NHS
University Hospitals Sussex
NHS Foundation Trust

Quality Account 2023-24

Contents

Part 1: Chief Executive Officer's Foreword

From 1 April 2023 to 31 March 2024, our colleagues at University Hospitals Sussex NHS Foundation Trust cared for more people in Sussex than ever before, and we wish to begin by saying a heartfelt and immense "thank you" to them all for everything they have achieved.

Over the past 12 months, 1.2 million patients had an outpatients' appointment. 421,000 people attended our emergency departments. 134,000 patients were admitted onto a ward. 50,000 people had surgery in our operating theatres. And 8,650 babies were welcomed into the world.

While remarkable just by themselves, these numbers are especially impressive given how extraordinarily challenging the year was on many different fronts - both for us, all our heath and care partners in Sussex, and the wider healthcare sector.

From unprecedented bouts of industrial action to enormous increases in demand for hospital services, the resilience demonstrated by our staff has been phenomenal and we owe them a huge debt of gratitude for all they have done in very trying circumstances.

Colleagues have done their utmost throughout the year to provide high quality care and keep our patients safe, and, at times, sadly this has led to more appointments and procedures being rescheduled and too many patients waiting longer than is acceptable to access our services.

We deeply regret this and wish to apologise to anyone who has been affected in this way. Throughout the year, we have been working extremely hard to reduce waiting times for patients and we can report improvements.

For example, our 4-hour A&E performance improved by around 6% year-on-year; with help from a national oversight group, we reduced our total waiting list every month from October to March, bucking the national trend; and improvements in cancer treatment waiting times exceeded planned recovery by the end of the year.

However, we know much more remains to be done and that the progress made to date will be cold comfort to patients who are still waiting too long to access services. The day-to-day reality for them, and the frontline teams who care for them, remains very challenging.

The context is important though. Each of our main hospitals has been operating either at, or above full capacity, for prolonged periods this year. And on many days, we have more than 300 patients in beds who no longer require hospital care, but who cannot leave due to staffing, capacity and funding issues in other parts of the local health and care sector.

The impacts of this are often most keenly observed in overcrowded emergency departments and full hospital wards, which in turn lead to longer waiting times and poorer patient experience - while there is much more still to do, many of the causes of this lie outside of the direct control of our Trust.

This is why we have strived to work ever more closely with all our partners from the Sussex Health and Care Partnership and NHS Sussex Integrated Care Board. The

systemic issues we face affect us all and it is only by working together that we can deliver the improvements we all want to see for patients.

We wish to thank all our primary care, community, mental health, ambulance, and social care colleagues for working with us during the year and for all their ongoing collaboration and support.

Improving Quality and Care Outcomes

Making improvements in our hospitals in everyone's business. Everyone is encouraged to share their ideas, speak up, and report all incidents to foster a learning safety culture founded upon the practices of continuous improvement.

In July we invested in a new, independent, and confidential Speak Up service, which is available to staff 24 hours a day, seven days a week. We also introduced a new incident reporting system which makes it easier to theme issues and share feedback and learning across the Trust. It also immediately alerts our Chief Medical Officer, Chief Nurse, and Patient Safety Director to all moderate or more severe harms that are reported.

Over the course of the year we have delivered our ambition is that at least 90% of patients rate their care as good or very good. Despite an overall downward trajectory for patient reported positivity about their care, throughout 2023/24 the average overall positive rating for the Trust using the Friends and Family Test (FFT) system was 90.1%. This is higher than the previous year (88%). We have also made improvements to quality and standards of care and patient outcomes through the achievement of 8 of the 9 CQUIN targets set.

Our SHMI (Summary Hospital Level Mortality Indicator) and HSMR (Hospital Standardised Mortality Ratio) have both remained within expected limited, and we have made a 4% improvement to our Crude Mortality rate.

Clinical Research and national best practice play a key part in delivering high quality services for our patients and we are proud of the work that has been achieved through participating in 91% of national audits and achieving an increase of 37% for recruitment of participants into National Institute of Health Research (NIHR) portfolio studies, improving our ranking amongst acute Trusts from 32nd to 24th.

We have also responded to visits from the Care Quality Commission, who returned to the Trust in August to inspect medicine and surgery services at our hospitals. In January, we received new CQC inspection reports from these visits and each hospital is now rated "Requires Improvement" overall, but "Outstanding" for Caring in most instances and the rating for Surgery services at Royal Sussex County Hospital was improved.

Key actions and recommendations from the CQC have been combined with feedback from other bodies such as NHS England, NHS Sussex and organisations such as Healthwatch and the Royal College of Surgeons to inform a new Quality and Safety Improvement Programme (QSIP) that was established in October.

Its core workstreams have been specifically designed to address the themes arising from CQC inspections and other oversight processes. These include improving quality, governance, risk management and assurance; meeting Well Led CQC criteria; improving access to surgery for patients; and improving the safety culture across the Trust.

QSIP, together with other major programmes of work to reduce waiting times for emergency, elective and cancer care, is the way we are implementing the positive changes that we; our patients, partners and regulators want to see. Our plans are detailed and robust, and designed to ensure that both us and our stakeholders can have confidence in the services and standards we are delivering.

To support this, we have invested in new technology and introduced new governance and live reporting processes to ensure we can provide information and assurance from every level of the Trust, from ward to board, by division of hospital, that provides insight and oversight of our large and complex Trust.

This is a key stage of our journey as a relatively young organisation that marked only its third birthday on 1 April 2024. Merging two large organisations during the Covid-19 pandemic was both complex and complicated. Each of our legacy Trusts brought strengths and weaknesses to the partnership and, distilling the best from each, and forging successful change, takes time. It cannot be rushed – but we have confidence in our trajectory and the ambition of our plans.

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

I hope you enjoy reading further details about UHSussex in this 2023/24 Quality Account which outlines our achievements and some of the work we will be undertaking in the coming year.

Dr George Findlay

Chief Executive

University Hospitals Sussex NHS Foundation Trust

1.1 Introduction to the Quality Account 2023/24

What we do

University Hospitals Sussex NHS Foundation Trust (UHSussex) was formed on 1st April 2021. The Trust was created by a merger of University Hospitals Sussex NHS Foundation Trust and Western Sussex Hospitals NHS Foundation Trust.

UHSussex serves a population of around 1.8 million people across a catchment area covering Brighton & Hove, East Sussex and West Sussex. The Trust employs nearly 20,000 people across five main hospital sites in Sussex and has an operating budget of more than £1 billion.

UHSussex runs seven hospitals in Chichester, Worthing, Shoreham, Haywards Health and Brighton and Hove, as well as numerous community and satellite services. The Trust is responsible for all district general acute services for Brighton and Hove, West and Mid Sussex and parts of East Sussex. It also provides specialised and tertiary services across Sussex and parts of the South East, including neuroscience, arterial vascular surgery, neonatology, specialised paediatric, cardiac, cancer, renal, infectious diseases and HIV medicine services.

Purpose of the Quality Account

NHS Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012, and the National Health Service (Quality Account) Regulations 2010, to produce an annual document detailing information in relation to the quality of services provided to local communities, any achievements and/or improvements made and any areas where further improvements may be required for each financial year. The Quality Account is therefore a key mechanism to enhance the Trust's accountability to the public and its commissioners, providing demonstrable evidence of measures undertaken in improving the quality of the Trust's services, and what further improvement is required. Quality accounts are therefore both retrospective and forward looking.

As part of the development of the Quality Account all Foundation Trusts are required to identify measurable priorities that are mapped against the three Darzi headings of Safe, Effective and Patient Experience.

The purpose of the account is to:

- promote quality improvement across the NHS
- increase public accountability
- allow the Trust to review the quality of care provided through its services
- demonstrate what improvements are planned
- respond and involve external stakeholders to gain their feedback including patients and the public.

UHSussex will continue to follow any advice and guidance put forward from NHS England to ensure patients continue to receive high quality care. For the completion of this quality account, NHS England has confirmed that NHS providers are no longer expected to obtain

assurance from their external auditors in the preparation of their quality account /quality report, however the trust has undertaken its own internal review to provide assurance that the required elements have been met (See Annex 1).

All elements of the Quality Account have also been assigned an Assurance Self-Assessment rating and explanation statement:

Self-Assessment Rating	Description of Rating
No Assurance	There are significant gaps in assurance of performance, systems or processes
Partial Assurance	There are gaps in assurance of performance, systems or processes
Assurance	Minor improvements needed in assurance of performance, systems or processes
Significant Assurance	There are no gaps in assurance of performance, systems or processes

Statements of Assurance from the Board

All NHS trusts are required in accordance with the statutory regulations to provide prescribed information in their Quality Account. This enables the Trust to inform the reader about the quality of their care and services during 2023/24 according to the national requirements. The data used in this section of the report has been gathered within the Trust from many different sources or provided to us from the Health and Social Care Information Centre (HSCIC). The information, format and presentation of the information in this part of the Quality Account is as prescribed in the National Health Service (Quality Accounts) Regulations 2010 and Amendment Regulations 2012 / 2017.

Part 2: Priorities for Improvement and Statements of Assurance from the Trust Board

2.1 Our Approach to Quality Improvement

2.1.1 Patient First Programme

Patient First is our long-term approach to transforming hospital services for the better: it is a process of continuous improvement that gives frontline staff the freedom to identify opportunities for positive, sustainable change and the skills to make it happen.

The Patient First Programme drives quality improvement at UHSussex. It comprises six strategic themes;

Strategic Theme	Vision	Goal
Patient	Excellent care every time	Positive experiences for all patients and their families
Sustainability	Making the most of our resources	High—quality, accessible services delivered within budget
People	A great place to work	Staff supported to provide excellent care
Quality	Best Outcomes	Zero Preventable harms and lowest mortality among similar trusts
Systems & Partnerships	Accessible Care	Achieving national standards for planned care, cancer and emergency care
Research & Innovation	Evidence-based improvement	Research and Innovation for all patents and staff

In simple terms the main aim of our Patient First Programme is to empower and enable everyone to be passionate about delivering excellent care every time. Further information about Patient First can be found on the Trust website.

2.1.2 Quality and Safety improvement Programme (QSIP)

The Quality and Safety improvement Programme (QSIP) was established to drive sustainable improvements in the services to patients provided by the Trust. The approach of QSIP is to borrow methodologies from a variety of improvement approaches rather than focus exclusively on lean methodology deployed by the Patient First programme. Whilst there are series of ongoing improvement projects that addresses areas where Trust's performance is below expectations, the QSIP programme is aimed at providing more dedicated focus on specific quality and safety metrics and processes that have been highlighted by the CQC as being below the required standard.

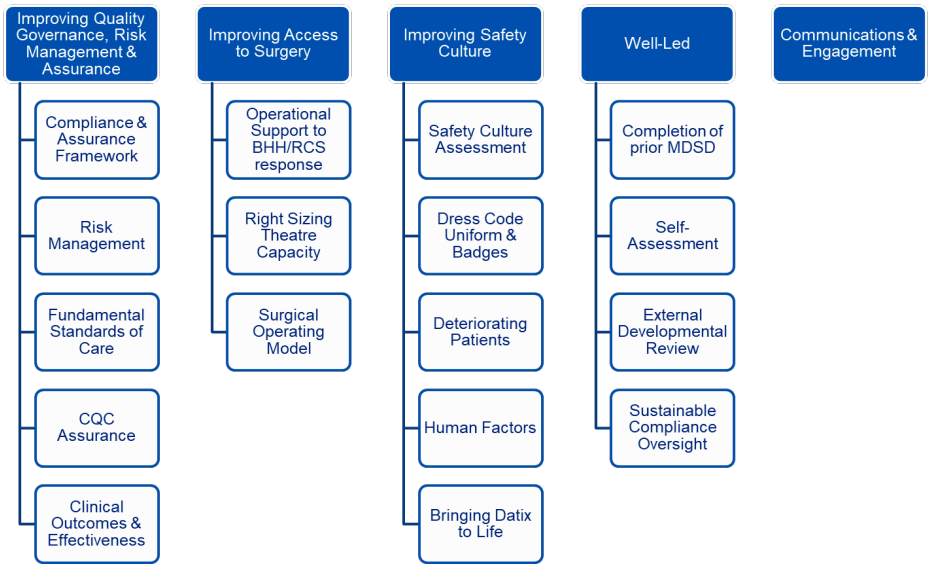
The QSIP programme aims are:

- To deliver sustainable improvement to the quality of our services.

- To engage and support staff in the improvement plan.
- Ensure a transparent internal process for staff to raise concerns with confidence.
- Ensure effective mechanisms for all staff to provide feedback and respond effectively to this feedback including staff survey, complaints, grievances, and whistleblowing concerns.
- Ongoing triangulation of the impact of improvement actions with wider quality metrics including patient and staff feedback, incidents, and complaints.

This programme has four main delivery workstreams, supported by a communication & engagement workstream, each led by a Trust Executive.

Figure 16 QSIP Workstreams:

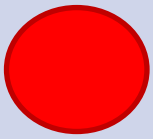


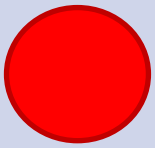
2.2 Priorities for Improvement

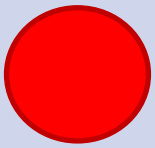
2.2.1 Progress against our 2022/23 Quality Account Priorities

The Trust 2022/23 Quality Account set out the commitment to the Trust's True Norths relating to Quality & Patient domains, as well as committing to enhance the data and metrics used to measure quality performance and improvement, which has been achieved through the implementation of the Trust wide Quality Scorecard, which provides metrics to enable the monitoring and assurance of Quality performance and improvement.

Patient First Quality Priorities 2022/23		
Domain	Description	Achievement
Patient To be in the top quartile nationally for patients rating heir experience as good or very good for all touchpoints	For all our patients to have a positive experience of the care that they receive within the organisation. The benchmark percentage of patients rating the trust as 'good' or 'very good' in FFT was below the top quartile of trusts' ratings nationally across all touch-points, with alternative in both satisfaction and response rates across sites and touch-points. This means that some patients attending our services are not having a positive experience of care.	
	Our ambition is that at least 90% of patients rate their care as good or very good. Despite an overall downward trajectory for patient reported positivity about their care, throughout 2023/24 the average overall positive rating for the Trust using the Friends and Family Test (FFT) system was 90.1%. This is higher than the previous year (88%). Each month, the Trust receives over 12,000 survey responses with an average response rate of 22%. As such the True North was on track for the year.	

Patient First Quality Priorities 2023/24		
Domain	Description	Achievement
Quality To achieve the lowest crude mortality rate within our peer group	To achieve a 10% reduction in mortality	
	Last year's Patient First programme set a goal of achieving the lowest crude mortality rate within our peer group (Trusts in the South East) with the goal of reducing crude mortality by 10%. The most recent data for our peer group (January 2022 to December 23) indicates that the Trust currently has the fifth highest crude mortality rate in the group of nine Trusts. The 12 month rolling crude mortality rate for the period April 2023 to March 2024 was 2.67% which is lower than the historical Trust rate of 2.78%. It should be noted that although crude mortality rates, are helpful indicators of the number of deaths occurring each month, they do not take account of case mix (i.e. how sick patients are) so it is not possible to compare the quality of care between hospitals using this measure alone. Hospitals with high crude mortality rates may be seeing patients who are sicker and require more complicated treatment than those with lower mortality rates, not that the quality of care provided is worse. Other mortality measures are also available including the Hospital Standardised Mortality Ratio and the Summary Hospital Mortality Indicator which are standardised to a national population and adjusted for risk.	

Patient First Quality Priorities 2023/24		
Domain	Description	Achievement
Quality "Zero harm" occurring to our patients when in our care. Harms contribute significantly to poor patient experience and outcomes and staff experience	5% reduction in the level of harms	
	For 23/24 this target has not been achieved. This is due to multiple contributing factors including access to a Trustwide incident reporting system (since merger), system capacity (particularly mental health and complex discharge from hospital), staff capacity, reporting culture and the increase in risk of harm from patients waiting for treatment post COVID. A significant programme of work has been underway to implement a new standardised, Trustwide incident reporting system that was fit for purpose and allowed for ease of reporting, feedback, and shared learning. When the baseline of incident reporting has been established; the trajectory for harm reduction with targeted and specific improvement programmes can be implemented. The system is now live and fully aligned with the Trust Clinical Operating Model (COM) allowing for full matrix working, visibility, and quality improvement between the divisional triumvirate and hospital senior management teams.	

Patient First Quality Priorities 2023/24		
Domain	Description	Achievement
Quality "Zero harm" occurring to our patients when in our care. Harms contribute significantly to poor patient experience and outcomes and staff experience	To reduce falls by 30%	
	Between February 22-and January 23 an average of 317 inpatient falls occurred each month (LCL 243-UCL 391 falls) in the Trust. A Trust wide falls reduction target of 30% was agreed which equated to 222 falls per month. During the last financial year an average of 288 falls per month has occurred, this equates to a 9% reduction in falls	

2.2.2 Quality Priorities 2024/25

During 2024/25 the Trust is likely to review and refresh the Patient First True North and Breakthrough Objectives relating to the Patient and Quality domains and these will be reported and reflected in next years Quality Account.

In addition, the Trust will deliver the following Quality Priorities:

Quality Priorities 2024/25 *to be achieved by April 25 unless otherwise stated*		
Domain	Description	How we will measure success
Safe Reducing harm and creating a culture of safety	Improved reporting of incidents from the 2022 national baseline of 54.9 per 1000 bed days	A rate of 60 per 1000 bed days
	Timely discussions with patients and their families where a harm incident has been identified	100% compliance with Duty of Candour
Effective Evidence based and best practice	Named Clinicians for all NICE Guidance	100% of NICE guidance has a named consultant
	Timely review of NICE Guidance & National Audit Recommendation Reports	80% of NICE guidance reviewed with 45 days of publication 75% of National Audit Reports reviewed within 45 days of publication
	Timely review of clinical documents	100% in date (or review) by 31 August 2025
	Full participation in the Specialised Services Quality Dashboards (SSQDs)	Data submitted to all SSQDs Routine monitoring each quarter for any outliers
Patient Experience All of our patients have an excellent experience of care	Patients describe their care as 'very good' or 'good'	90% score for recommend rate trust wide using envoy
Quality/Continuous Improvement	Development of a centralised action / recommendations register and learning outcomes framework	Centralised register implemented with a documented process for learning and outcomes
	Fundamental Standards of care	95% completion rate for the following audits: Patient Experience, Pressure Damage, Nutrition and Hydration, Infection Prevention, Handy Hygiene, Minimum Safety Standards, Medicines Safety Standards and NEWS2.

Sussex Integrated Care Board Priorities	The Trust supports the Sussex Integrated Care Board 'Improving Lives Together Strategy' which aims to • Improve health and health outcomes for local people and communities, especially those who are most disadvantaged • Tackle the health inequalities we have • Working better and smarter, getting the most value out of the funding we have • Do more to support our communities to develop socially and economically

2.3 Clinical Effectiveness & Assurance

2.3.1 Participation in National Clinical Audits (NCA) and National Confidential Enquiries into Patient Outcomes and Death (NCEPOD)

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex participated in 91% of eligible audits, however there are opportunities to improve the systems and processes to embed the outcomes, actions and recommendations from NCA & NCEPOD			

The Trust's participation in National Clinical Audits and National Confidential Enquiries into Patient Outcome and Death enables us to benchmark the quality of the services that we provide against other NHS Trusts. It also highlights best practice in providing high quality patient care and drives continuous improvement across our services.

During 2023/24 the Trust participated in 52 out of 57 national clinical audits, achieving 91% participation in eligible audits as set out in the HQIP National Clinical Audit and Patient Outcomes Programme Directory. Of the National Audits undertaken across the Trust:

UHSussex did not participate in the following audits:

- National Audit of Care at the End of Life (NACEL)
- National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer
- National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer
- National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)

Throughout 2023/2024 the Trust were eligible to partake in 7 confidential enquiries.

The list of NCA & NCEPOD audits and enquiries, number or registered cases and percentage submitted for each audit are detailed in Annex 2. Some areas have been marked as 'in progress' which means that the data is still being collated for the 2023/24 reporting period. Annex 2 also contains a summary of some of the key audit achievements

and planned actions for improvement. Annex 2 also contains a summary of the key audit achievements and planned actions for improvement.

2.3.2 Local Audits

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex improved the number of completed audits and action plans, however there are opportunities to improve the systems and processes to embed the outcomes, actions and recommendations from local audits			

Clinical Audit, including service evaluation drives improvement through a cycle of service reviews against recognised standards and then provides a baseline for implementing change as required. We also use audit to benchmark our care against local and national guidelines so we can put resources into areas requiring improvement; this is part of our commitment to ensuring the best treatment and care for our patients.

Local audits are registered via divisions throughout the course of the year and are based on areas of clinical interest, or undertaken in response to local patient safety, quality, or clinical effectiveness concerns. Audits were undertaken across all the Trust Divisions, overseen by the Clinical Outcomes and Effectiveness Team.

Year	Local Audits/Service Evaluations			
	No. Registered	No. Completed	Action Plans Completed	Action Plans In Progress
2023/24	238	91 (38%)	52 (22%)	186 (78%)
2022/23	262	34 (13%)	4 (2%)	30 (12%)

There is a need to ensure realistic timeframes to allow for the completion of audit actions/embedding new systems or processes in practice. Review of assurance that actions have been completed is therefore undertaken with a time lag. Annex 2 summarises actions taken in response to a small sample of local audits that have been completed and reported on throughout the year.

2.3.3 NICE (National Institute for Health & Care Excellence) Guidance

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex overarching compliance has improved, however there are opportunities to improve the systems and processes to review guidance in a timely way to identify and embed applicable recommendations			

NICE Guidelines, Clinical Guidelines, and Quality Standards are evidence-based recommendations for health and care in England. Whilst guidance published by NICE is

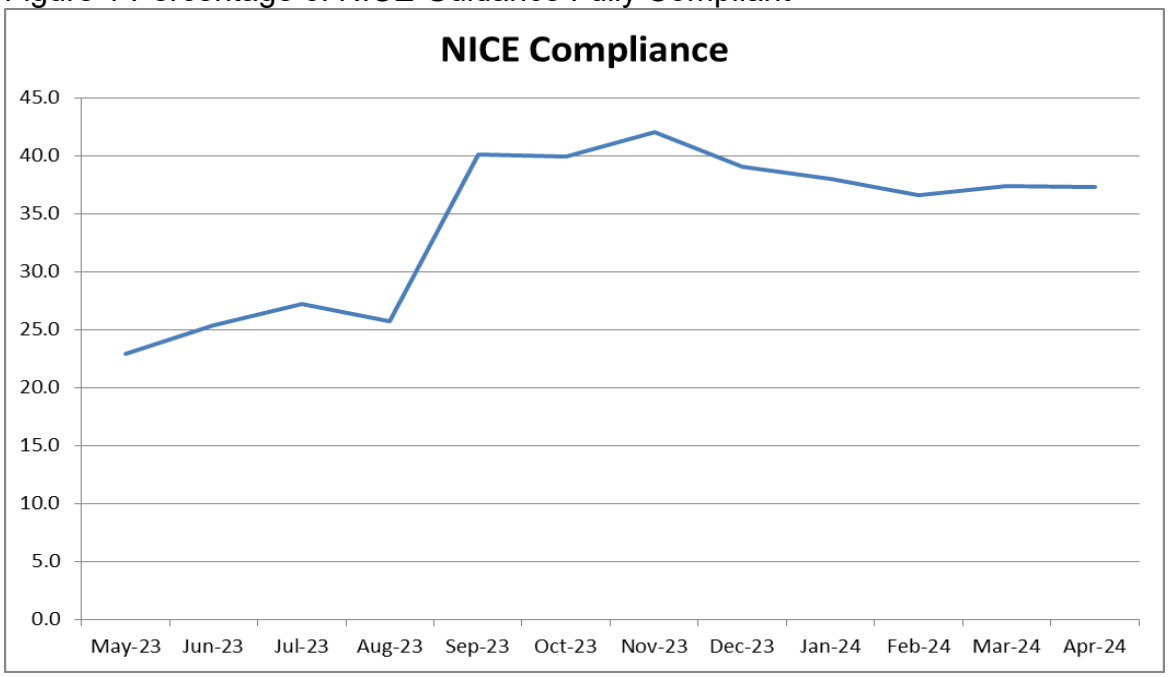
not statutory healthcare organisations are expected to take into account recommendations from NICE when developing and delivering services.

UHSussex takes a coordinated approach to the dissemination and implementation of NICE guidance through a standardised process that enables Clinical Division's to provide assurance on compliance.

Communication, reporting and dissemination of guidance to the Clinical Divisions is coordinated via a monthly NICE divisional dashboards and trackers.

During 2023/24 full compliance with NICE guidance has risen from 23% to 37%

Figure 1 Percentage of NICE Guidance Fully Compliant



NICE Technology Appraisals (TAs) are statutory guidance for which NHS healthcare services must make funding available and implement within three months from their date of issue. The formulary status for TAs is reviewed at the Medicine, Safety and Governance Group monthly. During 2023/24 NICE published 97 TA's all of these TA's have been reviewed in accordance with the Sussex Health and Care Partnership Area Prescribing Committee guidelines. The majority of TA's (n=53) have been approved for prescribing, supply and monitoring only in specialist care settings, 29 have been assessed as Non formulary and are therefore not suitable for prescribing in any setting. Nine TA's were assessed as not relevant for example Sebelipase alfa for treating Wolman disease is prescribed for the mangement of paediatric genetic disorders a service UHSussex is not commissioned to provide. Four TA's have been approved as suitable for prescibring in any setting. Finally, two have specialist recommendation status with ongoing prescribing and monitoring in any setting.

Management of NICE Guidance

The Clinical Outcomes & Effectiveness Team have undertaken a comprehensive review of the management of NICE guidance covering the receipt, dissemination, and implementation of all guidance issued by NICE.

During the final quarter of 2023/34 the following changes were implemented:

- Introduction of reporting of Technology Appraisals's
- Introduction of new Divisional Baseline Assessment Forms
- Review of Divisional Trackers, inclusive od speciality level performance data

During 2024/2025 the target is to reduce overdue NICE guidance from over 60% down to less than 25% by the end of August.

2.3.4 Patient led assessment in the care environment (PLACE) audit

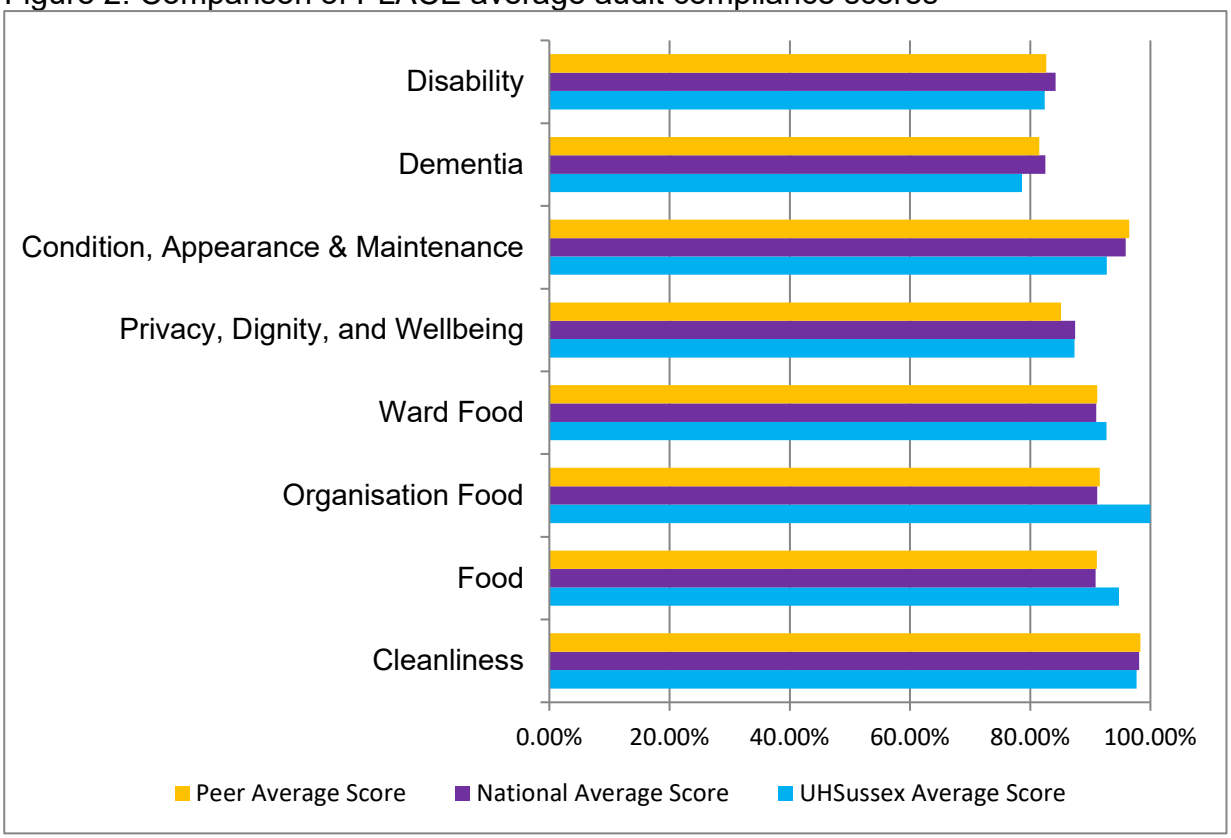
Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex scores are favourable in some areas, however there are opportunities to improve scores across dementia, cleanliness and condition, appearance and maintenance.			

The Trust undertook its annual PLACE assessments Between October and December 2023. Table 1 details the PLACE average audit compliance scores for all inpatient Hospital sites within the Trust as well as the National and Peer average scores:

Table 1: PLACE average audit compliance scores

	UHSussex Average Score	National Average Score	Peer Average Score
Cleanliness	97.72%	98.10%	98.34%
Food	94.75%	90.86%	91.08%
Organisation Food	99.99%	91.17%	91.57%
Ward Food	92.70%	90.98%	91.17%
Privacy, Dignity, and Wellbeing	87.38%	87.49%	85.14%
Condition, Appearance & Maintenance	92.72%	95.91%	96.45%
Dementia	78.61%	82.54%	81.49%
Disability	82.43%	84.25%	82.68%

Figure 2: Comparison of PLACE average audit compliance scores



The Trust has an established PLACE Group that meets weekly to complete planned audits for all sites and is attended by service leads, Facilities and Estates and Patient Representatives. The groups audits all required PLACE domains and reports into the monthly PLACE Review Meeting and Facilities and Estates Divisional Board.

2.3.5 Getting it Right First Time (GIRFT)

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is actively participating in Cohort 2			

During 2023/24, the Trust participated in one GIRFT deep dive review and six gateway reviews aimed at driving specialty improvement alongside peers from other trusts. The Trust's local GIRFT team works closely with divisional colleagues in progressing speciality implementation plans, which include GIRFT national and local recommendations, utilising Model Health System data to assess specialty performance across a range of quality metrics.

UH Sussex is actively participating in the Further Faster programme, joining Cohort 2 in November 2023. This is a GIRFT programme aimed at eradicating 52-week waits. This initiative is led by the Planned Care and Cancer Managing Director The further faster initiative funds improvements and the implementation of digital solutions to enhance patient care and operational efficiency. Currently, there are 20 specialties involved in this programme. The specialties are currently working on the handbook and checklist recently published by the GIRFT Further Faster team.

UHSussex joined the GIRFT Further Faster programme in November 2023. By December 2023, the 52-week waits had decreased by 20% from the peak in September 2023, despite challenges posed by industrial action and bank holidays. However, due to increased demand, waiting times have risen again.

The Further Faster programme facilitated improvements in several areas including patient-initiated follow-up (PIFU), reduction in Did Not Attend (DNA) rates, the standardisation of virtual or remote clinics and adoption of best practice pathways. Additionally, a Single Point of Access (SPOA) was established in some specialties. The published GIRFT Further Faster specialty handbooks are integrated into the Trust's annual planning to ensure continued progress.

2.3.6 Commissioning for Quality and Innovation (CQUIN)

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex delivered 8 of the 9 agreed programmes			

Nine CQUIN programmes were agreed, with eight out of the nine programmes having been successfully delivered.

Supporting patients to drink, eat and mobilise (DrEaM) after surgery:

Target: Ensuring 70-80% of patients drink, eat and mobilise ('DrEaMing') as soon as possible after surgery helping to prevent post-operative blood clots and respiratory complications resulting in an average 37.5% reduction in length of stay for patients who dream in the first 24 hours after surgery.

Performance	q1	q2	q3	q4
Achievement	79.0%	79.0%	80.5%	78%

Prompt switching of intravenous to oral antibiotic:

Target: Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.

Performance	q1	q2	q3	q4
Achievement	29.0%	11.0%	12.0%	12.0%

Compliance with timed diagnostic pathways for cancer services:

Target: Achieving 35-55% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways

Performance	q1	q2	q3	q4
Achievement	59.0%	51.0%	56.0%	61.0%

Assessment and documentation of pressure ulcer risk:

Target: Achieving 70-85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.

Performance	q1	q2	q3	q4
Achievement	43%	37%	79%	67.7%

Recording of and response to NEWS2 score for unplanned critical care admissions:

Target: Achieving 30% or more of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.

Performance	q1	q2	q3	q4
Achievement	66.6%	68.0%	75.5%	

Achievement of revascularisation standards for lower limb ischaemia:

Target: Achieving a minimum of 45% of revascularisation patients having their procedure within 5 days in order to reduce the delays in assessment, investigation, and revascularisation in patients with chronic limb threatening ischaemia, and in turn to reduce length of stay, in-hospital mortality rates, readmissions and amputation rates.

Performance	q1	q2	q3	q4
Achievement	57.0%	90.0%	60.4%	

Treatment of non small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway:

Target: Achieving 85% of adult patients with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-1) referred for treatment with curative intent, as per the NICE Quality Standard 17 recommendation.

Performance	q1	q2	q3	q4
Achievement	96.7%	100%	95.0%	88.6%

Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery:

Target: Achieving high quality shared decision (SDM) making conversations to support patients to make informed decisions based on available evidence and their personal values and preferences and knowledge of the risks, benefits and consequences of the options available to them.

Performance	q1	q2	q3	q4
Achievement	Data only required Q2 and Q4	80.0%	-	83.0%

Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres:

Target: Achieving a minimum of 40% of patients commencing treatment (prescribed, on Blueteq) within 4 weeks of a positive diagnosis of viraemia.

Performance	q1	q2	q3	q4
Achievement	-	93.3	83.3	73.3

2.3.7 Reporting to Secondary Uses Services (SUS)

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	SUS Data submission include the required information in over 98% of records			

The Secondary Uses Services (SUS) is designed to provide anonymous patient-based data for purposes others than direct clinical care such as health planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

UHSussex submitted records during 2023/24 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data (April 2023 – March 2024), which included the patient's valid NHS number was:

- 99.8% for admitted patient care:
- 99.9% for outpatient care and
- 98.8% for accident and emergency care

The percentage of records in the published data (April 2023 – March 2024), which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care; and
- 99.8% for accident and emergency care

2.3.8 Data Security and Protection Toolkit Attainment Levels

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex met most of the conditions, with submission of an action plan and received an independent Toolkit audit result of Amber/Green			

The Data Security and Protection Toolkit enables the Trusts to measure its compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

In 2022/23, our Information Governance Assessment submission met most of the conditions, and an action plan produced to guarantee all requirements are met going forward.

An independent audit report is generated for the Toolkit each year and is due to take place in April 2024. Last year, for this submission we have been rated as Amber/Green.

The Trust's full response for 2022/23 has yet to be submitted as the deadline is 30 June 2024.

2.3.9 Clinical Coding Error Rate

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex met or exceed expectations for clinical coding errors			

UHSussex was not subject to an Audit Commission Payment by Results clinical coding audit during 2023-24. However, a local clinical coding audit has been undertaken on 200 patients discharged in June 2023. In addition, Clinical Coding audit and quality assurance checks have been carried out monthly by an NHS Digital Approved Clinical Coding Auditor.

Episodes from Worthing Hospital and St Richards Hospital were audited from information available on the Evolve electronic document management system (eDMS) and episodes from Sussex Eye Hospital, Princess Royal Hospital and Royal Sussex County Hospital were audited from the paper casenotes.

	Percentage of Correct Codes	**Toolkit Rating**
Primary Diagnosis	99.00	Met Expectations
Secondary Diagnosis	88.71	Met Expectations
Primary Procedure	98.00	Exceeded Expectations
Secondary Procedure	92.92	Exceeded Expectations

As a result of undertaking the audit the Clinical Coding Manager will:

- Ensure that the Clinical Coding audit, recommendations and summary of changes document are shared with the Clinical Coders and issue guidance where errors or omissions have occurred.
- Ensure that the Clinical Coding team at RSCH and PRH are familiar with the yellow pre-op cataract and nursing pre-assessment documents and the importance of their use in the coding process.
- Remind the Clinical Coding team at WGH and SRH to include any conditions listed in the preassessment electronic form as part of the coded data.

- Hold National Standard refresher sessions for National Clinical Coding Standard PCSM6: Catheterisation of the bladder for Trial Without Catheter and DGCS.3 Comorbidities for the recording of mandatory comorbidities.

2.3.10 Data Quality and Actions to Improve Data Quality

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	A data quality group established to monitor data			

High quality information leads to improved decision making, which in turn results in better patient care, wellbeing and safety. We continued to focus on improving the quality of our performance data, and the Trust is taking the following actions to improve data quality:

- Staff in the Trust are continually encouraged to log data quality related incidents on DATIX. The incidents reported are constantly monitored and lessons identified for these cases and provide training and support to areas that would benefit from this most.
- Demographic Batch Service (DBS) processes are run as normal twice a day. This is supplemented by a new monthly DBS tracing of 'Dates of Death' and 'Name Aliases of new-borns' for the entire PAS Index (2.5 million records). from the NHS Spine
- Staff are activity encouraged to utilise the available resources (DQ Information Pack) as well as the two e-modules (Patient Identification and Data Quality Awareness).
- A "Data Quality Group" has also been established and since December 2023 has been regularly meeting.

2.3.11 Patient Reported Outcome Measures

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHsussex is below national averages for PROMs			

Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves for the following procedures:

- Hip replacement surgery;
- Knee replacement surgery

A higher score indicates better health and/or greater improvement in function following an operation.

Indicator Domain	Patient Reported Outcome Measures EQ 5D Index (casemix adjusted health gain) Helping people to recover from episodes of ill health or following injury					
Type of Surgery	UHSussex 2020-21	National average 2020-21	Best performing Trust 2020-21	Worst performing Trust 2020-21	UHSussex 2019-20	UHSussex 2018-19
Hip replacement	0.437	0.453	0.524	0.411	0.464	0.439
Knee replacement	0.295	0.317	0.369	0.254	0.314	0.317
Data Source	https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms					

The most recently finalised published adjusted health gain figures available cover the period 2020/21.

The table is based on the adjusted average health gain figures for the EQ5D outcome measures.

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reason: it has been taken from a national data set and the Trust's participation rate is high improving the reliability of the data.

2.3.12 Patients readmitted to a hospital

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	For adults the UHSussex performed better than previous years, but above the national average. For children UHSussex performed worse than previous years, but below the national average.			

The percentage of patients aged:

- 0 to 17; and
- 18 or over

readmitted to a hospital which forms part of the trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period.

Indicator Domain	**Crude Readmission Rate for patients readmitted to a hospital within 30 days of being discharged** Helping people to recover from episodes of ill health or following injury					
Age Group	UHSussex 2023	National average 2023	Best performing Trust 2023	Worst performing Trust 2023	UHSussex 2022-23	UHSussex 2021-22
Patients aged 0 to 17 years	9.99%	10.57%	4.51%	20/22%	9.72%	9.70%
Patients aged >18 years	8.94%	8.60	4.10	14.88	7.44%	13.49%
Data Source	Activity and Readmission Data produced using Healthcare Evaluation Database					

Table based on latest available data (January 2023 – December 2023)

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reasons: it is taken from a national provider.

Reducing 30 day readmissions to hospital is an important national indicator across the NHS. Improved discharge processes are key to ensuring patients are discharged to the right place and at the appropriate time in order to prevent the costly effects of re-admitting patients.

2.4 Regulatory Compliance

2.4.1 Care Quality Commissioner (CQC) Inspections & Ratings

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is rated as Requires Improvement overall.			

The CQC has undertaken several inspections across the Trust since the Trust was established in April 2021. The most recent inspection of our hospitals was in August 2023, and covered General Surgery and Medicine at our main hospital sites. Previous inspections included Maternity services across each of the Trust's four main sites, General Surgery at Royal Sussex County Hospital, the Emergency Department at the Royal Sussex County Hospital Royal Children's Hospital and Neurosurgery at the Royal Sussex County Hospital.

As a result of the inspection in August 2023 each hospital was rated as "*requires improvement"* as was the Trust overall. The previous inspections did not change hospital ratings from those inherited from Western Sussex Hospitals Foundation NHS Trust and Brighton and Sussex University Hospitals NHS Trust.

Table 2 shows the CQC ratings by domain for each of the four registered hospitals sites, noting that Southlands is registered under Worthing hospital.

Table 2: CQC ratings by domain for UHSussex

	Overall	Safe	Effective	Caring	Responsive	Well-led
Princess Royal	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
St Richard's	Requires Improvement	Requires Improvement	Good	Outstanding	Requires Improvement	Requires Improvement
Royal Sussex County	Requires Improvement	Requires Improvement	Requires Improvement	Outstanding	Requires Improvement	Requires Improvement
Worthing	Requires Improvement	Requires Improvement	Requires Improvement	Outstanding	Requires Improvement	Requires Improvement

The CQC reports include numerous positive comments in respect of good care and treatment, kind and compassionate staff, teams working well together, patients being respected and involved with their care and patients being supported to lead healthier lives and good local leadership. Of particular note, was the latest inspection of general surgery at the Royal Sussex County Hospital, which demonstrated improvement which supported a positive movement in overall hospital rating.

The CQC also made a series of recommendations or “must do actions”. Some of these are practical, such as improving training and appraisal rates and doing more to address staffing pressures, whereas others are cultural such as promoting a better learning culture, doing more to make sure colleagues feel able to speak up, and instilling confidence that concerns will be responded to. A full breakdown of Must Do Actions and performance against them in given in Annex 4.

In response to these reports and to drive sustained improvement the Trust established the Quality and Safety Improvement Programme (QSIP).

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period. However, the Trust has continued to engage with the CQC has sought to understand our services and provide insights for improvement.

2.4.2 Human Tissues Authority (HTA)

In November 23 the Independent Inquiry into the issues raised by the David Fuller case was published. The report made 17 recommendations; the Trust is currently complaint with 15 of these recommendations.

Mortuary staff are working on full compliance with the outstanding two recommendations, this will involve ensuring that five additional audits are undertaken, and a number of policies and procedures are updated. Work is also underway ensuring that all mortuary staff have enhanced rather than basic DBS checks.

The extensive programme of work undertaken in 23/24 was recognised by the Human Tissue Authority (HTA) visit in April 24. The HTA noted the high level of staff engagement, improved storage, significantly improved processes in relation to tissue retention and traceability.

2.4.3 Medicines & Healthcare Products Regulatory Authority (MHRA)

The pharmacy department received a MHRA inspection for its Wholesale Dealer Authorisation (WDA) 35588 on the 30th and 31st of October 2023 at Brighton General Hospital pharmacy procurement, Royal Sussex County Hospital and Worthing sites. Subsequently, re-inspection dates were booked for the 17th and 18th of June 2024 at Royal Sussex County Hospital and Worthing sites.

The licence revalidation was referred to the Inspection, Enforcement & Standards Division due to level of non-compliance and number of Critical and Major deficiencies raised. The Trust was able to respond on 20th November 2023 within the permitted timeframe. Subsequently the corrective actions were tracked and any actual or potential non-compliance within timescales were notified to MHRA as per process. Deficiency actions were completed within the timescale proposed (31 May 2024). Actions included the

implementation of a new comprehensive quality system and a new quality management system which now includes cross-site procedures. Responsible Person training has been undertaken either as refresher or for additional staff trained. Internal audit restarted in January 2024 cross-site to ensure that quality is embedded and actions raised are tracked and re-visited. Monthly oversight meetings have been put in place. Staff training is on-going for new systems including change control and deviation reporting and expiry date checking. Some challenges remain in place at Worthing due to the walk-in cold store failure and the use of temporary standalone fridges.

The aseptic preparation facilities are regulated by the Specialist Pharmacy Service (SPS). The Pharmacy Aseptic Unit at Royal Sussex County Hospital was inspected between the 4th and 5th July 2023. The overall deficiency rating of Medium Risk was allocated. A SPS review meeting took place on 5th December 2023 with a further interim review on 23rd January 2024. A re-inspection is booked for the 19th and 20th of June 2024. The overall rating of medium risk will likely continue to be given due to the age and non-compliance of the fabric of the facilities at Brighton (major deficiency). The deficiency action plan is being worked through with actions either completed or in-process. Actions included: Accountable pharmacist in post, capacity and contingency procedure update, Trust intrathecal policy update, updating environmental monitoring reporting, validation master plan reporting,

The Pharmacy Aseptic Unit at Worthing and St Richards Hospital took place on 8th, 9th and 10th August 2023. An overall deficiency rating of High Risk was allocated. The units were re-inspected on 29th January and the 1st and 2nd of February 2024. The overall deficiency rating was reduced to Medium Risk for both units. An overall rating of medium risk will continue to be given due to the age and non-compliance of the facilities at Worthing (major deficiency). The deficiency action plan is being worked through with actions in-process. Actions included: Environmental monitoring reporting, validation master plan reporting, capacity and contingency procedure update, Trust intrathecal policy update, Estates technical agreement, Planned Preventative Maintenace (St Richards Hospital)

Alignment of some Aseptic Unit systems cross-site is in process with increased interaction and knowledge share via Preparative Services monthly Board meetings.

2.5 Mortality & Learning from Deaths

Overview of new processes e.g. Learning from Deaths (LFD) meeting, panels.

2.5.1 Summary Hospital-Level Mortality Indicator

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex SHMI is as expected			

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England. SHMI is the ratio between the actual number of patients who died following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

The expected number of deaths is calculated from statistical models derived to estimate the risk of mortality based on the characteristics of the patients (including the condition the patient is in hospital for, other underlying conditions the patient suffers from, age, gender and method of admission to hospital).

SHMI gives an indication for each non-specialist acute NHS trust in England on whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected', 'as expected' or 'lower than expected' when compared to the national baseline.

Indicator Domain	**Summary Hospital-level Mortality Indicator** Preventing people from dying prematurely				
UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2022-23	UHSussex 2021-22
104.88 ***As expected***	100.00 **As expected**	71.28 ***Lower than expected***	121.07 ***Higher than expected***	111.59 ***As expected***	105.77 ***As expected***
Data Source	Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS England Digital				

Table based on latest available data (January 2023 - December 2023)

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reason that it is taken from a well-established national source.

The University Hospitals Sussex NHS Foundation Trust has taken the following actions to improve this score by routinely monitoring mortality rates at the Trusts Strategic Deployment Review Meeting. This monitoring includes looking at mortality rates and any

diagnostic conditions or procedures that may be flagged by early warning systems that have been put in place.

Palliative care indicators are included below to assist in the interpretation of SHMI by providing a summary of the varying levels of palliative care coding across non-specialist acute providers.

Indicator Domain	**Percentage of patient admissions with palliative care coded at either diagnosis or specialty level** Preventing people from dying prematurely				
UHSussex 2023	National average 2023	Best performing Trust for SHMI 2023	Worst performing Trust for SHMI 2023	UHSussex 2023-23	UHSussex 2021-22
2.33	2.00%	0.89%	4.02	2.8%	2.3%
Data Source	Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset				

Table based on latest available data (January 2023 - December 2024)

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reason that it is taken from a well-established national source.

The University Hospitals Sussex NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services by regularly monitoring mortality data at the Trust Strategic Deployment Review Group. Where concerns are identified a deeper dive into the data and in order to identify any possible concerns would be initiated.

2.5.2 Hospital Standardised Mortality Ratio (HSMR)

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex HSMR is as expected			

The HSMR is a ratio of the observed number of in-hospital deaths at the end of an inpatient admission to the expected number of in-hospital deaths (multiplied by 100) for 56 specific diagnostic (CCS) groups which account for 80% of in-hospital deaths. The expected deaths are calculated from logistic regression models with a case-mix adjustment that accounts for the patients age, sex, deprivation, admission method, the presence of palliative care, etc.

Care is needed when interpreting HSMR. Although a score of 100 indicates that the observed number of deaths matched the expected number in order to identify if variation from this is significant confidence intervals are calculated. A Poisson distribution model is used to calculate 95% and 99.9% confidence intervals and only when these have been crossed is performance classed as higher or lower than expected.

Indicator Domain	**Hospital Standardised Mortality Ratio** Preventing people from dying prematurely				
UHSussex 2023-24	National average 2023-24	Best performing Trust for SHMI 2023-24	Worst performing Trust for SHMI 2023-24	UHSussex 2022-23	UHSussex 2021-22
99.12 ***As Expected***	100.00 **As expected**	73.34 ***Lower than expected***	139.15 ***Higher than expected***	98.44 ***As expected***	94.13 ***As expected***
Data Source	HSMR data produced using Healthcare Evaluation Database				

Table based on latest available data (February 2023 - January 2024)

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reason that it is taken from a well-established national source.

The University Hospitals Sussex NHS Foundation Trust has taken the following actions to improve this score by routinely monitoring mortality rates at the Trusts Strategic Deployment Review Meeting. This monitoring includes looking at mortality rates and any diagnostic conditions or procedures that may be flagged by early warning systems that have been put in place.

2.5.3 Learning from Deaths

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Only 44% of Structured Judgement Reviews were completed in a timely way, resulting in a back log of outstanding reviews. There are opportunities to improve the systems and processes to complete reviews, and embed learning identified			

During 2023/24 4247 adults died under the care of University Hospitals Sussex NHS Foundation Trust, with

- 3874 adult deaths recorded as inpatient deaths, and
- 316 adult deaths recorded in the Emergency Department.

	Q1	Q2	Q3	Q4	Total
No. Deaths Recorded	879	978	1173	1160	4190
No. of patients that died were registered as having a Learning Disability	8	8	6	3	25
No. of adult patients that died were known to have Severe Mental Illness (SMI)	14	4	5	6	29

2.5.4 Medical Examiner Scrutiny and Coroner Referrals

The Medical Examiner Service was introduced in 2020 which provides independent scrutiny of all inpatient and Emergency Department deaths at University Hospitals Sussex NHS Foundation Trust, with;

- 22% of all deaths at UHSussex were referred to the Coroner.
- 11% of all deaths at UHSussex were investigated by the Coroner.

Role out of community service

The Department of Health and Social Care confirmed that new regulations governing Medical Examiners would take effect from September 2024. This is a change from April 2024. All UHSussex Medical Examiner Services are to achieve the revised statutory deadline of 9th September 2024.

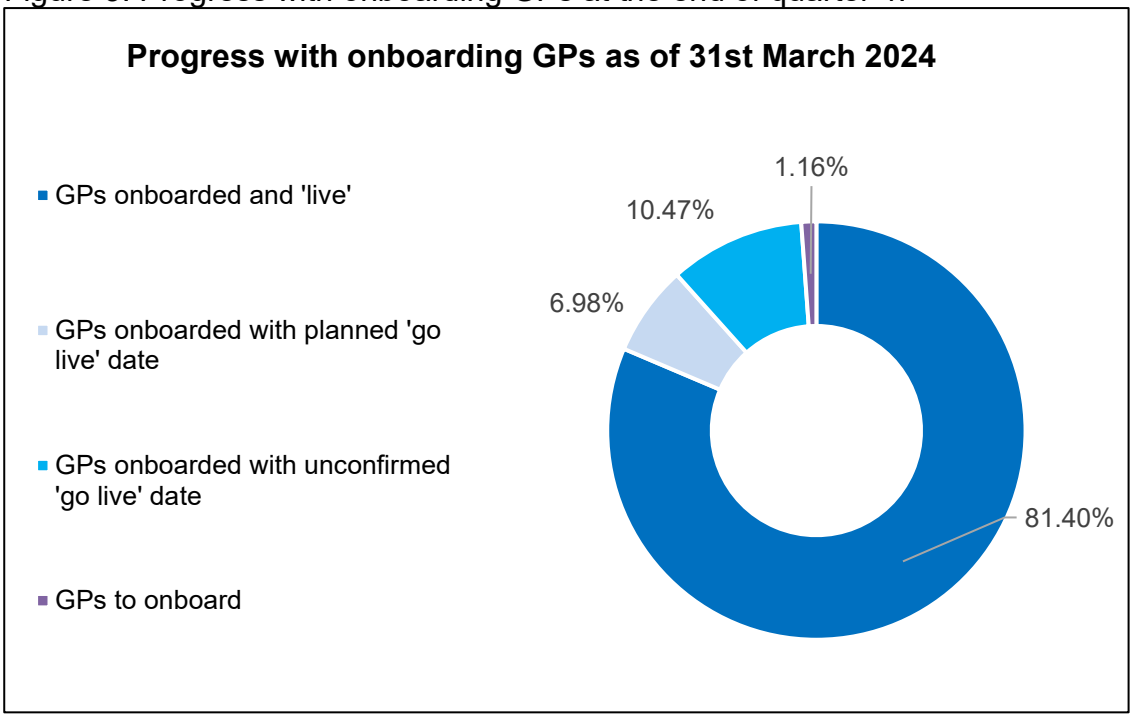
All Medical Examiner and Medical Examiner Officer posts have been filled across the West Sussex and Brighton & Mid Sussex Medical Examiner services.

All GPs have been onboarded with the exception of one practice that was reallocating to East Sussex due to boundary issue.

Table 3: Progress towards onboarding GPs at the end of quarter 4.

	East Brighton & Mid Sussex	West Sussex	Total	% all GPs
No. GPs onboarded and 'live'	28	42	70	81.40%
No. GPs onboarded with planned 'go live' date	4	2	6	6.98%
No. GPs onboarded with unconfirmed 'go live' date	7	2	9	10.47%
No. GPs to onboard	1	0	1	1.16%
Total	40	46	86	

Figure 3: Progress with onboarding GPs at the end of quarter 4.



Larger office space for the Medical Examiner services was identified to accommodate the bigger teams.

- **WGH** - Larger office space to accommodate the team has been allocated in the previous HR building.
- **SRH** - The community hub for WGH/SRH is based at Stillman House (SRH) with secure, lockable, pincode entry.
- **RSCH** - Office space adjacent to the bereavement team was identified in the Louisa Martindale Building (LMB.)
- **PRH** - Adequate office space was allocated and office equipment has been sourced.

Following Coroners inquests UHSussex received three Prevention of Future Death (PFD) notifications, however all three reports related to deaths which occurred before this period.

The following recommendations were received as a result, and all recommendations and improvements have been actioned, addressed and submitted to HM Coroner:

Princess Royal Hospital:

- *The competencies for those involved in medicine administration stated that medications should not be left at the bedside, but no guidance for the monitoring of medication for those patients who self administer prescriptions dispensed to them who do not take their medication at the time of dispensing it.*
- *Evidence at the inquest revealed that the Venous Thromboembolism Prevention Policy of University Hospitals Sussex NHS Foundation Trust version 1.4 did not make provision for assessment of risk to patients who attended hospital but were not admitted. There was no evidence of any other policy or procedure which did so.*

Worthing Hospital:

- *The inquest heard that some of the notes completed retrospectively were based on assumption rather than first-hand knowledge. Therefore, there was limited documented information available to treating clinicians following A's birth as to the events and treatment which had been provided to her.*

2.5.5 Mortality Reviews

Approximately 95% of referrals for SJR were received through the Medical Examiner Service, whilst approximately 5% were received from the Patient Safety Team, Clinical Divisions and other Trust services such as Patient Experience Teams.

During the reporting period 556 (13%) deaths were referred for independent Structured Judgement Review (SJR) or which 245 independent SJRs were completed of which, 197 SJRs were reviewed at the Trust Mortality Panel.

An SJR is completed for every patient with a learning disability and is shared with the Learning from Life and Death Review (LeDeR) Team. An SJR is completed for every patient with Severe Mental Illness.

	Q1	Q2	Q3	Q4	Total
No. Deaths referred for SJR	120	133	148	155	556
No. SJR Completed	35	47	28	135	245 (44%)

Implementation of new SJR model

All ME and MEO vacancies have been filled. Despite the date of statutory being postponed to September 2024, both West Sussex and Brighton & Mid Sussex ME services were prepared and commenced a phased approach to scrutinising community deaths from April 2024.

A new model for Structured Judgement Reviews was implemented and commenced in October 2023 with the first cohort of new SJRs completing online training and supervision from an experienced SJR Reviewer in January 2024. 31 new SJR reviewers have joined the Learning from Deaths team. During this time experienced reviewers focused resource on training and maintaining current processes to ensure all urgent SJRs were completed. During this period of training non-urgent SJRs were added to the total number of outstanding SJRs.

Activity increased from an average of 30 SJRs per quarter to over 90 SJRs completed in the final quarter of 2023/24.

The backlog of SJRs that had accumulated over previous years was reduced from 374 to 213 between 1st January 2024 and 31st March 2024 following implementation of the new SJR processes.

With 31 trained SJR reviewers available to complete SJRs, it is anticipated that there will be no outstanding SJRs by October 2024.

Table 4 SJR backlog Status as of 31st March 2024

	Comple-ted	Awaiting Panel	In Progress	Out-standing	Total
WGH	61	9	17	6	87
SRH	33	0	23	6	56
RSCH	4	1	7	169	12
PRH	0	1	1	32	2
Total	**98**	**11**	**48**	**213**	**157**

SJR Trainee Reviewer Progress

Figure 4: SJR Trainee Reviewer Progress as of 31st March 2024

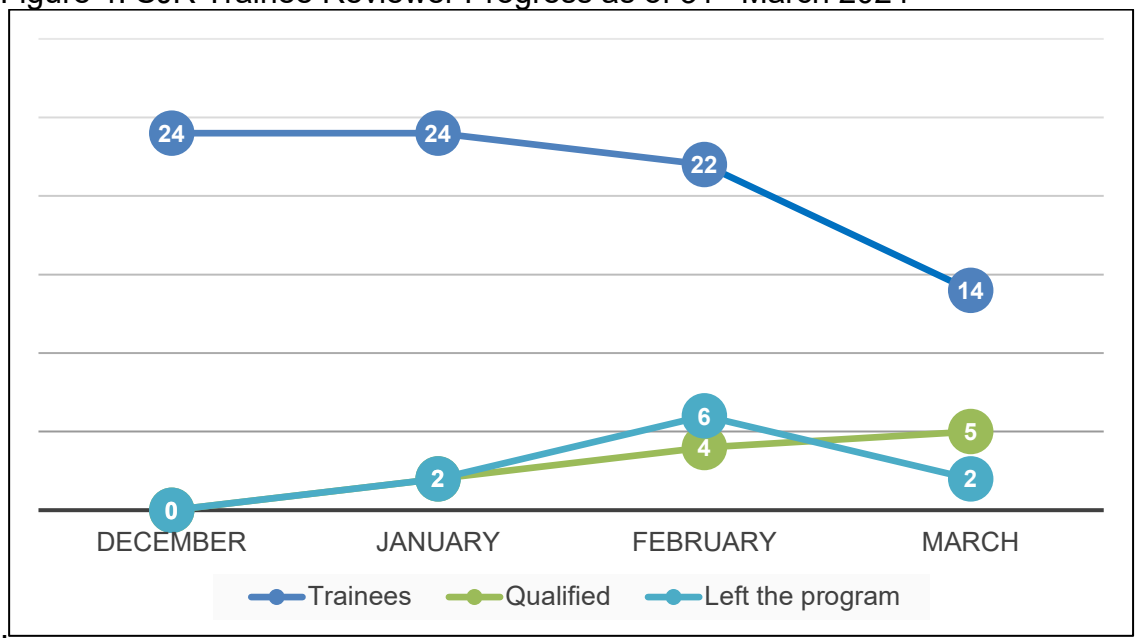
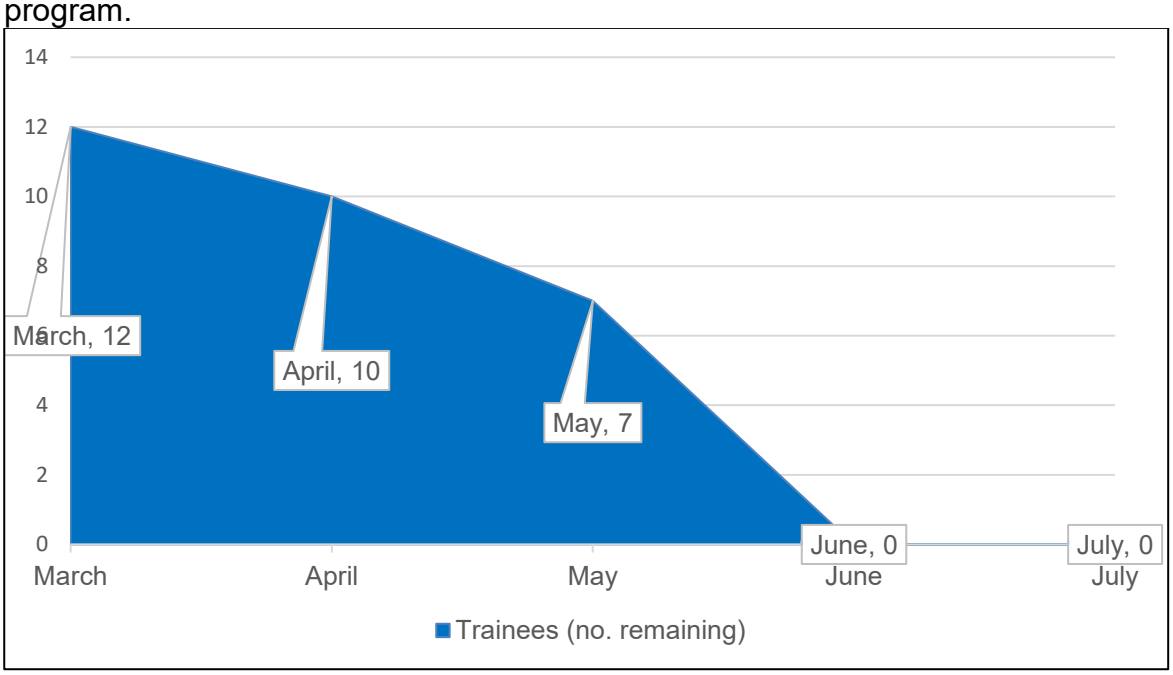


Figure 5: SJR trainee reviewer trajectory for all trainee reviewers who remain in the program.

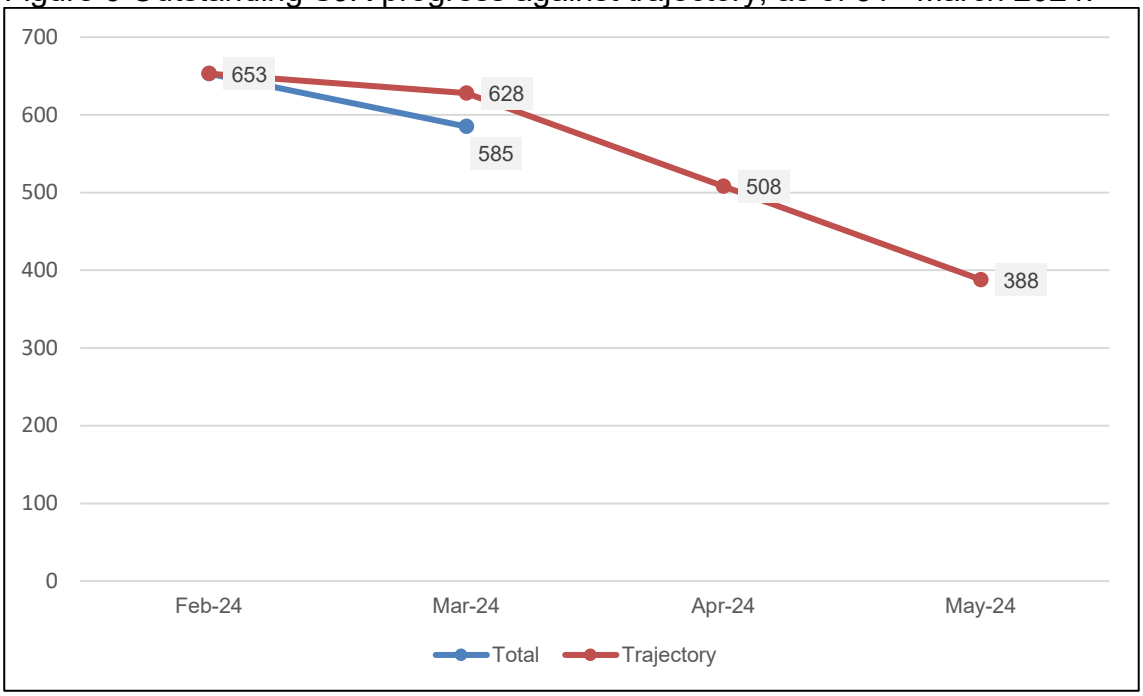


Clearing the SJR backlog and BAU is on track with the trajectory. Progress was slower for completing RSCH and PRH reviews due to insufficient resources within the LfD team to scan paper notes. All LfD team posts are now filled.

Table 5 Progress with all outstanding SJRs against trajectory, as of 31st March 2024.

	Trajectory	Actual
Historical Backlog	239	213
BAU	389	372
Total	628	585

Figure 6 Outstanding SJR progress against trajectory, as of 31st March 2024.



2.5.6 Learning from case record reviews (SJRs) and investigations

Structured Judgement Reviews provide a rich source of opportunities to learn from deaths. All reviews are shared with divisions to discuss and identify opportunities for learning and improvement.

Structured Judgement Reviews that identified the quality of care as “poor” or “very poor” produced learning themes around;

- delays in recognising a patient was nearing the end of their natural life
- absence of community end of life care planning resulting in missed opportunities to avoid admission into hospital when a person was recognised to be nearing or at the end of their natural life
- delays to implementing Packages of Care that would enable a person nearing the end of their natural life to return home or to their chosen placeo
- opportunities for learning and improvement around ceilings of care discussions, and in decision making/discussions with patients and their families regarding Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).

2.5.7 Patient deaths judged to be more likely than not to have been due to problems in care during the previous reporting period

A standardised scoring system developed by the Royal College of Physicians is used to determine whether a death, that has had a structured Judgement Review, is judged to be more likely than not to have been due to problems in care. The process enables the Trust to identify areas of care that can be learned from and whether poor care contributed to a death.

There were three cases that identified a death may have been avoided. Where poor care was identified, this was reported back to the clinical teams following a case review to enable the team to consider how learning could be implemented.

2.5.8 Action following our learning

During 2023/4 the Learning from Deaths service underwent significant changes to ensure adequate resource and robust processes enabled the Trust to effectively learn from deaths.

A restructure within the wider Clinical Outcomes and Effectiveness department ensured resource to provide a full Learning from Deaths team with senior Leadership, Management, Project Management and adequate administration support which also provides Leadership and Management to the Medical Examiner Service.

The Palliative Care team has continued to work with Sussex Integrated Care Board to progress the end of life care hub (ECHO) across Sussex to support those nearing the end of their life.

The SJR methodology and terminology currently used by the Royal College of Physicians was developed in 2017. Through listening to feedback from clinical teams and with a change to the Patient Safety Framework, UHSussex reviewed how the language used in the current SJR impacts learning.

Plans are in situ to redesign and adjust the language used across SJRs and how learning is implemented at UHSussex. The new SJR will retain the RCP SJR methodology and better highlight specific areas for learning that supports the new Patient Safety Pathway.

2.6 Patient Experience

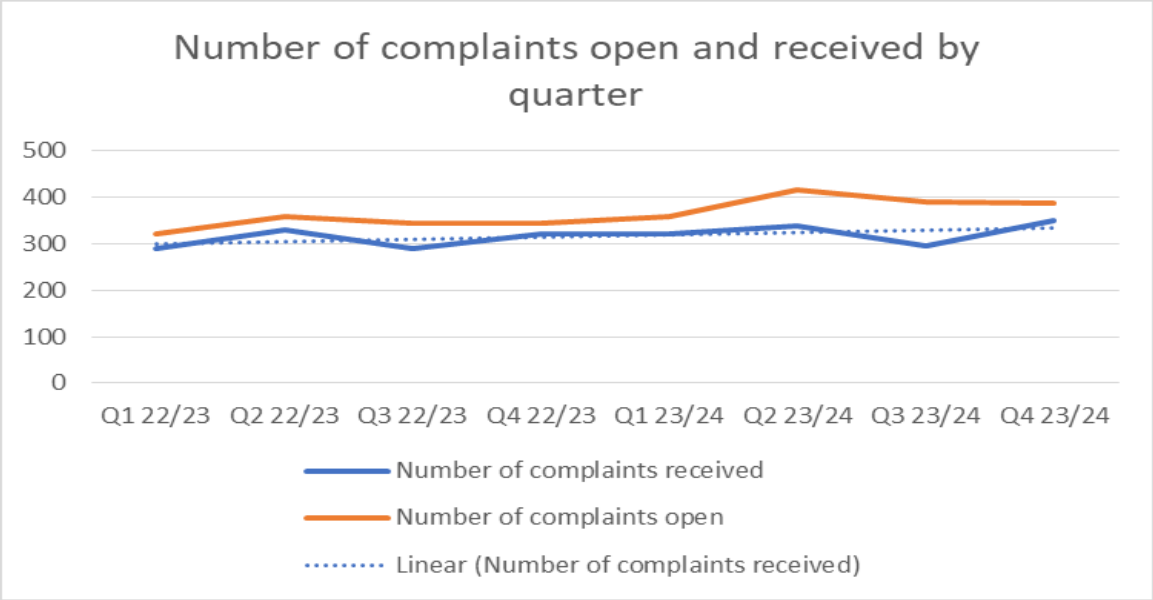
Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex had received increasing numbers of complaints of which 45% were closed within 60 working days. UHSussex has performed comparatively with national averages for Urgent Emergency Care and Maternity National Surveys			

Further details are provided in the UHSussex Patient Experience Annual Report.

2.6.1 Complaints and Concerns

Throughout 2023/24 the Trust has approved a new policy for responding to concerns and complaints, setting a local standard of aiming to close 80% of complaints within 60 working days. During the year, the Trust continued to receive increasing numbers of complaints, and since the new policy was introduced 45% were closed in 60 working days, reflecting the excess of demand over capacity for responding to complaints.

Figure 7 Numbers of complaints received by quarter through 2022/23 and 2023/24



Throughout 2023/24 UHSussex received 1,350 new complaints for investigation (an increase of 9% when compared to the same reporting period the previous year.

- 45% of complaints were closed within 60 days (the Trusts response timeframe)
- At the end of March the Trust had 383 complaints open, of which 177 had breached the Trust response timeframe
- 13% of complaints were re-opened following the initial response.

The most prevalent theme in complaints was clinical treatment followed by communication, discharge, end of life care and staff attitudes and behaviour.

2.6.2 Parliamentary & Health Service Ombudsman Complaints

Between 1 April 2023 and 31 March 2024 2% of complaints were accepted by the PHSO for investigation.

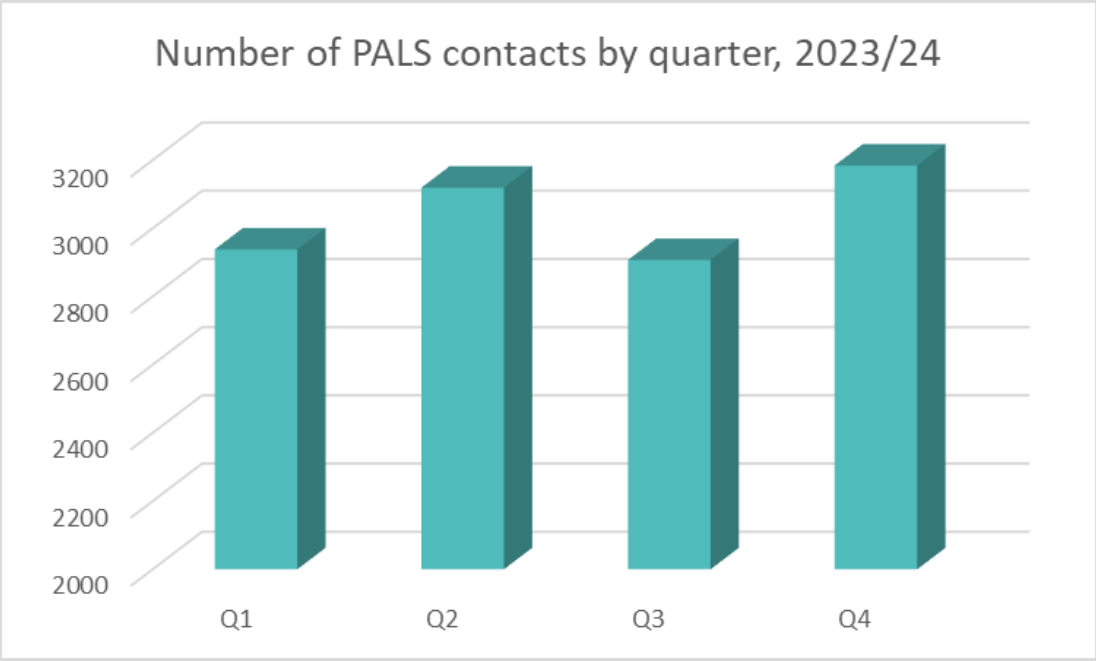
Of these less than 0.5% were upheld with the majority closed with no further action necessary indicating that despite the challenges in complaint response the quality of investigations and responses remains high.

2.6.3 Patient Advice & Liaison Service

The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters to patients and their families and provides a 'much needed point of contact for patients, their families and their carers' (NHS.UK 2018).

During the year, the numbers of PALS concerns received has increased, with 12,165 registered in 2023/24 compared to 11,616 in 2022/23 an increase of 4.7%. Increasingly patients are concerned about accessing results, appointments and dates for surgery. Concerns from cancer patients about access to radiology also increased through year.

Figure 8. Number of PALS concerns raised per quarter, 2023/24



2.6.4 National patient surveys - Responsiveness to the personal needs of patients

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Whilst National Data is not available, UHSussex performed comparatively with national performance in the three national surveys			

The National Patient Survey Programme (NPSP) is commissioned by the Care Quality Commission (CQC) the independent regulator of health and adult social care in England. UHSussex commissions Picker to administer the surveys.

2.6.5 Urgent and Emergency Care Survey

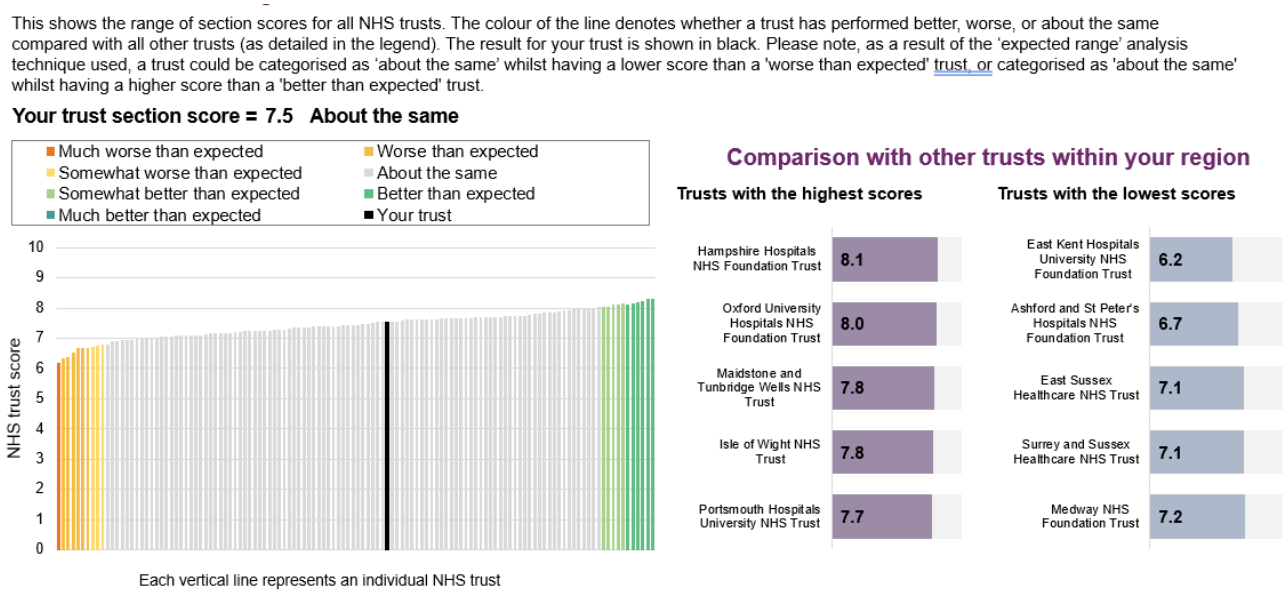
As part of the NPSP, the Urgent & Emergency Care (UEC) Survey first iteration was in 2003, and since 2012 it has been a biannual survey. For University Hospitals Sussex surveys were undertaken for type 1 services (Accident and Emergency services) and type 3 services (urgent treatment centres). As the Trust is newly merged, the 2022 surveys (received in 2023) present the first integrated survey report.

In total;

- 227 Type 1 patients completed the survey (25% response rate against a national average of 23%)
- 105 Type 3 patients completed eh survey (19% response rate against a national average of 22%)

Type 1 survey results:

The type 1 survey results identify that UHSussex ED services performed better than most in two areas, and as expected in 35. However, the trust was in the bottom third of the national results and in the bottom five in the region for arrival at ED and tests.



Type 3 survey results:

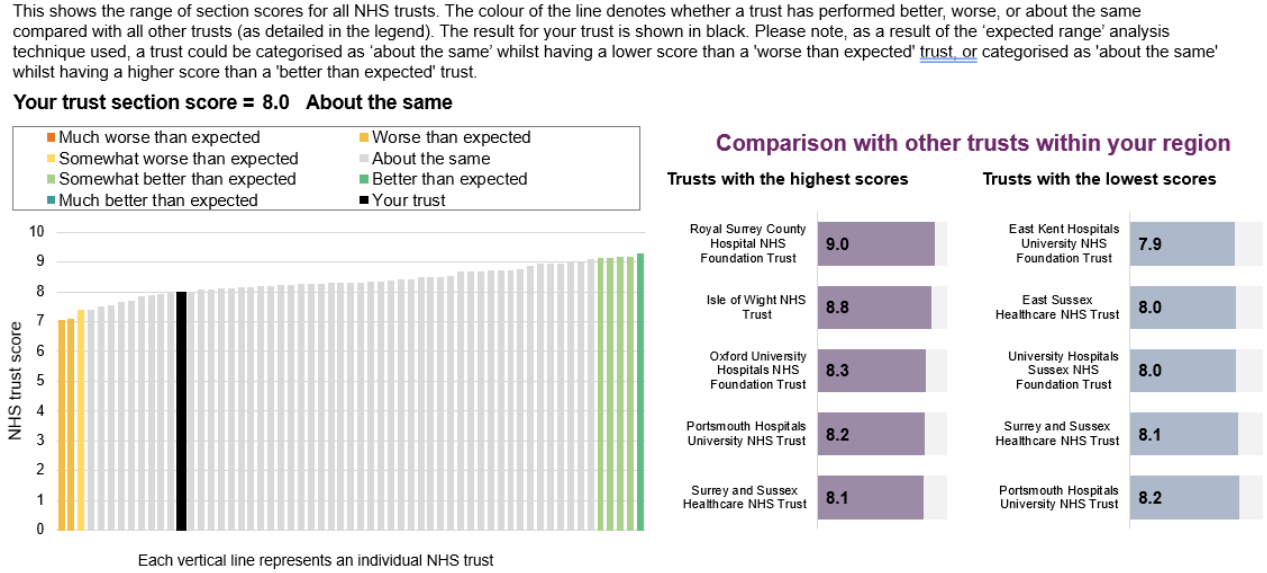
The type 3 survey identified that UHSussex performs somewhat worse than expected in two areas and as expected in 28 areas.

The Trust performed in the middle of the national table for arrivals (for which UHSussex was in the top 5 in the region) and for environment and facilities (however, was in the bottom 5 for the region for this measure).

However, the trust performed in bottom third nationally and was in the bottom 5 regionally for the following:

- Waiting
- Health professionals
- Care and treatment
- Tests
- Respect and dignity
- Overall experience

Figure 9 Type 3 survey results for overall experience

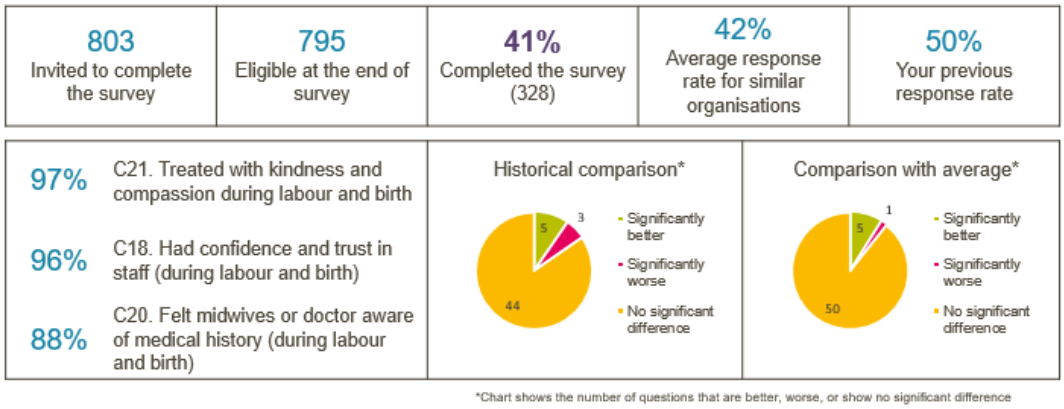


In particular, the trust performed worse than expected for explaining tests in a way that patients can understand and leaving treatment with the care and support required.

2.6.6 National Maternity Survey

The national maternity survey results were published in 2023. 328 patients completed the survey, which was below the average participation. The Trust was rated 20th Nationally for overall positive score.

Figure 10 Summary of survey participation and results



A particular improvement was noted in patients reporting that their partner was able to stay with them as long as they wanted in hospital after the birth (increased to 33.7% from 19.2% in 2022 and 12.5% in 2021) and this has been a focus of the work by the local

Maternity Voices Partnership (MV). However, this remains below the national averages and since the results were published, partners are now allowed to stay. A full improvement plan has been developed by the maternity service in response.

2.6.7 National Inpatient Survey

The Trust's responsiveness to the personal needs of its patients during the reporting period is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.

Indicator Domain	**Responsiveness to the personal needs of patients** Ensuring people have a positive experience of care				
UHSussex 2023	National average 2021	Best performing Trust 2021	Worst performing Trust 2021	UHSussex 2022	UHSussex 2021
*	74.5%	85.4%	67.3%	*	75.4
Data Source	NHS Digital 4.2 Responsiveness to inpatients' personal needs - NHS Digital				

Table based on latest available data (March 2022):

* Following the merger of NHS Digital and NHS England on 1st February 2023 a review of the NHS Outcomes Framework indicators has been commenced. As part of this review, the annual publication which was due to be released in March 2023 has been delayed.

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reasons: it is produced by the Picker Institute in accordance with strict criteria.

Further details of the result of the National In-Patient Survey are provided in the UHSussex Patient Experience Annual Report, however improvement work is underway to address;

- **Reducing night moves and disruption at night to support better sleeping** - The reducing length of stay Corporate Project has improved patients being allocated to the right bed the first time to reduce the need to move patients at night.
- **Reducing waits for admissions and beds** - The Trust breakthrough objective on the median hour of discharge has impacted on improving flow through our hospitals to reduce the wait for admission of patients into our beds.
- **Asking patients to give views on the quality of care** - as part of the fundamental standards, wards are now implementing patient experience ward rounds, reporting and auditing on the tendable system.
- **Discharge** - new discharge hubs led by the hospital directors of nursing have been implemented.
- **Doctor engagement in answering questions and providing information about care** - the change in governance with respect to complaint sign off from CMO to Chiefs of Service (on behalf of CEO) linked the Divisions directly to the complaint.

- **Improving feeding offer and support** - A new food and nutrition policy has been developed.

2.6.8 Friends & Family Test (FFT)

Staff who would recommend the trust to their family or friends

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex scores is improving, however it remains below national average			

The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

Indicator Domain	**Percentage of staff who would recommend the Trust as a provider of care to their family or friends** Ensuring people have a positive experience of care				
UHSussex 2023	National Median 2023	Best performing Trust 2023	Worst performing Trust 2023	UHSussex 2022	UHSussex 2021
59.6%	63.3%	88.8%	44.3%	57.4%	65.0%
Data Source	NHS NHS Staff Survey Results – NHS Staff Survey Results NHS Staff Survey dashboard (nhssurveys.co.uk)				

Table based on latest available data (NHS Staff Survey 2023)

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reasons it is produced by the Picker Institute in accordance with strict criteria.

The University Hospitals Sussex NHS Foundation Trust is continuing to focus on staff engagement as part of the Leadership, Culture & Workforce programme with the overall aim of improving staff engagement across the Trust.

Patients rating their care as good or very good (FFT)

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex performed above the national average for Maternity and Outpatients but below the national average for ED and In-Patients, whilst overall positive score have declined across the year			

Friends and family feedback is a trust priority as part of the true north domain for patient.

Throughout 2023/24 the average overall positive rating for the Trust using the Friends and Family Test (FFT) system was 90.1% and has declined through the year. Each month, the Trust receives over 12,000 survey responses with an average response rate of 22%.

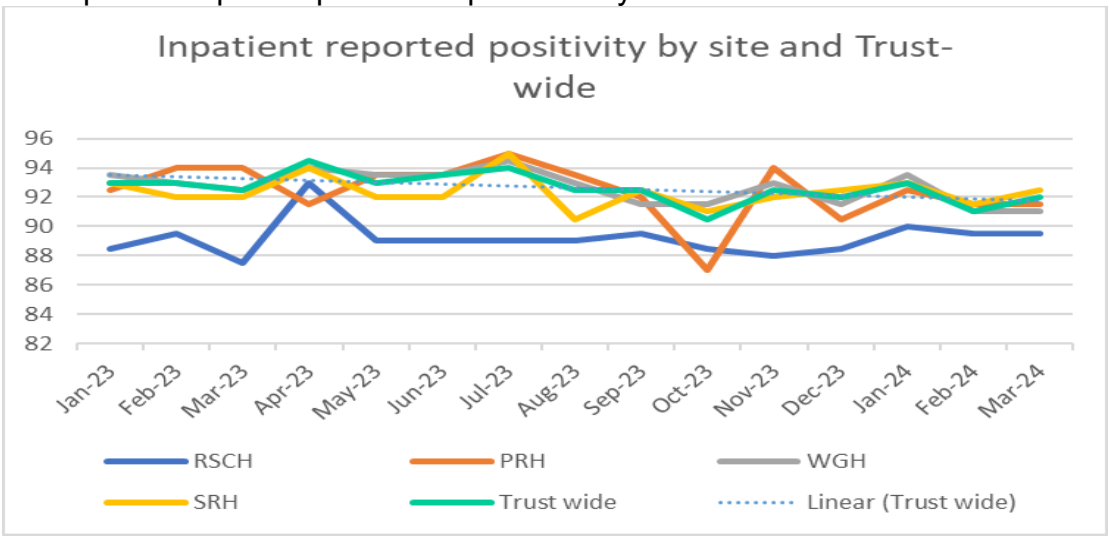
A declining overall level of patient-reported positivity was observed through 2023/24, and increasing percentage of patients reporting a negative experience. As such the True North if off track, in line with decreasing levels of public confidence in the NHS nationally.

Indicator **Domain**	**Percentage of inpatients rating their care as good or very good** **Ensuring people have a positive experience of care**				
UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2022-23	UHSussex 2021-22
90.1%	94.1%	99.62	83.7%	88.3%	93.8%
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (March 2023 to February 2024)

Inpatient reported positivity remained largely consistent in year, with the significant majority of patients describing their care as good or very good. However, at an average of 92%, this is below the national average.

Figure 11 Inpatient reported positive experience by site and trust for 2023/24



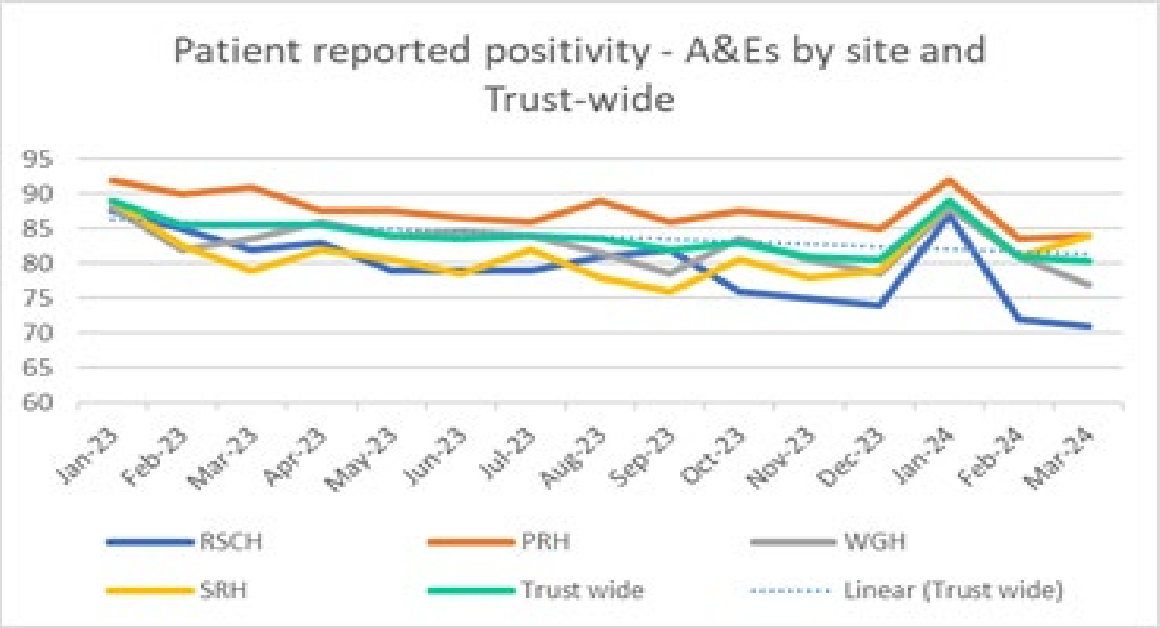
The main contributor to positive reviews was excellent care by the clinical staff, with negative reviews relating to waiting, pain management, clinical care and staff behaviour.

Indicator Domain	Percentage of A&E patients rating their care as good or very good Ensuring people have a positive experience of care				
UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2022-23	UHSussex 2021-22
79.5	83.2	95.2	61.3	77.3	76.9
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (March 2023 to February 2024)

44% of all FFT responses are from the emergency departments, and as such Trust-wide reporting is confounded by patient experience of A&Es. This declined throughout 2023/24 See figure 12), however, patient reported positivity of A&E at University Hospitals Sussex as a whole, remained above the national average at 82.6% (latest available national data in April 2024 is January 2024 with an average of 78% positive).

Figure 12: patient reported positive experience of emergency departments by site and trust for 2023/24

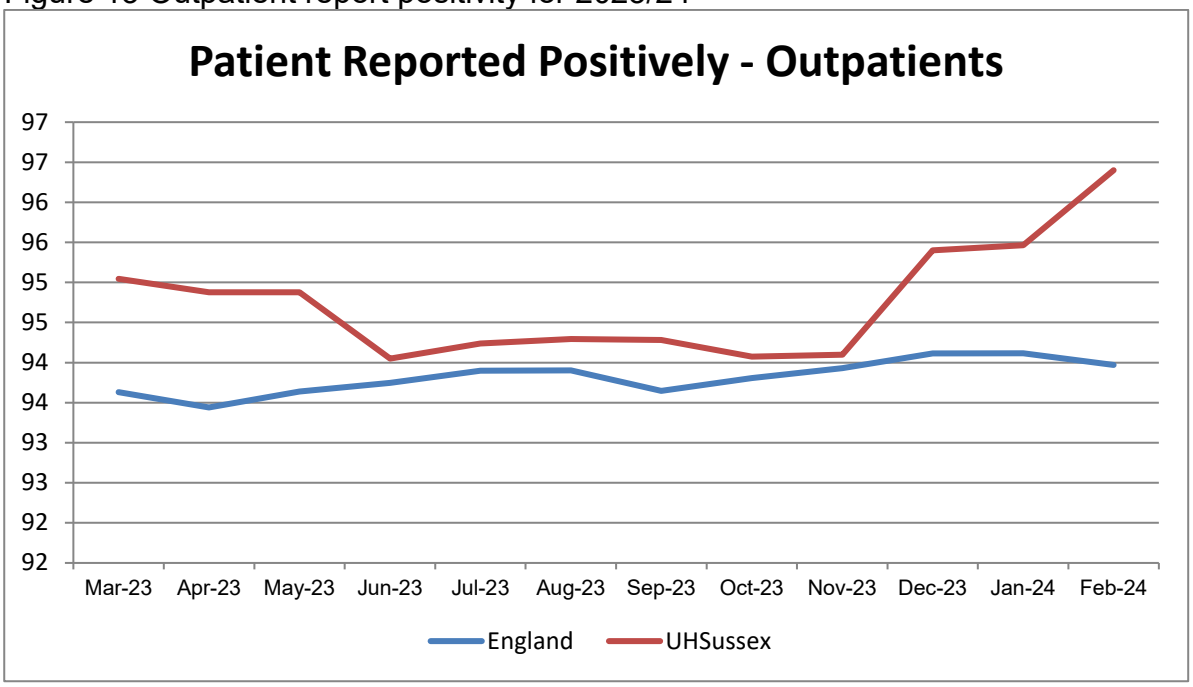


Indicator Domain	Percentage of Outpatients rating their care as good or very good Ensuring people have a positive experience of care				
UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2022-23	UHSussex 2021-22
94.5	93.0	98.9	81.2		
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (March 2023 to February 2024)

Outpatient reported at 94.5% on average positivity remained in line or above national average of 93% throughout the year.

Figure 13 Outpatient report positivity for 2023/24



Patients were positive in their feedback about the staff and the quality of clinical care and treatment. Whilst negative reviews were in the significant minority of responses, patients reported that they would have had a better experience if communication and attitudes from consultants had been better and if their appointment had been on time.

Indicator Domain	Percentage of Maternity rating their care as good or very good Question 1 is asked in the Antenatal Care setting Ensuring people have a positive experience of care				
UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2022-23	UHSussex 2021-22
*	91.97	100.00	65.00	*	*
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (April 2023 to March 2024)

* No data collected during this period

Indicator Domain	Percentage of Maternity rating their care as good or very good Question 2 is asked in the Birth setting Ensuring people have a positive experience of care				
UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2022-23	UHSussex 2021-22
89.59	80.24	100.00	42.86	90.15	93.48
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (April 2023 to March 2024)

Indicator Domain	Percentage of Maternity rating their care as good or very good Question 3 is asked in the Postnatal Ward setting Ensuring people have a positive experience of care				
UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2022-23	UHSussex 2021-22
92.85	92.32	100.00	73.52	93.85	93.85
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (April 2023 to March 2024)

Indicator Domain	Percentage of Maternity rating their care as good or very good Question 4 is asked in the Postnatal Ward setting Ensuring people have a positive experience of care				
UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2022-23	UHSussex 2021-22
86.96	91.57	100.00	81.13	87.45	94.37
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (April 2023 to March 2024)

Maternity patient reported experience is the most changeable, due to the smaller numbers of patients.

Patients report a positive experience of the staff, but that they found there to be fewer staff to care from them than they would have preferred.

2.6.9 Improving how we deliver our patient experience functions

During 2023/4 improvements to the structures and processes within patient experience teams have been implemented. This includes:

- Embedding increasingly efficient processes for management of concerns and complaints, in response to increasing demand from patients as a result of growing numbers of complaints and concerns received
- Bereavement services across the Trust have been integrated within patient experience under a single trust-wide manager to support high quality, consistent responsive services for families following the death of a loved one
- The friends and family test reporting system – envoy – has been rolled out, with new hierarchies enabling more responsive reporting by clinical area, site, division and touchpoint
- Closer working with patient safety services in the implementation of the patient safety incident response framework (PSIRF) and representation on the panel of the patient safety incident review group (PSIRG) has enabled improved triangulation of learning from patient feedback and patient safety escalations.
- Implementing the new DCIQ reporting system for patient feedback, ready for implementation in Q1 2024/25
- Refreshed Patient Experience and Engagement Group (PEEG) forming a core part of the trust's quality governance structures and to act as the programme board for the patient experience strategy
- A new improvement tracker has been introduced to capture improvement opportunities and actions generated from national patient surveys and from Healthwatch reports and feedback.

2.7 Patient Safety

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex has a lower rate of reporting than the national average, and less no-harm rated incidents			

2.7.1 Implementation of the Patient Safety Incident Response Framework (PSIRF)

The NHSE Patient Safety Incident Response Framework (PSIRF) and Patient Safety Incident Response Plan (PSIRP) sets out Trusts approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Both the PSIRP and UHSussex Patient Safety Incident Response Policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents and safety issues
4. Supportive oversight focused on strengthening response system functioning and improvement.

The Patient Safety Incident Response Plan (PSIRP) and policy was approved at Executive Board and by the ICB in November 2023. The new NHSE Patient Safety Incident Response Framework (PSIRF) went live on 4th December 2023. (Replacing the NHSE Serious Incident Framework 2015).

All incidents graded as near miss, moderate/severe harm and death are reviewed by a senior panel on a weekly basis at the Patient Safety Incident Response Group (PSIRG). Following the methodology of the new NHSE Patient Safety Incident Response Framework the level of harm, patient/family engagement and investigation is decided.

The Trust's new Patient Safety Syllabus was launched in February 2024. The training suite includes three 'levels' which have all be written and mapped out in accordance with the Patient Safety training syllabus curriculum. Those individuals identified to be learning response leads are expected to complete all three levels – level 1, 2a, and 2b.

- Level 1 - Patient Safety Fundamentals
- Level 2a - Patient Safety and Safety Science

- Level 2b - Practical applications – learning response leads

Duty of Candour training, co-produced by the patient safety partners launches in Q1 of 2024/25.

2.7.2 DCIQ Patient safety Improvement and Risk Management System

Previously (pre-merger to UHSussex) the incident reporting system, DatixWeb supported 2 different versions and several reporting systems within the Trust, including complaints, legal claims, incident reporting, Central Alerting System (CAS) national and local safety alerts and the risk register. Standardised, consistent effective and accurate Trust-wide data reporting was therefore problematic.

In 2023/24 a significant programme of work has been underway to implement a new standardised, Trustwide incident reporting system that was fit for purpose and allowed for ease of reporting, feedback, and shared learning.

The new system opens opportunities to enhance system functionality enabling improvements in the Trust's risk and quality management using the most up to date developments in the system.

February 2024 saw the go-live of the incident reporting module along with the integration from the NRLS to the new NHSE LfPSE platform.

The system is now fully aligned with the Trust Clinical Operating Model (COM) allowing for full matrix working between the divisional triumvirate and hospital senior management teams. Incident data is visible via an alerting system to the hospital directors and hospital directors of nursing to allow for risk mitigation and real time feedback to staff who report an incident. The Chief Medical Officer, Chief Nursing Officer and Director of Patient Safety and Learning all receive immediate alert notifications on reported incidents with a harm level of moderate and above.

2.7.3 Patient safety incidents resulting in Severe Harm or Death as reported to the Learning from Patient Safety Events (LfPSE) Service (From 2024)

Trust wide it is expected that patients do not suffer harm whilst in our care. However, it is recognised that there are patients who suffer new harm which is acquired during their time in hospital. This has a significant impact on patients, families, carers and staff and within the wider organisation. The Quality True North objective for harm reduction at UHSussex is 'Zero harm occurring to our patients when in our care'.

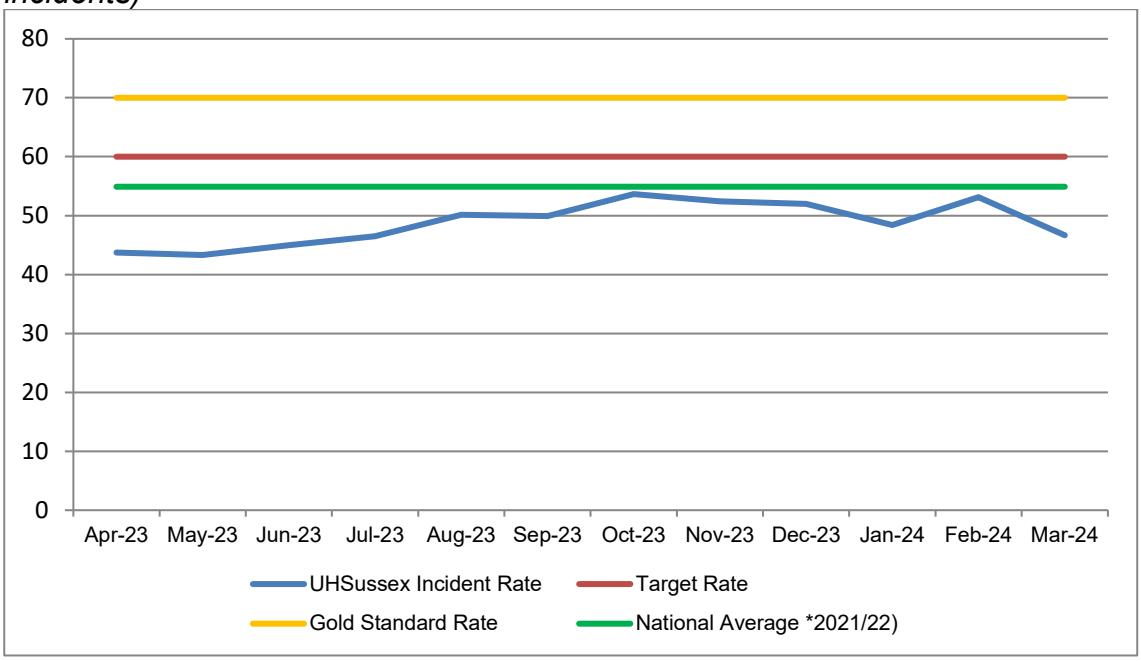
The Trust encourages all healthcare professionals to report incidents as soon as they occur to ensure timely investigation and outcomes, which are shared to support learning that is reflective of a positive safety culture.

The Trust uses nationally reported and verified data from the National Reporting and Learning System (NRLS) to benchmark its reporting culture against other like performing NHS Trusts.

In 2023/24 the overall average rate of incidents reported by UHSussex was 48.8 per 1000 bed days. The national average reporting rate as recorded by the National Reporting and Learning System in 2022 (NRLS) was 54.9, the current national reporting baseline has

been paused since 2022 due to the replacement of NRLS with the introduction of the NHSE Learning for Patient Safety Events in 23/24. 24/25 trust target is a reporting rate of 60 per 1000 bed-days.

Figure 14 UHSussex number of incidents reported per 1000 bed days *(excludes rejected incidents)*



The reporting methodology for harm measurement is currently under analysis. The submitted report harm grading (as graded by the reporter) requires a review, investigation and assessment for accuracy by the investigating manager (longer than the in-month reporting period). The reported (predicted in month) harm versus the final actual harm graded by LFPSE definition- frequently has significant variation. The Trust quarterly reports provide the ratified and more accurate data on actual harms. The most recent benchmarking was provided by the NRLS in 2022 prior to the staged implementation of the new NHSE LfPSE platform.

Table 6: Reported Harm categories'

Harm Category	UHSussex	National Benchmark*
No harm	60.5%	70%
Low harm	36.5%	27%
Moderate harm	2.39%	3%
Severe harm/Death	0.52%	0%
	100%	100%

*(NRLS 2022 pre LfPSE)

The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Indicator Domain	Patient safety incidents and the percentage that resulted in severe harm or death Treating and caring for people in a safe environment and protecting them from avoidable harm					
	UHSx 2023-24*	National average 2023- 23	Highest 2023- 23	Lowest 2023- 23	UHSx 2022- 23	UHSx 2021- 22
I) rate of incidents reported per 1000 bed days	Incident rates not reported in most recent publication					43.6
ii) rate of incidents that resulted in severe harm or death per 1000 bed days	Incident rates not reported in most recent publication					0.25
iii) Number of incidents resulting in severe harm or death	72	22.4	481	0	246	151
iv) % of severe harm or death over number of reported incidents	1.32	0.66	6.67	0	0.81%	0.58
Data Source	NHS Improvement NHS England » National Reporting and Learning System (NRLS) monthly report England					

The latest available data covers the period first quarter of 2023 (April to June).

University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reasons the data is derived from the National Reporting and Learning System for patient safety incidents and a panel of consultants reviews this data weekly in order to ensure every incident is correctly graded in accordance with guidance issued by the National Patient Safety Agency.

2.7.4 Serious Incidents

The Trust investigates all patient safety incidents, reported on our incident reporting system, DATIX. Incidents that are deemed serious incidents or never events undergo robust investigation, which involves root cause analysis (a systematic investigation that looks beyond the people concerned to understand underlying causes and environmental context in which the incident happened).

The Trust reported 72 Serious Incidents from April 2023 to December 2023 (PSIRF implemented) via StEIS (Strategic Executive Information System - supports the monitoring of investigations between NHS providers and commissioners).

The following themes from serious incidents are demonstrated in Table 7

Table 7: Theme of serious incidents

Serious Incidents – Themes	No.
Diagnostic incident including delay meeting SI criteria (inc. failure to act on test results)	19
Treatment delay meeting SI criteria	15
Maternity/obstetric incident meeting SI criteria: baby only	11
Surgical/invasive procedure meeting SI criteria	11
Sub-optimal care of the deteriorating patient meeting SI criteria	4
Medication incident meeting SI criteria	3
Apparent/actual/suspected self-inflicted harm meeting SI criteria	2
Maternity/obstetric incident meeting SI criteria: mother and baby	2
HCAI/infection control incident meeting SI criteria	1
Screening issues meeting SI criteria	1
Pressure ulcer meeting SI criteria	1
Disruptive/aggressive/violent behaviour meeting SI criteria	1
Environmental incident meeting SI criteria	1
Total	72

The four most reported serious incident themes which have been reviewed are detailed in Table 8.

Table 8 Review of themes for most frequently reported serious incidents

Serious Incidents Themes	
Diagnostic incident including delay meeting SI criteria	The Trust reported 19 serious incidents within this category. Incidents in this category occurred across different services. Common contributory factors included acuity and capacity (bed availability, clinic availability etc).
Treatment delay meeting SI criteria	15 serious incidents were reported in this criteria. The most common incidents within this category were surgical delays due to capacity.
Maternity/obstetric incident meeting SI criteria: baby only	11 incidents were reported under this category. Six of these incidents were investigated by MNSI. Themes include babies born in poor condition requiring transfer for cooling.
Surgical/invasive procedure meeting SI criteria	11 incidents were reported under this category. There has been focused learning from deaths of patients following surgical procedures.

Table 9 illustrates Patient Safety Incident Investigations (PSII) raised since December 2023/24:

Table 9 Review of themes for most frequently reported serious incidents

Patient Safety Incident Investigations criteria	No.
Death thought more likely than not due to problems in care	10
Incident meeting Each Baby Counts criteria (under MNSI investigation)	4
Incidents meeting the Never Events criteria	1

The Trust is committed to being open and honest with our patients. Undertaking Duty of Candour is a legal requirement for all safety incidents recorded as causing moderate harm, severe harm or death where we will formally apologise to the patient and/or family involved and undertake an investigation into their care.

We will feedback in writing the findings of our review and any actions we are taking to prevent a similar incident from happening again.

2.7.5 Never Events

The Trust reported four Never Events at the Royal Sussex County Hospital for the period between April 2023 and March 2024.

Never Events and Serious Incidents (SI) are subject to a thorough internal review to identify themes and learning. Up until December 2023 the Trust applied the 2015 NHSE Serious Incident Framework processes for undertaking root cause analysis methodology in respect of the Coroner notifications. A full investigation is undertaken and the outcome and recommendations reported to the Trust Board for each serious incident.

All serious incidents including Never Events were reported as required to the Care Quality Commission, Sussex Integrated Care Board, NHS Improvement and to NHS England. Since December 2023 the Trust has implemented the new NHSE Patient Safety Incident Response Framework (PSIRF) reporting all serious incidents as Patient Safety Incident Investigations (PSII).

Table 10: Reported Never Events

Never Event	Site	Date
Wrong route administration of medication	Royal Sussex County Hospital - Emergency Department	July 23
Wrong surgical prosthesis / implant	Royal Sussex County Hospital – Surgery	July 23
Retained surgical needle	Royal Sussex County Hospital – Neurosurgery	November 23
Retained surgical swab	Royal Sussex County Hospital – Maternity	December 23

Recommendations and shared learning:

1) Observational audits are completed within the theatre environment regarding compliance with the 5 steps to Safer Surgery. Improvement plans are completed to ensure compliance.
2) A UHSussex Trustwide Policy is developed for Safer Surgery in line with the WHO Safe Surgery Checklist and 5 Steps to Safer Surgery and the HSE National Policy and Procedure for Safe Surgery 2022.

Staff are familiarised with the environments and teams prior to surgery and standard working is implemented across sites. A Standard Operational Procedure is developed to ensure full continuity of care across the location.

2.7.6 Regulation 20: Duty of Candour

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex achieved an overall average score of 89% for compliance with Duty of Candour			

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Regulation 20 Duty of Candour ensures that healthcare providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The Trust audits 3 components of the Regulation 20 Duty of Candour.

1. Compliance with initial Duty of Candour conversation/apology
2. Compliance with initial Duty of Candour letter: follow up from meeting/conversation
3. Compliance with investigations/ review findings shared with patients / families

An overall average score of the 3 components forms the Trust compliance score of 89%:

To improve the quality of Regulation 20 Duty of Candour compliance reporting, the new DCIQ (DatixCloudIQ a Governance Risk and Compliance system) incident module has revised the data collection tools and process to ensure Trust compliance.

This new report includes detailed data to ensure that patient and families are communicated with at the earliest opportunity when moderate/severe harm or death has occurred.

The DCIQ templates have been collaboratively designed with stakeholder and divisional support.

Patient Safety and Duty of Compliance Training implemented was implemented in quarter 4.

2.7.7 Health Services Safety Investigations Body (HSSIB)

The following cases met criteria for investigation by HSSIB;

Datix Ref:	STEIS (SI Ref:)	Date Reported	Type (under EBC criteria)	Opened (declared as PSII)	Closed
262723	2023/12097	08/06/2023	Neonatal death	22/06/2023	05/02/2024
196081	2023/13336	11/06/2023	Intrapartum stillbirth	12/07/2023	05/02/2024
268207	2023/17200	05/09/2023	Neonatal cooling	12/09/2023	14/05/2024
198533	2023/15320	30/07/2023	Neonatal cooling	10/08/2023	Submitted 10/05/2024
201558	2023/18409	27/09/2023	Neonatal cooling	02/10/2023	Submitted 16/05/2024
199572	2023/16228	20/08/2023	Neonatal cooling	24/08/2023	N/A - still open
207401	2024/938	13/01/2024	Neonatal cooling	24/01/2024	N/A - still open
275721	2024/298	18/12/2023	Neonatal brain injury	09/01/2024	N/A - still open
276061	2024/313	20/12/2023	Neonatal brain injury	09/01/2024	N/A - still open
277101	2024/1103	12/01/2024	Neonatal cooling	29/01/2024	N/A - still open

2.7.8 Patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Group established to oversee the management of VTE			

During 23/24 a VTE Prevention Improvement Working Group was established with the aim of aligning VTE prevention across the Trust.

One of the roles of this group will be to monitor VTE risk assessment data. During the Covid pandemic the collation of VTE Risk assessment data was suspended. However, the national submission of data will once again be required from July 24 onwards, processes to report on this metric have now been established across all four sites.

A Data Quality Dashboard has been devised to monitor the quality of the data submitted.

Because of vacancies a backlog of cases exists for the routine review of hospital acquired thrombosis episodes, this has impacted on the quality of information available at RSCH and PRH used in the VTE annual report. Notable in this year's report was the 50% reduction in preventable hospital acquired thrombosis at WGH and SRH.

Significant financial saving has also been made by changes in Low Molecular Weight Heparin its estimated that changing to enoxaparin will result in a cost saving of £600,000 to £700,000 pa.

This indicator looks at the percentage of patients who were admitted to hospital and who were risk assessed for VTE during the reporting period.

Indicator Domain	**The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism** Treating and caring for people in a safe environment and protecting them from avoidable harm				
UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2022-23	UHSussex 2021-22
85.5%	*	*	*	*	*
Data Source	NHS Digital NHS England » Venous thromboembolism (VTE) risk assessment 2019/20				

* The VTE data collection and publication continues to be suspended. It was initially halted in order to release capacity in providers and commissioners to manage the COVID-19 pandemic. The last available data for this indicator covers the period April 2019 to Dec 2020 when 96.5% of patients were risk assessed for VTE, the national median for this time period was 95%.

3.7.9 Rate of C.difficile infection

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex exceed its ambition of 141 cases of C.Difficle reporting 157 cases.			

In 2023/24 the Trust reported a total of 157 cases of C.difficle, against an ambition of 141. This equates to a rate of 13.93 cases per 100,000 occupied bed days

C.difficile numbers finished 16 over trajectory. There was a clear end of year spike, which we believe was associated with increased testing due to ongoing norovirus outbreaks as well as an increase in samples sent in by GPs for patients in the community.

Despite the number of cases exceeding trajectory we did not have any definite outbreaks/ cross infection. One period of increased incidence at Worthing on investigation, was shown through ribotyping, to be unrelated cases.

Indicator	The rate per 100,000 bed days of trust apportioned cases of C. difficile infection that have occurred within the Trust amongst patients aged 2 or over				
Domain	Treating and caring for people in a safe environment and protecting them from avoidable harm				
UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2022-23	UHSussex 2021-22
13.93	21.74	Not Available	Not Available	18.96	16.42
Data Source	https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure				

Table based on latest available data April 2023 to January 2024

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reasons every case is scrutinised using a Root Cause Analysis (RCA) process to determine whether the case was linked with a lapse in the quality of care provided to patients.

The University Hospitals Sussex NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, there has been a focus on improved ward cleaning and use of chlorine where cases have occurred. There has also been an emphasis on commode cleaning and audits have shown some improvement.

All hospital onset cases of C.difficile toxin positive are subject to a clinical review to identify cause and elicit any learning.

The new link Champion programme will be an asset in helping ensure good communication to wards and departments and encourage more effective information sharing. The link champions will be able to reinforce positive IPC messaging and behaviours in their clinical environment.

2.7.10 Sepsis

Table 11 highlights the SHMI for sepsis suggesting that mortality for this condition is within the expected range being 4% below expected with 315 observed deaths against an expected number of 329.

Following a pilot in the summer of 2024, UHSussex is currently putting plans in place to undertake two audits on the management of sepsis, the first involving patients in the Emergency Department, the second will involve patients that develop sepsis during their inpatient stay. The audits will measure compliance with the sepsis six care bundle - a set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring- to be instituted within one hour of a suspected sepsis diagnosis.

Table 11 Sepsis SHMI

Metric	
SHMI	95.82
SHMI95%CI Lower	85.53
SHMI95%CI Upper	107.01
Expected number of deaths	328.75
Number of patients discharged who died in hospital or within 30 days	315
Number of mortalities occurring in the hospital	253
Number of provider spells	1400
Number of mortalities occurring out of hospital	62

2.7.11 Health Inequalities

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex has delivered some good interventions for smoking cessation, however there are further opportunities to develop and delivery a Health Inequalities Strategy			

The Trust is committed to delivering NHS England's approach to reducing adult health inequalities through the Core20PLUS5 programme. During the year the Executive lead for Health Inequalities transferred from the Chief Medical Officer to the Chief Strategy Officer.

2.7.12 Smoking Cessation

The biggest area of focus and improvement for the Trust has been in Smoking Cessation with the implementation of the Smoke Free Pregnancy Service, which has made positive improvements with;

- 93.1% of patients with CO monitoring at Booking*
- 87.3% of patients with CO monitoring at 36 weeks*
- 93.5% of patients referred to smoke free pregnancy service
- 75.5% of patients being offered a consultation within 5 days of referral
- 98% of patients being contacted within 1 working day of referral
- 32% of patients smoke free at 36 weeks
- 32% quit rate from those smoking at time of booking (8.1%) versus those smoking at 36 weeks 5.2%).

*Data from 13 June 2023 to 31 March 2024 due to change in maternity information system

In addition, the Trust has undertaken a piloted project within outpatients for patients post cardiac arrest/chest pain, capturing 177 patients over the period November 2023 to March

2024. During the pilot patients were counselled on smoking cessation and offered intervention and referral, of the 177 patients:

- 86% took up an intervention such as a vape
- 79% reduced the number of cigarettes smoked, and
- 29% quit smoking

This programme will now be rolled out across the wider outpatients setting.

2.7.13 Maternity Continuity of Care

NHS England's approach aims to ensure continuity of care for women of Black, Asian and minority ethnic communities and for the most deprived groups. The Trust has continuity of care teams across its four sites; however in line with the Ockendon report, focus is currently on reducing vacancies and stabilising the clinical workforce.

2.7.14 Early Diagnosis of Cancer

NHS England's approach aims to ensure 75% of cases are diagnosed at stage 1 or 2 by 2028. Over the last 12 months, the Trust has diagnosed 46% of cases at Stage 1 or 2.

2.7.15 Chronic Respiratory Disease

NHS England's approach aims to ensure a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up the uptake of COVID, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations. This intervention is mainly aimed at Primary Care delivery; however the Trust is exploring ways that it can support delivery.

2.7.16 Hypertension Case Finding

NHS England's approach aims to ensure a focus on diagnosis and optimal management of hypertension including optimal lipid management. This intervention is mainly aimed at Primary Care delivery; however the Trust is exploring ways that it can support delivery

Part 3: Other Quality Information

3.1 Guardian of Safer Working Annual Report on Rota Gaps & Plans for Improvement

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex has a robust exception reporting process with key data (including GOSW fines and Immediate safety concerns) presented to People Committee and LFG (local faculty group) fora. Rota gaps are reported quarterly by Medical workforce with a forward plan and clear evidence of recruitment / backfill strategy. UHSussex has an active junior doctors forum with cross departmental representation including medical workforce, operational and educational teams.			

In 23/24 a new pan-trust Guardian of safe working hours and exception reporting team was established based at Worthing site. The team is responsible for oversight of all exception reports submitted by trainees across UHSussex. The exception reporting team track exception reports, support the educational supervisor in timely closure and ensure next pay packet remuneration for Exception Reports. Thematic analysis of exception reporting data pan-trust provides high quality data to local faculty group leads to unlock key themes, variations in exception reporting behaviour and seek local solutions.

There have been a total of 1394 ERs during 23/24. The majority of exception reports at UHSussex are submitted by trainees in medical specialties (65% at WGH, 80% at SRH, 62% at RSCH and 92% at PRH sites).

Overall predominant themes of exception reports for 23/24 vary by site and include workload ward staffing levels and handover. A single ER may fulfil descriptive criteria for more than one theme.

Work load: Perception by the exception reporter that the clinical workload exceeds the capacity of a full team.

Ward staffing: Perception by the exception reporter that the team allocation was insufficient for the clinical work load.

Handover: Doctor stayed as they felt handing over tasks to another team was unsafe or inappropriate

- 424 exception reports have been submitted at WGH; workload (27%) and staffing (21%);
- 364 at SRH; workload (25%) and staffing (24%)
- 558 at RSCH; workload (25%) and handover (16%)
- 48 ER at PRH staffing (19%) and handover (18%)

Hospital Site:	No. Exception Reports
Worthing & Southlands Hospital	424
St Richards Hospital	364
Royal Alexandra Children's Hospital	45
Sussex Eye Hospital	3
Martlets Hospice	2
Royal Sussex County Hospital	463
Brighton General Hospital	45
Princess Royal Hospital	48
Total	1394

During the course of the year 11 immediate safety concerns have been submitted and agreed; 7 at St Richards Hospital and 4 at Worthing. The majority of immediate safety concerns in 23/24 have related to unsafe staffing levels out of hours at St Richards hospital within the Division of Medicine.

In 2023/24, across the Trust medical workforce pressures and resultant rota gaps were greatest in Medical specialties. This is reflected by high numbers of exception reports from trainees in medical specialities. The majority of exception reports at UHSussex are submitted by trainees in medical specialties (65% at Worthing, 80% at St Richards, 62% at Royal Sussex and 92% at Princess Royal sites).

The Division of Medicine at Worthing and St Richards Hospital is finalising a business case for investment in a junior doctor establishment to uplift minimum ward numbers in St Richards wards and enhance daytime and night time on calls with particular focus on numbers of doctors available for ward cover on the weekends. The Trust is also working with the British Association of Physicians of Indian Origin with which the Trust has a memorandum of understanding in creating additional recruitment pipelines to reduce rota gaps.

Locally employed doctors across divisions provide substantive back fill to bolster rota lines across the organisation. UHSussex medical recruitment has been successful with 42 posts offered at RSCH/PRH sites from August 24 and contracts extended for 43 Clinical fellows. At Worthing and St Richards Hospital 18 Trust doctors have extended contracts from August 24, there have been 6 new appointments (9 doctors recruited for the Emergency Department) with interviews ongoing.

Clinical areas staffed by non-training grades; (trust grade doctors/ locally employed doctors and clinical fellows) are under-represented in exception report data and this blind spot of organisational risk may be considered inequitable. The benefits of expanding access for exception reports to locally employed and Trust grade doctors have been recognised with a proposed timeframe for wider implementation of exception reports at UHSussex. This will be a key step and ensure exception reporting offers a mechanism for

remuneration and risk reporting for all doctors in training grade posts at UHSussex. The timeframe proposed at People Committee in January 2024 for expanding exception reporting to Trust grade doctors/locally employed doctors was six months. This followed a piece of work by Martyn Clark (Director of Integrated Education) which was also presented at the meeting.

In 23/24 key concerns as expressed by the junior doctors body have included; safe levels of staffing out of hours, provision of high quality rest facilities and transparency on strategies to mitigate rota gaps such as escalation of rates of pay for those vacant shifts meeting the definition of a ‘critical shift’.

The implementation of Healthrota digital rostering platform across the organisation continues to have a transformative impact for junior doctors, with Trainess in the Medical division at Royal County Hospital and Princess Royal sites and Surgery/Trauma and Orthopaedics at Worthing and St Richards having transitioned to Healthrota in August 2023. ST grades subsequently transitioned in October 2023. Healthrota provides wider visibility of rota patterns across teams and a robust means of ensuring safe staffing and delivery of non-clinical time (e.g. study leave, annual leave and professional development time). It offers greater flexibility for doctors choosing to undertake additional work and facilitates easier shift swaps. Benefits for rostering teams are clear; Healthrota highlights non-compliance and caps maximum working hours over a rota cycle. Furthermore moving to a standardised rostering platform increases user confidence, functionality and access to key data. Trainees using Healthrota at UHSussex describe a better overall rostering experience, with rotas consistently published with contractual notice.

There have been ten rounds of junior doctor industrial action since March 2023. UHSussex have an active junior doctor forum which aims to highlight and resolve issues relating to working practices, distribute Guardian fines and seek engagement from senior management. At UHSussex 49 Guardian fines have been issued for 23/24 (22 Worthing, 12 St Richards, 14 Royal Sussex site 1 Princess Royal site) resulting in a total Guardian fines allocation of £7226.10. In 23/24 key concerns as expressed by the junior doctors body have included; safe levels of staffing out of hours, provision of high quality rest facilities and transparency on strategies to mitigate rota gaps such as escalation of rates of pay for those vacant shifts meeting the definition of a ‘critical shift’. These concerns are being addressed by recruitment strategies and the use of external agencies such as BAPIO – (British Association of Physicians of Indian Origin); Trust wide implementation of Healthrota to improve rota resilience and development of a Trust wide acting down policy to set agreed rates of pay for additional activity.

3.2 NHS Staff Survey

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	The Staff Survey results are showing a positive trajectory with improvement in scores, closing the gap with NHS sector benchmark			

The NHS Staff Survey is one of the largest workforce surveys in the world. It has been carried out every year since 2003 and aims to improve staff experiences across the NHS. In 2021 the survey questions were aligned to the NHS People Promise, and comparative data are therefore provided (where available) for the last three years. In 2023, the survey was extended to Bank-only workers. The Trust scores are benchmarked against 121 other NHS Acute and NHS Acute & Community Trusts.

3.2.1 2023 Goals

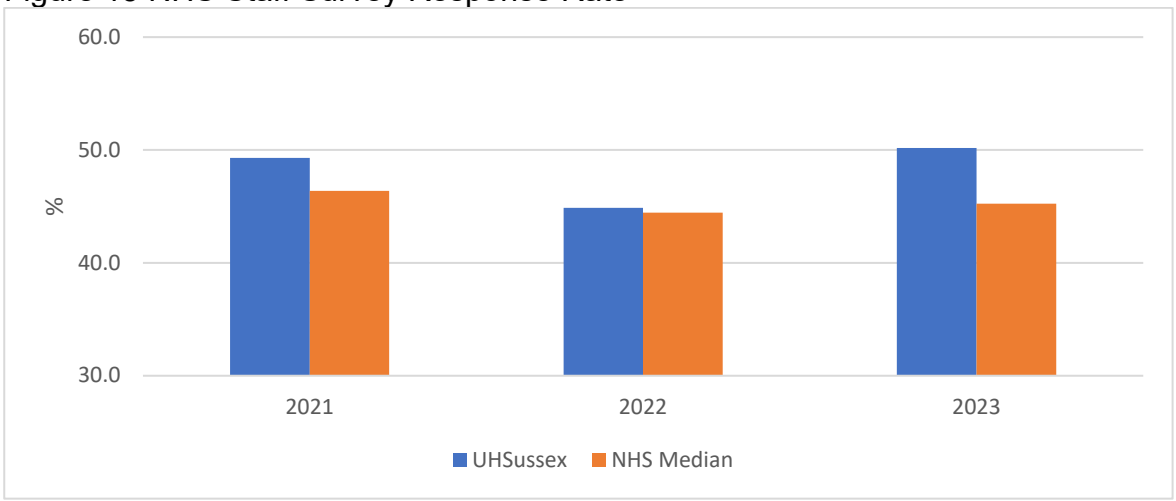
The Trust has met its aims for the 2023 NHS Staff Survey:

- to increase response rate, and continue to exceed the national median
- to improve the absolute scores against 2022 (at question, People Promise Element/Theme, and People Promise levels)
- to narrow the gap with the NHS average (benchmark) scores
- to make steady progress towards the Trust's ambition of scoring in the Upper Quartile (best 25%) compared to other NHS Acute and Acute & Community Trusts.

3.2.2 Response rate

For the last three years, the Trust response rate has been higher than the NHS median. This indicates a high level of staff engagement. In 2023, the Trust exceeded its internal target of 50% response rate (vs 45% NHS median), with 8,453 staff responding. Of these, 2,402 substantive staff and 523 Bank staff provided freetext comments, all of which have been analysed and themed.

Figure 15 NHS Staff Survey Response Rate



3.2.3 Analysis

Table 12 highlights the Trusts scores in the 2023 staff survey.

- The results show that the Trust improved against all seven People Promises and two People Themes. Expressed as a percentage, the Trust improved by 0.5% (We each have a voice that counts) to 5.0% (Morale).
- For we work flexibly, the Trust score was the same as NHS average. For the other eight People Promise elements/themes, the Trust scores were poorer than the NHS average. However, the gap narrowed for all nine elements/themes.
- The largest gap between 2023 Trust score and NHS average is for Staff Engagement. The Staff Engagement metric comprises nine questions (in three domains: Motivation, Involvement, Advocacy). The Trust improved its scores for all nine questions – by 1.2% (Able to suggest improvements) to 9.5% (Recommend as a place to work). The high staff response rate also indicates a high level of staff engagement.

Table 12 UHSussex scores in the 2023 staff survey

People Promise Element & Theme	2021			2022				2023			
	UHSx	NHS Avg	Gap	UHSx	Diff +/-	NHS Avg	Gap	UHSx	Diff +/-	NHS Avg	Gap
We work flexibly	5.86	5.96	-0.10	5.97	0.11	6.01	-0.04	6.20	0.23	6.20	0.00
We are a team	6.47	6.58	-0.11	6.52	0.05	6.64	-0.12	6.64	0.12	6.75	-0.11
We are compassionate and inclusive	7.07	7.20	-0.13	7.04	-0.03	7.18	-0.14	7.12	0.08	7.24	-0.12
We are recognised and rewarded	5.62	5.82	-0.20	5.55	-0.07	5.73	-0.18	5.75	0.20	5.94	-0.19
We are safe and healthy	5.67	5.90	-0.23	5.62	-0.05	5.89	-0.27	5.85	0.23	6.06	-0.21
We are always learning	5.04	5.23	-0.19	5.19	0.15	5.35	-0.16	5.40	0.21	5.61	-0.21
We each have a voice that counts	6.49	6.67	-0.18	6.45	-0.04	6.65	-0.20	6.48	0.03	6.70	-0.22
Morale	5.51	5.74	-0.23	5.42	-0.09	5.69	-0.27	5.69	0.27	5.91	-0.22
Staff Engagement	6.61	6.84	-0.23	6.54	-0.07	6.80	-0.26	6.66	0.12	6.91	-0.25

At individual question level, 17% of the Trust's 2023 scores were better than the NHS Average. These were:

- Understanding and kindness (Q8b), appreciation (Q8d), respect (Q7c) and politeness (Q8c) from colleagues
- Feeling valued by (Q7h) and attached to (Q7i) the team, and enjoying working with colleagues (Q7e)
- Opportunities for Flexible Working (Q4d, Q6d), and achieving a good Work-Home Balance (Q6c)
- The Trust's making Reasonable Adjustments (Q31b)
- Manager interest in staff member's health and wellbeing (Q9d)
- Having shared team objectives (Q7a)

3.2.4 Summary & Action Plan 2024/25

Key areas of focus for 2024/25 will be the questions where the Trust score worsened in 2023 and there is the largest gap with the NHS Average. These largely relate to acting on patient concerns (Q25b), clinical concerns (Q20b), errors and near-misses (Q19c), and providing feedback on actions taken (Q19d). The Trust has established the Quality & Safety Improvement Programme (QSIP) to provide an enhanced focus on quality and

safety. This has included the launch of RLDatix incident reporting and data analysis software in February 2024.

Although the Trust score for ‘We work flexibly’ was the same as the NHS Average, analysis by Staff Group identifies a wide range of experience. During 2024/25 the Trust intends to pilot self-rostering for Medical & Dental staff.

3.3 Operation Performance Relevant to Quality of Care

3.3.1 Emergency Department performance

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Performance of the Trust's six emergency departments is not meeting the national standards and has seen a deterioration compared to a national improvement			

Despite the improvements made in 2021-2024, performance of the Trust's six emergency departments is not meeting the national standards, as demonstrated by data from March 2024:

A&E and Emergency Flow	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Trend
A&E 4 Hour Performance UHS	71.66%	72.16%	71.40%	72.26%	69.42%	69.29%	69.32%	68.45%	68.02%	70.02%	68.27%	69.05%	69.60%	
A&E Attendances	32,093	35,961	35,185	35,322	34,460	35,009	35,630	33,973	35,077	30,201	29,840	33,977	35,265	
Ambulance Handovers	6,576	7,101	6,459	6,999	7,002	6,786	7,097	6,754	7,166	7,298	6,701	7,152	6,808	
Emergency Admissions > 1 LOS	3,176	3,301	3,239	3,276	3,221	3,256	3394	3286	3397	3318	3064	3413	3143	
Occupied Beds	1,644	1,623	1,606	1,559	1,585	1,588	1,613	1,651	1,659	1,709	1,689	1,668	1670	
Bed Occupancy	95.2%	95.5%	95.1%	93.2%	95.0%	95.7%	96.3%	97.2%	96.0%	96.2%	95.3%	95.6%	95.7%	
Average LOS (Excl LOS 0)	9.3	10.0	9.29	9.31	8.91	8.74	8.97	8.86	9.16	9.64	9.59	9.40	9.40	
> 7 day LOS Patients	1064	1038	1002	948	961	972	977	1023	1040	1082	1080	1064	1090	
>21 day LOS Patients	496	475	439	435	407	447	422	448	464	487	483	490	517	
Ave. MRD per day	294	290	291	272	251	264	260	304	288	324	325	328	324	

A&E and Emergency Flow	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Trend
A&E 4 Hour Performance UHS	71.66%	72.16%	71.40%	72.26%	69.42%	69.29%	69.32%	68.45%	68.02%	70.02%	68.27%	69.05%	69.60%	
RSCH	56.69%	52.68%	52.84%	52.96%	51.92%	55.54%	50.45%	58.50%	56.14%	60.75%	55.87%	56.66%	54.34%	
PRH	70.75%	76.08%	72.96%	71.36%	76.00%	74.82%	75.90%	68.69%	68.96%	72.97%	67.82%	70.45%	70.43%	
RACH	90.21%	88.14%	90.96%	94.01%	94.04%	85.77%	87.94%	78.50%	78.31%	79.87%	83.77%	79.09%	87.38%	
Worthing	68.95%	70.65%	71.69%	71.23%	63.43%	62.17%	64.20%	60.62%	59.70%	60.90%	58.25%	60.60%	59.12%	
SRH	58.71%	60.23%	57.32%	62.50%	56.00%	55.29%	56.29%	53.99%	57.25%	57.48%	58.35%	61.14%	63.76%	
A&E Performance National	*74.6%*	*74.0%*	*73.3%*	*74.0%*	*73.0%*	*71.6%*	*70.2%*	*69.7%*	*69.4%*	*70.0%*	*70.9%*	*74.2%*	*74.4%*	

Patients being seen within four hours: The Trust achieved 67.4% in March 24, a 0.9% deterioration from February 2024, and a 1.4% drop in performance compared to March 23. The national average improving by 3.3% over the same period.

Patients waiting longer than 12 hours: The metric deteriorated in March overall and is variable by site, with 17.4% of patients breaching 12 hrs at RSCH, compared to 13.0% last March and 16.5% last month. Worthing with 7.7% from 6.7% last month. Improvements were seen at PRH with an increase to 7.5% from 9.7% in the previous month and SRH with 10.5% from 11%. Emergency improvement plans are going to be widened to include all divisions which contribute to UEC performance.

Long length of stay: There has been a decrease in average LoS to 9.4 days from 9.6 last month and 9.7 in March last year. LLoS (>21 days) remains high at 490 in March, increased from 483 in Feb-24, and higher than 468 in Mar 23. The stranded cohort (>7 days) was 1064 in Mar-24, a slight improvement from 1080 in Feb-24, but worse than 1045 in Mar-23.

Occupied beds make up 25-20% (n=468-525 since Jan 24) and of for those staying longer than 21 days, of whom since the turn of 2024, 300-340 are medically ready for discharge.

The UEC Improvement Plan, and site based recovery plans, will deliver against the following four key NHSE standards and operational targets for each of the four main hospital sites within UHSx:

- 78% of patients in ED seen, treated, admitted or discharged within 4 hours by March 2025
- No more than 5% of patients waiting over 12 hours from arrival in ED
- 10% reduction in number of patients with a Length of Stay of over 7 days
- Reduce ambulance handover delays over 60 minutes to 4%

These targets will be achieved through our improvement plans, but work will continue to improve on these metrics further.

Our four sites have unique urgent and emergency care improvement plans described in this document. Across the site-based plans, there are common improvement initiatives which are being led at a Trust-wide level. This includes corporate projects to reduce length of day and supporting a reduced median hour of discharge.

The improvement plans detailed in this document are shaped by a wealth of insights, including from our patients, Healthwatch, other NHS partners and local authorities. We recognise that urgent and emergency care is delivered and influenced by and interdependent on the workings of a complex system of partnerships, as detailed in system urgent and emergency care plans.

Our plans are focused on improvements that are within the internal control of the Trust and are designed to be considered within the context of system plans, such as those for managing demand at the front door and care outside of hospitals.

3.3.2 Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway.

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is below national average, with the majority of patients waiting over 18 weeks			

The NHS constitution sets a standard that 92 per cent of people waiting for elective (non-urgent) treatment, for example, cataract surgery or a knee replacement, should wait no longer than 18 weeks from their referral to their first treatment.

Indicator	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway				
UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2022-23	UHSussex 2021-22
42.9%	57.6%	100.0%	34.8%	46.8%	56.3%
Data Source	Statistics » Consultant-led Referral to Treatment Waiting Times Data 2023-24 (england.nhs.uk)				

Table based on patients waiting to receive treatment at the end of February 2024

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reasons data is taken direct from the internal clinical system(s) and is validated by the appropriate service.

3.3.3 Maximum six-week wait for diagnostic procedures

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is below national average with the majority of patients waiting over 6 weeks			

Diagnostic waiting times are now part of the NHS Constitution, which pledges that patients should wait less than 6 weeks for a diagnostic test from the time that the request has been sent.

Indicator	Percentage of patients waiting more than six-week wait for diagnostic procedures				
UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2022-23	UHSussex 2021-22
29.7%	21.5%	0.0%	73.4%	22.2%	25.9%
Data Source	Statistics » Monthly Diagnostics Data 2023-24 (england.nhs.uk)				

Table based on latest available data March 2023 to February 2024

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reasons data is taken direct from the internal clinical system(s) and is validated by the appropriate service.

3.4 Participation in Clinical Research

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex improved the recruitment of participants and ranking when benchmarked with other Acute Trusts.			

Research and Innovation drive continuous quality improvement in healthcare and helps NHS organisations attract and retain a high calibre workforce. University Hospitals Sussex has a Research and Innovation True North ambition putting research at the heart of the Patient First vision, the Trust's long-term approach to transforming hospital services for the better. The Trust focuses its continuous improvement work through strategic themes as the components to deliver 'excellent care every time'. In October 2022 we established a sixth strategic theme, one for Research and Innovation, reflecting our ambition and potential as a tertiary centre.

This vision is set out in our new Research and Innovation Strategy 2023-2028, which outlines our ambition for University Hospitals Sussex to be a place where all patients and staff have the opportunity to participate in high-quality research and innovation which is relevant to them, and in which we work with partners across Sussex to ensure the whole population benefits from health and care research and innovation. We will achieve this by broadening engagement in research across our organisation and throughout our workforce, and working in closer partnership across the NHS Sussex Integrated Care System, other health and care service providers in Sussex and academic partners including the Brighton and Sussex Medical School (BSMS).

This year the Research and Innovation Breakthrough Objective has focused on growing and broadening the opportunities for our patients and staff to take part in research by increasing the number of active research studies, increasing the number of patients recruited to research studies and broadening the involvement of different clinical services and their staff in delivering research.

We have exceeded our annual Breakthrough Objective of 10% growth in recruitment of participants into National Institute of Health Research (NIHR) Portfolio studies. This year we have recruited 7,534 (37% Increase from 2022/23) participants into 182 portfolio studies across a range of clinical specialties. Of these 5,283 patients participated in potentially lifesaving clinical trials of new medications, devices or procedures. When benchmarked against other NHS acute trusts, we have improved our rank from 32nd to 24th acute NHS Trust for patient recruitment in 2023/24.

The Trust's most research active specialties have continued to excel with strong recruitment to a broad portfolio of studies in; cancer, cardiovascular disease, infection, renal medicine and paediatrics. This year a wider range of clinical specialties have made substantial contributions to our research profile. The success of our largest recruiting study this year was enabled by our research midwives. We opened suites of new studies in respiratory medicine, gastroenterology and surgery.

This year we introduced a new process to track University Hospitals Sussex academic publications and have compiled data for April to December 2023. During these nine months, there were 560 academic publications in total and 363 of these were research studies. 210 research studies had a member of University Hospitals Sussex staff listed as the primary author.

Research by University Hospitals Sussex was cited as evidence within 236 health policy and guidance documents (both national and international) published in 2023. This includes UHSussex citations in 30 NICE guidelines and 13 WHO publications.

A significant new initiative launched this year to support our ambitions to embed research in the Trust's clinical operating model has been the creation of eight new Divisional Leads in research. Within each division senior clinicians with expertise in research leadership are now supporting the Divisional Chiefs and the Research and Innovation team to build tailored local business plans for research growth founded on embedding research roles in the workforce.

We have continued to drive the development of the Brighton and Sussex Health Research Partnership. The HRP was established in 2022 by UH Sussex, Brighton and Sussex Medical School and Sussex Partnership Foundation Trust to build on shared research infrastructure to grow capacity and capability for research and facilitate research across organisational boundaries. The partnership has matured over the year to broaden NHS, academic, public health and social care input right across the Integrated Care System. One of the key areas of work this year has been to support research careers development in our workforce. We have collaborated through the partnership this year to establish a new Research Training Hub which provides single point of contact for advice, best practice, information on health and care academic careers and recruitment to research fellowships. It will also provide training and development for academic clinicians and health and social care professionals at all stages of their academic journey. The hub will provide specific support for trainees on the Integrated Academic Training Programme, current PhD students across the trust and its partners, and pre/post-doctoral healthcare professionals.

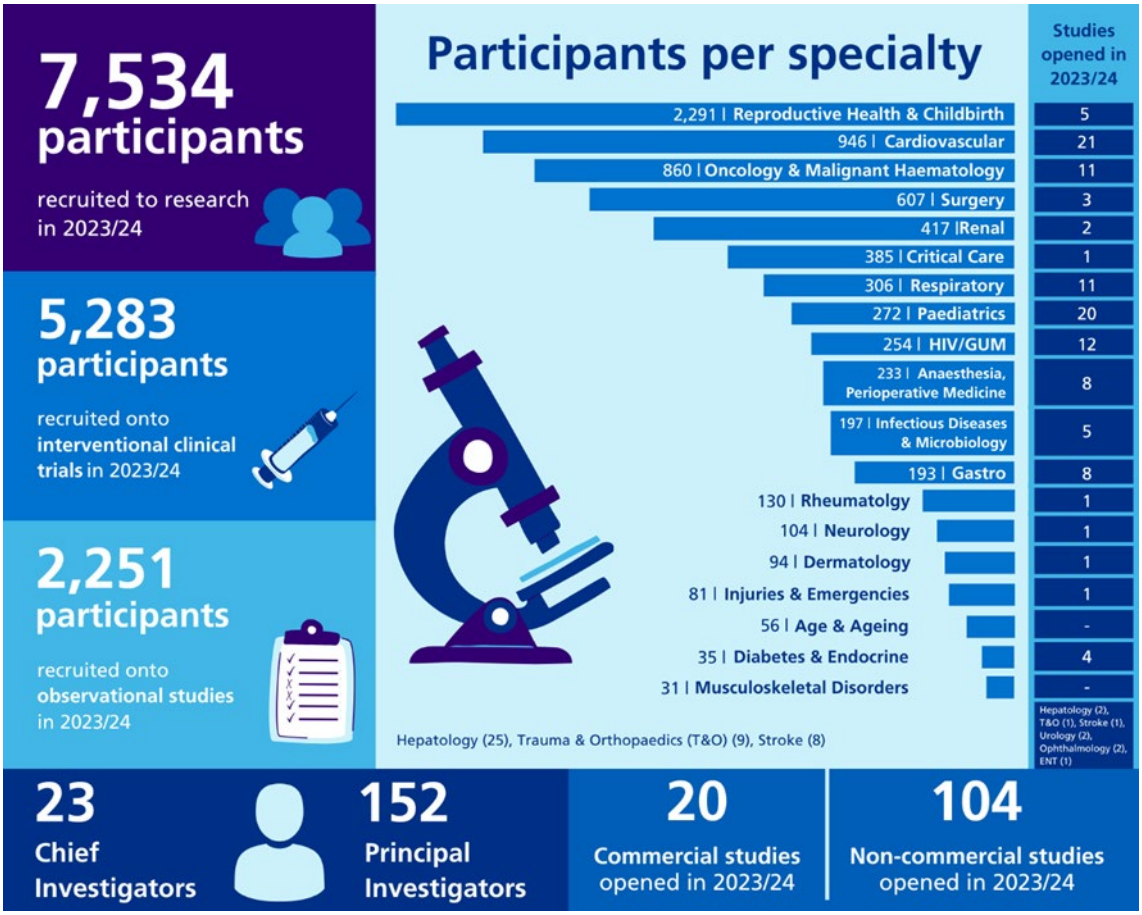
A further major new partnership this year has been with the Trust's charity My UHSussex to build community and patient engagement in research and develop staff research skills. This will help us build a strong external, public facing profile, helping engage the public fully in our research. It will meet the charity's aims providing clear and immediate impacts of charity funding and donations, in a priority area for the charity and the Trust. The funding is supporting a programme of research training opportunities for staff across a range of health professions. These include

- early "internship awards" to introduce staff to research for the first time,
- "accelerator awards" for staff with research ideas and projects with opportunities to develop their ideas into projects that can secure substantive funding
- "fellowships" supporting a small number of the most promising early-career researchers in the Trust undertake substantial periods of research with potential to directly drive up the quality of care experienced by our patients.

These schemes build on the continued success of programmes introduced in 2022-3. This year we awarded a further four UHSussex doctorial awards funded jointly through funding from NHS England, Brighton and Sussex Medical School and our commercial research success. In total we now have 10 junior doctors funded by the scheme doing doctorial level degrees across the trust in specialties including cancer, haematology, diabetes, dermatology, cardiology, paediatric infection, frailty, preoperative care and sexual health,

We have hosted clinical fellows supporting research delivery at our Clinical Research Facility at the RSCH and supported X NIHR-funded ACF and ACLs across the Trust

We are also working with MyUHSussex on a programme of public engagement work, again working across the ICS through the Health Research Partnership we have secured NHS England funding for a Sussex Research Engagement Network to work with voluntary sector organisations and communities in Sussex which are currently least involved in health and care research, delivering community engagement events, supporting development of community researchers. We have supported the HRPs creation of a strategic Public and Community Advisory Group for research who provide oversight of research strategy development and delivery for the HRP and NHS partners including NHS Sussex, linking with existing Patient and Public Advisory Groups across the system and especially linking with the NIHR Kenty Surrey and Sussex Applied Research Collaboration.



3.5 Voluntary Services

Assurance Self-Assessment	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is making good use of its volunteers			

At the end of the financial year of 2023/24, UHSussex had 727 registered volunteers who had contributed their time throughout the year to support and deliver various functions and activities across the Trust. Each fulfilling a role that impacts upon enhancing both patient and staff experience and the experience of visitors, relatives, and carers. Service delivery; volunteer activities support or lead therapeutic interventions and access to services. Operational support: carrying out tasks that enable efficiency and effectiveness within the delivery of services. And the involvement and improvement of services through lived experiences.

There are a variety of roles currently being fulfilled across the seven hospitals of the Trust in Brighton, Worthing, Shoreham and Chichester, including:

- A&E and all Emergency floors
- Activities for patients
- Administration and Reception across various departments within the Trust
- Auxilary Services
- Chaplaincy
- Clinic Support across various departments within the Trust
- Complimentary Therapists
- Counselling
- Crisis Response
- Dementia Support
- Dining Support
- Gardening
- Libraries across the Trust
- Patient Support
- Pharmacy
- Portering
- Wayfinding
- Ward Support

As part of the new strategic framework, we will be looking at introducing income generation roles in support of the My University Sussex Hospital Charity. A micro-volunteering offer and a Trust-wide corporate volunteering offer.

Current partnerships with voluntary and charitable organisations also contribute to the on-going effort including those who volunteer for the League of Friends across all sites. Macmillan Cancer Support, Carers Support West Sussex, Hospital radio across all sites, Pets as Therapy Dogs and countless other local community organisations whose contributions are vital to supporting the delivery of services in the region.

With the appointment of the Head of Voluntary Services in January, work on resourcing the team across the Trust, designing a new 5-year strategy and operational plan has

begun to ensure that the service is supporting the NHS Long-term plan and delivering the recommendations of the NHS Volunteering Taskforce as effectively as possible.

The importance of the role of volunteers within the NHS has never been more important than in the current financial climate. As financial and health pressures continue to grow and increase pressures on already existing demands. A clear, effective and impactful strategy will enable the Trust to move forward to deliver its Patient First strategy, ensuring that the very best care is always offered to those who receive it.

Annex 1: Assurance Report on Quality

There is no requirement for a foundation trust to commission external assurance on its quality report for 2023/24; however the Trust has undertaken its own internal review to provide assurance that the required elements are met;

Description of prescribed Information	Areas applicable to UHSx Foundation Trust	National Average	UHSussex Performance	Supporting commentary and page number
(a) The value and banding of the hospital-level mortality indicator ('SHMI') for the trust for the reporting period; and	Inpatient Care – all sites	100	104.88	Within expected range Page 27
(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	Inpatient Care – all sites	2.99	1.98%	Palliative care indicators are included below to assist in the interpretation of SHMI by providing a summary of the varying levels of palliative care coding Page 28
The Trust's patient reported outcome measures (PROMs) Scores for: (i) Groin hernia surgery (ii) Varicose vein surgery (iii) Hip replacement surgery (iv) Knee replacement surgery Reported during the period	Elective orthopaedic surgery	 0.453 0.295	 0.437 0.317	A higher score indicates better health and/or greater improvement in function following an operation. Page 22

Description of prescribed Information	Areas applicable to UHSx Foundation Trust	National Average	UHSussex Performance	Supporting commentary and page number
The percentage of patients aged (i) 0 to 17 and (ii) 18 or over Readmitted to a hospital which forms of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	Inpatient Care – all sites	10.57% 8.60%	9.99% 8.94%	Emergency readmissions – where patients are readmitted to hospital in an emergency within 30 days of discharge. Page 23
The Trust's responsiveness to the personal needs of its patients during the reporting period		74.5%	85.4%	A measure of the level of communicating and engaging with patients and carers with the aim of identifying and meet their non-clinical needs Page 40
The percentage of staff employed by or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	Staff employed by, or under contract to the Trust	63.3%	59.6%	The staff and patients FFT is a feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how. Page 42, 42 and 44
Friends and Family Test – Patient. The data made available by National Health Service Trust or NHS Foundation Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients	Adult inpatients	94.1%	92.7%	

Description of prescribed Information	Areas applicable to UHSx Foundation Trust	National Average	UHSussex Performance	Supporting commentary and page number
Patients discharged from Accident and Emergency (types 1 and 2)	A&E attendees	79.5%	83.2%	
The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	Inpatients across all sites	21.74	13.93	The incidence rate of hospital-onset cases of C.difficile infection Page 56
The number and where available rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death			43.6	Reporting rate of patient safety incidents Page 50

Annex 2: Additional Data Sets

A2.1 Participation status for 2023-24 National Audit Programme

National clinical audits	Eligible	2023/24 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
UK Parkinson's Audit	Specialist	Confirmed - all eligible divisions participating	100%
Sentinel Stroke National Audit Programme (SSNAP)	Specialist	Confirmed - all eligible divisions participating	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Medicine RSCH & PRH / Medicine SRH & WH	Confirmed - all eligible divisions participating	100%
National Vascular Registry	Specialist	Confirmed - all eligible divisions participating	100%
National Neurosurgical Audit Programme	Specialist	Confirmed - all eligible divisions participating	100%
National Major Trauma Registry (NMTR)	Specialist	Confirmed - all eligible divisions participating	In Progress
Myocardial Ischaemia National Audit Project (MINAP)	Specialist	Confirmed - all eligible divisions participating	100%
Elective Surgery (National PROMs Programme)	Surgery SRH & WH / Surgery RSCH & PRH	Confirmed - all eligible divisions participating	100%

National clinical audits	Eligible	2023/24 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
Perioperative Quality Improvement Programme (PQIP)	Surgery SRH & WH / Surgery RSCH & PRH	partial participation	100%
Paediatric Intensive Care Audit Network (PICANet)	Women & Children	Confirmed - all eligible divisions participating	100%
National Paediatric Diabetes Audit (NPDA)	Women & Children	Confirmed - all eligible divisions participating	In Progress
National Neonatal Audit Programme (NNAP)	Women & Children	Confirmed - all eligible divisions participating	In Progress
National Heart Failure Audit	Specialist	Confirmed - all eligible divisions participating	100%
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Specialist	Confirmed - all eligible divisions participating	100%
National Audit of Cardiac Rhythm Management (CRM)	Specialist	Confirmed - all eligible divisions participating	100%
COPD Secondary Care-	Medicine RSCH & PRH / Medicine SRH & WH	Confirmed - all eligible divisions participating	In Progress
Adult Asthma Secondary Care	Medicine RSCH & PRH / Medicine SRH & WH	Confirmed - all eligible divisions participating	In Progress

National clinical audits	Eligible	2023/24 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
National Prostate Cancer Audit (NPCA)	Surgery SRH & WH	Confirmed - all eligible divisions participating	100%
National Maternity and Perinatal Audit (NMPA)	Women & Children	Confirmed - all eligible divisions participating	100%
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	Women & Children	Non-participation agreed	Non-participation agreed Lack of resource
National Child Mortality Database (NCMD) Programme	Women & Children	Confirmed - all eligible divisions participating	100%
Paediatric Asthma Secondary Care	Women & Children	Confirmed - all eligible divisions participating	100%
National Pregnancy in Diabetes Audit (NPID)	Women & Children / Medicine RSCH & PRH	Confirmed - all eligible divisions participating	100%
National Cataract Audit	Surgery SRH & WH / Surgery RSCH & PRH	Confirmed - all eligible divisions participating	PRH, STH, SRH as 'not enough data to meet eligibility of the audit
Age-related Macular Degeneration Audit (AMD)	Surgery SRH & WH / Surgery RSCH & PRH	Non-participation agreed	Non-participation agreed Incompatible IT software

National clinical audits	Eligible	2023/24 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
National Obesity Audit (NOA)	Medicine SRH & WH	Awaiting confirmation - participation not known	0%
National Adult Cardiac Surgery Audit	Specialist	Confirmed - all eligible divisions participating	100%
Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Specialist	Confirmed - all eligible divisions participating	100%
National Congenital Heart Disease Audit (NCHDA)	Specialist	Confirmed - all eligible divisions participating	100%
National Lung Cancer Audit (NLCA)	Medicine RSCH & PRH / Medicine SRH & WH	Confirmed - all eligible divisions participating	100%
National Joint Registry (NJR)	Surgery RSCH & PRH / Surgery SRH & WH	Confirmed - all eligible divisions participating	100%
National Head and Neck Cancer Audit (HANA)	Cancer	This audit is on hold	This audit is on hold
National Bowel Cancer Audit (NBOCA)	Surgery SRH & WH / Surgery RSCH & PRH	Confirmed - all eligible divisions participating	100%
National Oesophago-Gastric Cancer Audit (NOGCA)	Cancer / Surgery RSCH & PRH	Confirmed - all eligible divisions participating	This part of the service has been suspended. Audit on hold

National clinical audits	Eligible	2023/24 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
National Emergency Laparotomy Audit (NELA)	Surgery SRH & WH / Surgery RSCH & PRH	Confirmed - all eligible divisions participating	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Surgery SRH & WH / Surgery RSCH & PRH	Confirmed - all eligible divisions participating	100%
National Comparative Audit of Blood Transfusion	Clinical Support Services	Confirmed - all eligible divisions participating	100%
Bedside Transfusion Audit	Clinical Support Services	Confirmed - all eligible divisions participating	100%
National Audit of Cardiac Rehabilitation	Specialist	Confirmed - all eligible divisions participating	100%
UK Renal Registry National Acute Kidney Injury Audit	Specialist	Confirmed - all eligible divisions participating	100%
UK Renal Registry Chronic Kidney Disease Audit	Specialist	Confirmed - all eligible divisions participating	100%
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Cancer	Non-participation agreed	Non-participation agreed Lack of resource

National clinical audits	Eligible	2023/24 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Cancer	Non-participation agreed	Non-participation agreed Lack of resource
Care in general hospitals (round 6)	Corporate	Confirmed - all eligible divisions participating	100%
National Audit of Care at the End of Life (NACEL)	Cancer	Non-participation agreed	Non-participation agreed Lack of resource
National Diabetes Footcare Audit (NDFA)	Medicine RSCH & PRH / Medicine SRH & WH	Confirmed - 1 or more eligible divisions participating	Non participation at SRH/ PRH/ RSCH due to limited resource
National Diabetes Inpatient Safety Audit (NDISA)	Medicine RSCH & PRH / Medicine SRH & WH	Confirmed - all eligible divisions participating	In progress
NDA Integrated Specialist Survey	Medicine RSCH & PRH / Medicine SRH & WH	Confirmed - all eligible divisions participating	100%
National Core Diabetes Audit	Medicine RSCH & PRH / Medicine SRH & WH	Confirmed - all eligible divisions participating	100%

National clinical audits	Eligible	2023/24 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]	Surgery RSCH & PRH / Medicine SRH & WH	Confirmed - 1 or more eligible divisions participating	WH- non participation due to lack of resource
National Audit of Inpatient Falls (NAIF)	Corporate	Confirmed - all eligible divisions participating	In progress
National Hip Fracture Database (NHFD)	Surgery SRH & WH / Surgery RSCH & PRH	Confirmed - all eligible divisions participating	In progress
Mental Health (Self-Harm) (RCEM) Year 2	Medicine RSCH & PRH / Medicine SRH & WH	Confirmed - all eligible divisions participating	In progress
Infection Prevention and Control (RCEM) (year 3)	Medicine SRH & WH	Confirmed - all eligible divisions participating	In progress
Time critical medications (RCEM) Pilot	Medicine SRH & WH / Medicine RSCH & PRH	Confirmed - all eligible divisions participating	In progress
Care of Older People (RCEM). Year 2.	Medicine RSCH & PRH / Medicine SRH & WH	Confirmed - all eligible divisions participating	In progress
Intensive Care National Audit & Research Centre	Surgery SRH & WH / Surgery RSCH & PRH	Confirmed - all eligible divisions participating	In progress

National clinical audits	Eligible	2023/24 Participation status	Percentage of relevant cases submitted/ or reason for non-participation
Adult Respiratory Support Audit	Medicine RSCH & PRH / Medicine SRH & WH	Confirmed - all eligible divisions participating	100%

A2.2 Actions planned or undertaken as a result of participation in the National Audit Programme

Title	Action taken or planned
National Audit of Care at the End of Life (NACEL)	UHSussex Palliative Care Team has successfully embedded a digital EOLC Toolkit, including comfort observations into Patient Trac across all 4 main hospital sites, aligned with this is the ability to seek assurance that good EOLC is being delivered through a digital EOLC dataset embedded in UHSussex Compass BI platform.
National Lung Cancer Audit (NLCA)	Appointment of a clinical data lead with protected time for reviewing and checking the team's data returns and for championing improvements in the completeness of key data items. Increase referrals for navigational bronchoscopy for the difficult biopsies Targeted lung health checks in place which should lead to less emergency presentations. Increased awareness from the programme should help
National Hip Fracture Database (NHFD)	Implemented 120 day follow up for NOFs Change supplier of DHS and encourage more use in A1 and 2 fractures
National Emergency Laparotomy Audit (NELA)	Updated pathway agreed/approved by Emergency Surgery Improvement Group in March 2023 Devised system to capture patients referred but not 'accepted' by critical care (data not routinely captured by audit) Integration into laparotomy pathway (April 2023)
National Audit of Dementia	Delirium Assessment included on the Induction Teaching Programme for F1/F2 doctors Admission documentation has been reviewed a now includes the 4AT delirium assessment tool Delirium Protocol has been reviewed and updated

Title	Action taken or planned
National Early Inflammatory Arthritis Audit (NEIAA)	Offer psychological support/service for the EIA patients Plans to increase the workforce capacity (consultants, nurses, SpR)

A2.3 Participation status for 2023-24 National confidential enquiries programme

National confidential enquiries	Eligible	Participated	Percentage submitted
Juvenile Idiopathic Arthritis	Yes	Yes	67%
Community Acquired Pneumonia	Yes	Yes	48%
Testicular Torsion Study	Yes	Yes	80%
Crohn's Disease	Yes	Yes	28%
Transition from child to adult health services	Yes	Yes	41%
End of Life Care	Yes	Yes	In progress
Rehabilitation following critical illness	Yes	Yes	In progress

A2.4 Actions planned or undertaken as a result of participation in the National Audit Programme

Title	Action taken or planned
National Audit of Care at the End of Life (NACEL)	UHSussex Palliative Care Team has successfully embedded a digital EOLC Toolkit, including comfort observations into Patient Trac across all 4 main hospital sites, aligned with this is the ability to seek assurance that good EOLC is being delivered through a digital EOLC dataset embedded in UHSussex Compass BI platform.
National Lung Cancer Audit (NLCA)	Appointment of a clinical data lead with protected time for reviewing and checking the team's data returns and for championing improvements in the completeness of key data items. Increase referrals for navigational bronchoscopy for the difficult biopsies Targeted lung health checks in place which should lead to less emergency presentations. Increased awareness from the programme should help
National Hip Fracture Database (NHFD)	Implemented 120 day follow up for NOFs Change supplier of DHS and encourage more use in A1 and 2 fractures
National Emergency Laparotomy Audit (NELA)	Updated pathway agreed/approved by Emergency Surgery Improvement Group in March 2023 Devised system to capture patients referred but not 'accepted' by critical care (data not routinely captured by audit) Integration into laparotomy pathway (April 2023)

Title	Action taken or planned
National Audit of Dementia	Delirium Assessment included on the Induction Teaching Programme for F1/F2 doctors Admission documentation has been reviewed a now includes the 4AT delirium assessment tool Delirium Protocol has been reviewed and updated
National Early Inflammatory Arthritis Audit (NEIAA)	Offer psychological support/service for the EIA patients Plans to increase the workforce capacity (consultants, nurses, SpR)

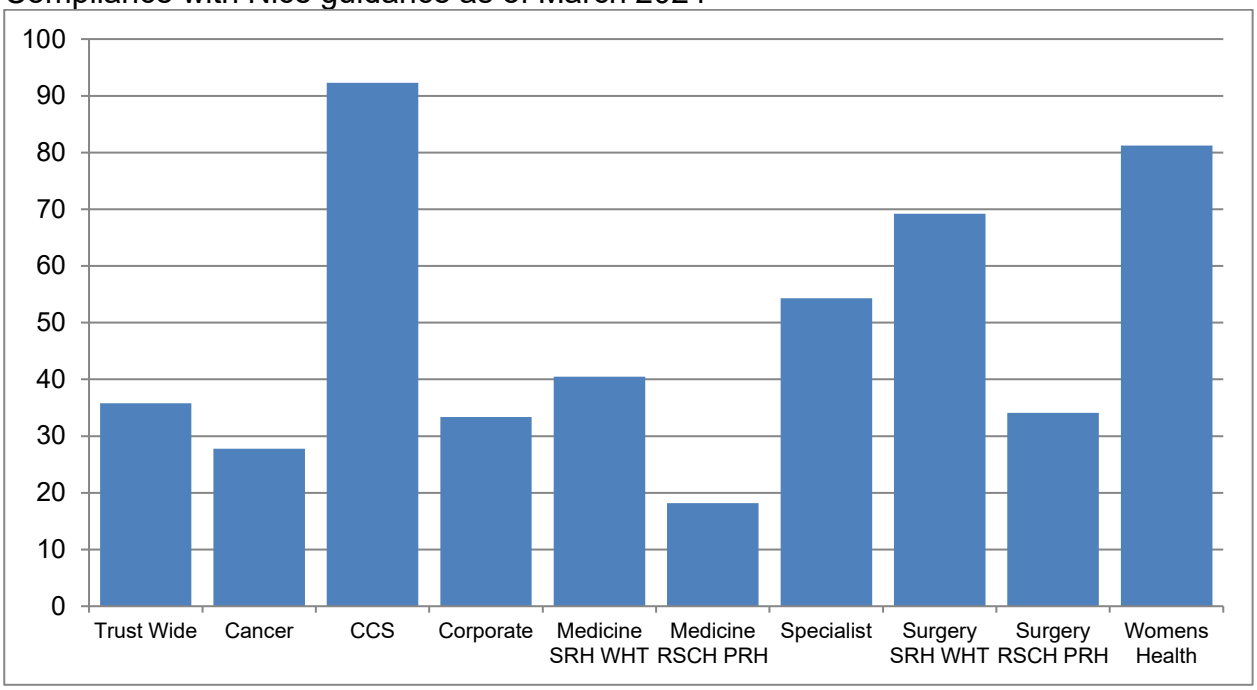
A2.5 Actions planned or undertaken as a result of participation in Local Audits

Speciality	Project Title	Actions to improve the quality of care
Maxillo-Facial	An Audit on the appropriate use of Urgent Treatment Clinic (MFU11) with Maxillo-Facial unit at St. Richard's Hospital, Chichester	• New E referral tool was constructed using SBAR tool for referrals. This tool was published on Trust intranet
Radiography	Compliance with 'Pause & Check' in Radiology [2022]	• Implemented mobile CRIS in X-ray department and review processes when using mobile CRIS in Radiology • Ensure all radiographers have anatomical markers and tablets • Reviewed the booking system for patients to avoid multiple bookings in short time
Cancer	WH Quality Improvement project assessing the benefits of implementing a nutritional screening tool on the Chemotherapy day unit (MDCU)	• Reviewed tool 1 to: • Simplify questions/formatting. • Add free form text box for additional comments. • Include a question on activity to reflect use in ambulatory care setting. • Add stratified care plan. • Add Signposting for patients around who to contact if any questions or concerns. • Signposting for patients concerned about weight gain.

Speciality	Project Title	Actions to improve the quality of care
Emergency Medicine	Improving handovers for junior doctors in Infectious Diseases	• Implementation of a formal face to face induction by registrars • Ensuring the continuation of face-to-face inductions & that documents are updated yearly • Ensuring the handover document is sent out prior to every rotation to new colleagues
T&O Surgery	WH Re-audit management of distal radius fractures adults	• Advice leaflet for Return to School and Sport following head injury developed • Updates to existing proforma to include checkbox for return to school/sport advice given • Teaching presentation to doctors, disseminate information to lead paeds nurses
Paediatric	Audit of Compliance with Requirement to fit Tamperproof Battery Compartments to Vulnerable Children	• Changes to database structure to make clear battery drawer used • Changes to database to ensure data entry regarding battery drawer • All staff to update battery drawer status for all children at time of appointment
Paediatric	Senior sign off of fever in under 1s in RACH CED	• Fever under one sign off added to microguide Fever no focus in children < 5 years. • Sign off for fevers under 1 added to CED safety rules.

A2.6 NICE Guidance Data

Compliance with Nice guidance as of March 2024



A2.7 CQC Must Do Actions and Progress

Date	June 24	SRO	Director: Patient Safety and Learning	Exec	Chief Nursing Officer	On/ off track	On track

Problem statement/ ambition: CQC, following numerous visits and inspections since the Trust was merged have identified a number of actions to be completed by the Trust to demonstrate that improvement has taken place. The ambition is that at least 90% of all CQC must/should do actions to be completed by Q3.

What does the data tell us?	Current position
CQC inspections for the following areas have been undertaken since the beginning of 2022: ► Well-led 2022 – all complete Surgery 2022 – 8/11 complete ► ED 2022 - all complete ► Maternity 2022 – PRH ¾ complete, 9/11 WGH, RSCH and SRH all complete ► UGI 2022 – no longer applicable ► Neurosurgery 2023 - all complete ► Comprehensive 2023 (as below – action plans submitted)	All must and should do actions from the following inspections are complete: well-led, maternity RSCH, maternity SRH, RSCH ED 2022, neurosurgery 2023. For other inspections, the position is as follows:
Actions and milestones	**Risks and mitigations: KPIs**
	► There are outstanding actions for surgery from 2022 (progress at risk) relating to management of cancellations and preventing delays for which there is not yet an agreed timeline for completion – **mitigation**: addressed through surgery and planned care work streams. ► No trust compliance function to provide rigorous oversight – **mitigation** is to make best use of limited internal resources ► Some required actions risk incompletion due to financial implications – **mitigation** - these will be considered through Trust's prioritisation process **KPIS:** ► % 'must' and 'should' do actions completed for each inspection.
Governance	**Evidence**
CQC Steering Group reporting into Patient and Quality Committee, then to the Board/ Monthly QRM including BAU reports and safety escalations	CQC action plans and reports to P&QC

Annex 3: Statements from Stakeholders

Annex 3.1 Statement from Sussex Integrated Care Board

Thank you for giving NHS Sussex ICB the opportunity to comment on the University Hospital Sussex Quality Account for 2023/2024. We appreciate the ongoing collaborative working with University Hospitals Sussex over 2023/2024, notably at the monthly Quality Review Meetings. We note the challenges that UHSx have faced over the past year of which include; periodic industrial action, increase in demand for hospital services, patients waiting longer both in emergency departments and for treatment. The self-assessment rating of the Quality Account offers clear oversight of where progress has been made and where there are opportunities to improve. The Trust is noted to have made progress against some of the Patient First Quality Priorities in 2023/2024, including:

- • Achieving 90% for FFT which is higher than the previous year of 88%.
- • Improvements in the quality and standards of care by achieving eight out of nine CQUIN targets.

The Trust has positively increased governance and oversight through introducing and aligning digital systems and processes across the Trust, with the aim to improve oversight from ward to board of patient safety, quality of care and decision making, resulting in improved patient care. We would like to thank the Trust for the continued work on the Patient First Programme and True North priorities, along with the introduction of the Quality and Safety Improvement Programme (QSIP) to drive sustainable improvements in the services patients receive from the Trust. During 2023, the Trust has had several Care Quality Commission (CQC) inspections, which have resulted in an overall Trust rating of Requires Improvement. University Hospitals Sussex has established a Quality and Safety Improvement Programme, which covers four main workstreams:

- • Improving Governance Risk Management and Assurance
- • Improving Access to Surgery
- • Improving Safety Culture
- • Well Led.

NHS Sussex acknowledge that University Hospitals Sussex's aim is to provide a sustainable and dedicated focus on the main workstreams highlighted within the QSIP as these address the areas in the CQC report which are below the required standard. This work should positively impact on patient safety and care going forwards into 2024/2025. NHS Sussex recognise the importance of the future priorities for University Hospitals Sussex for 2024/2025 which include:

- • Reducing harm and creating a culture of safety
- • Evidence based and best practice
- • All of our patients have an excellent experience of care
- • Ongoing quality improvement through coordinated oversight and using Fundamental Standards of Care.

NHS Sussex look forward to the continued collaborative working with UHSx and wider system partners over the coming year.

Allison Cannon - Chief Nursing Officer On behalf of NHS Sussex

Annex 3.2 Statement from Trust Lead Governor

This is an extremely comprehensive account of the performance of the Trust across the complete spectrum of care and operational activities when the Trust was facing unparalleled challenges from Industrial action to increasing demand on care services. It is a testament to the Trusts' ability to recognise the importance of working with all the available partnerships such as the Sussex Hospitals Care Partnership, the Integrated Care Boards and other associated care providers in the wider health sector.

This Quality Account clearly demonstrates that the Trust acknowledges where improvements are needed and sets out their plans for improvement, balancing research alongside daily activities, is the future for achieving reduction in waiting lists and improving the experiences of the staff and patients at the point of care. This is coupled with a focused and realistic strategic thinking to develop skills and constructing a system of mutually working together.

The Governors recognise that this Quality Account document evidences in great detail how the Trust is openly accepting where problems have arisen with honesty and vigour and by utilising the development of the Quality Safety Improvement Plan and coupled with the resilience of the staff, encourages positivity and optimism for the future.

Lindy Tomsett - Lead Governor UHSussex NHS Foundation Trust

Annex 4: Statement of Directors' responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2022/23 and supporting guidance Detailed requirements for quality reports 2022/23
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2022 to March 2023 o papers relating to quality reported to the board over the period April 2022 to March 2023 o feedback from commissioners dated 14 June 2023
    - feedback from councillors dated 21 June 2023
    - the trust's 2022-23 complaints report for the period April 2022 to March 2023 published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the 2022/23 national patient survey results - currently unpublished
    - the 2022/23 national staff survey
    - CQC inspection report dated April 2023
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board:

Alan McCarthy MBE DL

Chair, University Hospitals Sussex Foundation Trust

Date: 26 June 2024

Dr. George Findlay
Chief Executive Officer, University Hospitals Sussex Foundation Trust
Date: 26 June 2024

Annex 5: Glossary of Terms and Acronyms

Care Bundle A set of interventions that, when used together, significantly improve patient outcomes.

Care Quality Commission (CQC) An independent regulator responsible for monitoring and performance measuring all health and social care services in England.

Clinical Audit The process by which clinical staff measure how well the Trust performs against agreed standards. Action plans for improvement are often based on the findings of an audit.

Clinical Pathways The standardisation of care practices to reduce variability and improve outcomes for patients.

***Clostridium Difficile* (C.Diff)** A form of bacteria that is present naturally in the gut of around 2/3s of children and 3% of adults. On their own they are harmless, but under the presence of some antibiotics they will multiply and produce toxins (poisons) which cause illness such as diarrhoea and fever. At this point, a person is said to be infected with C. difficile.

Commissioning for Quality and Innovation (CQUIN) The CQUIN framework supports improvements in the quality of services and the creation of new, improved patterns of care.

Datix A web-based clinical incident reporting and risk management software for healthcare and social care organisations.

Friends and Family Test (FFT) The FFT is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Governance The systems and processes by which health bodies lead, direct and control their functions in order to achieve organisational objectives and by which they relate to their partners and wider community.

Healthrota Digital rostering platform for managing doctors roistering

Information Governance (IG) Information Governance allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

IG Toolkit The Information Governance Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information, Governance policies and standards. It also allows members of the public to view information of participating organisations.

IRIS The Trusts e-learning site

LFPSE - Learn from Patient Safety Events The Learn from Patient Safety Events service is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare.

Major Trauma Centre (MTC) A network of 22 new centres throughout the UK, specialising in treating patients who suffer from major trauma.

Mortality Review A process in which the circumstances surrounding the care of a patient who died during hospitalisation are systematically examined to establish whether the clinical care the patient received was appropriate, provide assurance on the quality of care and identify learning, plans for improvement and pathway redesign where required.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) NCEPOD assists in maintaining and improving standards of healthcare for adults and children by reviewing the management of patients and by undertaking confidential surveys and research.

National Early Warning Score (NEWS) NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. NEWS2 is the updated version of this tool.

National Institute for Health and Clinical Excellence (NICE) The National Institute for Health and Clinical Excellence provides independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.

PatientTrack The software used by the Trust as an electronic observation solution to replace the paper process of recording vital signs (e.g. temperature, heart rate), calculating the Early Warning Score (EWS) and automatically alerting for a clinical response when required.

ReSPECT **A Recommended Summary Plan for Emergency Care and Treatment** (ReSPECT) is a process that creates a summary of personalised recommendations for an individual who does not have capacity to make, or express choices when accessing clinical care in an emergency. It aims to respect both patient preferences and clinical judgement. Emergencies may include death or cardiac arrest, but are not limited to those events. The agreed realistic clinical recommendations that are recorded on the ReSPECT form include a recommendation on whether or not, CPR should be attempted if the person's heart and breathing stop.

Root Cause Analysis (RCA) RCA is a process designed for use in investigating and categorising the root causes of events. When incidents happen, it is important that lessons are learned across the NHS to prevent the same incident occurring elsewhere. RCA investigation is a well-recognised way of doing this.

Serious Incidents (SIs) Something out of the ordinary or unexpected. It is an incident – or a series of incidents – that, if left unattended, may pose a risk to service users or the health and safety of staff, visitors and others.

Structured Judgement Mortality Review The SJR methodology has been validated and used in practice within a large NHS region. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.