff from ethnic minority groups. In band 5, medical: non-consultant and trainee grades there was a much higher than expected representation of ethnic minority staff.

Our findings

The Diversity and Equality section of the NHS staff survey also showed a decline in scores. Staff were asked if their 'organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age'. Scores for this question have dropped nationally between 2020 and 2021 from 85% to 56%, with the best national scores for a trust standing at 70%. The scores for the trust were slightly worse than the national average, dropping from 85% in 2020 to 53% in 2021.

Survey results showed that staff from ethnic minority groups were more likely than their White colleagues to experience poorer outcomes with regard to pay, autonomy and time pressures, team working and burnout. The Workforce Race Equality Standard (WRES) data provided by the trust showed the relative likelihood of staff from ethnic minority groups entering a formal disciplinary process compared to White staff was 1.7 times greater. Trust data also showed staff from ethnic minority groups were more likely to experience harassment, bullying and abuse than White staff. When compared to the acute sector average UHSx staff were more likely to experience harassment, bullying and abuse by almost 10% When legacy trust data from 2020 was reviewed it showed *t*his figure had increased across the board, whether this was from other staff groups or patients, relatives and the public.

The 2021 NHS staff survey saw the trust ranked 104 out of 126 Acute and Acute and Community Trusts staff for the engagement score. The trust had a strategic aim to increase the number of staff recommending the trust as a place to work. However, the survey results reported a decrease of 13% from the trust baseline in the last survey. The average national sector score also decreased by 9% from 2020 to 58%. The trust was 24% below the best trust score. Staff engagement within the divisions showed a variation in survey theme scores. Six legacy west divisions (Western Sussex NHS Foundation Trust) scored above the trust theme score of 6.6 and legacy east (Brighton and Sussex NHS Foundation Trust) all scoring below, with the Surgical division scoring worst at 6.2.

The survey asked staff if they would be happy to have a friend or relative treated in the trust. This had also decreased by 10% to 65%. The average trust score decreased by 7% from 2020 to 67%, the trust was 2% worse than the national average. The survey also asked staff if they were able to make improvements happen in their area of work'. This question saw a decrease of 6% to 51%.

The morale section of the survey was made up of 13 questions. The trust saw decreased results in all questions when compared with the 2020 survey. The survey asked staff if 'There was enough staff at this organisation to do their job properly. This question saw a 14% decline from the previous year. This reduction was seen across both legacy east and west sites. The National sector results also followed this trend and evidence a significant 11% decline. The questions relating to the care of patients/service users is my organisations top priority' decreased by 7% to 72% and was 3% worse than the national sector average of 75%.

According to trust Electronic Staff Record (ESR) data 5% of 16,387 the trust's staff had declared a disability. However, 23% of 7,960 staff who answered the NHS staff survey in 2021, reported having a long lasting health condition or illness. This large variance to the trust data showed there were more staff identifying as having a long-term condition/illness than was captured through on the ESR workforce data. The differences in information is to be expected given the different approaches of the ESR and the survey to capturing information. This wasn't an issue specific to the trust, as nationally there is an under-reporting of disability information on ESR. Senior leaders at the trust told us the high level of responses to the staff survey enabled them to gain a good insight into the needs of disabled staff.

A high number of nursing and medical staff told us about the significant value and invaluable support Healthcare Assistants (HCA) provided to clinical teams. There was a consistent theme in our conversations with staff relating to the potential loss of HCAs to other sectors due to the low pay, particularly the Band 2 grades. Staff were very worried about

the impact this would have on patient safety. Staff expressed a sincere wish the organisation could make this staff group feel more valued and recognised for the substantial contribution they make to the organisation. The health care assistants we spoke with shared the same concerns. The staff survey results were used to develop the trust's 'People' strategy.

The trust had recognised the cultural issues at the trust and there was detail in the new strategy about how the trust intended to address them. The people's strategy included plans to support and realise cultural improvements. The strategy included, but was not limited to, staff being able to raise concerns which were addressed, a health and wellbeing plan, and an equality, diversity and inclusion plan.

Governance

The trust changed its governance processes to strengthen the organisational oversight on safety in its services just before our inspection.

The governance systems were new which meant CQC were unable to assess the quality of the systems and risk oversight. However, our previous inspections clearly identified concerns the historic systems and processes did not operate in a way that always protected patients or staff.

The trust had introduced new strengthened governance systems and processes with an aim of standardising and improving processes trust wide. There were a range of sub-committees, with good representation by non-executive directors that fed into the governance system. We were unable to assess the quality of these systems because they were in their infancy and not embedded in practice.

However, in relation to the surgical services, the Royal College of Surgeons neurosurgery review (September 2019) and the Health Education England (HEE) Urgent Concern review (2020) reports all made reference to similar recommendations in terms of governance, risk oversight and culture. Surgical trainee doctors were withdrawn and currently remain withdrawn. The findings from CQC inspections carried out in the last 18 months indicated that trust governance processes had not been able to identify problems in some of the trust's services and so had not been able to support improvements in those areas. Concerns included but were not restricted to: a lack of administration roles to support the governance function, insufficient job planning for clinical staff to undertake governance and risk roles, lack of independence and scrutiny over data collection, meaningful audit processes that improve quality, poor morbidity and mortality (M&M) processes, incidents reporting, and a lack of central governance oversight and support from the central governance team resulting in poor oversight at board level for some divisions. This meant there was an impact on the trust's ability to effectively scrutinise and escalate to the lead directors as required.

Whilst we saw significant improvement in our recent maternity inspections, we saw little or no improvement in surgery since our first visit in September 2021. Our last two inspections of general surgery resulted in conditions being placed on the trust registration in May 2022. Our recent inspection of the elective upper gastrointestinal cancer services resulted in part of the service being suspended in August 2022.

The trust commissioned a Royal College of Surgeons review of the Neurosurgery service in 2019. The report highlighted ten key recommendations which included reviewing consultant job plans, addressing interpersonal difficulties, improving theatres utilisation, listening to staff, equipment review, and identification of need and the on-call rotas and improving the effectives of mortality and morbidity meetings. Whilst our inspection of Neurosurgery recognised the improvements made, we also noted the similarities in the 2019 findings with CQC's inspection findings in surgery at the Royal Sussex County Hospital in September 2021, April 2022 and August 2022. We also note the similar findings in the

Our findings

2020 Health Education England Quality review. This report identified several areas that required improvement and included but were not restricted to patient safety, record keeping, particularly in relation to clinical governance, a lack of leadership and ownership of the of the problems in the surgical department, poor supervision, support and teaching opportunities for trainee doctors, who also reported a 'toxic' culture in the department. The report also raised concerns about the quality of morbidity and mortality meetings which did not meet Royal College of Surgeons' guidelines. The report stated 'when asked, trainees confirmed the medical director and chief executive were aware of the concerns.' CQC have received evidence from senior staff that they also raised similar concerns between 2019 and 2022. CQC's recent inspection surgical inspection findings showed little improvement against the recurrent concerning themes. The 2022 Dawson report reiterates the same findings which means there was little progress made to address the governance, risk, leadership and culture concerns over a four-year period.

The deanery withdrew surgical trainees from the Royal Sussex County Hospital as a result of the ongoing and unresolved problems in the surgical directorate. Whilst their recent quality assurance visit in October 2022 showed some improvement, trainees will not return for the foreseeable future.

We continue to receive concerns about governance and risk processes in general surgery at the Royal Sussex County Hospital. The ongoing concerns we have received relate to individual poor behaviours, data validity, poor mortality and morbidity processes preventing learning, and the safety culture. These concerns are still being reviewed.

However, since our last inspection of the elective upper gastrointestinal cancer services, the trust had taken steps to address the concerns we found. Actions taken include a new clinical director, audit lead, improved administration support and better central governance oversight and independence in the division. The trust has also commissioned an independent review into the data validity concerns we raised. The trust carried out its own diagnostic review of governance in 2022 which highlighted key areas for improvement including the lack of a robust business intelligence function to support metrics and oversight. The trust scorecard (which collates trends and performance data across divisions and sites and provides assurance to the Quality Committee and Board) was also under review. There were known challenges with some of the data indicators which include a review of the coding function which was potentially affecting the trust SHMI indicator. The highest values were seen in the Royal Sussex County Hospital and Princess Royal Hospital sites.

The review also indicated the Quality Governance Steering Group (QGSG) had insufficient time to effectively cover all aspects of quality related to divisions in this meeting. The review found little evidence that best practice guidelines were used regularly for divisional or site level quality and safety forums. The trust had refreshed all board reports structure in line with Patient First programme to put patients first. The quality committee also revised their format resulting in a minimum of 10 meetings a year to improve oversight and efficiency.

NHSE carried out a review of the trust finances as part of the well-led process. As of 1 April 2021, all general ledger and financial services are now provided in-house through a newly upgraded ledger. The Trust Internal Audit Report for 2021/22 flagged a moderate risk around a small number of system controls during the implementation and noted that the gaps had been addressed during the audit and are now operating as required.

The trust used internal audit to support it to drive to improvement and this was referenced in the Annual Internal Audit report. Several the areas for attention were aligned to areas that had been subject to significant change during the merger of the 2 trusts. The report concluded the trust continued to perform strongly in areas of core assurance and the trust received an overall conclusion of moderate assurance

Our findings

A theme raised in the Internal Audit Report and that came through in interviews, relates to the challenge of harmonising information and reports, addressing manual data processes and aligning data policies across all trust sites. This was necessary to ensure management has information that can be used to confirm and contrast performance information effectively. The trust executive has recognised this challenge and the trust was in the process of strengthening its business intelligence team and the outputs produced for management.

An external audit carried out an unqualified audit opinion and Value for Money (VFM) conclusion in 2021/22 and did not identify any significant weaknesses in the trust's financial systems. The external audit report notes that the trust's finance team was responsive and engaged throughout the audit process. The review found evidence of good financial governance discipline in respect of financial performance. The trust used the Patient First Improvement Programme as a framework for achieving its objectives. Sustainability was one of a small number of "True North" goals that embeds achievement of the trust's breakeven financial plan as a key metric against which performance was managed. A layered framework of oversight was in place to oversee financial performance including a formal quarterly Board Sustainability Committee (with interim monthly sessions) and Divisional Strategy Deployment Reviews (SDRs). Standardised escalation processes that include intervention and support are enacted if key financial metrics are not routinely achieved by divisions.

The trust submitted its financial plan for 2022/23 on 20 June 2022 at breakeven in the context of an overall breakeven plan for the Integrated Care System. The process to develop the plan was discussed during interviews and follows a sound methodology involving internal and external stakeholders. Risks to delivery of the plan were consistently recognised through interviews, notably workforce challenges (recruitment & retention), managing cost pressures related to extra escalation capacity (linked to addressing high agency expenditure) and delivery of the efficiency programme.

The trust described a "road map" to rectify the year to date variance to plan and achieve the breakeven financial plan; targeting agency expenditure and implementing workstreams to reduce costs relating to excess length of stay & escalation capacity. The risks to achieving the trust's financial sustainability duties are flagged as red/amber on the Board Assurance Framework.

The trust has recently undertaken a self-assessment audit for financial governance as recommended by NHS England. The trust has concluded that there are 9 areas (of 72) that required action. Three of the 9 areas related to increasing financial training and development and the need to enhance financial acumen of staff across the newly merged trust, particularly where staff have taken up new roles and responsibilities. The need to enhance general financial training was recognised in interviews held and it is recommended that the trust takes action to make improvements in this area to improve core financial stewardship.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, but at times this was not effective. While known risks were identified and high-level risks escalated with identified actions to reduce their impact, there was variability and a lack of pace in the trust response to mitigate and manage these in some core services.

Risk, issues and poor performance were not always dealt with appropriately or quickly enough.

Our findings

There were many examples of key concerns raised by that were not dealt with or not given necessary priority in our previous inspection reports. CQC highlighted serious concerns with the governance and risk oversight of the surgery services at the Royal Sussex County Hospital in surgery in September 2021 and there has been little improvement in the last twelve months. Similar findings were identified by stakeholder reports in 2019 and 2020. Although the trust was addressing these concerns, the pace of the action to our initial findings was slow given the significant risks identified.

There was a similarly a prolonged approach to resolving the suspension of junior doctor trainees at the Royal Sussex County Hospital. However, the trust had now trust strengthened its senior educational leadership and had improved oversight of education. An Education Board and a sub-committee of this board now focused on statutory and mandatory training to improve the trust educational provision. Although there was improved feedback from junior doctors and stronger engagement with educational bodies, there were still significant challenges to be overcome before the junior doctors returned to general surgical training at Royal Sussex County Hospital.

During the onsite inspection CQC looked at 10 serious incident reviews completed by the trust. All were of good quality and clearly identified the learning from each case. As part of the off site inspection process we reviewed a sample of incident reports/investigations for the 18 months preceding the inspection. This showed the trust did not always allocate an accurate harm score to the incident. This meant that there was a risk that the levels of harm were incorrectly categorised, and therefore not investigated or learned from. It also indicated there was a lack of effective oversight of incident handling in the trust. This issue also had a potential impact on the trust's ability to uphold the duty of candour (DOC) regulations. The trust reported being 100% compliant with the duty of candour regulations. However, CQC were aware of one case where DOC was not discharged in a timely way in line with trust policy or national guidance, which the trust had subsequently addressed.

There was potential risk to the effectiveness of the trust's new governance process. The electronic incident reporting system was one of the key tools which fed into the new governance risk management system. However, staff did not report all incidents because they either had no time or felt it was "pointless.". Medical staff said they rarely reported incidents. Staff continued to say learning from incidents was not embedded into usual practices. This meant not all incidents were reported, investigated or learned from which could result in harm to people using services at the trust. However, the trust had identified this as a risk to managing and learning from incidents and were acting to reduce this risk. This included a trust wide Patient Safety Group aimed to improve trust wide reporting and learning from incidents as well as work towards implementing the new national Patient Safety Incident Response Framework.

There was no substantively appointed guardian of safe working hours for the Royal Sussex County hospital and Princess Royal hospital from April 2022. Whilst a process of oversight of this work had been determined it was undertaken weakly and therefore this process required improvement The guardian of safe working hours ensures that issues of compliance with safe working hours are addressed by the doctor and the employer as appropriate. It provides assurance to the board of the employing organisation that doctors' working hours are safe. This meant junior doctors did not have easy access to guardian support should they wish to raise concerns.

Trends and themes from complaints were monitored and discussed at board level. These were also used to drive service improvement.

The pharmacy service was working on an integration plan post-merger. This work involved retaining the preferred practice and guidelines, procedures and policies from one trust and rolling it out across the other. Medicines optimisation and pharmacy governance processes were integrated into the trust's quality and safety structures. Pharmacy services had undertaken several audits which were used to monitor quality and improve the service. They department was in the process of publishing an audit related to omitted medicines doses within the emergency

departments. The pharmacy service was working locally and with other NHS trusts across the ICS area to improve the consistency of medicines optimisation within the ICS area. The service was also planning on developing the recently created roles for healthcare undergraduates including the development of pharmacist apprenticeship roles. However, the chief pharmacist role was an interim post and there was no succession planning to ensure continued quality leadership of the pharmacy service.

The trust ran a clinical area peer review programme. This meant staff visited clinical areas outside of their own setting to do visual observations. Information from these visits was fed back to staff and used for service improvement.

The trust recognised the risk of the differences between hospitals and the additional complexity of the new governance systems as well as the new Clinical Operating Model for frontline teams. To address this, the trust had set up improvement boards across the divisions with the aim to identify and support cross-division improvement programmes.

The trust maintained a corporate RAG (red, amber, green) rated risk register which was reviewed regularly. Leaders confidently told us the frequency and process used to review the risks and they showed good knowledge of what the recorded risks were.

The trust operated a Board Assurance Framework (BAF). A BAF brings together the information relating to the organisational risks and strategic objectives. The BAF accurately captured the organisational risks and the strategic priorities. There was a board reporting schedule which the trust adhered to. BAF risks were reviewed at board meetings.

The Board Assurance Framework (BAF) identified 13 strategic risks. The trust assessed each risk against the trust's risk appetite when setting their target score. Each risk had a dedicated lead executive and lead oversight committee allocated. Of the 13 documented risks 12 were rated as high risk and one as moderate. Two of the highest risks recorded related to workforce and the trust not to deliver and demonstrate consistent compliance with operational and NHS constitutional standards. A risk relating to system and partnership working had reduced to a moderate risk when last reviewed in July 2022.

Trust risk registers did not demonstrate the trust identified all risks and took action to lessen risks. Risks documented on the risk registers were rated as to their level of risk (Red, Amber, Green) and reviewed. However, there was lack of evidence on the risk registers that the trust had mitigation or control measures in place to manage many of the risks. There were no entries about the poor governance, risk management and poor leadership risk in the surgery services at the Royal Sussex County Hospital. There was no entry about the recognised poor behaviours and culture issues which had a significant relevance to ensuring safe and effective care and fundamental to staff welfare. There were a number of historic entries which dated back as far as 2012 and 2016 on the 'specialist' register that remained current and unresolved. The women's and children register did not reference the low numbers of nursing staff or the outdated staff template currently being used.

There were a number of acute risks the organisation faced. All staff, from ward to board shared the same worries about staffing levels, capacity, flow and care of patients with mental health conditions, long waiting lists and access to theatre, particularly for emergency patients. There were still local mitigations the trust could take to improve safety. The trust was supported by the ICS and system partners to make improvements. However, it is also important to acknowledge the challenges the trust faced in the context of both system and national challenges. These included staff shortages, COVID-19 absence, long-term sickness and absence, an increased number of more acutely unwell patients requiring care, reduced access to primary care, social care and community care provision.

Our findings

Documentary evidence showed insufficient numbers of medical staff in the Surgical Division at the Royal Sussex County Hospital. Surgical consultants and their juniors continued to raise concerns about the medical staffing and the impact it had on their ability to provide a safe service and poor patient experience. The evidence showed medical staffing in the surgical directorate was a significant problem every day. This affected patient safety, ward rounds, discharge planning, theatre effectiveness, out of hours on call cover and was not indicative of a rota that supported FY2 and registrars. Medical staff shortages had a negative effect on consultants and junior doctors' wellbeing and nursing staff's ability to get timely medical reviews. It also negatively impacted the quality of training, support and supervision provided to junior doctors. Consultants continued to raise concerns daily.

There was a lack of evidence the trust was taking an opportunity to share best practices between directorates. An example of this was the lack of sharing of the innovative and award winning approach to digital workforce planning in the Urgent and Emergency Department at the Royal Sussex County Hospital to address workforce pressures. Although the Emergency Department required an increase in their consultant template to deal with the increase in clinical demand, the team had developed a hybrid consultant rota which met the Royal College staffing guidelines for emergency medicine. Some of the benefits of the initiative included staff feeling happier, with more leave preventing burn out, a more flexible working environment, improved training opportunities and a positive working environment. Administration time was also reduced, and the department had a greater pool of resource to call upon when required. A second example was the successful recruitment of staff to roles in the Estate and Facilities team and a positive staff engagement score for this team of staff. However, there was no evidence to indicate the trust had learnt from this success to support improvements elsewhere in the trust.

The trust had undertaken a successful international recruitment drive for clinical staff. A recent maternity recruitment drive saw most of the trust's newly qualified student midwifes recruited into full time positions. However, these actions alone may not be sufficient to safeguard the organisation from workforce pressures.

The other significant risk related to care and welfare of mental health patients (adults and children) awaiting acute mental health beds. The trust worked well with the local Mental health trust and the Integrated Care System to support safe care and treatment for these patients. However, there was still a significant risk to patients who experienced severe delays and were in an inappropriate care setting. The number of patients awaiting mental health beds had increased significantly and this put additional pressure on trust bed availability and staffing levels. It also put additional pressure on the staffing numbers because patients experiencing mental health illnesses required an enhanced level of monitoring and supervision to ensure their safety. Emergency department staff told us they felt an increased risk of patient on staff aggression and violence from patients with mental health illnesses who were in an inappropriate care setting. Staff spoke about their frustration at the long waits for acute mental health beds.

Due to emerging concerns about data management the trust has commissioned an external review to explore this, and other safety concerns brought to our attention after the well led inspection. The trust has commissioned an independent review to explore these concerns and will respond to CQC in due course.

Information Management

The trust collected data and analysed it and used it to improve services. Data was used to understand performance and make decisions.

The trust collected data and used it to inform key decisions. Leaders understood that using technology brought cost and outcome benefits for the organisation, staff and patients.

Our findings

There was recorded investment in IT infrastructure to future proof the organisation. Information was kept confidential and stored securely.

Information technology (IT) incidents were not always reported via the trust incident reporting system. Staff told us these incidents were currently informally captured in two ways. For example, there was a presumed expectation clinical staff reported IT problems as incidents as well as an expectation they were discussed locally in the project management teams. This meant there was potential the board did not see the totality of the challenges, frequency of or impact these types of incidents had on services. As the organisation improves its digital maturity and relies more heavily on technology and data to drive improvement, there is potential to miss trends and themes from IT issues that may directly impact patient care and cause additional pressures for staff.

Engagement

The trust had improved how it collaborated with partner organisations to help improve services for patients in the wider healthcare system.

The trust used and evidenced multiple formats and platforms to communicate with staff. However, staff still told us they did not feel engaged with or felt these methods worked. Staff reported feeling disconnected from the senior leadership team.

Maternity listening events were rolled out in October 2021. These well attended listening events meant staff could raise concerns directly with senior trust staff. These events had a meaningful impact on service delivery, staff welfare and executive visibility.

A similar approach was currently being taken in the emergency department at the Royal Sussex County Emergency Department so executives and senior leaders could get to the heart of staff concerns in the department. Information we received following the inspection suggested these were starting to make some impact.

University Hospital Sussex was seen as a valuable member of the wider healthcare economy. The executive team described continuous engagement with system partners with the aim of improving services for patients and staff. Whilst some system partners benefited from a close working relationship with the trust, other relationships were still in their infancy. This meant the trust was not currently benefiting from the depth and breadth of support that could be provided from all stakeholders and regulators.

The trust ran a staff awards programme to reward staff excellence. In May 2022 the trust received over 1,300 nominations from staff. Winners included the Estates team who won the governor's award for getting the hospital ready for COVID-19 at short notice and the Infection, Prevention and Control team who won team of the year for the support they provided during the pandemic.

Patient experience reports from local Healthwatch groups evidenced improved engagement with both Brighton and Hove and West Sussex branches. It was clear from reviewing the commentary in the Healthwatch reports there was a degree of commonality in their report narratives and the trust's own data. The ongoing engagement work with Healthwatch meant there was a useful external and independent patient experience review process that could be used as a 'sense check' against the trust's own data.

The pharmacy service was working locally and with other NHS trusts across the Integrated Care System (ICS) are to improve the consistency of medicines optimisation within the ICS area.

Our findings

The trust had a 'true north' objective to be in the top 20% of NHS trusts in the country for recommendation by patients responding to the Friends and Family Test (FFT). Friends and family data shows the majority of patients were satisfied they had a good experience of services. The inpatient satisfaction scores at St Richard's and Worthing Hospitals was above the national average at 97.8% compared to 94% and Outpatient satisfaction across the trust was better than the current national average. However, the trust saw an increase in the number of concerns being raised (57% since Quarter 2 2021/22).

There were a number of support networks and clubs at the trust. These included the armed forces community, carers support for West Sussex, carers hub, disabled staff network, LGBTQi network, religious and believe network.

The trust celebrated all cultures with numerous network groups and initiatives such as the Workforce Race Equality Standard (WRES) Working Group; BAME Celebrating Cultures Network and Diversity Matters Group.

Coaching support was also available for ethnic minority staff.

Learning, continuous improvement and innovation.

All staff were committed to continually learning and improving services.

There was improved participation in research. The trust has recruited over 3,500 patients to 217 non COVID-19 studies in the disease areas including cancer, cardiovascular disease, dermatology diabetes, gastro, infectious diseases, haematology, pathology, HIV & sexual health neurology, ophthalmology and children medicines.

There was an innovative and award winning approach to digital workforce planning in the Urgent and Emergency Department at the Royal Sussex County Hospital to address workforce pressures. Whilst the department required an increase in their consultant template to deal with the increase in demand the team have developed hybrid consultant rota which meets the Royal College staffing guidelines for emergency medicine.

The trust was working to reduce its environmental impact. A total of 450 staff signed up as green ambassadors to champion the ongoing work on reducing the trusts environmental impact. The estates team had developed a state-of-the-art laundry facilities on the St Richard's site. This improved the effectiveness of laundry provision in the trust and reduced the trust's carbon footprint and environmental impact.

The team had worked on the 3T's (new hospital) project, a car parking permit scheme, and developed a new staff health and wellbeing programme for staff.

A facilities and estates staff matter focus group was designed for and set up by the team. The group met every four to six weeks to discuss issues that were important to them. Some group meetings had also benefitted from guest speakers covering topics on Financial Wellbeing, Sustainability, Wellbeing Workshops, Waste Management, Functional Skills support for English, Maths and Digital Skills, People First, Planet First Green Ambassador talk.

The trust was an exemplar in the NHS's Food Standards project. The team worked with patients to develop a bite size grazing menu which was available at Worthing and St Richards hospitals.

The trust held the first ever 'Estates and Facilities day' to celebrate, thank and recognise the contribution the team made to the trust. The estates and facilities division have also developed a regular staff newsletter that included personal

reflections or “covid stories” submitted by staff members to be shared with colleagues and “A Day In The Life of” stories in newsletters and Schwartz rounds. Schwartz Rounds can be defined as conversations with staff about the emotional impact of their work. Schwartz Rounds provide an opportunity for staff from all disciplines across a healthcare organisation to reflect on the emotional aspects of their work.

The pharmacy services were planning to continue to develop the recently created roles for the healthcare undergraduates, this included the development of pharmacist apprenticeships roles. The trust held its first University Hospital Sussex Medical education and trainee excellence awards.

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Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↓↓ May 2023	Outstanding ➔➔ May 2023	Outstanding ➔➔ May 2023	Requires Improvement ↓↓ May 2023	Inadequate ↓↓↓ May 2023	Requires Improvement ↓↓ May 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Sussex County Hospital	Inadequate ↓↓ May 2023	Good →← May 2023	Outstanding →← May 2023	Requires Improvement →← May 2023	Inadequate ↓↓ May 2023	Inadequate ↓↓ May 2023
Princess Royal Hospital	Requires Improvement ↓ May 2023	Good →← May 2023	Good →← May 2023	Good →← May 2023	Requires Improvement ↓ May 2023	Requires Improvement ↓ May 2023
Bexhill Hospital	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Southlands Hospital	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
St Richard's Hospital	Good →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Good ↓ May 2023	Outstanding →← May 2023
Worthing Hospital	Good →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Good ↓ May 2023	Outstanding →← May 2023
Hove Polyclinic	Good Aug 2014	Not rated	Good Aug 2014	Requires improvement Aug 2014	Good Aug 2014	Good Aug 2014
Overall trust	Requires Improvement ↓↓ May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Requires Improvement ↓↓ May 2023	Inadequate ↓↓↓ May 2023	Requires Improvement ↓↓ May 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Royal Sussex County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jan 2019	Good Jan 2019	Outstanding Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Services for children & young people	Good Aug 2017	Outstanding Aug 2017	Outstanding Aug 2017	Good Aug 2017	Good Aug 2017	Outstanding Aug 2017
Critical care	Good Jan 2019	Good Jan 2019	Outstanding Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
End of life care	Good Aug 2017	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Surgery	Inadequate →← May 2023	Good →← May 2023	Good →← May 2023	Good →← May 2023	Inadequate →← May 2023	Inadequate →← May 2023
Urgent and emergency services	Requires improvement Jul 2022	Good Jul 2022	Good Jul 2022	Requires improvement Jul 2022	Good Jul 2022	Requires improvement Jul 2022
Maternity	Inadequate Dec 2021	Outstanding Jan 2019	Good Jan 2019	Good Jan 2019	Inadequate Dec 2021	Inadequate Dec 2021
Outpatients	Good Jan 2019	Not rated	Good Jan 2019	Requires improvement Jan 2019	Requires improvement Jan 2019	Requires improvement Jan 2019
Overall	Inadequate ↓↓ May 2023	Good →← May 2023	Outstanding →← May 2023	Requires Improvement →← May 2023	Inadequate ↓↓ May 2023	Inadequate ↓↓ May 2023

Rating for Princess Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jan 2019	Good Jan 2019	Outstanding Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Services for children & young people	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Critical care	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
End of life care	Good Aug 2017	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Surgery	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Urgent and emergency services	Requires improvement Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019	Good Jan 2019
Maternity	Requires Improvement ➔➔ May 2023	Outstanding ➔➔ May 2023	Good ➔➔ May 2023	Good ➔➔ May 2023	Inadequate ➔➔ May 2023	Requires Improvement ➔➔ May 2023
Outpatients	Good Jan 2019	Not rated	Good Jan 2019	Requires improvement Jan 2019	Requires improvement Jan 2019	Requires improvement Jan 2019
Overall	Requires Improvement ↓ May 2023	Good ➔➔ May 2023	Good ➔➔ May 2023	Good ➔➔ May 2023	Requires Improvement ↓ May 2023	Requires Improvement ↓ May 2023

Rating for Bexhill Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Overall	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014

Rating for Southlands Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
Outpatients	Good Oct 2019	Not rated	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Overall	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019

Rating for St Richard's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Apr 2016	Good Apr 2016	Good Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016
Services for children & young people	Outstanding Apr 2016	Good Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016
Critical care	Good Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019
End of life care	Good Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016
Surgery	Good Apr 2016	Good Apr 2016	Outstanding Apr 2016	Requires improvement Apr 2016	Good Apr 2016	Good Apr 2016
Urgent and emergency services	Good Apr 2016	Good Apr 2016	Good Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016
Outpatients	Good Oct 2019	Not rated	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Maternity	Requires Improvement →← May 2023	Outstanding May 2023	Outstanding May 2023	Good May 2023	Requires Improvement →← May 2023	Requires Improvement →← May 2023
Overall	Good →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Good ↓ May 2023	Outstanding →← May 2023

Rating for Worthing Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Apr 2016	Good Apr 2016	Good Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016
Services for children & young people	Outstanding Apr 2016	Good Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016
Critical care	Good Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019
End of life care	Good Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016
Surgery	Good Apr 2016	Good Apr 2016	Outstanding Apr 2016	Requires improvement Apr 2016	Good Apr 2016	Good Apr 2016
Urgent and emergency services	Good Apr 2016	Good Apr 2016	Good Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016	Outstanding Apr 2016
Outpatients	Good Oct 2019	Not rated	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Maternity	Requires Improvement →← May 2023	Outstanding May 2023	Outstanding May 2023	Good May 2023	Requires Improvement →← May 2023	Requires Improvement →← May 2023
Overall	Good →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Good ↓ May 2023	Outstanding →← May 2023

Rating for Hove Polyclinic

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Aug 2014	Not rated	Good Aug 2014	Requires improvement Aug 2014	Good Aug 2014	Good Aug 2014
Overall	Good Aug 2014	Not rated	Good Aug 2014	Requires improvement Aug 2014	Good Aug 2014	Good Aug 2014

Princess Royal Hospital

Lewes Road
Haywards Heath
RH16 4EX
Tel: 01444441881

Description of this hospital

Princess Royal Hospital was not inspected during this current inspection. However, we have included it in this inspection report in order to aggregate the ratings from the focused inspection of maternity services carried out in September 2021. The aggregation of ratings from that inspection has resulted in a change of rating for Princess Royal Hospital.

Maternity

Requires Improvement ● →←

Is the service safe?

Requires Improvement ● →←

The rating of requires improvement is unchanged from the September 2021 focused inspection of maternity services. Details about the reasons for this rating are in the report of the September 2021 inspection.

Is the service effective?

Outstanding ☆ →←

This rating judgment was made in 2019 and has not been reviewed.

Is the service caring?

Good ● →←

This rating judgment was made in 2019 and has not been reviewed.

Is the service responsive?

Good ● →←

This rating judgment was made in 2019 and has not been reviewed.

Is the service well-led?

Inadequate ● →←

The rating of inadequate is unchanged from the September 2021 focused inspection of maternity services. Details about the reasons for this rating are in the report of the September 2021 inspection.

St Richard's Hospital

St Richards Hospital
Spitalfield Lane
Chichester
PO19 6SE
Tel: 01243788122
www.westernsussexhospitals.nhs.uk

Description of this hospital

St Richard's Hospital was not inspected during this current inspection. However, we have included it in this inspection report in order to aggregate the ratings from the focused inspection of maternity services carried out in September 2021. The aggregation of ratings from that inspection has not resulted in a change of rating for St Richard's Hospital.

Maternity

Requires Improvement ● →←

Is the service safe?

Requires Improvement ● →←

The rating of requires improvement is unchanged from the September 2021 focused inspection of maternity services. Details about the reasons for this rating are in the report of the September 2021 inspection.

Is the service effective?

Outstanding ☆

This rating judgment was made in 2016 and has not been reviewed.

Is the service caring?

Outstanding ☆

This rating judgment was made in 2016 and has not been reviewed.

Is the service responsive?

Good ●

This rating judgment was made in 2016 and has not been reviewed.

Is the service well-led?

Requires Improvement ● →←

The rating of requires improvement is unchanged from the September 2021 focused inspection of maternity services. Details about the reasons for this rating are in the report of the September 2021 inspection.

Worthing Hospital

Lyndhurst Road
Worthing
BN11 2DH
Tel: 01903205111
www.westernsussexhospitals.nhs.uk

Description of this hospital

Worthing Hospital was not inspected during this current inspection. However, we have included it in this inspection report in order to aggregate the ratings from the focused inspection of maternity services carried out in September 2021. The aggregation of ratings from that inspection has resulted in a change of rating for Worthing Hospital.

Maternity

Requires Improvement ● ➔➔

Is the service safe?

Requires Improvement ● ➔➔

The rating of requires improvement is unchanged from the September 2021 focused inspection of maternity services. Details about the reasons for this rating are in the report of the September 2021 inspection.

Is the service effective?

Outstanding ☆

This rating judgment was made in 2016 and has not been reviewed.

Is the service caring?

Outstanding ☆

This rating judgment was made in 2016 and has not been reviewed.

Is the service responsive?

Good ●

This rating judgment was made in 2016 and has not been reviewed.

Is the service well-led?

Requires Improvement ● ➔➔

The rating of requires improvement is unchanged from the September 2021 focused inspection of maternity services. Details about the reasons for this rating are in the report of the September 2021 inspection.

Royal Sussex County Hospital

Eastern Road
Brighton
BN2 5BE
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www.bsuh.nhs.uk

Description of this hospital

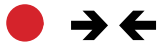
We carried out this unannounced focused inspection of surgery, focusing on the neurosurgical service at Royal Sussex County Hospital, because we had received information of concern about the safety and quality of the service. We did not rate the service at this inspection. The previous rating of inadequate for surgery services at Royal Sussex County Hospital remains the same.

During the inspection we spoke with staff including managers, nursing staff, theatre staff, medical staff of all grades and senior leaders. We observed the environment and reviewed documents and information provided by the trust as part of the inspection process.

Surgery

Inadequate 

Is the service safe?

Inadequate 

Mandatory training

The service provided mandatory training in key skills to all staff. However, the service did not make sure everyone completed the mandatory training.

Some nursing staff were not up to date with their mandatory training. Records showed nursing staff on the ward and in theatres were above the trust target of 90% for completion of mandatory training. However, overall completion of basic life support training for staff working on the ward was 82%, which did not meet the trust target. Staff said the trust had deferred basic life support training until services were relocated into the new hospital building in spring 2023, so they could make the training specific to the new environment and any new equipment.

Medical staff were not up to date with their mandatory training. Records showed medical staff across the neurosurgical service was below the trust target of 90% for completion of mandatory training. Overall, their average completion rate was 80%, with completion rates ranging from 65% to 90%. The only topic where they had met the trust target was moving and handling training.

Clinical staff did not complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Records showed mandatory training did not include training about meeting the needs of patients with mental health needs, learning disabilities, autism and dementia. Since July 2022 it is a legal requirement for all staff to receive training in how to interact with people with a learning disability and autistic people.

Managers monitored mandatory training and alerted staff when they needed to update their training. The educators and managers monitored staff mandatory training compliance as part of their quality auditing processes. The online mandatory training system alerted staff when mandatory training was due. Staff said if there was no capacity to complete online mandatory training during their shifts, they received additional pay to complete it at home. However, despite this approach, the service could not be assured it was effective as some mandatory training figures were below trust targets.

Environment and equipment

The design and use of facilities, premises and equipment did not fully support the safety of people.

The design of the environment did not fully meet the needs of the service. The physical environment of the ward did not allow for ease of storage of all equipment. Large pieces of equipment, such as special seating, had to be stored in the corridor outside the ward.

The service had limited facilities to meet the needs of patients' families. There was a quiet room on the ward that was used to accommodate families when discussing ongoing care and treatment and breaking bad news. However, this

room was not solely for the use of patients' families. It was used to accommodate patients waiting to be discharged and to facilitate the trust's boarding process. This was when, to reduce patient congestion in the emergency department, patients were allocated from the emergency department to a ward when there was not yet a bed space available for them. The room was also used as a breakout space for staff if they needed it.

The service did not have enough suitable equipment to help them to safely care for patients. Therapy staff said some equipment was old and needed replacing but had been told there were insufficient funds to replace old equipment. They said there was also insufficient specialist seating, which had the potential to affect patients' ongoing recovery and rehabilitation following neurosurgery.

Timely and effective surgical treatment for some patients was potentially compromised by the fact the service had only 1 C-Arm. A C-Arm is a mobile imaging unit used primarily for x-ray imaging during surgical procedures. There was no contingency plan for accessing replacement equipment if the C-Arm developed a fault. Our review of incidents reported by the service to the National Reporting and Learning System showed that from January 2022 to September 2022 there had been 3 reported incidents about the availability and use of the C-Arm. The incidents included occasions where the C-Arm had to be repeatedly moved between 2 theatres whilst surgery was taking place. This increased the risk of infection and cross contamination. One incident detailed that the anaesthetic team complained because the repeated plugging and unplugging of the C Arm affected patient monitoring. Although there were only 3 reported incidents about how having only 1 C-Arm had an adverse effect on the service, one of them detailed "This is a recurring incident to which no one is taking ownership."

Availability of equipment affected the running of theatres. Our review of incidents reported by the service to the National Reporting and Learning System showed that from January 2022 to September 2022 there were 5 incidents reported about the non-availability of equipment. This included no availability of a thoracotomy kit for surgery, no availability of a specialised table for planned spinal surgery and surgery cancelled due to lack of equipment. There were 2 reported incidents about the lack of monitoring equipment to transport patients who were intubated and ventilated. This affected patients who were being transferred from theatres to critical care areas and patients who needed to be transferred to the scanning department whilst intubated and ventilated. Detail in these incident entries indicated that this had been a long-standing issue. However, records of governance meetings and the neurosurgery and spinal steering group meetings showed that the service was taking action to purchase an additional spinal operating table and monitoring equipment to transport patients who were intubated and ventilated. Following the inspection, the trust informed us that both the spinal table and monitoring equipment had been purchased and were in use.

Ward staff said there was always enough equipment to meet the nursing needs of patients on the ward. All patients had access to call bells to seek assistance from ward staff. Patients said staff usually came to them quickly when they called for assistance. Call bells were observed to be answered quickly during the day of the inspection.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough staff to care for patients and keep them safe. Ward staff said that the actual number of staff working on the ward did not always meet the planned number of staff for a shift. Staffing was one of the risks detailed on the risk register for the service. Staff described the affect this had on patient care. This included patients only having hand and face washes rather than full washes and sometimes patients having to wait for assistance. Some staff said there said there had been a higher number of incidents of patient falls as a result of staffing

shortages. The ward manager had allocated management time in the staff rota, but managers frequently had to be included in the staff numbers to support safe care of patients. An example of this occurred on the day of the inspection, when the divisional lead nurse for neurosciences and stroke services was mostly working on the ward supporting staff with managing patient flow.

The ward staff rota for October 2022 showed a range of staffing levels throughout the month. This ranged from 4 to 8 registered nurses on each shift and for health care assistants from two to six each shift. There was no indication on the staff rota as to what the optimum level of staffing was to maintain a safe service on the ward. Staffing was displayed on the ward, but this did not demonstrate what the planned/optimum levels of staffing were for the ward.

Our review of incidents reported by the service to the National Reporting and Learning System showed that from January 2022 to September 2022 there had been 15 reported incidents about lack of staff that adversely affected the ability to provide safe care and treatment. This included a lack of staff to observe and monitor patients known to be at risk of falls, resulting in patient falls that were potentially avoidable.

Recovery staffing had been increased to 2 nurses overnight, to enable safe care for post-operative patients accommodated in the recovery area overnight. However, the recovery staff rota for October 2022 showed there were 6 weekday shifts that only had 1 nurse rostered to work the night shift.

Our review of incidents reported by the service to the National Reporting and Learning System showed that from January 2022 to September 2022 there were 9 reported incidents about shortage of staff in theatres, with 2 of them detailing that staffing numbers did not meet the national guidelines for staffing published by the Association for Perioperative Practice.

There were shortages of nurses working in the interventional neuroradiology service. Our review of incidents reported by the service to the National Reporting and Learning System showed that from January 2022 to September 2022 there were 5 reported incidents of nursing staff available for this service. This resulted in delays for patients requiring interventional radiological treatments for their conditions.

The service was developing a team of specialist nurse practitioners. There were 2 spinal nurse practitioners and the service was recruiting a vascular nurse practitioner. The service also had clinical nurse specialists for head injury, and brain and spinal tumours. This meant patients were supported by nurses who had the relevant specialist skills and knowledge about their conditions.

Managers made sure all bank staff had a full induction and understood the service. The ward regularly used bank nursing staff. Bank staff said they completed an induction to the trust and to the area they were working in.

Allied health professionals staffing

The service did not always have enough allied health professionals with the right qualifications, skills, training and experience to provide the right care and treatment to patients.

The service did not always have enough allied health professionals to keep patients safe. Physiotherapists and occupational therapists said that although they were staffed to planned levels, they did not have enough capacity to fully meet the needs of all patients. They described that there were no therapists allocated to support neurosurgical patients ready for discharge to the wards from critical care. This meant that some patients did not always receive all their planned therapy as the therapists had provide treatment to neurosurgical patients in critical care.

There was no therapy service at weekends and bank holidays which had the potential to adversely affect patients' ongoing recovery and rehabilitation from neurosurgery. Patients did not receive any focused rehabilitation therapy over weekends or bank holidays. Therapy staff provided therapy plans for nursing staff to follow but acknowledged that nursing staff did not always have time to follow the plans. However, for patients requiring therapy assistance with breathing difficulties, they had access to a respiratory physiotherapist on call at weekends, bank holidays and overnight.

The service did not have enough radiographers to support safe surgery. Our review of incidents reported by the service to the National Reporting and Learning System showed that from January 2022 to September 2022 there were 5 incidents where there were insufficient radiography staff to carry out neurosurgery effectively and safely. This included incidents where emergency neurosurgery was cancelled because of no availability of radiography staff.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough medical staff to keep patients safe. There were sufficient numbers of consultant neurosurgeons and registrars. However, the service did not have of neurosurgeons allocated to subspecialties, which increased the risk of patients being treated by surgeons who were not experienced in that subspecialty. The service was in the process of addressing this concern. Surgeons had been asked to express their preference for subspecialties and this was currently being worked on. Staff said there was no evidence of avoidable patient harm as a result of neurosurgeons not having subspecialties. The registrar rota ensured there was a dedicated cranial and a dedicated spinal registrar on duty each day. There was a junior doctor and a registrar doctor available on site at night.

There were challenges with ensuring there were sufficient junior doctors. Staff said there had been a lack of junior doctors during the summer months in 2022 during which consultants and registrars worked additional hours to ensure the junior doctors rota was covered to keep patients safe.

To assess the effectiveness and safety of medical cover of the neurosurgical service we requested a copy of the medical staff rota for October 2022. However, the trust failed to provide this information.

The service always had a consultant on call during evenings and weekends. Consultant on call rotas supported safe management of all neurosurgical patients. Consultant on call rotas had been revised to promote the safe treatment of patients with cranial conditions and those with spinal conditions. There was now always a cranial consultant and a spinal consultant on call.

Incidents

The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, it was not assured that staff reported all incidents or that near misses were reported.

Staff reported incidents and near misses using the trust's electronic incident reporting process. However, our review of incidents reported by the service from January 2022 to September 2022 to the National Reporting and Learning System suggested that not all incidents or near misses were reported. There was one entry about two theatres running concurrently that both required radiology, but the service only had the one portable imaging machine. The incident entry detailed that this event occurred frequently but there were no other similar entries.

Surgery

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Reports of incident investigation showed that verbal and written apologies were given to patients and their families and that copies of investigation reports were shared with them.

Staff received feedback from the investigation of incidents. Staff said they received feedback about incidents through safety briefings and team meetings. Records of ward meetings showed incidents related to the ward, such as the completion of patient observations and patient falls were discussed. There was evidence that staff were trying make changes and improvements to reduce the risk of similar incidents occurring. The ward improvement board showed the multidisciplinary ward team were looking at how to reduce the number of patient falls on the ward.

Staff used mortality and morbidity meetings to learn from events and identify where improvements could be made. Mortality and morbidity meetings are a recognised and recommended process to support a systemic approach to the review of patient deaths or care complications in order to improve patient care. The neurosurgical service held mortality and morbidity meetings every other month. Records showed they were well attended. The meetings followed a standard structure with all deaths and poor outcomes following surgery reviewed to identify any learning.

Managers investigated incidents thoroughly. Records of incident investigations showed investigations were comprehensive, identified the cause, confirmed involvement with the patient and resulted in actions to reduce similar occurrences.

Patients and their families were involved in these investigations. Reports of investigations showed patients and their families were invited to contribute to the investigation process. Their questions and concerns were considered and explored during the investigation process.

Is the service effective?

Good 

We have not carried out a full inspection of the effective domain and this good rating is from the inspection of surgery out in 2019.

Competent staff

The service made sure staff were competent for their roles. Managers provided staff with support to develop. However, managers did not always appraise staff's work performance.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. The trust policy required staff to receive yearly appraisals. At the time of inspection only 73% of the nursing staff on the ward had received an appraisal in the last 12 months. Of the nursing staff working in theatres, 93% had received an appraisal in the past 12 months. However, all medical staff had received an appraisal.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior medical staff said they received good support from their clinical supervisors. Records showed that all medical staff had received an annual appraisal.

Surgery

The clinical educators supported the learning and development needs of staff. There was a dedicated nurse clinical educator who supported staff training and development on the ward. There was a structured training programme for staff to equip them with the knowledge and skills to effectively care for patients on the ward. The training programme was multidisciplinary, including therapy and nursing staff. Ward staff commented positively about the support and training received.

Medical staff had dedicated training time once a week and all medical staff we spoke with spoke positively about the training they received.

Managers identified poor staff performance promptly and supported staff to improve. Concerns had been raised about the skill set of the consultant neurosurgeons. This related to the number of subspecialties in neurosurgery and concerns that some surgeons were carrying out surgery of a subspecialty type they had limited experience and skills in. The service was in the process of addressing this by allocating subspecialties to them following surveying which subspecialties they had experience in and which they preferred.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.

Staff said there was sometimes a lack of contribution from consultants in multidisciplinary meetings held on the ward with patients and their families to discuss ongoing care, rehabilitation and discharge plans. Therapy staff said this sometimes resulted in them having to discuss recovery and outcomes with patients and their families, rather than medical staff, including if it involved giving bad news.

Staff held multidisciplinary meetings to discuss patients and improve their care. A multi-disciplinary team meeting is a weekly or monthly meeting that takes place between health care professionals, to discuss individual patient cases. Every patient with a new diagnosis of cancer is discussed and their scans and biopsies are reviewed by the team. Using the combined expertise of each team member and taking into account the specific needs of each patient, the multi-disciplinary team meeting will recommend a treatment plan. Multidisciplinary meetings were held for different neurosurgical subspecialties. Named neurosurgical consultants for each subspecialty attended the relevant meeting and were listed as a core member of the multidisciplinary meeting. The trust required core members of the multidisciplinary meeting to attend 66% of the meetings each year. However, records showed that most consultants listed as a core member of the multidisciplinary meeting did not meet this target, with attendance ranging from 0% to 77%. This increased the risk that there were insufficient numbers and mixes of health care professionals at the meetings to ensure effective discussions and challenges about the care and treatment of patients with complex healthcare needs took place.

Is the service caring?

Good 

This rating judgment was made in 2019 and has not been reviewed.

Surgery

Is the service responsive?

Good ➔➔

This good rating is from the inspection of surgery out in 2019. We have not carried out a full inspection of the responsive domain and this good rating is from the inspection of surgery out in 2019.

Access and flow

People could not always access the service in a timely manner. There were significant delays in waiting times from referral to treatment.

The neurosurgery service experienced challenges with patient flow. There were multiple reasons for this.

Theatre capacity did not meet the needs of the patient population. There were two neurosurgical theatres and no dedicated emergency theatre. This meant elective surgery was frequently disrupted to meet the needs of patients requiring emergency surgery. Data provided by the trust showed that between October 2021 and September 2022, 51 patients had their surgical procedure cancelled on the day of surgery due to a more urgent case being added to the list. Staff said that cancelling patient's operations was one of the worst things about the service.

Challenges with discharges resulted in patients not being able to be admitted to the ward. Staff said that reasons for delayed discharges included long waiting lists for rehabilitation inpatient services and some consultants not fully engaged with planning for the discharge of patients.

Staff said theatres were frequently delayed in starting, with often the first surgical procedure of the day not starting until 11am. Reasons for this were attributed to bed availability, both on the ward and in critical care. Surgery was not able to start until there was assurance a bed was available for the patient following their surgery. To overcome the lack of post-operative beds, the service used the theatre recovery area to accommodate 2 patients post operatively overnight with a planned ward bed available for them the day after surgery There was a structured process for this. Patients suitable to be accommodated in recovery were identified by the anaesthetist the day before surgery and informed they would be cared for in recovery. Additional recovery staff had been recruited to ensure patients could be cared for in recovery overnight. However, there was not always a bed available for patients the day after surgery. Our review of incidents reported by the service from January 2022 to September 2022 to the National Reporting and Learning System showed there had been 4 reported incidents where there were no beds allocated for patients after an overnight stay in recovery.

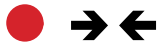
Patients also experienced cancellation of their surgical procedures due to lack of bed availability. Data provided by the trust showed that between October 2021 and September 2022, 41 patients had their surgical procedure cancelled because there was no critical care bed available for them after their surgery and 5 patients had surgery cancelled because there was no ward bed avaible.

Managers monitored waiting times and took some action to improve the timeliness of when patients could access services. However, many patients did not receive treatment within the time frames set out in national targets. Waiting times and lists were reviewed at the clinical governance meetings. Data provided by the trust for October 2022 showed that for urgent neurosurgery 54 patients had been waiting for over 52 weeks, with 8 patients waiting over 100 weeks for their surgery. For routine neurosurgery 45 patients had waited over 52 weeks, with 4 patients waiting over 100 weeks.

Surgery

For urgent spinal surgery 33 patients had been waiting over 52 weeks for their surgery, with 2 patients waiting over 100 weeks. For routine spinal surgery 25 patients had waited over 52 weeks, with 3 of those waiting over 100 weeks. To address the waiting list, the service, with the support of NHS England, had arranged for some patients to have their spinal surgery at other independent hospitals.

Is the service well-led?

Inadequate 

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced and were taking actions to manage them. However, some leaders were not always visible and approachable in the service for staff.

There was a clearly defined leadership structure for the neurosurgical service. This included a matron, clinical lead for neurosurgery and a divisional operations director. The trust was undergoing a restructure and the neurosurgery service was soon to be part of the neurosurgery, spinal, major trauma, plastic and burns division.

Leaders demonstrated an understanding about the priorities and issues the neurosurgical service faced. The Neurosurgery and Spinal Clinical Outcomes Steering Group that was set up in May 2020 in response to the findings of an external review of the service, included a range of clinical and non-clinical leaders from the neurosurgery service. This ensured leaders understood and contributed to the actions to address those issues and priorities. However, some of the changes that needed to be made were reliant on the move into a new hospital build. Leaders were aware of some of the challenges this move would pose, including the fact that at the time of the inspection there was still uncertainty about the number of theatres that neurosurgery would have in the new building and there was uncertainty about the location of radiology services to support the service. They were in the process of developing business cases to support the increase in theatres, staffing and facilities.

Staff views were mixed about the visibility and how approachable trust leaders were. Staff spoke highly of their immediate leaders, saying they could approach them with concerns and issues and that their immediate leaders were supportive. However, some staff felt removed from the senior leaders and felt senior leaders did not fully understand the issues faced by the service on a day to day basis. Some staff said they did not see the senior leaders, such as the managing director for planned care and cancer and the divisional director for specialist services. During the inspection these two leaders were on the ward and several staff commented they did not know who they were.

Vision and Strategy

The service had an informal vision for what it wanted to achieve.

There was no current formalised strategy for the neurosurgery service. However, the strategy had been to follow and complete the actions from the plan developed in response to an independent review of the service. The clinical lead for the service said the strategy going forward would be based on the key elements of that action plan but was currently not formalised.

Surgery

Culture

Not all staff felt respected, supported and valued by all members of the neurosurgical team. The service did not have a culture where all staff felt able to raise concerns without fear. However, most staff were focused on the needs of patients receiving care.

Some medical staff commented that staff shortages in the medical team sometimes meant that staff were not supported as well as they could be. However, most staff felt respected, supported and valued by their immediate leaders. This included nursing staff who felt supported by their nurse leaders and junior medical staff supported by their senior medical staff.

The service had a recent history of poor culture and behaviours from consultant medical staff. To address the previous poor behaviours of consultants, all neurosurgical consultants had signed a behavioural charter. This set out the expected behaviours that the consultants should demonstrate in their work and in their interactions with colleagues. To measure progress and improvements in the culture and behaviours of the consultants and other staff, the neurosurgical service carried out behavioural surveys every three months. Staff results of the surveys showed improvements in the behaviours of consultants and other staff. Theatre staff said that whereas it used to be a common occurrence that consultants would speak to colleagues in theatres in a disrespectful manner, this very rarely happened now.

However, results from the behavioural surveys did not demonstrate those improvements. We asked the trust for copies of the behavioural survey results for the 12 months prior to the inspection. They provided copies of results for October 2020, January 2021, April 2021, July 2021 and January 2022, not the 12 months prior to the inspection. It was not clear whether the behavioural surveys had continued after January 2022 or whether the service had continued to monitor any changes in staff behaviours from that date. Results up to January 2022 showed that just over half of staff responding to the survey consistently responded they had witnessed or been on the receiving end of unacceptable behaviour from a colleague or colleagues. Across the survey results most staff (74% - 82%) consistently responded that they were not able to approach the individual or individuals to discuss their behaviour.

The behavioural survey gave opportunities for staff to describe any positive behaviours they had witnessed. The survey in January 2022 detailed that staff thought the administration team worked well together and detailed the positive behaviours of some named consultants. They were described as committed to teaching both medical and nursing staff, an asset to the trust with their continued support and extra work and their generally behaviour was very collegiate and mutually supportive. However, there were also negative comments which included “it’s been business as usual - there is no trust between certain consultants” and “ sometimes you have to admit defeat and start afresh – I don’t think this lot can work together as a group.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a defined governance process in the neurosurgical service with a named clinical lead for governance. This included governance meetings, team meetings and safety huddles. Records of governance meetings showed the clinical effectiveness of the service was reviewed. This included a review of performance, safety, incidents, infection control, complaints, training and staffing.

Staff were clear about their roles and accountabilities. The service had a reporting structure that identified who staff were accountable to. Staff showed they knew who they directly reported to.

The service had processes to share information with staff. Staff said they received information about what was happening in their service and an overview of what was happening in the hospital and trust through the daily safety huddles and in team meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Processes to monitor and manage performance were included in the governance processes where patient outcomes, patient flow and referral to treatment times were reviewed. The service took part in national and local audits to support the monitoring of and plans to improve the performance of the service. National audits included submission to the Neurosurgical National Audit Programme which showed mortality rates for the neurosurgical service at the trust were similar to national average performance. The nationwide Getting it Right First-Time review of neurosurgical services in 2018 identified areas for improvement across all neurosurgical services. The service had developed an action plan in response to address the identified areas for improvement. However, many of the actions were currently on hold until the service moved into the new hospital build in spring 2023. It was evident from review of governance records and this action plan that there was a significant reliance on the move into the new build to support improvements to the service. However, it was clear from governance meeting records it could not yet be assured that this would bring improvements to the patient flow. There was still debate and negotiation around what the provision for neurosurgical theatres would be.

Management of risk was supported by a risk register. Risks were recorded at department, division and trust level. The top risks recorded on the neurosurgery risk register concerned staff relationships, capacity for spinal surgery and risk of patient harm due to lack of emergency theatre sessions. There was evidence the risks were reviewed. There was detail of actions to lessen the risks and each risk had a nominated member of staff who was responsible for managing the risk. Staff followed a process to escalate risks onto the risk register and to escalate high level risks to the trust board. The risk register mostly reflected what staff considered to be the main risks for the service. This included staffing, patient flow, lack of theatre capacity and culture of the service. However, therapy staff identified their top risks as not being able to provide effective therapy to some patients because there was insufficient specialist seating for patients and no rehabilitative therapy for patients over the weekend. There was no detail about these risks on the risks register.

The service had completed waiting list harm reviews. Senior leaders said no harm had been identified to those patients waiting a long time on waiting lists for treatment. However, there was some detail in incident reviews that some patients may have been exposed to risk of harm or may have experienced harm due to their extended time on waiting lists.

Following an independent review of the trust's neurosurgical services in 2019, changes were being made to the service to improve performance and reduce risks to the service. This included the recruitment of specialist nurse practitioners, improvements in the culture of the service, improvements to the leadership and governance of the service, changes to the consultants on call rotas and structure subspecialty roles of the consultants.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Staff had an understanding of quality improvement methods and how to use them.

Surgery

Staff were committed to improving services. There was evidence on the ward that staff were using quality improvement methods to support a reduction in the number of patient falls on the ward. Ward meeting records, governance meeting records and the Neurosurgical and Spinal Clinical Steering Group meeting records demonstrated that staff were taking actions to make improvements to the service and improve patient experience.

NHS
University Hospitals Sussex
NHS Foundation Trust

Brighton & Hove HOSC

Dr George Findlay | Chief Executive Officer

12 July 2023

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CQC report

University Hospitals Sussex NHS Foundation Trust

Ratings	
Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Outstanding**
Are services caring?	**Outstanding**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Inadequate**

CQC report – your hospital site

University Hospitals Sussex NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Sussex County Hospital	Inadequate ↓↓ May 2023	Good →← May 2023	Outstanding →← May 2023	Requires Improvement →← May 2023	Inadequate ↓↓ May 2023	Inadequate ↓↓ May 2023
Princess Royal Hospital	Requires Improvement ↓ May 2023	Good →← May 2023	Good →← May 2023	Good →← May 2023	Requires Improvement ↓ May 2023	Requires Improvement ↓ May 2023
Southlands Hospital	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
St Richard's Hospital	Good →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Good ↓ May 2023	Outstanding →← May 2023
Worthing Hospital	Good →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Good ↓ May 2023	Outstanding →← May 2023
Overall trust	Requires Improvement ↓↓ May 2023	Outstanding →← May 2023	Outstanding →← May 2023	Requires Improvement ↓↓ May 2023	Inadequate ↓↓↓ May 2023	Requires Improvement ↓↓ May 2023

Well-led inspection report: Negative findings

University Hospitals Sussex NHS Foundation Trust

- Leadership visibility and communication
- Support for staff
- Speaking up
- Culture
- Improvement actions required
- System Oversight Framework recommendation

Well-led inspection: Positive findings

University Hospitals Sussex NHS Foundation Trust

- Improvement strategy
- Leaders' experience, capacity and capability
- Praise from patients
- Executive team's skills, knowledge and experience
- New operating model

Timeline

University Hospitals Sussex NHS Foundation Trust

2022	October 2022	2022-2023	2023	May 2023	Next
Due diligence Staff survey COM agreed Surgery culture Discussions re Trust culture	PF refresh agreed CQC inspection	Divisional leadership Hospital leadership Strengthening FTSU £120m capital investment	Progress on waiting times Progress on UEC Cancer performance Culture plans agreed	CQC publication	Culture work continues Focus on delivering Patient First strategy Capitalise on opening of LMB

Reflections

University Hospitals Sussex NHS Foundation Trust

- Timing was tough seven months ago when last inspection took place
- The CQC findings largely echo what we already knew at the time
- Huge amount of improvement work already underway and showing results
- Also, the CQC found many positives about care, frontline teams, and how we are organised to meet our challenges

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But...

- … we mustn't underestimate these findings, or dismiss them.
- Some people feel unheard, and our challenges are significant
- Delivering care is really tough, winter was immensely difficult and operational pressures continue – people are tired, and under pressure

Progress to date

University Hospitals Sussex NHS Foundation Trust

Elective care

Tackling 78-week waiters, then 65-week waits

Urgent and emergency care

Huge demands, improving performance

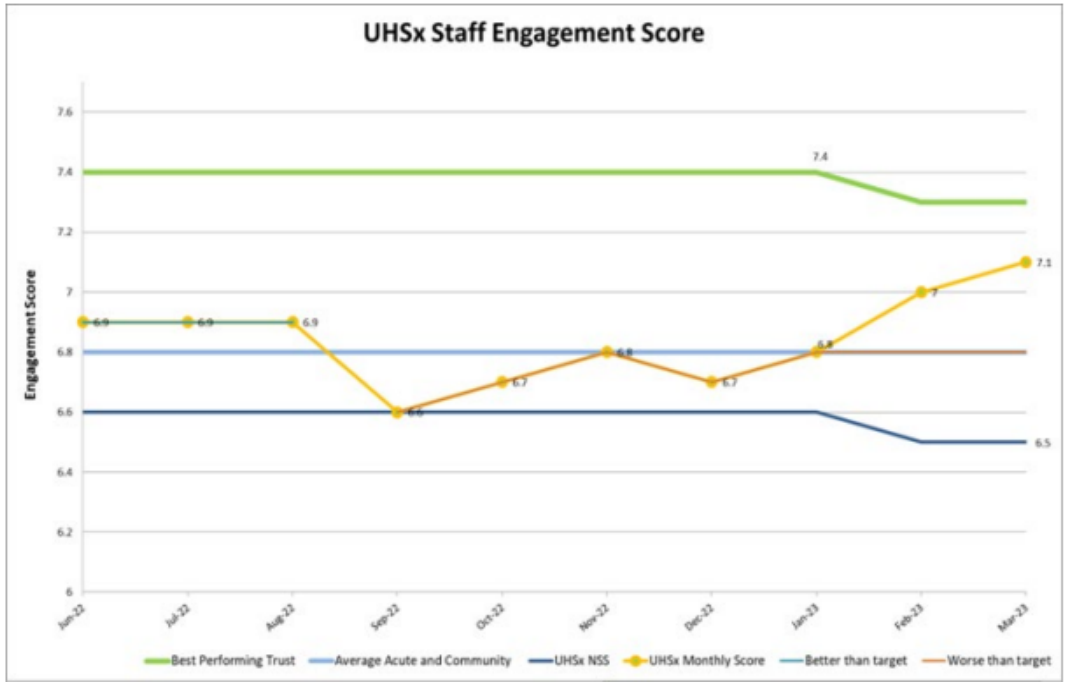
Cancer care

Rising demands, some performance stronger than ever

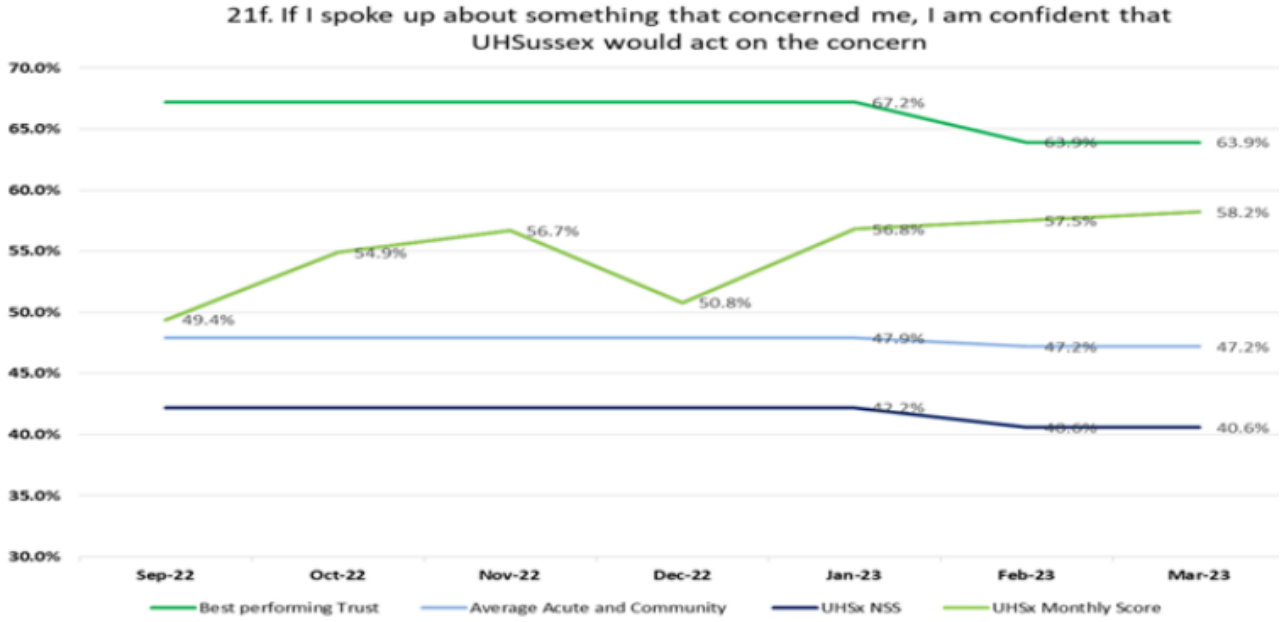
Speaking up - progress

University Hospitals Sussex NHS Foundation Trust

True North



Breakthrough Objective



What comes next?

University Hospitals Sussex NHS Foundation Trust

Patient

Vision

Excellent care every time

Breakthrough

Clear communication

Sustainability

Vision

Making the most of our resources

Breakthrough

Improving productivity

People

Vision

A great place to work

Breakthrough

Staff voices count

Quality

Vision

Best outcomes

Breakthrough

Fewer falls | Earlier intervention

Systems & Partnerships

Vision

Accessible care

Breakthrough

Home for lunch

Research & Innovation

Vision

Evidence-based improvement

Breakthrough

Taking part

124

Address CQC actions

University Hospitals Sussex NHS Foundation Trust

8 x *must do* actions, including:

- Trust must ensure all staff report incidents via trust reporting system
- Trust must ensure it reviews current medical staffing levels in Surgery
- The trust must ensure it seeks and acts quickly on feedback from staff

125

5 x *should do* actions, including

- The trust should consider reviewing current staff engagement processes
- The trust should review how incidents are being graded
- Trust should ensure the Freedom to Speak up Guardian and the Freedom to Speak up champions have sufficient resources

Capitalise on developments

New Louisa Martindale Building

- £500 million new hospital building now open
- New home for more than 30 wards / departments
- State-of-the-art, purpose-built facilities
- Great for morale, recruitment and improvement

£48 million Emergency Department rebuild

- Expanding ED into newly vacated clinical space
- Modernise department to C21st standards
- Improve patient experience and outcomes
- Plus, at same time complete Stages 2&3 of 3Ts

Any questions?

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Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item 8

Subject: **University Hospitals Sussex NHS Foundation Trust Capital Investment Programme**

Date of meeting: **12 July 2023**

Report of: **Executive Director, Governance, People & Resources**

Contact Officer: **Name: Giles Rossington**
Tel: 01273 295514
Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: **All**

For general release

1. Purpose of the report and policy context

1.1 This report presents information on University Hospitals Sussex NHS Foundation Trust (UHSx) plans for capital investment on the Royal Sussex County (RSCH) site. Additional information provided by UHSx is included as Appendix 1 to this report.

2. Recommendations

2.1 That Committee notes progress in delivering University Hospitals Sussex capital investment plans (see Appendix 1).

3. Context and background information

3.1 The Royal Sussex County Hospital (RSCH) is the principal general hospital for residents of Brighton & Hove and for many East and West Sussex residents also. In addition RSCH offers a range of specialist acute services for people across Sussex and the South East of England. However, RSCH includes some of the oldest NHS buildings still in clinical use and it has long been recognised that improvements are required.

3.2 The 3Ts programme (Tertiary, Teaching and Trauma) is a major, Treasury-funded, initiative to redevelop the RSCH, providing better facilities for general hospital services and significantly expanding the hospital's specialist facilities. Appendix 1 to this report includes information about the completion of phase 1 of 3Ts, with the opening of the Louisa Martindale Building. Appendix 1 also includes information on phase 2 of 3Ts, including the Sussex cancer centre; and on plans to reconfigure the RSCH Emergency Department.

3.3 Operating an estate that is cramped and in some instances not fit for purpose presents many challenges, and is a significant factor in the relatively poor performance of some RSCH services over recent years. The Trust's capital plans should address some of these issues, leading to improved clinical outcomes and better patient experience.

4. Analysis and consideration of alternative options

4.1 Not relevant to this information report.

5. Community engagement and consultation

5.1 None undertaken for this information report.

6. Conclusion

6.1 Members are asked to note University Hospitals Sussex capital improvement plans.

7. Financial implications

7.1 Not applicable to this report for information

8. Legal implications

8.1 There are no legal implications to this report.

Name of lawyer consulted: Elizabeth Culbert Date consulted 01/06/2023

9. Equalities implications

9.1 None directly for this information report. Members may wish to note the steps taken by UHSx to ensure that their capital developments meet the needs of people with protected characteristics, for example in terms of disability access, or in terms of providing an in-patient environment that supports the needs of people with dementia.

10. Sustainability implications

10.1 None directly for this information report. Members may wish to note the steps taken by UHSx to ensure that their capital developments are constructed and operated in a sustainable manner.

Supporting Documentation

1. Appendices [delete if not applicable]

1. Information provided by University Hospitals Sussex NHS Foundation Trust on the Trust capital programme.

University Hospitals Sussex
NHS Foundation Trust

Capital Development & Property update Royal Sussex County Hospital

Brighton and Hove Health Overview and Scrutiny Committee

Wed12 July 2023

Contents

- Introduction to Capital Development and Property
  - James Millar - Deputy Director of Capital Development and Property
  - Mr Peter Larsen-Disney - Clinical Director 3Ts Redevelopment Programme
- Newly opened Louisa Martindale Building
- 3Ts stage 2&3, including new Sussex Cancer Centre
- Summary of further capital projects at RSCH
- Focus on £48m Acute Floor Reconfiguration programme
  - Gordon Houliston - Divisional Director of Operations | Medicine Division (RSCH)
  - Dr Maria Grech - Emergency Department Clinical Lead & Consultant (RSCH)
- Questions

Introduction to Capital Development & Property

- **University Hospitals Sussex** – seven main hospitals in Sussex, including St Richard's in Chichester, Worthing Hospital, Southlands in Shoreham and Princess Royal in Haywards Heath
- **Brighton & Hove** – Royal Sussex County Hospital, Royal Alexandra Children's Hospital, and Sussex Eye Hospital
- **Capital budgets**
  - 2022/23 - £118m | RSCH £55m
  - 2023/24 - £106m | RSCH £39m
- **Scope, projects and aspirations**
  - Responsible for creation of new clinical and non-clinical space for the Trust and extensive refurbishment of existing spaces
  - Oversee the delivery and installation of highly complex services such as diagnostics, theatres, radiotherapy etc.
  - Manage the Trust's property portfolio including acquisitions and disposals

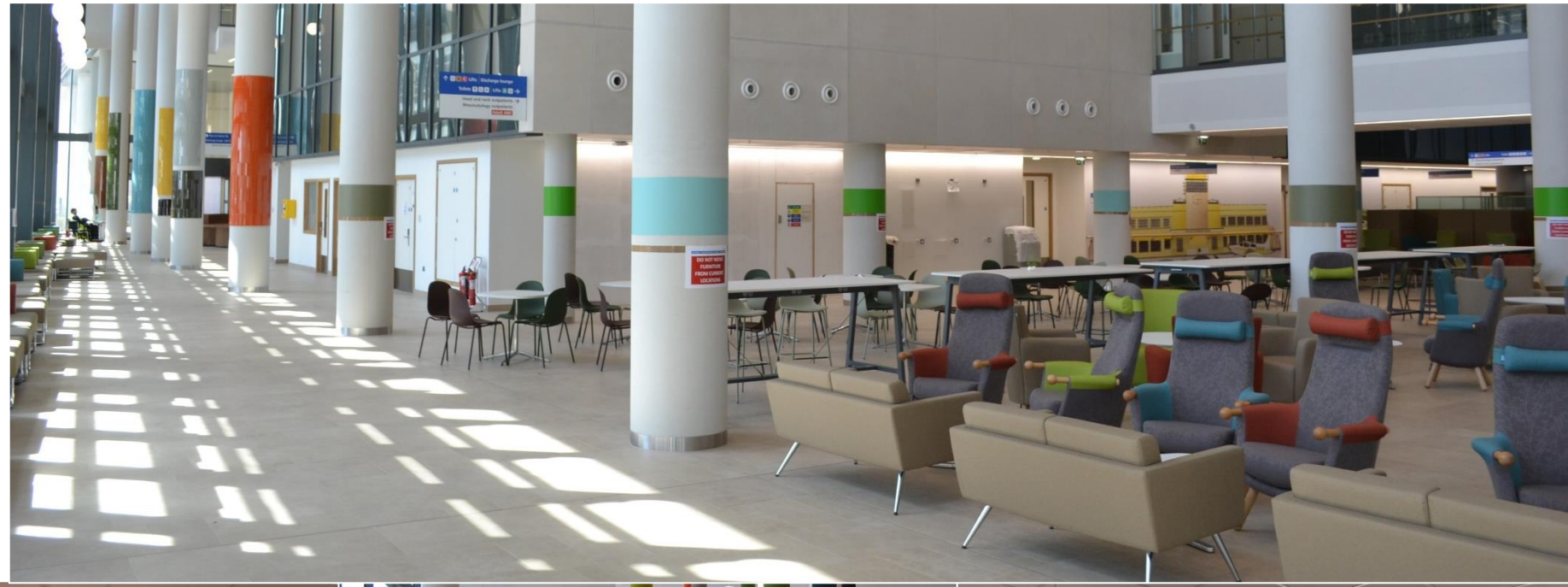
3Ts stage 1 – Louisa Martindale Building

- **State of the art** accommodation for outpatient, ward and specialist services that opened for patients last month.
- **Louisa Martindale Building** is the newest clinical building in NHS England. Alongside it is the Barry Building, the oldest.
- **Stunning sea views** from wards that are located in the upper half of the building.
- **65% of beds are in single rooms**, with the remainder in 4-bed single-sex bays.
- **Spacious and purpose designed** Outpatient services are located in the lower half of the building.
- **Better access from Welcome Space** and underground car park with 107 spaces for only patients and visitors.
- **£500m investment** is a once in a generation improvement, taking estate from C19th into C21st.

3Ts stage 1 – Louisa Martindale Building

University Hospitals Sussex NHS Foundation Trust

- Right, main public waiting area, level 1
- Below, left to right,
- Rehabilitation terrace
- Imaging waiting room
- The Welcome Space
- Spacious 4-bed bay with sea views



3Ts stage 2 & 3 – new cancer centre

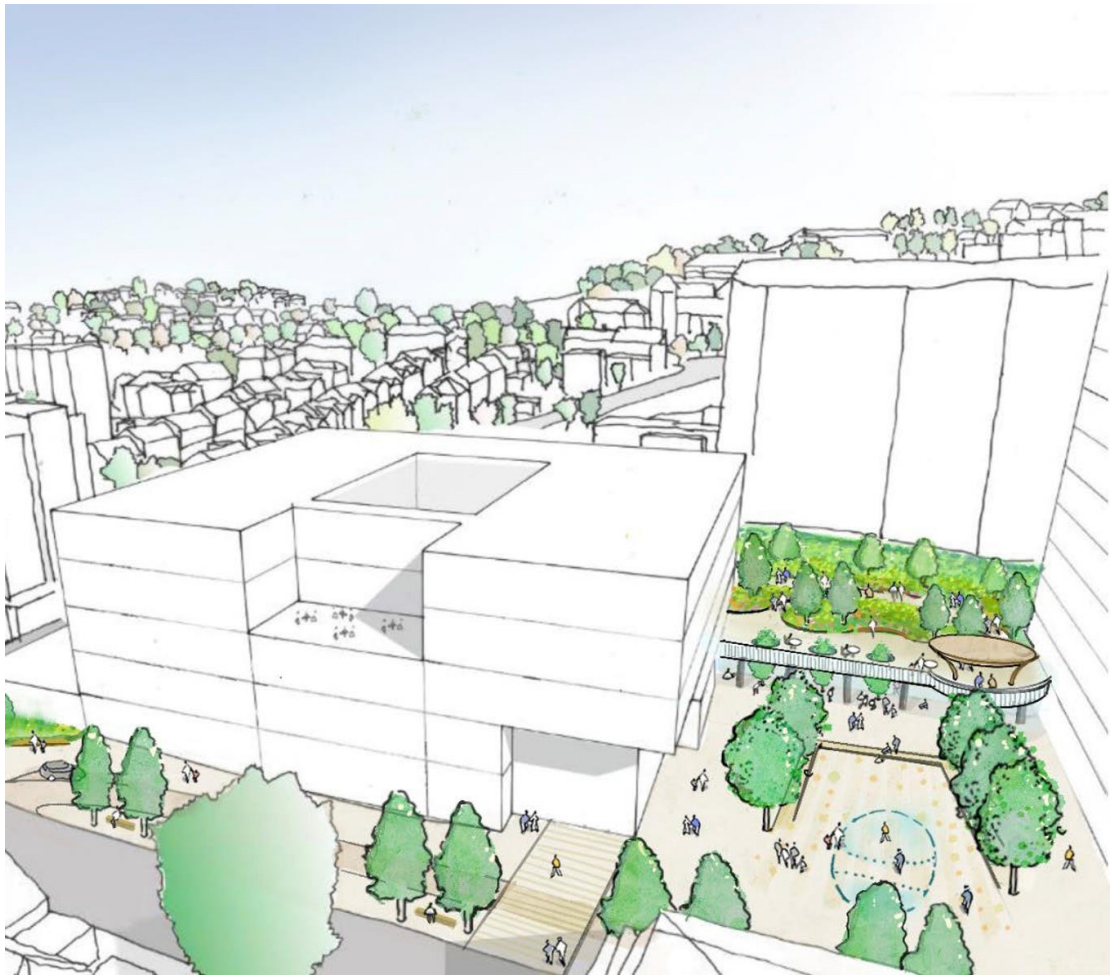
University Hospitals Sussex NHS Foundation Trust

- **Stage 2** - the C19th Barry Building is being demolished to make way for a Sussex Cancer Centre fit for the C21st
- Value of investment £154m
- Completion: Estimated 2026

- **Stage 3** - a new facilities yard for the RSCH estate
- Value of investment £17m
- Completion: Estimated 2027

Sussex Cancer Centre improvements

- Our cancer outpatient, treatment and wards will be brought together for the first time
- The building is designed to support the complex care needs of patients with cancer
- The opportunity to expand both our chemotherapy and radiotherapy provision will:
  - allow more patients to be treated closer to home
  - enable the service to meet the important 31-day time to treatment targets for more patients
- The potential to expand ward capacity will reduce:
  - transfers to other hospitals and
  - daily journeys from other hospitals for in-patient treatments at the Sussex Cancer Centre



Other RSCH capital projects 2023/24

- **New Paediatric Audiology department** with four acoustic booths, a vestibular room and ancillary spaces. An enabler for the Barry Building decant and 3Ts Stage 2. Recently completed. **£3.9m**

- **Cladding remediation project to enable helideck** to be safely used by larger helicopters carrying emergency patients without damaging the exterior of the higher levels of the Thomas Kemp Tower. **£1.05m**

- **Imaging system install** with 3 x CT, 2 x new X-Ray systems and a Fluoroscopy system, two of which are charity funded. **£2.6m**

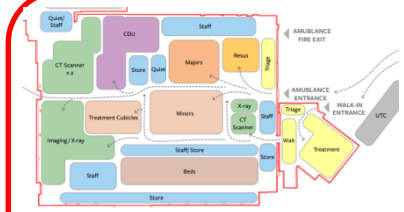
Acute Floor Reconfiguration Overview

Gordon Houliston, Divisional Director of Operations | Medicine RSCH & PRH
Dr Maria Grech - RSCH ED Clinical Lead & ED Consultant

Why redevelop the Acute Floor at RSCH?

University Hospitals Sussex NHS Foundation Trust

Facilities are **not fit for purpose** or in line with national standards



The current layout and size **does not optimise flow**

Modelling shows that **more clinical spaces** are needed to meet demand

Av. of **41.6%** of patients seen within **4 hrs**

Up to **33** patients in the ED corridor and median of **14**

12hr performance has been **steadily decreasing**

Waiting is a key theme in **37%** of A&E FFT responses

healthwatch Brighton and Hove

A&E needs "additional space" & "a clean environment where patients feel safe"

Care Quality Commission

Emergency Care Improvement Support Team

Safer, faster, better care for patients

Recommendations have been made to **improve** the physical department

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What do we want to achieve?

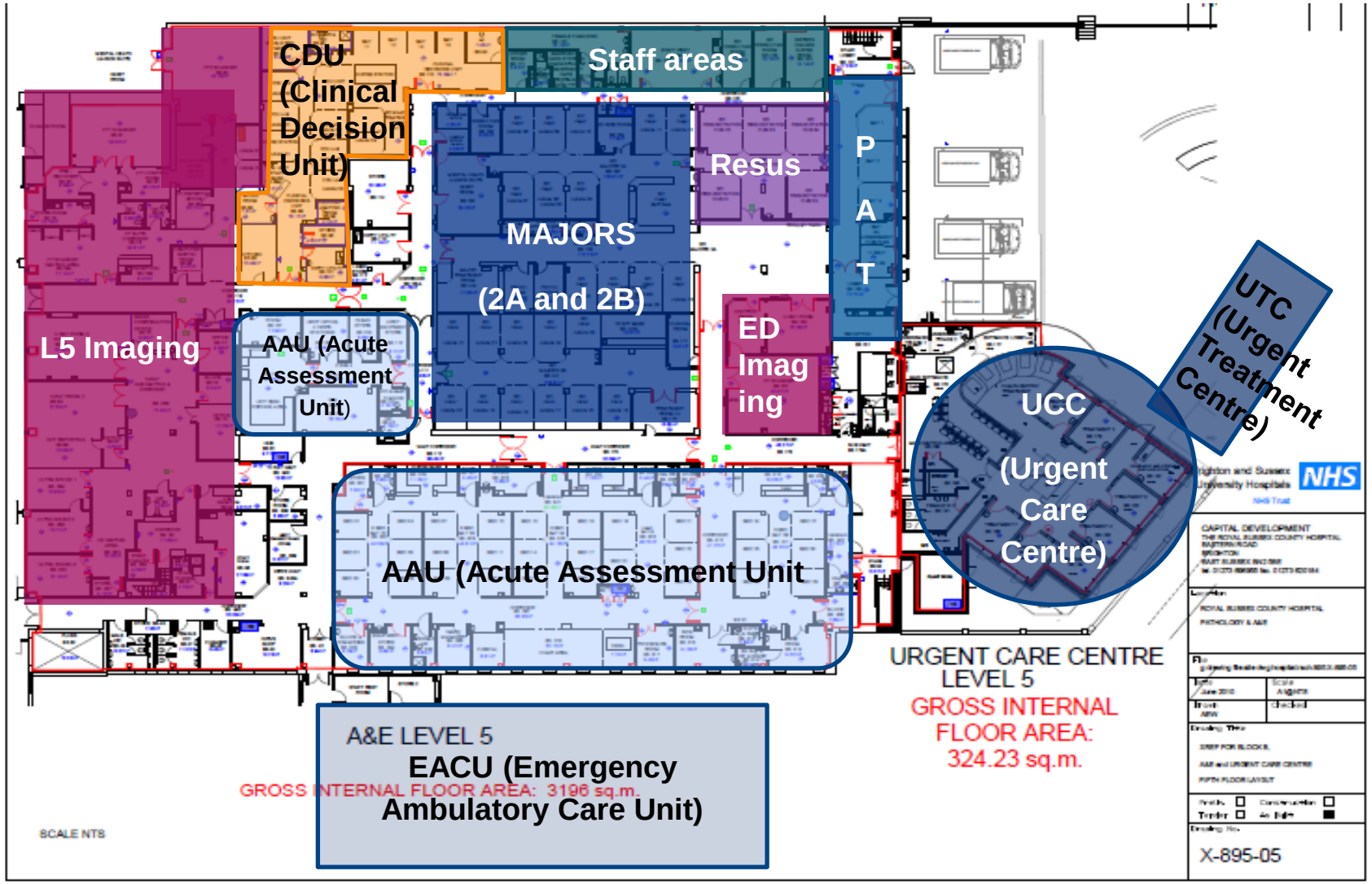
University Hospitals Sussex NHS Foundation Trust

We have five key objectives:

- Improve the environment for patients and their families
- Improve the working conditions for staff
- Deliver national best practice and new models of care
- Increase size of Acute Floor, including resuscitation area, and reduce waiting times for patients
- Improve multidisciplinary teamwork that optimises clinical safety and reduces risk

Aligns with True North for Patient, People, Quality, Sustainability and Systems & Partnerships

What current areas does it affect?



- Walk in entrance
- Urgent Treatment Centre, including waiting room and examination rooms
- Ambulance bays and arrivals
- Resus
- Patient Assessment and Triage (PAT)
- Majors cubicles
- Majors chaired area (Fit2Sit)
- Same Day Emergency Care (current Emergency Ambulatory Care Unit – EACU)
- Acute Assessment Unit (AAU)

What has already happened?

- UHSussex Trust Management Board and the Sussex Integrated Care Board have agreed £48m investment to reconfigure the RSCH Acute Floor over the next 4 years
- A programme team and governance structure has been set up to oversee and manage delivery of the programme
- The clinical team have agreed a brief that sets out what is needed from the project
- A building contractor and architects have been employed and are developing designs with the Acute Floor clinical teams and managers. Initial layouts are being reviewed to maintain the programme and budget.
- The clinical team has reviewed the model of care and have developed a future model that will deliver improvements in patient journeys alongside the physical environment improvements.
- A clinical audit has been completed to make sure we understand the future demand for each area of the Acute Floor
- Work is also underway by the clinical team to review the workforce requirements for the new department, and test the impact of the new clinical model in the new department using patient flow simulation software

What will the future department look like?

- Initial designs are still being developed and costed
- Department will increase in size by expanding into nearby areas recently vacated by other services moving to Louisa Martindale Building
- Clinical areas will be brought up to modern standards with larger and more cubicles across the department
- Some majors cubicles will be low sensory and suitable for patients with mental health issues
- The new department will deliver an expanded Resuscitation area, Patient Assessment & Triage (PAT) area, Urgent Treatment Centre waiting area and examination rooms and an improved environment throughout

What will improve?

Patient First Theme	Description
Patient	• Reduced crowding in Emergency Department (ED) majors and urgent care waiting room • Reduction in time to treatment, admission or discharge (4hr target) • Patients reporting a good or very good experience • Zero patients receiving corridor care • Increased privacy and dignity
Sustainability	• All walk in patients arrive through the Urgent Treatment Centre (UTC) front door • Clinical streaming from UTC for the sickest patients to majors or resuscitation area • Dedicated entrance for arrivals by ambulance
People	• Improved staff experience and facilities • Reduced staff turnover • Efficient working environment • Compliance with training requirements for all Emergency Department/Acute Floor staff
Systems & Partnerships	• Improve/consistently meet ambulance handover times against national standards • Increased streaming to ambulatory pathways (fit2sit) • Direct acceptance of GP expected patients to the assessment unit
Quality	• Improvement in patient outcomes • Reduction in patient harms

Next steps

University Hospitals Sussex NHS Foundation Trust

May/June 2023

- Refinement of the design by the capital and design team
- Clinical team to review the updated design
- Develop the overall phasing strategy
- Overall clinical model to be finalised including demand for units
- Test model using simulation software
- Workforce options and requirements
- Develop digital strategy
- Develop communication strategy

July/August 2023

- Work starts to clear areas vacated by move to Louisa Martindale ahead of construction phase
- Continue with design stages ahead of construction
- Further refinement of phasing strategy and plans on how the department will continue to run
- Confirm benefits to be delivered
- Develop Outline Business Case (OBC)

Summary

- The Acute Floor at RSCH has not been fit for purpose for a number of years but practicable solutions and funding have proved difficult to secure, until now
- The £48m reconfiguration programme has been made possible by the opening of the Louisa Martindale Building, enabling expansion into newly vacated space
- The construction project will be complex, with the Acute Floor remaining operational throughout – but the result will be a modern, purpose-designed emergency care environment for patients, their loved ones, and staff

Questions

Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item 9

Subject: **Winter Pressures 2022-23**

Date of meeting: **12 July 2023**

Report of: **Executive Director, Strategy, Governance & Resources**

Contact Officer: **Name: Giles Rossington**
Tel: 01273 295514
Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: **All**

For general release

1. Purpose of the report and policy context

1.1 This report presents information on how well local health and care services coped with winter pressures in 2022-23. The report complements the paper on winter planning 2022-23 that was presented to the 23 November 2022 HOSC meeting.

2. Recommendations

2.1 That Committee notes the information on health and care system performance over the winter 202223 period; and notes the lessons learnt from this.

3. Context and background information

3.1 Health & Care systems typically experience a surge in activity during the winter months. This is partly due to seasonal infectious illnesses (flu, norovirus); but also because colder weather exacerbates a range of pre-existing problems (e.g. respiratory and circulatory conditions). Extreme weather may also lead to greater levels of activity. The presence of Covid presents an additional risk at the current time. Increases in demand for services can put a severe strain on systems, most obviously emergency healthcare. This is particularly the case when systems are at or near to capacity at all times of the year.

3.2 In order to manage this seasonal demand surge, health & care systems are required to develop whole system (e.g. Sussex) winter plans. In November 2022, NHS commissioners and BHCC Health & Adult Social Care (HASC) presented on Sussex winter planning to the HOSC:

https://democracy.brighton-hove.gov.uk/ieListDocuments.aspx?CId=911&MId=10889&Ver=4

3.3 Typically, the HOSC considers a report on winter planning in the autumn of a year and then a report on how the system performed in reality in the spring or early summer of the following year. NHS Sussex has provided information on system performance over winter 22/23 (Appendix 1).

4. Analysis and consideration of alternative options

4.1 Not relevant to this information report.

5. Community engagement and consultation

5.1 Not relevant to this information report.

6. Conclusion

6.1 Members are asked to note health and care system performance across the past winter and to note the lessons learnt for future planning.

7. Financial implications

7.1 None for this information report.

8. Legal implications

8.1 There are no legal implications to this report.

Name of lawyer consulted: Elizabeth Culbert Date consulted 01/06/23

9. Equalities implications

9.1 None directly to this report for information.

10. Sustainability implications

10.1 None directly to this report for information.

Supporting Documentation

1. Appendices [delete if not applicable]

1. Information provided by NHS Sussex on system performance winter 2022-23.

NHS Sussex

NHS Sussex Winter 2022/23 Review and Evaluation

Report for Health Overview and Scrutiny Committee

July 2023

Improving Lives Together

1 TABLE OF CONTENTS

NHS Sussex Winter Plan: Update

1.0 Introduction

This report provides an update on the Winter presentation done at HOSC (23 November 2022), and evaluation of, the impact of the NHS Sussex Winter Plan. It identifies learning to be taken forward to further enhance planning for Winter 2023/24.

It includes:

- Performance and recovery of Urgent and Emergency Services
- Workforce pressures and staff wellbeing
- An overview of Urgent and Emergency system performance
- An outline of key performance measures for the system:
    - Emergency Department waiting times. Proportion of patients >12 hours from arrival
    - Number of admissions for Covid-19 and seasonal flu
    - Ambulance handover times

As previously reported, the delivery of the Sussex Winter Plan was overseen by a weekly Winter Board, chaired by the NHS Sussex Chief Executive, and attended by NHS Provider Chief Executive Officers, System Executives and Local Authority Directors of Social Care. They ensured that strategic leadership decisions required in response to emerging issues or risks through the Winter were taken in a joined-up way and considered the needs of our population and the needs of staff working across both health and care.

The Sussex Winter Plan was informed by detailed capacity and demand modelling with evidence-based assumptions related to seasonal urgent and emergency demand trends, the forecast impact of further Covid-19 waves, and seasonal flu related demand.

2.0 Our delivery plan:

2.1. Discharge, including rapid improvement workstream actions

As previously reported most patients in Brighton and Hove continue to be discharged home from hospital without the need of further support. However, for the small proportion of patients who might need social care, rehabilitation services or longer term residential or nursing care to support their discharge, the health and care system has collaborated to develop and implement full plans to support people over the winter period. This has included additional health, social care and voluntary sector capacity[1] to support people to return home; additional bedded capacity for people who are ready for discharge and need further assessment for their longer-term care needs; a range of measures aimed at improving the workforce capacity in the care market; and additional support for

[1] Home from Hospital and Assisted Discharge services

carers. Enhanced work with the councils is also supporting discharge pathways for more vulnerable and complex patients who are homeless or have housing difficulties.

Additional capacity for Winter

Within the context of this wide range of additional capacity and support in Brighton and Hove this winter, there was a sustained reduction in the numbers of patients who are assessed as medically ready for discharge and are waiting to be discharged.

Additional homecare hours (over 300 a week) and additional beds (over 30 new step-down beds) were secured for the winter and into spring, drawing on additional national funding. Specialist beds e.g. Homeless step down for patients with additional complexities were commissioned to support flow, and a pilot project to increase the in-reach therapy available across all our beds to get people fitter, quicker, was rolled out. A weekend discharge team was mobilised alongside key additional workforce to identify patients more rapidly for intermediate care services earlier in their pathway, which directly led to improvements in rates of weekend discharges. We increased the presence of health and social care at the front door of our acute hospital, supporting patients with what they needed to get them home and to prevent the need to be admitted. Other schemes including increasing utilisation of Voluntary Sector capacity to support discharge alongside Personal Health Grants were mobilised to improve system flow, patient support, and experience. Social Care Colleagues increased their ability to provide CareLink and other technology enabled services, keeping people safer at home. The 'High Intensity User Service' was expended, identifying, and then supporting patients who present very frequently at ED, often for reasons outside of an acute medical crisis.

2.2. Out of hospital urgent care rapid improvement programme

The focus of the out of hospital urgent care workstream was to improve ambulance response times by improving join up and input from alternative services to best support our patients.

As previously reported a key development has been the Admissions Avoidance Single Point of Access (AASPA). This went live on 14 December 2022. It provides a single 24/7 telephone number for South East Coast Ambulance Service (SECAmb) for professionals. It is a clinically led service where SECAmb crews are able to discuss a patient's condition, determine the right service for the patient and once clinically referred, have the confidence to leave the patient safely at home where clinically appropriate to do so, allowing the crew to get back on the road. It connects crews into alternative services such as Urgent Community Response services and reduces the number of patients being conveyed to hospital.

The ambition is to expand this service to become the single access point for all admissions avoidance contacts from health care professionals, including GPs, across Sussex. This means that for some people for whom other services can best meet their needs, they do not need to be taken to hospital for assessment or admission.

The continued development of the AASPA is a recognised priority in the NHS Sussex 2023/24 Shared Delivery Plan (SDP) and will be taken forward as a priority workstream within the NHS Sussex Urgent and Emergency Care Delivery Programme.

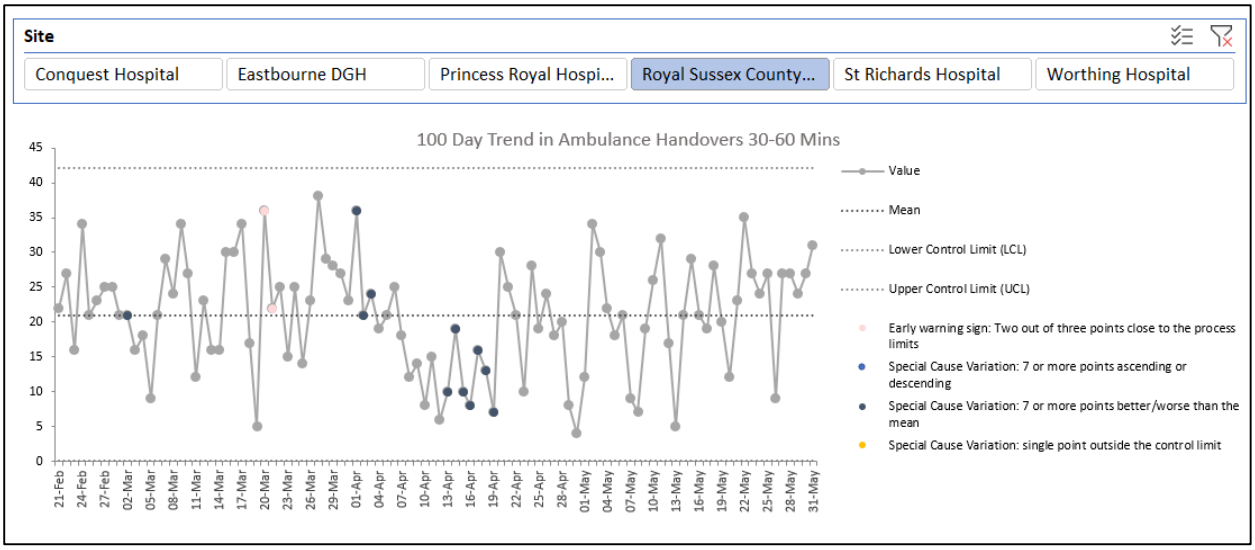
2.3. Improvements in ambulance performance

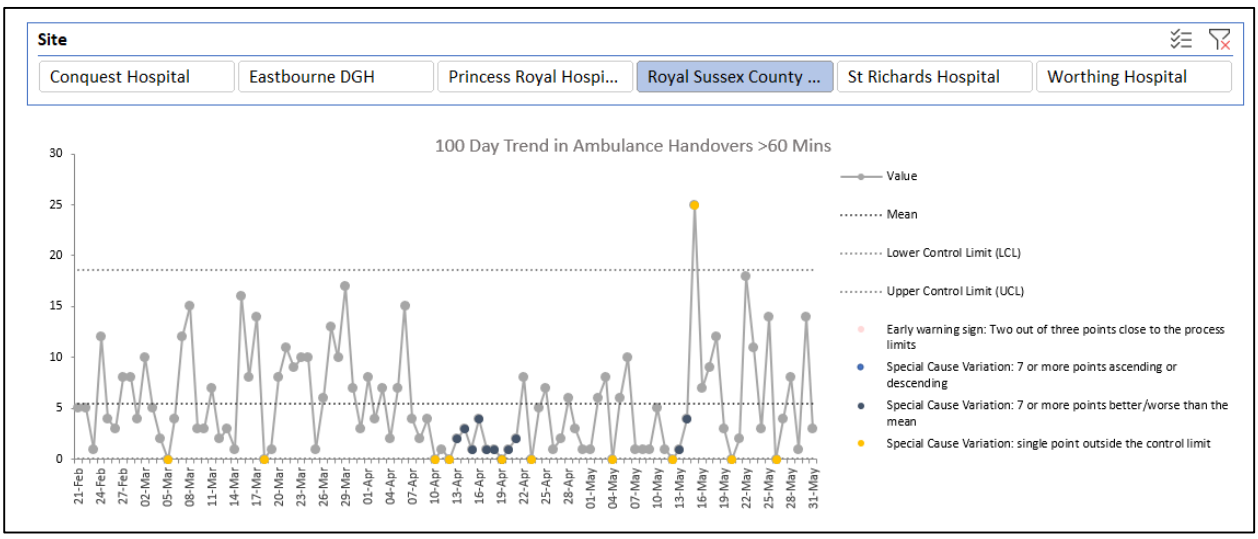
Overall, there has been continued high demand and the ambulance service has not consistently been able to meet its national response time targets.

Developments such as the rollout of the pan-Sussex Admissions Avoidance Single Point of Access, the funding of additional SECAmb resource to embed change and close working between SECAmb and community teams have been positive, and we expect to see performance improvements as the utilisation of alternative community pathways to reduce avoidable dispatch and conveyance increases. Sussex ICB has recently taken over as lead commissioner of the service from Surrey Heartlands ICB and will oversee the implementation of CQC actions which will contribute further to service improvement.

Ambulance handover delays continue to be an area of key focus across our system and the acute hospital sites have worked closely with SECAmb on improvement plans to ensure no delays.

Royal Sussex County Hospital Ambulance





2.4 Improvements in 111 performance

Following significant pressure and increases in call volumes experienced nationally, which saw call abandonment rates approach 50% in December, activity has now reduced to closer to seasonal norms and the abandonment rate has been reduced to between 15.44% and 18.65% between January to March. Clinical contact rates within the Clinical Assessment Service have exceeded 50% ensuring that patients can talk to a clinician when they need to. Where call handlers reach an initial disposition of either Emergency Department (ED) or for ambulance dispatch, clinicians continue to validate these calls to ensure either an Emergency Department or ambulance are appropriate with over 45% of people able to be directed to a more appropriate service for them.

Recruitment and training are ongoing to achieve the target establishment for call handlers and deliver the required improvements to move towards achieving 95% of calls being answered in 60 seconds and to reduce call abandonment rate to <5%. Trajectories for attainment are being agreed through contract management mechanisms. In the interim, additional capacity has been secured from VOCARE, a national provider of urgent and out of hours services commissioned by NHS England, as a temporary arrangement which has been in place from December 2022, whilst recruitment is ongoing and to meet the immediate need.

We continue to ensure improvement actions and targets are robustly overseen through agreed contractual and governance mechanisms.

2.5 Acute Hospital Urgent Care Services

As previously reported our plans to improve flow to our co-located and stand-alone Brighton Walk in Centre and the Urgent Treatment Centres (UTCs) have included increased face to face GP appointments and additional clinical workforce at Lewes Urgent Treatment Centre. These measures further improve the capacity of these services available to local people, therefore freeing up more time for the emergency medics to treat the seriously unwell.

Our local hospitals have continued to operate flexibly to support flow through their organisations by responding to varying levels of demand through opening additional escalation areas to increase the amount of bedded capacity available, ensuring access and support is available for the population of Brighton and Hove.

2.6 Acute Hospital Emergency Care Services

The winter pressures on Emergency Departments were considerable. Services to support admission avoidance, redirection away from Hospital and alternatives to hospital were fully utilised.

The performance of the system was measured by 4 clinical triggers:

1. Number of ambulance handover delays >60 minutes
2. Number of patients in the Emergency Department >12 hours
3. Number of patients receiving care in Emergency Department (ED) corridors
4. Number of super surge beds open (non-bedded areas used for inpatients)

The above metrics and associated triggers were used in addition to the existing system agreed Operational Pressures Escalation Levels Framework (OPEL).

Brighton and Hove A&E Delivery Board areas will operate Operational Pressures Escalation Level (OPEL) 1 when operating within normal parameters. At OPEL 1 and 2, we would anticipate operations and escalation to be delegated to the relevant named individuals in each organisation across the A&E Delivery Board. At OPEL 3 and 4 however, it is expected that there will be executive level involvement across the A&E Delivery Board.

The above metrics were and continue to be the principal measure of escalation and pressure levels across the system.

The framework was developed to identify site and acute hospital based escalation triggers for each of the 4 key acute metrics. The triggers were calibrated in a consistent way across all acute sites using historic activity data and are aligned to the variation in normal A&E demand observed at each site.

The response to these triggers is defined within action cards that have been developed for each organisation which describe the actions required to support de-escalation.

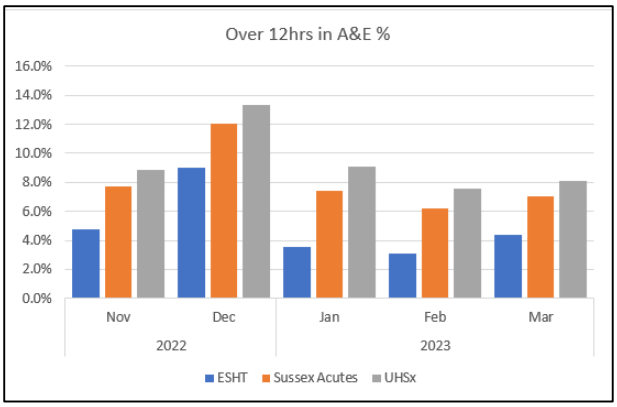
2.6.1 Length of stay in the Emergency Departments

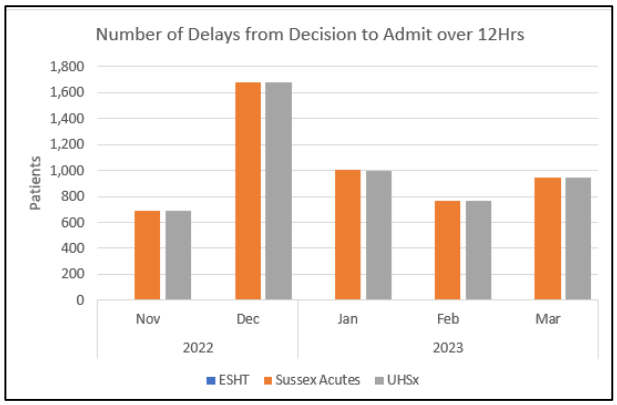
The length of stay for patients within the Emergency Departments was impacted by a number of factors such as Covid-19, Influenza and Industrial Action. The performance is reflected in the graphs below. The impact has reduced since its peak in December 2022.

The Royal Sussex County Hospital saw high numbers of patients waiting >12 hours in the Emergency Department from the time a decision to admit them to hospital was made. The reason for the delays within the Emergency Department is multifactorial:

- Insufficient capacity across the hospital to support the current level of demand the hospital has been seeing.
- A reduction in the number of patients medically fit for discharge in acute hospital beds as result of the increased capacity. Key challenges to timely discharges were complexity, COVID and challenges in the care market.

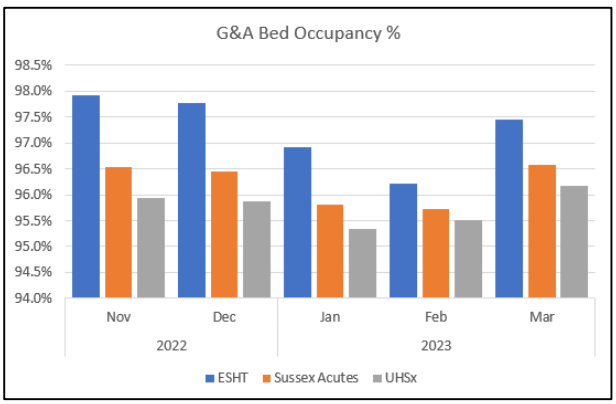
The Princess Royal Hospital saw a small number exceeding 12 hours.





2.6.2 Hospital Occupancy

Hospital occupancy across Sussex continues to be high. Whilst there was a slight decrease in January and February 2023, March 2023 saw a slight incline.



2.7 Out of hospital pathways

2.7.1 Virtual Wards

Virtual wards provide an alternative for patients, who would otherwise be in hospital, to receive the acute care, monitoring, and treatment they need at the place they call home (including care homes) safely and conveniently. The model was successfully launched in Sussex in December 2022 and maximum capacity achieved has been 112 against 107 plan in April. Up to 25 May 2023 3585 patients have benefited from the new service in in Sussex, Supporting admission avoidance and timely discharge. The service offer in B&H includes Respiratory, Hospital at home, Community Respiratory and Frailty going live by March 24, with a minimum capacity of 35. In addition to adult Virtual Wards services, As of May 2023 Sussex Virtual Wards started to capture Childrens and Young Peoples capacity provided by Acorns at UHSx. By March 2024, the total Sussex capacity will be 146.

There continues to be very positive patient feedback on this service and further case studies will promote the use of the service this year.

2.7.2 Examples of other pathways

As previously reported, our Urgent Treatment Centres and Minor Injury Units (MIUs) continue to support patients where their condition is best suited to these settings. Our remote GP service, LIVI, has enabled patients to be reviewed and treated remotely where appropriate, therefore freeing up capacity for those with more urgent of complex needs to be seen by our Emergency Departments. Our Same Day Emergency Care (SDEC) services have also been enhanced through improved pathways between SECAmb and clinical services, removing the need to go via the Emergency Department; these services have also increased their medical workforce capacity to support demand for their services over the winter period.

Our work with our council and local voluntary and community sector continues to enable support to people who are homeless or have housing difficulties and those who may need help with more complex needs and people who need help with welfare benefits advice. Our Safe Spaces in Brighton City centre continued to operate on Saturday nights to support and advise vulnerable people as part of the night-time economy who may otherwise require support from an Emergency Department.

At times of pressure and peak demand we increased the capacity at Urgent Treatment Centre. This included GP cover at the Royal Alexander Childrens Hospital in response to Strep A

2.8 Increasing primary care capacity and improving care for people who are high risk of hospital admissions

Additional winter funds were made available, weighted for areas of high deprivation, to increase capacity during the winter months. In total, about £800k was made available initially to bring in additional clinicians, offer specialist clinics, and generally increase access to GP services across Sussex. This has resulted in approximately 39,000 additional appointments.

Respiratory Hubs were set up to meet the additional demand caused by paediatric Streptococcus A (Strep A). In December, an unusually high number of patients were attending practices, UTC and A&E with Strep A and Scarlet Fever symptoms. 5 hubs, 9 spokes and 3 remote services were launched from early January 23 – April 23 for GP Practices, 111 and UTCs to divert patients for same day appointments, to ease pressure on the system. The hubs were spread across Sussex and saw a total of 12,000 patients. Additional capacity was also provided at UTC's during busy periods.

The hub Brighton was at the Walk-in Centre by Brighton Station, with additional remote capacity covering the rest of the city. This offered 2022 Face to Face and 3162 virtual additional appointments between December 2022 and March 2023. These winter initiatives have now been independently evaluated by the Kent Surrey Academic Science Network, and draft findings confirm that they were welcomed by staff and patients demonstrated value for money. The full report will be available in July 2023 and will directly inform planning for winter 2023-2024.

Other schemes include a 'High Intensity User Service' -identifying and then supporting patients who present very frequently at ED – often for reasons outside of an acute medical crisis. In the first year of the service, in patients being support have experienced:

- 58% reduction in ED attendances
- 81% reduction in ambulance conveyances

- 31% reduction in non-elective admissions
- Service users reported improvements across multiple domains (happiness, loneliness and health interfering with social activities improved the most)

On 9 May 2023 NHS England and the Department of Health and Social Care issued their "Plan for Recovering Access to Primary Care" (PCRP). The plan builds on the Fuller Stocktake report and forms part of the Government's commitment to improve access to general practice outlined in its Autumn statement. The PCRP focusses specifically on the aspects of the Fuller Stocktake report that concern "tackling the 8am rush", with the stated aim of "reducing the pressure on General Practice" to allow it to stabilise and thus engage with the broader transformation agenda around themes such as Integrated Community Teams, as well as ensuring short- and medium-term improvements in patient experience and satisfaction. Its publication is timely given the ambitious programme of change set out in the Integrated community System Shared Delivery Plan (SDP). The ask for all systems is to produce a "System Level Access Recovery Plan" which will define our short medium and long term activities to improve the patient experience of accessing primary care, and will be presented to the NHS Sussex Board in Autumn 2023, with a further update to be provided in February/March 2024.

2.9 St Johns Ambulance service to the homeless

Targeted Podiatry and Wound care Support through a roving clinic with inclusion of social prescribing has supported a reduction in hospital admissions and attendance to A&E. Static and roving clinics in locations that meet the needs of the service users providing specialist wound care and specialist Podiatry care were in place all over winter. The service also provides holistic support: sign posting and advocacy, first aid, a safe space, flu vaccinations, sexual health advice and pregnancy testing, smoking cessation.

Opening hours:

Monday and Tuesdays 14.00—20.00 pm
Alternate Fridays 14.00—20.00 pm
Alternate Saturdays 09.00- 15.30 pm

2.10 Mental Health

The plans for mental health services over winter ensured a particular focus on supporting people with mental health needs in the right place for them; reducing the number of patients having to receive inpatient support outside of the county; and reducing delays in supporting patients to be discharged from inpatient services. There has been a significant amount of work undertaken with Sussex Partnership NHS Foundation Trust to support this, as well as across the wider system. Whilst mental health pressures have continued beyond the peak winter period the sustained reduction in patients receiving their inpatient care outside of Sussex has continued. The number of patients being assessed as requiring acute psychiatric admission over winter has been on a reducing trend although patients have waited longer for admission than is ideal. The root cause of the challenge in accessing timely inpatient mental health care is one of flow, rather than demand, primarily due to the number of patients whose onward care from hospital is delayed.

Key actions have included an increased use of Havens (dedicated, mental health crisis assessment facilities that provide support and assessment for adults 24 hours a day) especially to provide an alternative to waiting in an Emergency Department, the promotion of the Sussex Mental Health Line and Staying Well Cafes, the development of a Section 136 support service in Eastbourne & Worthing and the Blue Light Triage service in North West Sussex.

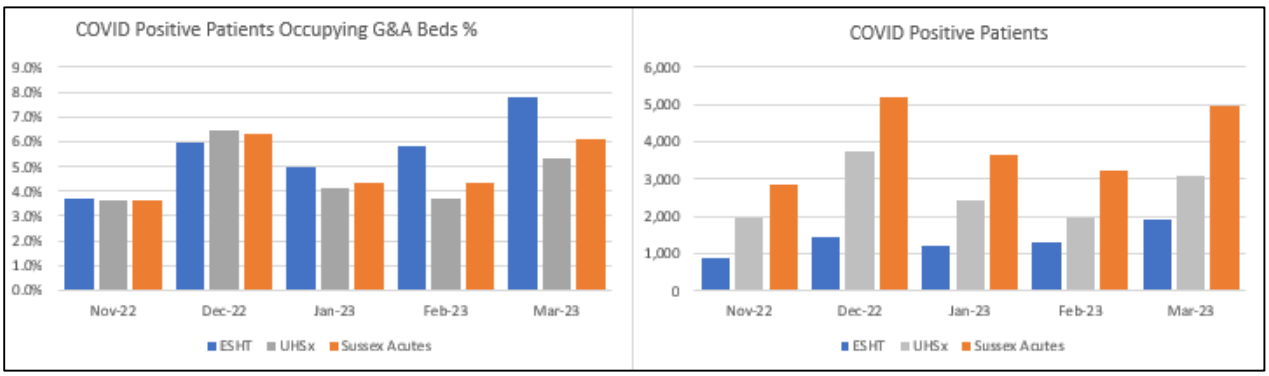
The highest number of total non-SPFT beds was 103 (81 SPFT commissioned acute Independent Sector beds in Sussex and 22 out of area placements) on 14 September 2022 which reduced to 0 in November 2022. There have been small numbers of Out of Area Placements used since that date and the current number of OAPs is two (May 2023).

As part of our system discharge plans, we have also invested in initiatives over winter to reduce the length of time patients are waiting to be discharged from mental health inpatient settings and to support children and young people who attend our Emergency Departments with a mental health need.

2.10 Infection Prevention and Control

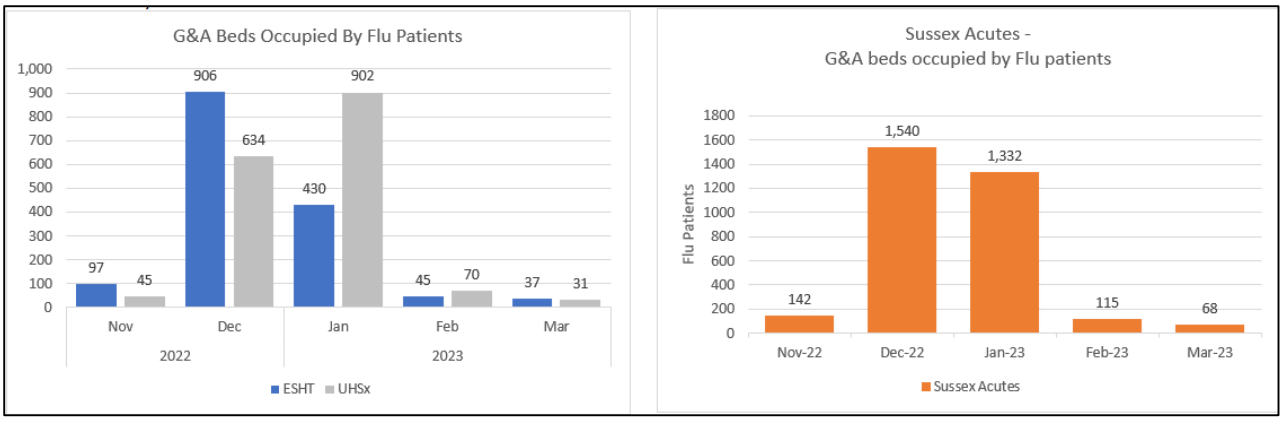
This winter saw an increase across viral outbreaks and secondary bacterial infections such as COVID 19, Influenza, Norovirus and Group A Streptococcus (GAS). The Sussex Integrated Care System have a dedicated Infection Prevention Team that supports all NHS and social care providers with maintaining high standards of infection prevention to maintain high quality and safe services.

2.11 Covid Admissions



2.12 Influenza Admissions

Influenza affected bed availability during December and January with a high number of admissions across all hospitals in Sussex. This significantly reduced from February onwards.



2.13 Workforce

2.13.1 Workforce Capacity

Over winter is an identified risk within our system plan and this has been further exacerbated by the current industrial action affecting our providers and ambulance services.

The following measures are in place to ensure that the workforce issues arising from industrial action are addressed:

The sharing of risks and issues at the weekly System Chief People Officer meetings across all our organisations

Shared intelligence about local derogations and liaison arrangements with strike committees

Sharing of real-time information about staff numbers participating in industrial action and services affected and regular communication with the Regional Operations Centre to support the smooth management of services across strike days.

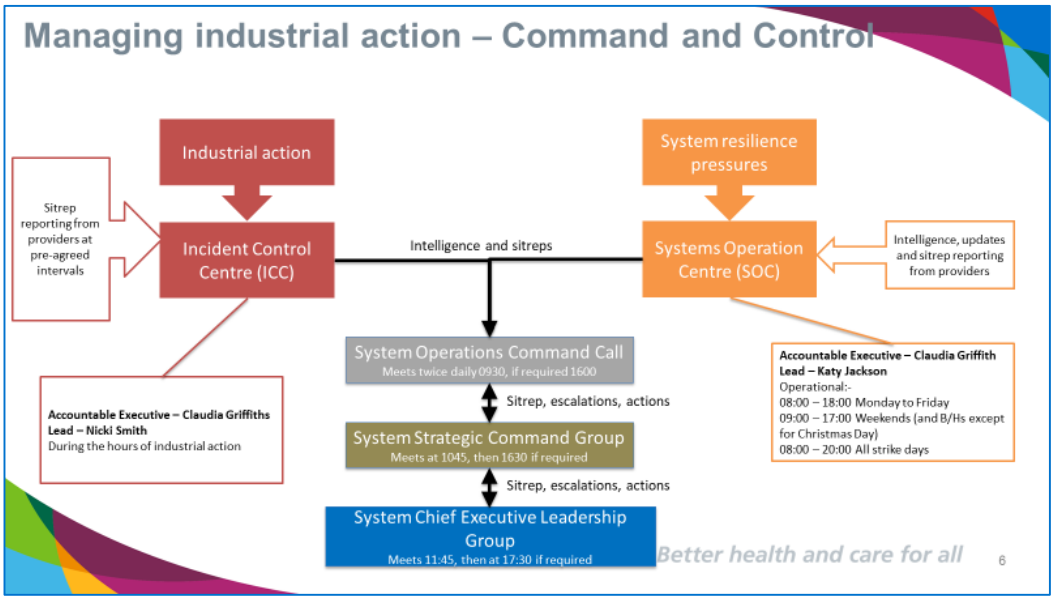
2.13.2 Industrial Action

Periods of industrial action have affected all aspects of the health and social care system. So far in 2023 there have been 28 days of industrial action affecting healthcare providers in Sussex from a number of healthcare workers unions, plus education and transport workers unions.

The ICB has managed a co-ordinated Sussex response to every period of industrial action to date that has had an expected impact on healthcare. Throughout each period of industrial action a battle rhythm of command and control meetings are set run to ensure a coordinated response, Incident Coordination Centres are established, virtually or physically, and collaborative working with system partners is coordinated by the ICB to ensure robust planning for service delivery across all industrial action days and management of the actions that need to take place to mitigate any risks that emerge during the action.

This is coordinated through the Sussex Incident Control Centre (SxOC) which operates 08:00-18:00 seven days a week. During periods of Industrial Action, the SxOC opening times are extended to match South East Regional Operating Centre opening hours. Health organisations across

Sussex also have similar incident control arrangements in place, with a robust and well-tested on-call mechanism managing the response out of hours.



System partners work together to develop plans to identify and mitigate the potential risks associated with the industrial action, ensuring the system is in the best place possible entering into periods of action.

The key impact of industrial action on the system is the addition of significant operational pressures on an already pressured system and exhausted workforce, and the knock-on effect of the rescheduling of elective care, which is only undertaken when absolutely necessary to ensure patient safety. To mitigate this staff are moved around and rotas re-worked to prioritise critical areas, agency and bank staff are brought in where available to provide cover, and elective care appointments are re-booked as soon as possible to avoid delays to care.

System-wide debriefs, co-ordinated by the ICB, are undertaken after each period of industrial action and identified learning is shared and used to inform planning for future periods of action.

2.14 Planned Care Recovery Programme

The Sussex Planned Care Recovery plan has focussed on improving access to services for patients and reducing waiting time by maximising existing capacity across the system and transforming how care is provided. While winter pressures and industrial action have led to some cancellations of planned care, every effort is made to rebook those patients who are affected at the earliest opportunity.

2.15 Public Health – Brighton and Hove

The Public Health protection teams and the ICB infection control teams have continued to work closely together providing support to the Sussex care provider market with infection prevention control support.

3.0 Learning from the Winter Plan and Actions Taken

3.1 Winter Plan Review and Feedback

In April 2023, system partners were asked for their feedback as to how we had performed against our given aims. Respondents were asked to answer 4 simple questions:

1. What were our high-level achievements?
2. What have we learnt?
3. What are our outstanding priorities?
4. What is our Forward Delivery Approach?

Responses were received from across the Sussex system, including ICB Place Based OPEX's, Acute Providers, Clinical Leads, Community Providers, Mental Health and Local Authorities.

3.2 Top Themes:

- Strategic Vision
  - To develop and align place-based models for integrated health and care within overarching NHS Sussex strategy.
  - To evaluate outcomes and focus on most impactful as priorities for the future.
  - Develop a decision-making forum to develop and implement plans to support NHS Sussex Strategy.
  - Continue with Sussex Discharge Frontrunner Programme
- Winter Planning
  - To have a dedicated System winter clinical lead.
  - To use a coordinated approach to winter planning, in particular discharge.
  - To achieve clarity on recurring funding and budgets as early in the year as possible.
  - To develop models now for next winter.
- Planning
  - To balance central guidance vs local risk and longer-term planning for surge periods.
  - For Operational Exec Groups (OPEX) continue to plan/ mitigate operational pressure across the system including industrial action.
  - To consider resource to provide consistent comparable system wide evaluation of schemes.
- Pathway Redesign
  - To establish a cross ICB Task and Finish Group to support continued SECAmb delivery and pathways optimisation.
- Digital Integration
  - A dashboard of system impact to be utilised to ensure data-driven approach and ongoing monitoring against initiatives.
- Collaboration
  - To continue to reduce organisation barriers to improve integrated working.
  - To maintain cross service and multi system engagement.

Learning from evaluation of seasonal plans is routinely incorporated in future planning where it is within the gift of the ICB. The learning has been widely shared across all the partners within the Integrated Care System.

The ICB have also taken part in a Nationally lead review of Winter 2022/23. It is likely that this will influence the shape of National priorities for Winter 2023/24.

4.0 Summary

In summary the operating model implemented for winter implemented by the system has enabled the system to effectively respond to and manage periods of significant exceptional pressure and elevated system risk as a whole system.

The winter operating model meeting cadence enabled the system to respond in an agile way with the model and system escalation framework being rapidly adapted and further developed in response to live learning and the specific issues and risks identified. However, there is a need to consider how clinical input into the system UEC surge planning and delivery/oversight infrastructure can be further strengthened ahead of next winter as part of the System Operations Centre function' further development.

The approach to system capacity and demand modelling to inform surge planning and risk mitigations needs to be further developed to provide a more accurate assessment of the impact of deployed capacity schemes and there is a need to strengthen the alignment with internal provider capacity and demand models.

The focus on system agreed priority areas for rapid improvement over winter to provide risk mitigation has resulted in a range of positive achievements being achieved by the system.

Priority area improvements for next winter will be included as part of the system's programme delivery architecture for 2023-24.

Healthwatch Brighton and Hove Annual Report, 2023

healthwatch
Brighton and Hove

Your health and social care champion

Healthwatch gathers thousands of comments and lived experience from people about a wide range of health and social care services.

People tell us how services do or don't work well together.

We make sure NHS leaders and other decision-makers hear what people and communities have told us and ask that they use this feedback to improve care for all.

Each Healthwatch has a statutory duty to produce an annual report, detailing its activity over the past year and to publish this by 30 June.

It is a requirement to share this with the Overview and Scrutiny Committee.

It is also shared with Healthwatch England, the Care Quality Commission, Senior Integrated Care System leaders, Local Authority, partners and the public.

Achievements

- 5 staff, 45 volunteers, 12 Directors
- 16 reports (covering dentistry, mental health and accommodation needs, GP access, digital exclusion, escalating the voices of LGBTQ+ communities)
- Engaging nearly 2000 people
- Nearly 1000 meetings attended.

Some of our impacts are seen in:

- Recommissioning of care home providers and Non-emergency patient transport
- Escalation of concerns about NHS dentistry in Parliament
- Patients' views reflected in JSNA strategies for Mental Health and Digital Inclusion
- Escalation of concerns to reverse plans to close public toilet facilities
- Delivering improvements to hospital environments and nutrition
- Delivering an annual conference with partners about the ICS
- Helpline supporting 240 people with concerns, queries, complaints
- Supporting the delivery of 'Improving Lives Together' and Shared Delivery Plan.

Our future priorities

Aligned to the city's Health Wellbeing Strategy and Shared Delivery Plan – to ensure that patient voices will be at the heart of any changes to deliver our integrated care system:

- Children and Young People
- Access to primary care
- Supporting our local Hospitals
- Health inequalities

But we will continue to listen to everything patients tell us and escalate their concerns, even if these are not part of the stated priorities.

As an organisation:

- Work more in partnership
- Raise our profile
- Challenge and act as a 'critical friend' using our independence

For more information

Healthwatch Brighton & Hove
www.healthwatchbrightonandhove.co.uk

e: Alan Boyd, CEO - alan@healthwatchbrightonandhove.co.uk

e. Geoffrey Bowden, Chair Chair@healthwatchbrightonandhove.co.uk

healthwatch Brighton and Hove

Together

we're making health and social care better

healthwatch Awards 2022 Highly commended

Annual Report 2022–23

"In the last ten years, the health and social care landscape has changed dramatically, but the dedication of local Healthwatch hasn't. Your local Healthwatch has worked tirelessly to make sure the views of local people are heard, and NHS and social care leaders use your feedback to make care better."

Louise Ansari
Healthwatch National Director

Contents

About us

Healthwatch Brighton and Hove is your local health and social care champion.

We make sure NHS leaders and decision makers hear your voice and use your feedback to improve care. We can also help you to find reliable and trustworthy information and advice.

The Healthwatch vision

To bring closer the day when everyone gets the care they need.

The Healthwatch mission

To make sure that people's experiences help make health and care better.

Healthwatch values are:

- **Listening** to people and making sure their voices are heard.
- **Including** everyone in the conversation – especially those who don't always have their voices heard.
- **Analysing** different people's experiences to learn how to improve care.
- **Acting** on feedback and driving change.
- **Partnering** with care providers, Government, and the voluntary sector – serving as the public's independent advocate.

Message from our Chair

Geoffrey Bowden, Chair Healthwatch Brighton and Hove

It has been a year of change. We bid farewell to my predecessor Fran McCabe, who retired and to fellow board members Karen Barford, Neil McIntosh and Catherine Swann. Chief Executive David Liley also retired, and we welcomed Alan Boyd as our new CEO.

In the meantime, the NHS and social care has rarely been out of the headlines. Sometimes for the wrong reasons, but also for the right ones – particularly when highlighting the dedication of NHS staff striving to deliver care under the strains and stresses of Covid and its aftermath.

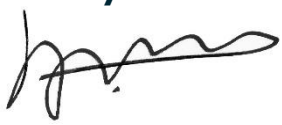
Throughout, we have played our role by listening to the concerns of local people and shining a light on areas where our recommendations could lead to service improvements, whether that was looking at the availability of NHS dentistry, access to GP services, or digital exclusion. Exercising our powers under Enter and View, which had been suspended during Covid, gradually restarted.

Our home team produced 16 reports, and, in the process, engaged with more than 1,500 individuals. Additionally, we arranged panel discussions to identify the public's priorities for our workplan and organised a conference looking at the impact of the new Integrated Care System.

> *"None of this would have been possible without the dedicated support of our 45 volunteers, who clocked up 4,500 hours gathering data and attending meetings on our behalf. In fact, we were represented at more than 980 decision-making meetings last year."*

We have worked with neighbouring Healthwatch and collaborated with third sector organisations, such as Brighton and Hove Switchboard, all of which and much more, is covered in this annual review of our work.

Geoffrey Bowden



What other organisations say about us

"Healthwatch continues to make a significant and positive difference to the lives of people who have a mental health problem, a learning disability or who are neurodivergent in Brighton and Hove. We are constantly striving to improve the quality of care we provide to the local communities we serve. Healthwatch is a valued partner in helping us achieve this."

Dr Jane Padmore, Chief Executive Officer
Sussex Partnership NHS Foundation Trust

"We are delighted that Healthwatch Brighton and Hove is represented at Sussex Community NHS Foundation Trust's (SCFT) Patient Experience Group. They bring rich and valuable insight as well as a local health perspective to support SCFT deliver our ambitions within the Patient and Carer Experience and Involvement Strategy."

Howard Prescott, Associate Director of Quality and Safety,
Sussex Community NHS Foundation Trust

"It's been 10 years now since Healthwatch was established. Over that time our relationships have matured and embedded. The Council welcomes the role that Healthwatch plays in putting the peoples' voices at the heart of health and social care in the city and respecting their independence. I look forward to their continuing future critical challenge and observations / recommendations on how services are delivered to our local population."

Rob Persey, Executive Director
Health & Adult Social Care, Brighton and Hove City Council

"We have worked closely with Healthwatch Brighton and Hove over the last year, and really value their support, thoughtful input and commitment to ensuring that the voices and experiences of the people and communities of Brighton and Hove are at the centre of our work and help to further improve health and care in the city. In partnership, we have focused together on the development of our system five-year health and care strategy and our Shared Delivery Plan, and a number of key areas including outpatient transformation and the redesign of non-emergency patient transport services. We have also worked collaboratively with Healthwatch to develop and use surveys effectively as a way to obtain views of local people on our priority areas of work.

I would also like to share our thanks to David Liley, who has been a key partner working with health organisations in the city for many years, and we look forward to our continued work with the new leadership and team to ensure that we focus on the needs of those living in Brighton and Hove, ensuring that the changes made can have a real impact on their health and their lives."

Lola Banjoko, Executive Managing Director of Commissioning for Brighton and Hove at NHS Sussex

"Healthwatch Brighton and Hove is an essential partner in our Sussex health and care system who enable the voices of people and communities across our city to be heard so that we can improve our health and care services to meet these needs. The Healthwatch team has also been a constructive and collaborative partner in the development of our five-year Sussex Integrated Care Strategy - Improving Lives Together - which has been built on what people and Healthwatch have told us.

As we finalise our Shared Delivery Plan, which sets out how we will turn this vision into reality, I look forward to continuing to work with the team at Healthwatch Brighton and Hove so that we can join-up and improve the access, experience, and outcomes from our health and care services to make a real difference to the lives of people in our city."

Stephen Lightfoot, Chair of NHS Sussex

"Joint working between Healthwatch Brighton and Hove and University Hospitals Sussex has continued to have positive impact on our services and the experiences of our patients throughout 2022/23. Support and challenge from Healthwatch, and representing the voice of our patients, has informed many improvements, including those relating to communication, feeding and our emergency department.

We are grateful to Healthwatch for their continued enablement of the patient voice and being a key partner for us in Brighton & Hove. We look forward to continuing this valuable work and developing further ways we support and enable one another for the benefit of our patients."

Dr Nicole Chavaudra
Director of Patient Experience, Engagement and Involvement
University Hospitals Sussex

"By engaging with people to ensure that their voices are heard, Healthwatch obtains feedback directly from those receiving care and support from the home care providers commissioned by the council. This feedback provides valuable insight into the experiences of those in receipt of these services, including what works well and areas for improvement. Healthwatch acts on the feedback they receive to support positive change for individuals alongside facilitating constructive developments within the sector."

Claire Rowland, Health and Adult Social Care Commissioner
Brighton and Hove City Council

"I very much welcome the development of a new Sussex wide role that builds on the existing constructive relationships NHS Sussex holds with our three Healthwatch organisations. Healthwatch play a critical role in helping the voice of local people to be heard and we are committed to continuing to strengthen how we work together."

Tom Gurney, Chief Communications Officer
NHS Sussex

Our work this year

Services can't make improvements without hearing your views. That's why over the last year we have gathered your views on topics, including GP access, dentistry, mental health, the quality of home care and many more. This allowed us to understand the full picture and feed your views back to services to help them improve.

Our work on Dentistry

Availability of NHS dentists

People have continued to tell us about their difficulties in accessing NHS dentists and we have heard of people only being offered private treatment.

We have continued to raise the impact this is having with partners and decision makers including NHS England, the Local Dental Committee (which represents dental practices in the South-East) and city leaders for health and social care.

To support patients, we published:

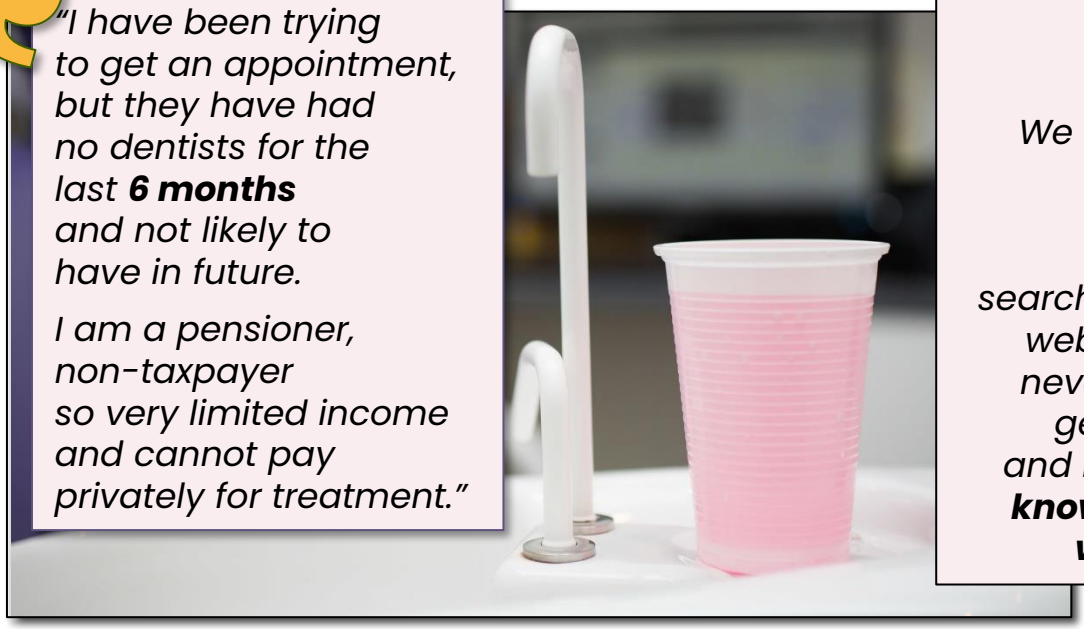
- A bulletin on the dental crisis in June to give background to the current crisis, a compilation of people's concerns and actions we'd taken.
- We led the development of a **Healthwatch in Sussex** patient leaflet, working with local dentists to produce 'A Healthwatch guide to your rights and accessing the treatment you need - what you need to know'. This is available on our website and was shared with every dentist across Brighton and Hove, as well as Councillors and MPs.

We continue to push for reform and better access to NHS dentistry:

- We led a joint response to a Parliamentary Inquiry on dentistry which was published on March 7th 2023.
- We have asked 16 questions in Parliament to the Minister for Health with the help of Caroline Lucas MP's office - read our report.
- We have given media interviews to ensure the impact this is having on people is not forgotten.

*"I have been trying to get an appointment, but they have had no dentists for the last **6 months** and not likely to have in future.*

I am a pensioner, non-taxpayer so very limited income and cannot pay privately for treatment."



*"Neither my partner nor I have had a dentist **since the pandemic started**.*

*We have called numerous dentists, constantly searched the NHS website (which never seems to get updated) and **really don't know what else we can do**?"*

Working across Sussex

See our **Healthwatch in Sussex** section to learn about the work on dentistry we undertook with our colleagues in Healthwatch in West and East Sussex.

Our work on General Practice

Access to GP appointments across Sussex

The impacts of Covid-19 continue to affect access to primary care. People have shared with us their difficulties in getting appointments and repeat prescriptions.

We conducted a survey asking for people's opinions about GP access and their preferences for online and face-to-face appointments and **851** people across Sussex responded. We compared some findings with a June 2020 project to see how people's views and experiences had changed in the two years since the pandemic.

Key findings:

- More than half of people had delayed making appointments when in need.
- Hybrid appointments (remote and face-to-face) were preferred by over two-thirds of people.
- 1 in 6 people did not want any form of remote appointment.
- Most people want an appointment without delay, and a more precise time to get a phone or video call.

Compared to our 2020 survey:

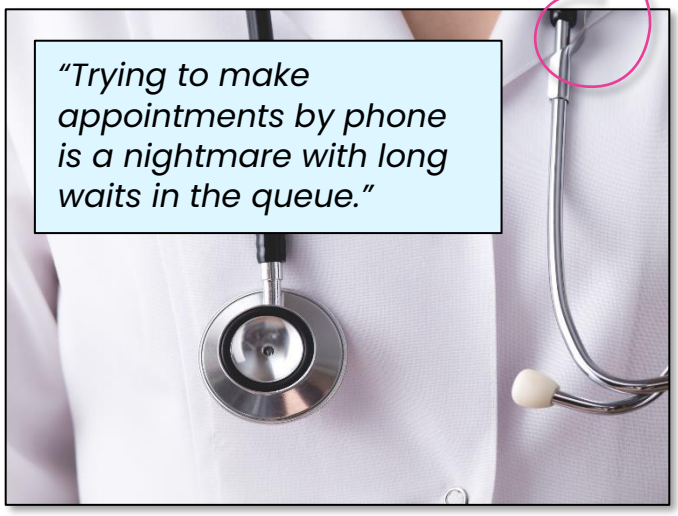
- A preference to see a GP without delay had increased significantly.
- A greater proportion of people showed some criticism towards remote GP appointments.
- More people agreed that 'only having phone or video appointments' would put them off getting support.
- Fewer people agreed that 'you could get just as much advice by phone or video compared to a face-to-face'.

Our impact

Our findings have been shared with the Chief Primary Care Officer at NHS Sussex. We also issued press release, resulting in an interview with BBC Sussex. Our data ties in with the ICS priorities where *'further increasing access to GP services'* was announced as one of four top priorities for the NHS in Sussex this year.

What next

We plan to further analyse the comments made by those who participated in our survey and to hold conversations with people to learn more about their experiences and opinions.



"My current GP practice has excellent access to both appointments and information. I can book appointments online or use the app. They then phone but will get you in for a face-to-face very quickly if needed. The receptionists are also lovely and cannot do enough to help."

Read the GP Access Report

Our work on General Practice

New Larchwood Surgery Hours

In 2021, New Larchwood Surgery reduced its opening hours to the concern of local residents, who asked for our help. We surveyed 385 patients to find out about the impact of this change, with **59%** of people being dissatisfied with the new opening hours and **81%** wanting to see the surgery open for longer.

By escalating patient's voices, we helped them reverse the decision and additional funding helped secure further sessions at the surgery, opening four days a week. In November 2022, our work supporting the patients of New Larchwood Surgery received a Highly Commended award from Healthwatch England.

> *"Many congratulations - your local Healthwatch has been shortlisted for one of these awards because your efforts and dedication have resulted in real impact, ensuring patients' voices are heard.*
>
> *Our impact awards demonstrate the many ways Local Healthwatch represent their communities and act as a force for positive change both locally and nationally."*
>
> **Sir Robert Francis KC**
> Then Chair of Healthwatch England

> *"I would like to thank you from the bottom of my heart for the sterling work you put in on our behalf. Now we have the final findings from you and consequently, the resulting actions from the CCG and GPs at the surgery."*
>
> **Anna de Wit, Chair, Coldean Residents Association**

Read the Press Release

Review of GP websites

Our volunteers conducted an independent review of the websites for all 34 GP practices in Brighton and Hove. We found a vast difference in the quality of, and ease of access, to information and identified websites that we felt needed support.

Read more about this pan-Sussex project in the **Healthwatch in Sussex** section.

5-year Review

This year, we looked back at our work on GP services over the last five years, summarising the key areas we have investigated since 2018. Our report highlights how much has changed, and what hasn't. We used your insights and escalated these with providers of GP services, those who commission primary care, the CQC and Healthwatch England.

Read the report

Our work with Local Hospitals

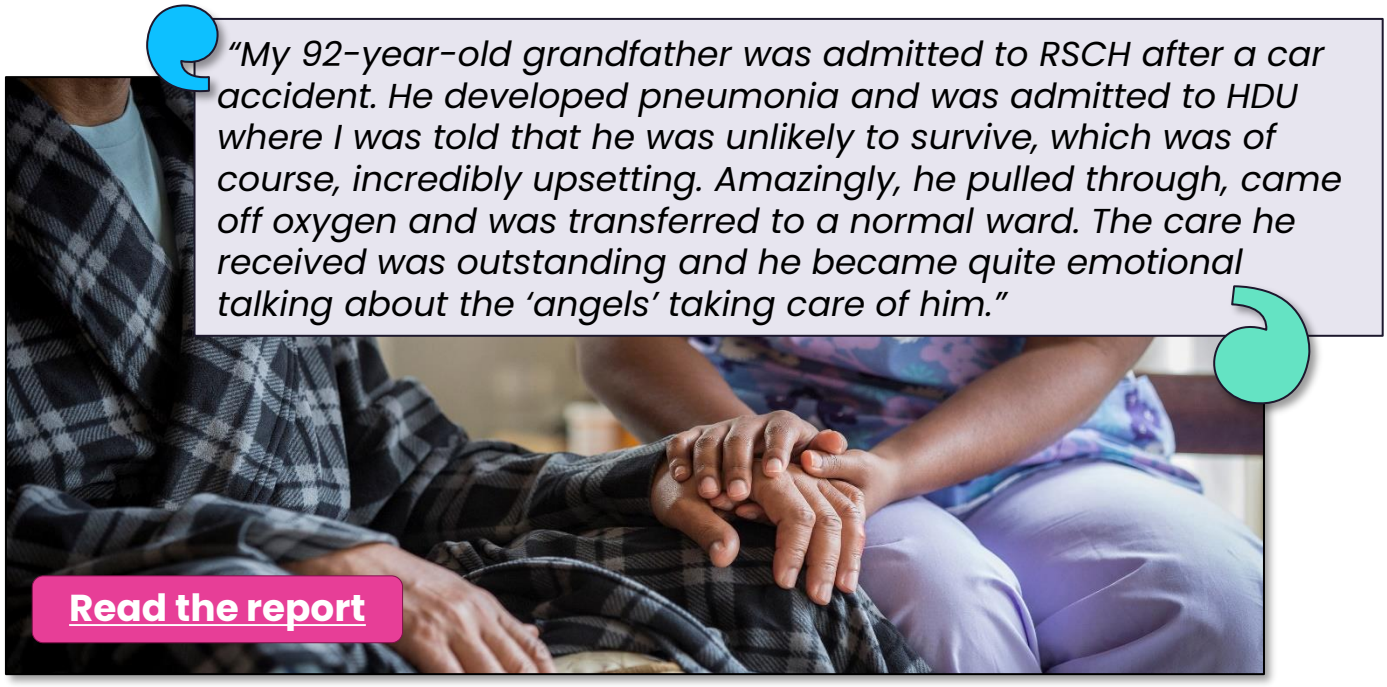
Three local hospital Trusts provide care for patients across Sussex and in this section, we describe some of our partnership working over the past year.

University Hospitals Sussex Trust

Our Enter and View visits

Our Enter and View powers allow us to visit care settings to review them. Using these powers our volunteers visited Solomon Ward, which supports stroke patients. They also undertook food tasting on the Renal Unit where they raised concerns about a lack of engagement between some clinical staff and patients. We discussed the findings with the Trust which were described as "*very powerful*". In November, the Trust told us they had used our feedback to support patient mealtimes by:

- Liaising with dietitians and health care staff to hone their skills.
- Discussing this with senior nurses, who took our findings back to their wards to discuss with their teams.
- Exploring aligning visiting times with mealtimes so that patients can be supported by their loved ones and utilising volunteers to help.



Volunteers reviewing patient leaflets

Three Healthwatch volunteers are members of the Trust's 'Carers Patients Information Group'. This year, as part of this team, they reviewed 21 patient leaflets covering topics as diverse as radiotherapy, endometriosis and virtual wards. Their suggested improvements have been incorporated to improve the language and content so that the final leaflets offer the best advice possible to patients.

Read the patient leaflets

Volunteers supporting good Food and nutrition

Two volunteers attend the Food Improvement Group giving their insight on initiatives to improve food nutrition. They're contributions are warmly welcomed by the Trust.

Our work with Local Hospitals

Supporting Patient-Led Assessments of the Care Environment programme (PLACE)

In October, our volunteers joined the Healthwatch staff team to help University Hospitals Sussex Trust (UHSx) complete their 'PLACE' assessments, which focus on the environment where care is delivered to people, such as hospital wards.

> *"Support and challenge from Healthwatch, and representing the voice of our patients, has informed many improvements, including those relating to communication, feeding and our emergency department.*
>
> *We are grateful to Healthwatch for their continued enablement of the patient voice and being a key partner for us in the city."*
>
> **Dr Nicole Chavaudra**
> Director of Patient Experience, Engagement and Involvement, UHSx

We visited three hospitals and various wards. The Trust recorded all of our observations and suggested improvements. We also observed mealtimes which were well organised, offering excellent quality and choice to patients.

We attend meetings at the Trust and meet regularly with the Director of Patient Experience to share and learn more about patient insight and initiatives to improve care.

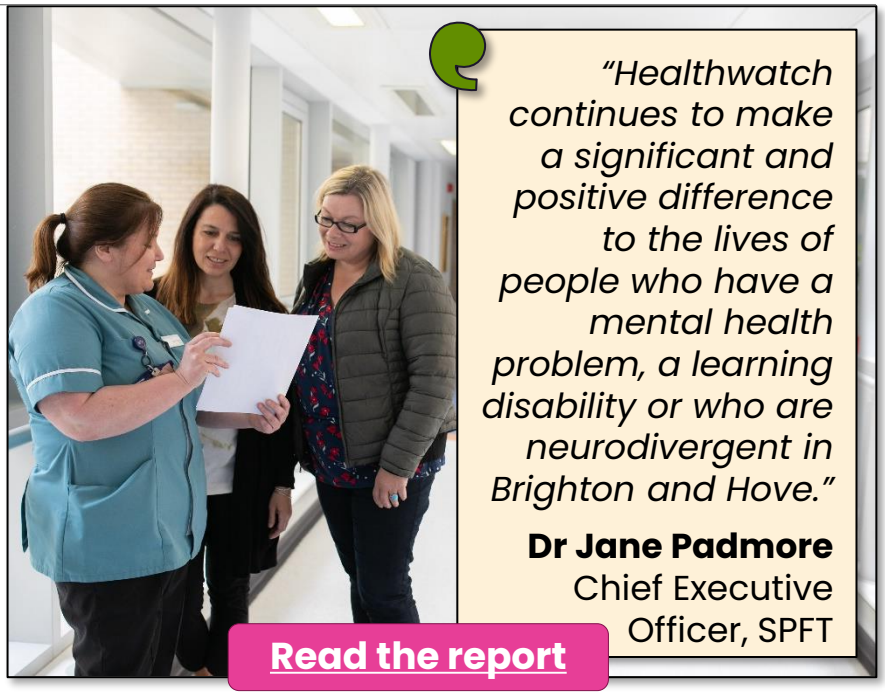
We share your feedback with them, good and bad.

Sussex Partnership Foundation Trust (SPFT)

Our volunteers and staff visited Mill View Hospital and Rutland Gardens, to carry out PLACE visits for SPFT, which runs both sites.

Our findings were very positive and the Trust welcomed our observations and recorded any minor repairs or actions that were needed.

We also meet regularly with the Trust's senior team to discuss patient insight and learn more about their work.



> *"Healthwatch continues to make a significant and positive difference to the lives of people who have a mental health problem, a learning disability or who are neurodivergent in Brighton and Hove."*
>
> **Dr Jane Padmore**
> Chief Executive Officer, SPFT

Read the report

Sussex Community Foundation Trust (SCFT)

A volunteer regularly attends the Trust's Patient Experience Group where we share and learn more about patient insight and initiatives to improve community care. Their role brings *"rich and valuable insight as well as a local health perspective to support SCFT deliver our ambitions."*

Our work on Social Care

Restarting our Homecare Check project

In November 2022, we restarted our project previously called 'Lay Assessors' and rebranded this as '**Homecare Check**' to more accurately reflect the work we do. We had paused the project in February 2020 to deliver our award-winning Hospital Discharge service that we ran during the Covid pandemic.

Homecare Check is run in partnership with the local council. Our volunteers regularly visit and interview local residents who have home care services provided by independent companies, but paid for, either fully or partly, by the council. We report our findings to the council monthly so they can share them with the care providers and assess the quality and safety of services provided.

Key findings since November 2022

Out of 95 people interviewed:

- **93%** thought it was very/extremely useful that feedback was used to assess the performance of their home care provider.
- **89%** agreed or strongly agreed they were happy with how their carers treated them.
- **88%** were extremely or very satisfied with the help they got from their providers.
- **80%** felt their care package met their needs.
- **28%** had made a complaint and though most were satisfied with how the complaint was handled, several were not satisfied
- **11** Service users were referred for a care package review.
- **11** were signposted to other services, including their GP, Together Co, and given information and encouraged to speak to their homecare providers about additional support needs.
- **3** were referred for safeguarding concerns.

"She said that she has excellent care from her regular carer who she says is more like a trusted friend"

Volunteer Lay Assessor

Though individual concerns were raised around issues of communication and being informed of changes, the majority of those we spoke to were pleased with how their carers treated them, thought they did a great job and were satisfied with the help they received from their care provider.

"Feels that new staff are not given enough time for training. Often only shadow a couple of visits and then expected to visit alone."

Volunteer Lay Assessor

Our work on Mental Health

We were commissioned by Brighton and Hove City Council (BHCC) and NHS Sussex to explore the experiences of those who use mental health services and of using accommodation that provide mental health support.

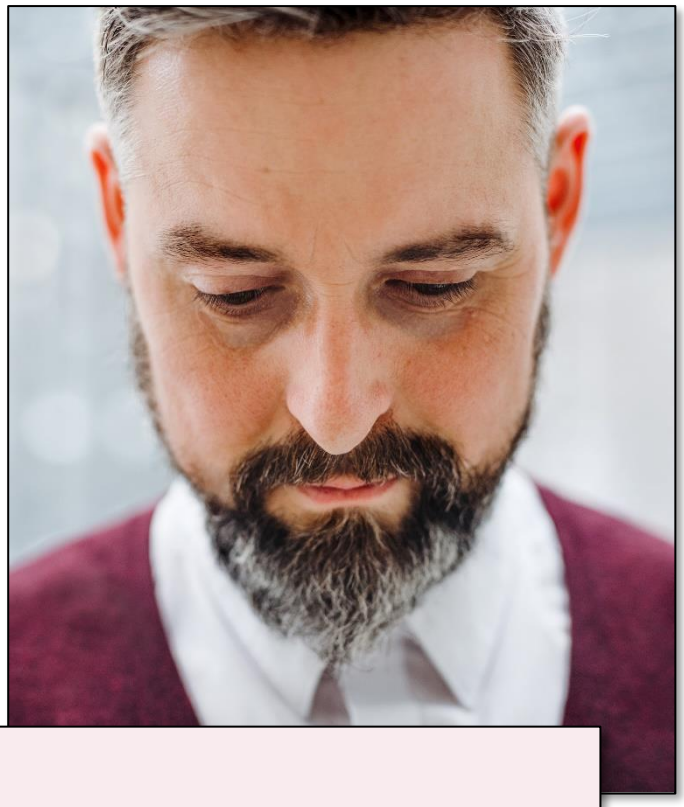
The purpose was to help inform two important documents both of which will have long-term impacts for service provision. The first was the Brighton and Hove Mental Health and Housing Plan and the second was the Mental Health Joint Strategic Needs Assessment (JSNA) 2023.

We received 137 responses to a survey aimed at those who use services and 96 from professionals. We conducted 4 in-depth interviews with service users. We also ran an online poll requesting suggested improvements to mental health services in the city.

We used the findings to make 12 recommendations, aimed at making more effective use of existing resources.

Our recommendations have been shared at the city's Mental Health Oversight Board. They have been welcomed by the Executive Managing Director at NHS Sussex and at the Mental Health JSNA Board.

BHCC and NHS Sussex also welcomed our recommendations saying they would be "used to inform" both the Housing Plan, JSNA and "other areas of mental health transformation including the transformation of community mental health services and crisis care."



People told us

"My support was excellent. I can't really criticise it."

"I did not feel like my views were listened to until I was properly in crisis, and even then, the options I was offered were incredibly limited which didn't meet what I needed."

"The NHS gave me a list of charities when they refused to help me, but they weren't available, or the wait list was too long or too expensive. I have struggled terribly for months with my mental health but there is no help."

Read the full report

Our work on Maternity

Last winter, we interviewed five women (four mothers and one partner) about their emotional wellbeing during pregnancy, **during birth and the post birth period.**

Our interviews spanned the two years since March 2020 and included the pandemic period. We asked people about the general care and support they received as well as any mental health issues they had experienced during this time.

Our key findings, shown on the next page, were fed into a national report by Healthwatch England. We will be publishing our own report this summer.

People told us

"She just was the right person for us in terms of she didn't try and make it fluffy."

"The assumption that you have post-natal depression, rather than recognising you are having an emotional response to an emotional situation, which is appropriate, but those feelings need acknowledging."

"It isn't usually during the immediate post-natal period that the mother needs support, as you are just dealing with the baby, it is often months' later, and there is rarely any follow-up."

Read the full report

Key findings:

During pregnancy

- People wanted clear and honest communication pre-birth to prepare them for a difficult birth, being a Mum or what to expect with morning sickness.
- They also wanted to see better levels of understanding about anxiety during pregnancy and appropriate provision of services, such as someone to talk to.

In-hospital experience

- Again, people wanted clear and honest communication. One Mum was told *"this hospital is full, try the next"* having been advised to visit there.
- Listen to the Mum's instincts. One expectant Mum was sent home although her "gut instinct" was that something was wrong, and she was taken in by ambulance the next day.
- A lack of support. A Mum in labour was left alone for 12 hours with no support or pain relief and "felt she was not wanted there".
- Unnecessary medical procedures. A Mum was given a C-section when an earlier assessment could have offered inducement.
- Lack of information. A new Mum who was separated from her newborn was not kept informed about how her baby was doing.

Post-childbirth experience (back home)

- A lack of peer-to-peer support was available, for example, for a Mother who had lost a twin.
- Inappropriate comments made by staff. In one case a midwife provided unwanted and upsetting "advice" on familial relations which were unconnected with the maternity experience.
- No consistency of care. One Mum benefitted from seeing the same Community Midwife from pre- to post-birth. Other Mums expressed they would have liked this.
- Poor GP check-up after 6-8 weeks. These checks focus on the physical health of baby and not the Mum or their emotional health.
- Lack of proactive emotional support. The real need for emotional support was often only identified 6-12 months later, once the immediacy of baby's needs had lessoned or the Mum's had returned to work.

Other concerns

- Partners feeling left out. One Mum mentioned that her husband was never asked about his experience and in another case, an LGBTQ+ partner was questioned on her status as a parent (at A&E).

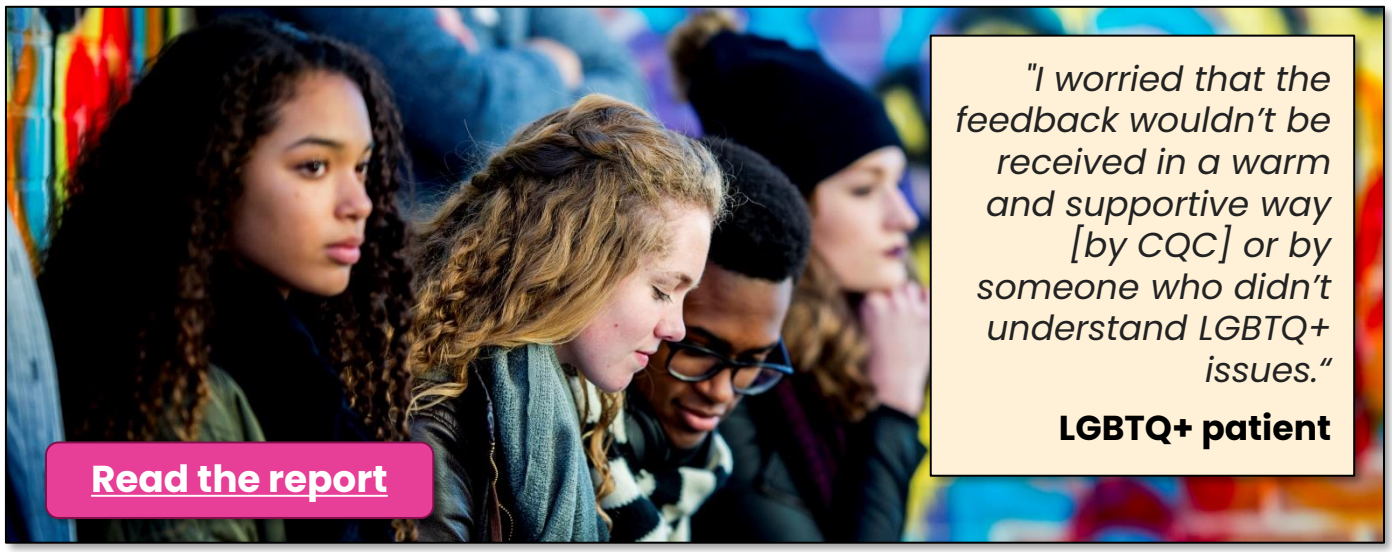
Our work supporting LGBTQ+ communities

We joined forces with Brighton and Hove Switchboard, a local charity that provides a range of support to the local LGBTQ+ population of our city.

We worked together to collect LGBTQ+ patients' experiences of using health and social care services. We also asked them how existing feedback systems could be improved to encourage them to share their experiences. A total of 120 people completed our two surveys, including 59 young people. People shared their views through focus groups, and we interviewed leads of local LGBTQ+ groups and conducted one-to one interviews with local people.

Healthwatch and Switchboard shared our findings with the CQC, who had asked us to run this project as they wanted to increase their levels of engagement with different communities. Since our report, we have met Switchboard and the CQC several times to discuss the progress being made against our 17 recommendations, and we have been heartened by the response.

We said	CQC response
Feedback forms should be more inclusive and shorter	CQC is working with its LGBTQ staff network and Switchboard shared guidance on using inclusive language and CQC is reviewing the number of questions they ask
CQC should use online and social media to attract feedback from younger LGBTQ+ people	CQC has recruited 11 young people to act as online and media advisers to support their work
CQC should use QR codes to make it easier to access feedback forms	CQC tested this approach which was successful so more QR codes will be used in the future
CQC need to tell people how their feedback is used to make improvements to services	CQC are exploring different options to tell the public how their feedback is processed and used in their work



Our work tackling the closure of toilet facilities in the city

In January 2023, we received enquiries through our helpline about public toilet facilities closing in various locations across the city. Concerns were also shared by the communities supported by the Friends, Families and Travellers charity (FFT).

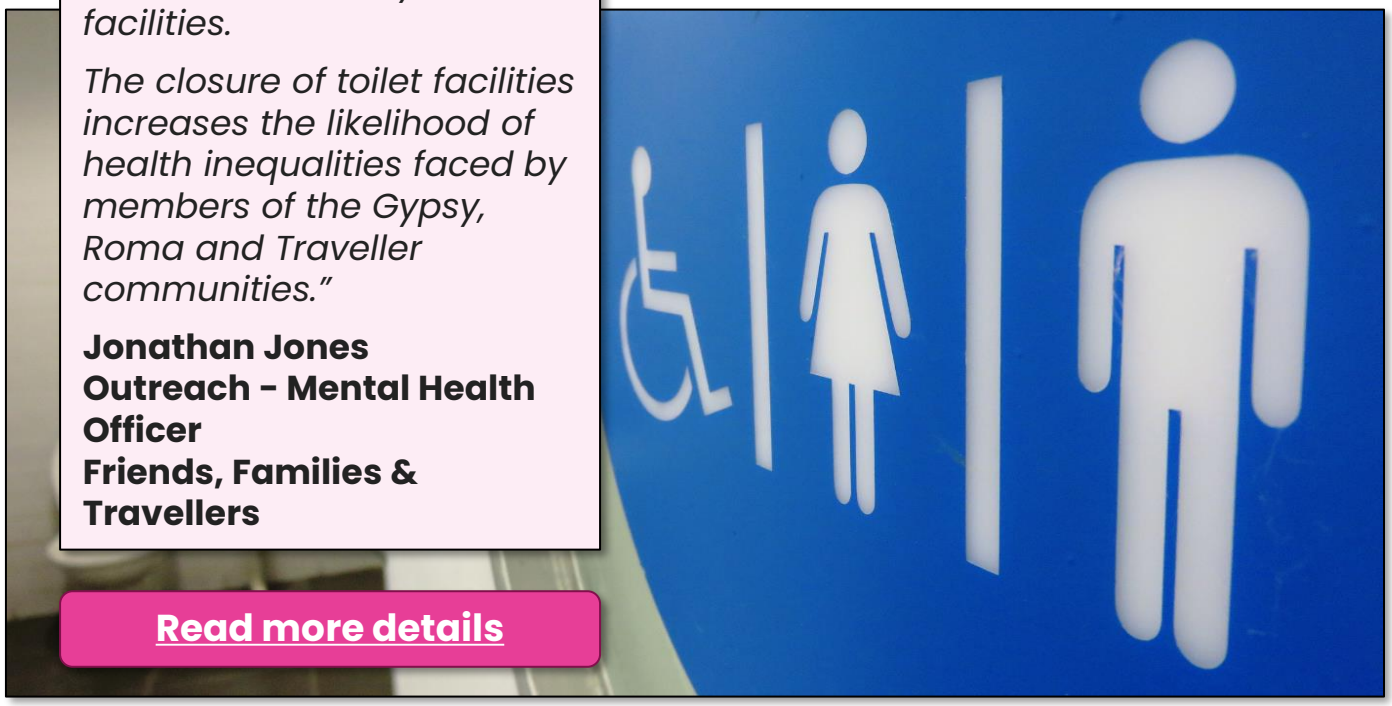
In response, we and FFT wrote to the Council's Policy and Resources Committee expressing our concerns in liaison with and on behalf of members of the public who had contacted us. On February 14th, 2023, we received a reply from Councillor Phélim Mac Cafferty committing more funding to keep as many public toilets available as possible, describing how they intend to continue to fund public services, including public toilets.

Impact of closures

The closures could impact on many people, including some who have protected characteristics including families, pregnant and menstruating women, elderly people, people with long-term incontinence issues, those that are wheelchair bound and with other mobility issues, carers, school groups, and people from the travelling community.

The city could also suffer as a tourist and holiday destination, as some visitors could be reluctant to spend time in locations where there are no public facilities.

> *"There is a clear correlation between issues surrounding hidden Traveller incontinence and lack of accessible sanitary facilities.*
>
> *The closure of toilet facilities increases the likelihood of health inequalities faced by members of the Gypsy, Roma and Traveller communities."*
>
> **Jonathan Jones**
> **Outreach - Mental Health Officer**
> **Friends, Families & Travellers**



Read more details

The Council has since developed a plan for the medium to long term provision of public toilets. At the time of writing, refurbished toilets include Kings Esplanade, Daltons, Station Road and the Saltdean Undercliff public toilets. Read more here.

The intelligence we gathered enabled us to effectively contribute to the reversal of the plans to close public toilet facilities in the city.

Some of our other work

Helpline

Two long-standing and brilliant Healthwatch volunteers have supported us by running our Helpline service, answering your calls and emails. This year they received 240 helpline enquiries with the main area of concern being how to make a complaint about health or social care services or treatment, followed by enquiries about accessing NHS dentistry and GP appointments.

"Just wanted to say a big thanks for being really helpful and supportive at a time when I was feeling very distressed."

Helpline User

Outpatient patient engagement workshops

We were commissioned by NHS Sussex to run four workshops with people who had experience of the outpatient system. Over the course of four weeks, 35 participants from across Sussex were provided with information to read and videos to watch to increase their knowledge of various initiatives that are designed to transform the system. Participants spoke about their own experiences and used their increased knowledge to provide suggestions as to how the initiatives could work and how to overcome potential barriers. Our results will be published this summer.

Healthwatch Conference

We organised the '**Healthwatch, NHS and local people in collaboration: Southeast Regional Conference**' on 28th June 2022, alongside our Healthwatch partners in East and West Sussex, Surrey, Kent and Medway.

65 people attended to hear from keynote speakers Louise Ansari, Director of Healthwatch England and Stephen Lightfoot, Chair NHS Sussex about the future of the new Integrated Care System for Sussex and partnership working.

"The Healthwatch Regional Conference came at a crucial time...

...focusing on what Healthwatch does best, interrogating the detail, questioning the NHS jargon, and providing timely meaningful critical feedback."

Tom Goodridge, Director of Communications NHS Sussex

Read our Conference report

Supporting the Digital Inclusion Strategy

Health services are increasingly going online but not everyone can easily access these alternatives. This year, we have described the impact of 'digital exclusion' feeding this into meetings we attend, such as the Digital First Working Group. Our reports contributed to the Brighton and Hove Digital Inclusion Strategy 2023-2027. Our recommendations were well received by the Brighton and Hove Executive Leadership Team.

"Pulls together a very compelling argument for a more joined up approach and to share learning from the variety of initiatives in the city."

B&H Executive Leadership Team

Read our Digital Exclusion report

Healthwatch in Sussex

A local Healthwatch partnership

Over the past year, the three Healthwatch teams in Sussex have collaborated as **Healthwatch in Sussex** to capture and share feedback on dentistry, long COVID, primary care access, dementia, outpatients and more. Partnership working enhances our ability to champion public and patient voice on these and other health and care themes at a Sussex-wide level.

Our collaborative working has been recognised and acknowledged as good practice by our national body Healthwatch England and NHS Sussex, and we will continue to work together to ensure that people sit at the heart of health and care services over the next 12 months and beyond.

GP Website Reviews

Last year, Healthwatch in Sussex were invited by NHS Sussex to complete a pan-Sussex review of all GP websites. This included 34 practices in Brighton and Hove.

Findings from the pan-Sussex review were presented and discussed with stakeholders at the Digital First Working Group on 11th August 2022.

Following further consideration by the Digital First Board in September, a plan was approved to offer financial support to those practices identified as being most in need to help them improve their website content and format.

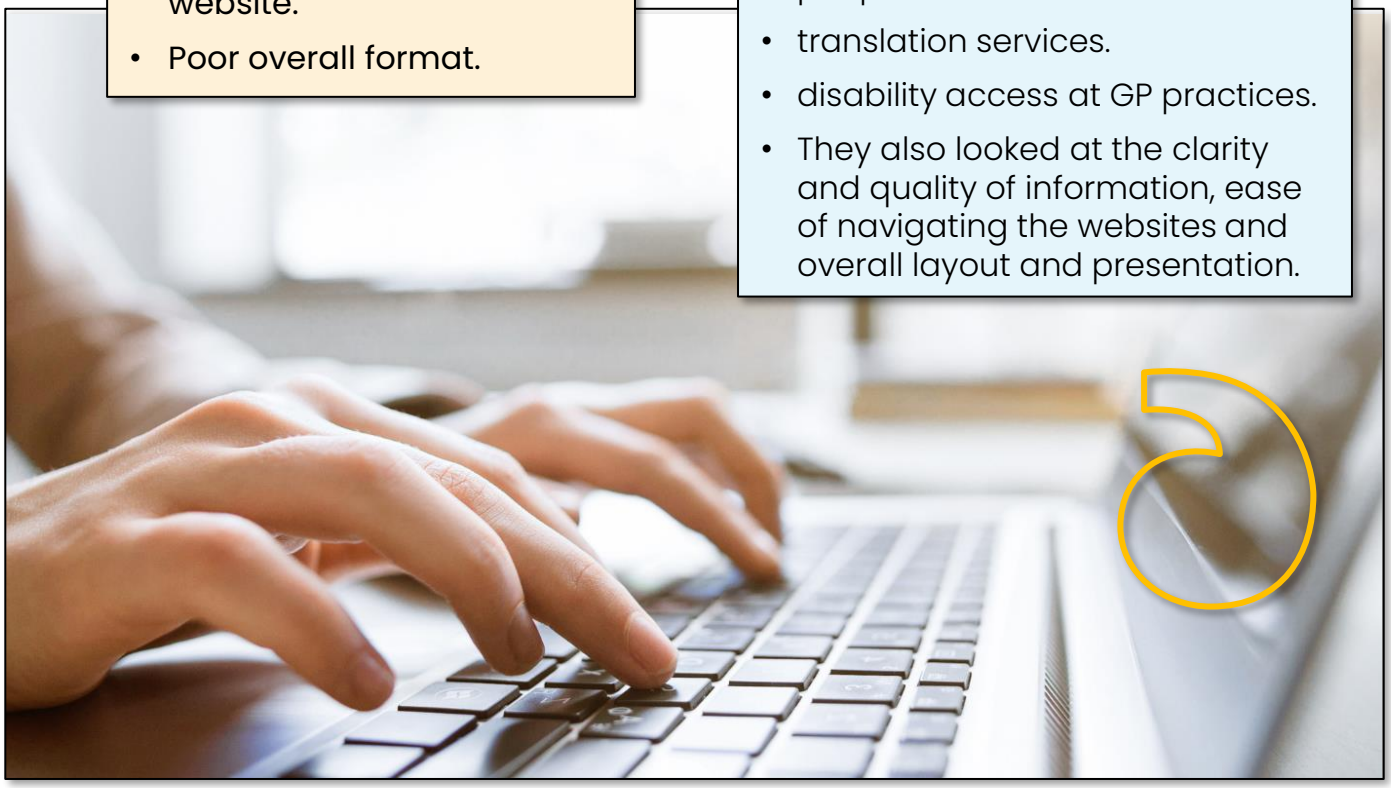
This improvement work has already started meaning that patients should start to see some improvements to GP websites.

The most in need websites all had the following in common:

- A lack of information (or poor clarity and lack of consistency).
- Difficulty in navigating the website.
- Poor overall format.

Between September to October 2022, volunteers looked at:

- whether the websites had patient notices about Covid-19.
- how to book an appointment.
- the types of appointments available (remote, or face-to-face).
- options to book or receive a repeat prescription (online, email or post).
- information for new patients wishing to register.
- advice about who to contact in an emergency (e.g. NHS 111).
- how to make complaints or provide feedback.
- specific information about services such as mental health or support available for young people and carers.
- translation services.
- disability access at GP practices.
- They also looked at the clarity and quality of information, ease of navigating the websites and overall layout and presentation.



Dentistry

Access to NHS Dentistry is an issue that has affected many patients across Sussex, and as Healthwatch in Sussex we:

Developed a Healthwatch in Sussex patient leaflet called '*A Healthwatch guide to your rights and accessing the treatment you need*'. We produced this by working with local dentists.

What are your rights?

Submitted a joint response to a Parliamentary Inquiry on dentistry, which was published on March 7th 2023. We described the local impact and made suggestions for how the current crisis could be improved.

Read the response

Undertook further patient engagement from December 2022 to January 2023.

This followed a Government and NHS announcement of changes intended to support improvements in dentistry provision. We wanted to learn whether these changes had led to any improvements in the experiences of patients.

We met with the NHS Sussex lead for Pharmacy, Optometry and Dentistry in January 2023 to discuss what we'd heard from patients and what the ICS's plans were.

As part of this, we learnt that the ICS is creating a new dental working group and Healthwatch in Sussex will be involved. Healthwatch now also has quarterly meetings with the ICS lead.

Across Sussex, we found some alarming findings, and that people in Brighton and Hove were more dissatisfied:

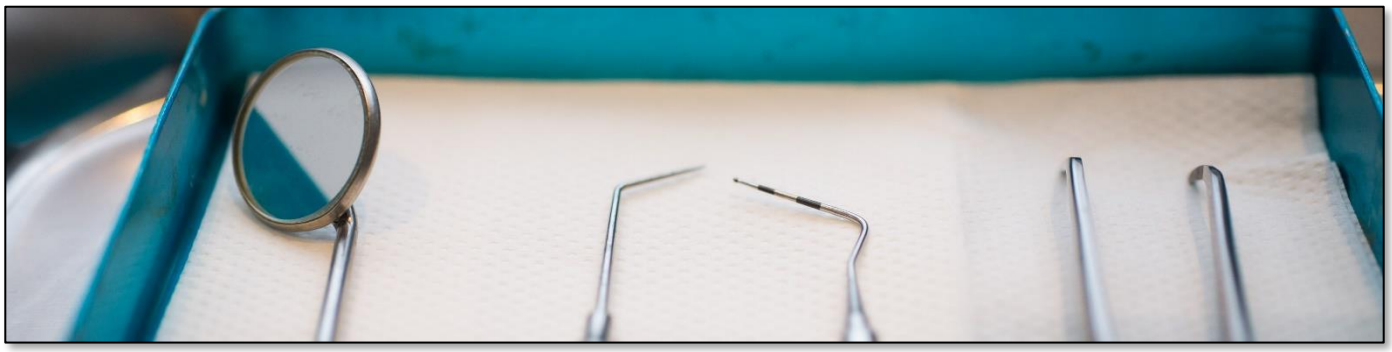
62% of people were not confident about their ability to access NHS dental services over the next 12 months, either for themselves or others. For Brighton and Hove residents, this was 70%.

45% of people told us they were dissatisfied/very dissatisfied about their ability to find a dentist offering NHS treatments. For Brighton and Hove residents, this was 65%

42% of people were dissatisfied/very dissatisfied with the waiting times to see someone. For Brighton and Hove residents, this was 57%

Read the report

We have continued to share our insight with Healthwatch England to support their campaigning to improve dental access and provision. Read more here.



Non-Emergency Patient Transport Service

The Non-Emergency Patient Transport Service (NEPTS) is a Sussex-wide service, transporting patients to and from their appointments, seven days a week, providing around 300,000 journeys a year. Healthwatch in Sussex has carried out four separate patient reviews of the service since 2016, with our latest report published in 2020.

This year, we have been working closely with those responsible for commissioning a new transport service, from 2025. Through this regular collaboration, we have ensured that your views and ideas about how the service can be improved are reflected in the revised service specification – this is the document that sets out what the provider of the service must deliver. This means that your views lie at the heart of this service's redesign. We have been asked to join the panel which will assess the bids to run the service. We will ensure that any provider has a clear focus on delivering the best service for patients.

The service must now include:

- a requirement to deliver better communications with patients so that they are advised when their transport will be arriving.
- a dedicated focus on renal patients.
- a requirement to establish and host fully accessible patient forums so that your views are regularly collected.
- a requirement to better promote alternatives to NEPTS for those who are not eligible for the service.

"Frustration with waiting, without knowing when they will arrive."

Service User

"We have worked closely with Healthwatch over the last year and have received wonderful support and thoughtful input into our redesign of non-emergency patient transport services. They have encouraged us to consider from the outset how this service impacts and supports patients and in so doing have co-designed a service which puts quality and patient experience at the heart of the service."

Sarah Mackmin-Wood, Associate Director of Urgent and Emergency Care South Central Ambulance Service NHS Foundation Trust (SCAS)

Long-Covid Survey

Our survey explored people's symptoms of Long-Covid and the impact of this on people's lives. Long-Covid is a new and evolving condition brought on by a Covid-19 infection. The precise causes are not clear, and their impacts can vary from person to person which can create issues for diagnosis, treatment and management of the condition. As more than 500,000 people across Sussex have contracted Covid-19, this will affect the wellbeing of some of our population, both now and in the future.

We asked people if they had sought advice, including from the Post-Covid Assessment and Support Service (PCASS), and people's views about the type of follow-up assistance and care that would be most helpful in meeting their needs.

> *"Since opening in 2021, PCASS provided care and rehabilitation for long COVID to more than 3,300 patients. The service has been continuously developing. We welcome the findings of the Healthwatch report and are now working closely with our partners to further develop and raise awareness of the service."*
>
> **Dr Dinesh Sinha, Chief Medical Officer NHS Sussex**

94 people replied and the survey helped to understand public and patient experiences. It enabled us to produce recommendations that have been shared with health and care providers and decision-makers.

Our report was published in March.

We are continuing to work closely with NHS Sussex to follow up on our recommendations, monitor how residents are affected by Long-Covid and share the feedback we receive.

Read the report

Liaison Role

NHS Sussex and Healthwatch in Sussex have worked in partnership to create a new role, which is being delivered by **Katrina Broadhill**. Katrina's role will support the three Healthwatch in Sussex teams in their work engaging with the health and care system which can be complex and hard to navigate. The role will support communication between Healthwatch and NHS Sussex and make it easier to share insight from local Healthwatch into programmes of work.

> *"I am passionate about creating a fairer and more equitable society. As an intermediary to the three local Healthwatch in Sussex, this new role gives our integrated care system a single route to Healthwatch for all Sussex-wide activities, simplifying and sharing communication and provision of Healthwatch insight."*

More about the Liaison Role

Reports Published 2022-23

We published 16 reports this year describing our work and your experiences of health and social care services.

1. Feedback on the A&E Department, Royal Sussex County Hospital - April 2022
2. Healthwatch continues to support our city's COVID-19 Vaccination Enquiry Service - May 2022
3. NHS dentistry - a Healthwatch bulletin - June 2022
4. Supporting LGBTQ+ people in Brighton and Hove to share their experiences of health and social care services - June 2022.
5. Healthwatch Brighton and Hove - Annual Report 2022 - June 2022
6. Typologies of digital exclusion - A Healthwatch report - July 2022
7. Mental Health Services in Brighton and Hove - experiences of service users and professionals - July 2022
8. Healthwatch, NHS and local people in collaboration: Southeast Regional Conference, 28th June 2022 - July 2022.
9. Healthwatch Brighton and Hove helpline enquiries April to June 2022 - July 2022
10. Enter & View Report: Royal Sussex County Hospital July 2022 - August 2022
11. Healthwatch Brighton and Hove helpline enquiries July to September 2022. - October 2022
12. Healthwatch Brighton and Hove six-month Performance Report - October 2022
13. Our enter and view report on Sussex Partnership Foundation Trust sites - November 2022.
14. Access to GP appointments across Sussex – public opinion. - January 2023
15. Healthwatch Helpline service - Public enquiries report during Oct - Dec 2022 - January 2023.
16. Healthwatch - Our focussed work on GP services in Brighton and Hove - March 2023.

Read the reports at HealthwatchBrightonandHove.co.uk/news-and-reports

Volunteers

We're supported by an amazing team of volunteers, who are at the heart of what we do.

Thanks to their efforts in the community, we're able to understand what is working on health and social care, and what needs improving.

This year our volunteers:

- Visited people in their homes to ask about their home care.
- Reviewed patient leaflets produced by our local hospital.
- Attended community events on our behalf.
- Carried out Enter & View visits to local services to help them improve.
- Reviewed GP and dentist websites to review accessibility.
- Answered people's questions and queries on our Helpline and signposted them to support.
- And much more.

Volunteers

Finnur Bjarnason – Homecare Check

"Being part of the Homecare project has been very rewarding. Not only have I felt like I was able to make a difference and contribute to the community, but the home visits have also been very memorable.

They give the opportunity to have conversations with people of such varying backgrounds and with such different stories.

The whole team at Healthwatch is also very supportive and friendly, as are the other volunteers. I think it's great way to engage and volunteer."

Elaine Foster – Homecare / Helpline

"I've been a volunteer with Healthwatch Brighton and Hove since 2020.

I first worked on the hospital discharge project and now, with a fellow volunteer, I answer queries via the website and Helpline. I deal with a wide range of requests from health service complaints to community engagement.

It's a very valuable resource for patients and the public and an interesting project to be involved in."

Dr Khalid Ali - Director

"Working as a Director on the Healthwatch Brighton and Hove board over the last two years has been a rewarding experience on several fronts. Hearing from people using health and social care services was an eye-opener on 'what matters' from a user's perspective.

Sharing people's lived experience with their care providers has challenged the 'status quo' and resulted in improvements in access to primary and secondary healthcare.

I work alongside an inspiring team of volunteers and staff who always go the extra mile to support their clients and each other. My work here has been educational, impactful and fun."

To learn more about volunteering with us, call 01273 234 040 or email interested@hwbh.co.uk

Volunteers

Reemanne Baghdadi - Student

"My time spent volunteering with Healthwatch has been very enjoyable! As a public health student, I have been given the opportunity to explore health and social care through a lens that I would not have through studies alone. I have worked on two fantastic projects.

The Outpatient Transformation workshops was so eye-opening, to hear peoples lived experience and their invaluable feedback on how to improve the services they use. I have also been given the opportunity to carry out independent service mapping in Brighton, equipping me with skills that will benefit me greatly.

The Healthwatch team have always made me feel appreciated and supported and I hope to continue to support the team. "

John Gough - Meeting Representative

"I have been volunteering for Healthwatch as a Meeting Representative for the last year and it's a role I would recommend to anyone who has an interest in being part of a team thats aim it is to improve our local Health Services.

Being a Meeting Rep has given me the opportunity to listen to, collate and present the views of our local citizens to Healthcare Professionals, and has at the same time given me an insight into appreciating at first-hand, the work and dedication that NHS Staff apply to their various roles.

I've really enjoyed being a small part of this process of improvement - which hopefully will, through the involvement of local people eventually benefit everyone."

Ian Bretman - Meeting Representative

"I had served on an NHS Board in London before moving to this area and was keen to make use of my experience and to learn more about the services provided to the local community. I was asked to represent Healthwatch on the Sussex-wide Primary Care Commissioning Group and the Sussex Community Foundation Trust's Patient Engagement Group and have been doing this for the past few months.

As well as attending the meetings themselves, I liaise with Healthwatch staff before the meeting to see if there are matters they would like me to raise, and I also provide a short report back after the meeting about what was discussed.

It's been very interesting to attend these meetings and I have found NHS staff that I've worked with very welcoming and keen to develop their understanding of patient experience. The Healthwatch team is likewise very supportive and friendly."

Volunteers

Fran O'Neill – Enter & View / Helpline

"I first started at Healthwatch towards the end of 2019, on the hospital discharge wellbeing service that focused on calling people recently discharged from hospital to check they had the support they needed. It became more pertinent in early 2020 when the pandemic started and little face-to-face contact for people being discharged from hospital.

It was good to use some of my hospital skills and knowledge to help support people. The program was very successful (and highly commended!) and ran for over two years. At six months, I moved onto the vaccination helpline, which was also very rewarding.

I now deal with messages left by people looking for information or advice. It's less demanding as I'm now back at work, but I am free to do what I like and can, and totally supported by the team. They are only ever an email or a phone call away and usually have the answers to the question you may be asking, and if they don't, they find out! I have been on training courses to support what I need and gatherings where we meet other volunteers, which is nice. There are ongoing projects you could be involved in with plenty of variety. I would recommend joining Healthwatch if you can!"

Chris Jennings – Meeting Representative / Support

I have been representing Healthwatch on the Local Dental Committee for East Sussex and Brighton & Hove and at meetings of the Routine Dentistry Managed Care Network for Kent, Surrey and Sussex.

Doing this, I can relay information to dentists on the problems patients and the public raise with Healthwatch and also feedback to Healthwatch the dentists' perspectives on their problems, concerns and initiatives.

This contributed to some useful products such as "Dentistry – A Healthwatch guide to your rights and accessing the treatment you need" and helped raise the profile of the problems being experienced by patients in accessing NHS Dental care. I have also been undertaking some data collection and analysis work on some of the Healthwatch surveys, which is work I enjoy and uses skills gained when I was working.

Most recently I have acted as a note-taker for the series of Deliberative Engagement Workshops run by Healthwatch in Sussex and the NHS to test and obtain feedback on plans for Outpatient Transformation. It is good to see all the Sussex Healthwatch working together and beginning to engage with the new Sussex Integrated Care Board now running local services.

To learn more about volunteering with us, call 01273 234 040 or email interested@hwbh.co.uk

Authorised Representatives

During this year we had **52 Authorised Representatives** able to review services, attend decision-making forums and speak up for patients and care service users.
This was made up of **45** volunteers – including directors – and **7** members of staff.

Alan Boyd
Alastair Hignell
Angelika Wydra
Asher Foister
Barbara Myers
Bob Deschene
Brigid Day
Cara Redlich
Caroline Trimby
Catherine Swann
Chris Jennings
Christine D'Cruz
Christopher Morey
Cindy Willey
Clary Collicutt
Conor Sheehan
David Liley
Dr Khalid Ali
Duncan Stewart
Elaine Crush
Elaine Foster-Page
Francis McCabe
Fran O'Neill
Geoffrey Bowden
Gillian Connor
Hadi Kebbeh
Hilary Martin
Howard Lewis
Jo Kaddish
John Gough
Judi Holly
Karen Barford
Leah Ashley
Lester Coleman
Lynne Shields
Maureen Smalldridge
Mazzie Sharp
Michelle Kay
Neil McIntosh
Nicholas Gorvett
Nick Goslett
Paul Koczerzat
Peter Burton
Robin Guilleret
Roger Squier
Sophie Crowton
Sophie Reilly
Sue Seymour
Sylvia New
Tracey Tremlett
Vanessa Greenaway
Will Anjos

Thank you

Our last 10 years...

151 Volunteers Contributed over

54,000 hrs = 2,250 days

to help our community

Including 25 Volunteer Board Members

We made 1,761 Recommendations

- 281 Reports Published
- 277 Newsletters & Bulletins
- 650 Website News Posts
- 5,700 posts on Facebook
- 5,800 Tweets

10,500 Health & social care meetings

44,000 people engaged

594 Services reviewed

3,300 helpline enquiries

25 Staff Members

390 Press Releases & media interviews

320,000 Website Hits

4 Awards

- healthwatch Awards 2016 Highly commended
- healthwatch Awards 2021 Highly commended
- healthwatch Awards 2021 Shortlisted
- healthwatch Awards 2021 Highly commended

10 Years

This year was a special celebration for us as we marked our 10th anniversary.

At the heart of everything we've done have been our city's residents. None of this could have been possible without the efforts of all the people who have worked for us, our various Board members and our outstanding volunteers. Read our report.

We could also not have succeeded without the support of our various partners working across the voluntary and community sector, NHS services, the Council, our other Healthwatch colleagues, and those who commission and deliver services.

To everyone who has been involved in our success – thank you.

A potted history of key dates	
2012	Healthwatch is set up under the Health and Social Care Act 2012.
2013	Healthwatch Brighton and Hove is formally inaugurated in April 2013. We are hosted by Community Works and our first staff team join us. We also publish our first report.
2014	The Mayor of Brighton & Hove formally launches Healthwatch Brighton and Hove on 5th March. We are formally registered as a Community Interest Company on 14th October. Our first volunteers join us this year.
2014 /2015	Our Board of Directors is formed. We begin our Enter and View Visits to local health and social care services, launch our newsletter and start our public helpline. More than 1000 people sign up to receive our newsletter.
2015	We become an independent Community Interest Company in April.
2016	We win two Highly Commended awards from Healthwatch England for our partnership working.
2017	We set up our monthly volunteer led visits to our local hospitals.
2017	We establish our Young Healthwatch.
2017/ 2018	Young Healthwatch publishes their first report looking at Accident & Emergency (A&E) experiences of mental health services.
2019	We launch our Homecare check service, still operating today.
2020	We start to issue our COVID bulletins and start our award-winning Hospital Discharge project. More than 70 volunteers support our work throughout the pandemic.
2021	We win our third Highly Commended award from Healthwatch England for our Hospital Discharge project. Our End-of-Life project is also shortlisted. Our volunteers speak to 1,700 people recently discharged from hospital.
2022	We win our fourth Highly Commended award for our work in helping patients to overturn a decision to reduce opening hours at a local GP practice. We are also awarded a 3-year direct contract renewal to continue running Healthwatch for the city.

Chair & Directors

Our board of directors are all volunteers

Geoffrey Bowden
Chair

Christine D'Cruz
Director

Karen Barford
Director

Howard Lewis
Director

Angelika Wydra
Director

Dr Khalid Ali
Director

Alastair Hignell
Director

Sophie Crowton
Director

Gillian Connor
Director

Christopher Morey
Director

Goodbyes

"I joined Healthwatch as a volunteer in 2014 and became a board member the following year. I've seen a transformation from an organisation with very little profile with the public, health service providers or commissioners to one that has one making a real difference in helping shape the delivery of health and social care services across our city, as well as a truly effective campaigning force, ensuring that health and social care users and their families have their voices heard and listened to.

I look forward to watching Healthwatch Brighton & Hove continue to grow in strength as a patient champion over the years to come."

Neil McIntosh ~ Director from October 2015 to October 2022

Goodbyes

Catherine Swann is a senior public health civil servant and chartered psychologist with over 20 years' experience in national NHS and academia.

She has been an invaluable member of the board, and over the years made a great contribution to our work.

Catherine Swann ~ Director from October 2015 to October 2022

"I am so grateful as someone living in the City for the huge positive impact that the dedicated team of staff and volunteers have on local health and social care services. The team go above and beyond their commissioned requirements to ensure that they respond to the current and future needs of the local community and this was particularly evidenced by their swift adaptation of services during the Covid-19 pandemic.

It has been an absolute honour to be a small part of Brighton and Hove Healthwatch's journey over the last four years. All the very best."

Karen Barford ~ Director from April 2019 to June 2023

"It has come to the time for me to retire after 6 years as Chief Executive with Healthwatch Brighton and Hove, 10 years with Healthwatch and 50 years working in Health and Social Care. My first job was as a porter in a hospital in Belfast, so in that time I have gone literally from the Boiler Room to the Board Room.

Healthwatch in Brighton and Hove is going from strength to strength, with new leadership, staff and a fresh commitment to promoting patient and public voices. The post-Covid world is full of change in health and social care and it has never been more important to design the future learning from people, families and communities who use services today. At a time of upheaval, Healthwatch brings HOPE = 'Hearing Other Peoples Experiences'. Let us use those experiences to call our leaders to account and build a better future.

Thanks again to all the team at Healthwatch and the whole Health and Care Community locally for providing me with the privilege to lead, to serve and to make a difference."

David Liley ~ Chief Executive from April 2016 to February 2023

Learn more about our directors at
healthwatchbrightonandhove.co.uk/our-board

Staff Team

Alan Boyd
Chief Executive

Dr Lester Coleman
Head of Research

Michelle Kay
Project Coordinator

Will Anjos
Project Coordinator

Clary Collicutt
Project Coordinator

Clare Funnell
Communications
& Engagement Officer

Katy Francis
Project Support Officer

Left to right: Katy, Will, Clare, Michelle, Clary, Lester and Alan.

Learn more about our staff at
healthwatchbrightonandhove.co.uk/our-staff

Message from our Chief Executive

"A year of change".

"This feels like the best phrase to describe the last 12 months. In July, a new Integrated Care System, Sussex Health and Care, was created to deliver more joined-up services to ensure people receive the best care possible. A new Board, NHS Sussex, was also created to oversee its work and set the priorities for all NHS organisations in Sussex. The CQC, the independent regulator of health and social care in England, has implemented a new approach to their work and there have also been changes to the leadership at other Healthwatch teams in East and West Sussex.

And even at Healthwatch Brighton and Hove in the last year, we have appointed a new Chair, Geoffrey Bowden, and new CEO – me! Most recently, we've welcomed new staff members, Katy and Clare to our team and we are pleased to host Katrina Broadhill in a brand new strategic role, which is already delivering closer working between all three Sussex Healthwatch teams and the health and care system. We've also warmly welcomed some amazing new volunteers and said a fond farewell to David Liley, former CEO and Fran McCabe, former Chair.

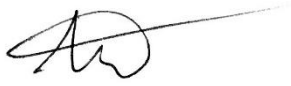
> *"Regardless of the changes that are happening, Healthwatch Brighton and Hove will be here to listen to patients, gather their experiences and views and ensure health and care providers listen and act on them."*

That is a lot of change. Sometimes change can feel overwhelming but it is also an opportunity to step back, reflect, try new things and strengthen relationships - and that's what I hope Healthwatch Brighton and Hove will achieve over the next year.

Throughout this period of change, Healthwatch staff team and volunteers, existing and new, have continued to deliver excellence in public engagement and high-quality reporting. Projects delivered by Lester, Michelle, Will and Clary with the support of our dedicated volunteers, have continued to help services improve in the city and across Sussex. Recognition for the quality and impact of our work came in the form of another 'Highly Commended' award from Healthwatch England.

Regardless of the changes that are happening, we will be here to listen to patients, gather their experiences and views and ensure health and care providers listen and act on them. Ultimately, it is your stories that help create change, so thank you on behalf of myself and the wider team for sharing them with us."

Alan Boyd



Finance

To help us carry out our work we receive funding from our local authority under the Health and Social Care Act 2012.

Our income and expenditure

Income		Expenditure	
Annual grant from Government	£178,600	Expenditure on pay	£198,778
Additional income	£94,748	Non-pay expenditure	£30,505
		Office & management fee	£19,142
Total income	**£273,348**	**Total expenditure**	**£248,425**

Additional income includes the following project work:

- Exploring Dementia Pathways in Sussex
- Delivering a council funded Homecare Check
- Exploring Mental Health & Housing
- Delivering an Outpatients series of workshops
- Running a Discharge Project
- Working to amplify LBGTQ+ voices
- Delivering Healthwatch Engagement Activity
- Organising a Healthwatch England Regional Conference
- Conducting interviews on Maternal Mental Health

Future Priorities

Our areas of priority for 2023-24

1. Hearing from more people via partnership working

   We will continue to form strong relationships and deliver more projects in partnership with local Voluntary and Community groups. This will mean that we hear from more people and more communities in the city, including those whose voices are less prominently heard at the moment. By working with community partners, we will support the overarching ambition to reduce health inequalities across the city.

   As part of this, we will focus on hearing from more Children and Young People.

2. Escalating your concerns

   We will continue to capture your views, experiences and opinions. We will do this through our projects and helpline, but also by attending more public events and through partnerships with other local organisations. We will support them to get their service user's views heard in forums that Healthwatch has privileged access to such as the Health and Wellbeing Board, the Sussex Integrated Care Assembly and others.

   Key areas of focus for us will be to help improve access to services, notably primary care services such as GPs, dentists and others.

3. Continuing to act as a 'critical friend'

   We will continue to work in partnership with system leaders and providers and challenge them to demonstrate how they have used feedback from patients to deliver improvements. We will offer our continued support to help them achieve this.

   At the same time, we will monitor and challenge the progress made by our Integrated Care System against their published priorities to deliver better joined-up care for everyone.

   We will use our independence from the NHS and Council to help achieve this.

In addition to these priorities, we will also work harder to raise public awareness of what we do and the impact that our work has.

Statutory statements

Healthwatch Brighton and Hove, Community Base, 113 Queens Road, Brighton BN1 3XG.

Healthwatch Brighton and Hove uses the Healthwatch Trademark when undertaking our statutory activities as covered by the licence agreement.

The way we work

Involvement of volunteers and lay people in our governance and decision-making

This past year, our Healthwatch Board has consisted of 10 members who have worked on a voluntary basis to provide direction, oversight and scrutiny to our activities.

Our Board has ensured that decisions about priority areas of work reflect the concerns and interests of our diverse local community.

Throughout 2022/23 the Board met 6 times and made decisions on matters including the appointment of a new Chair, a new Chief Executive, and signed off our financial accounts.

Methods and systems used across the year to obtain people's experiences

We use a wide range of approaches to ensure that as many people as possible have the opportunity to provide us with insight about their experience of using services.

During 2022/23 we have been available by phone, email, provided a webform on our website and through social media, as well as attending meetings of community groups and forums.

We ensure that this annual report is made available to as many members of the public and partner organisations as possible. We publish it online, to our local Healthwatch Community, share with Healthwatch England, promote to the local media and present the report formally to the Brighton and Hove Health and Wellbeing Board and Health Overview and Scrutiny Committee .

Taking people's experiences to decision makers

We ensure that people who can make decisions about services hear about the insight and experiences that have been shared with us.

For example, we take information to the city's Health and Wellbeing Board and Health Overview Scrutiny Committee. We routinely meet with senior representatives at our local hospital Trusts and Care Quality Commission. We also sit on the city's Adult Safeguarding Board.

We also take insight and experiences to decision-makers across the Sussex Health and Care Partnership (our Integrated Care System). We hold a privileged seat at our city's Health and Care Assembly and Patient Experience Committee.

We also share our data with Healthwatch England to help address health and care issues at a national level.

Glossary

+	A&E	**Accident & Emergency Department** Also referred to as ED for Emergency Department.
+	BHCC	**Brighton & Hove County Council**
+	CQC	**The Care Quality Commission** The independent regulator of health and social care services in England.
+	ICB	**Integrated Care Board.** Whose main role is to agree the strategic priorities and resource allocation for all NHS organisations in Sussex.
+	JSNA	**Joint Strategic Needs Assessments** Bring together evidence from a range of sources to improve the health and wellbeing results of the local community and reduce inequalities for all ages.
+	RSCH	**Royal Sussex County Hospital.** Part of University Hospitals Sussex NHS Foundation Trust. The Hospital is an acute teaching hospital in Brighton.
+	SHCP	**Sussex Health and Care Partnership** Is an Integrated Care System (ICS) which serves a population of more than 1.7 million people in Sussex.
+	SPFT	**Sussex Partnership Foundation Trust** A specialist NHS organisation providing mental health, learning disability and neurodevelopmental services to people living in South East England
+	SCFT	**Sussex Community Foundation Trust.** The main provider of community NHS health and care across Brighton and Hove, East Sussex, High Weald Lewes and Havens and West Sussex.
+	ICS	**Integrated Care System** A way of working that brings together all the health and care organisations in a particular local area, to work together more closely.
+	UHSx	**University Hospitals Sussex NHS Foundation Trust** The main hospital trust which includes RSCH, Worthing Hospital and Princes Royal.

Healthwatch Brighton and Hove

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