University Hospitals Sussex NHS Foundation Trust

Meeting of the Board of Directors

10:00 to 13:00 on Thursday 08 May 2025

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

AGENDA – MEETING IN PUBLIC

Item:1	10:00	**Welcome and Apologies for Absence** *Apologies: Wayne Orr*	*To note*	Verbal	Presenter: Philippa Slinger
		Confirmation of Quoracy *A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present this being eight Board members. With a minimum of two Executives and two Non-Executive Directors.*	*To agree*	Verbal	Presenter: Philippa Slinger
Item:2	10:00	**Declarations of Interests**	*To determine if any action is required*	Verbal	Presenter: All
Item:3	10:00	**Minutes of UHSussex Board Meeting held on 31 March 2025**	*To approve*	Enclosure	Presenter: Philippa Slinger
Item:4	10:05	**Matters Arising from the Minutes**	*None*	Verbal	Presenter: Philippa Slinger
Item:5	10.05	**Questions from the public** To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	*To respond*	Verbal	Presenter: Philippa Slinger
Item:6	10:30	**Patient Story**	*To note*	Verbal	Presenter: Maggie Davies
Item:7	11:00	**Report from Chief Executive**	*To receive and note overview of the Trust's activities*	Enclosure	Presenter: George Findlay
		<u>Performance and Risk</u>			
Item:8	11:20	**Integrated Performance Report** • ***Chief Executive's Introduction*** • ***Patient***	*To receive and note*	Enclosure	Presenter: George Findlay

- ***People***
- ***Sustainability (financial performance)***
- ***Quality***
- ***Systems and Partnerships***
- ***Research and Innovation***
- ***National Oversight Framework***

During this item the Chair will invite Board members to ask questions and discuss any pertinent areas of the Integrated Performance Report and agree any necessary actions.

Item:9	12:00	**Single Improvement Plan Report**	*To note*	Enclosure	Presenter: Katie Urch
Item:10	12:05	**Maternity Update**	*To receive and note papers*	Enclosure	Presenter: Emma Chambers
	break 12.15	***5 Minute Break***			
		<u>ASSURANCE REPORTS FROM COMMITTEES</u>			
		<u>Escalated Items Only:</u>			
Item:11	12:20	**Report from the Research Innovation & Digital Strategy Assurance Committee from the meeting held on the 29 April 2025**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Jackie Cassell
Item:12	12:25	**Report from Patient & Quality Assurance Committee from the meetings held on the 25 February 2025, 25 March 2025, 29 April 2025**	*To note assurance from Committee and action recommendations from the Committee, and noting the Safeguarding and Patient Experience Q4 reports*	Enclosure	Presenter: Lucy Bloem
Item:13	12:35	**Report from People & Culture Assurance Committee from the meetings held on the 25 March 2025, 30 April 2025**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Paul Layzell
Item:14	12:40	**Report from Finance & Performance Assurance Committee from the meetings held on the 27 February 2025, 27 March 2025, 01 May 2025**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Philip Hogan

Item:15	12:45	**Report from Audit Committee from the meeting held on the 22 April 2025**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: David Curley
Item:16	12:50	**Report from Strategy and Major Projects Assurance Committee from the meeting held on the 01 May 2025**	*To agree Terms of Reference as recommended by the Committee*	Enclosure	Presenter: Paul Layzell
		OTHER			
Item:18	13:00	**Any Other Business** To receive any notified urgent business and action	*To receive any notified urgent business and action*	Verbal	Presenter: Philippa Slinger
Item:19	13:00	**Date and time of next meeting:** The next meeting in public of the Board of Directors is scheduled to take place at **10.00 on Thursday 05 June 2025.**		Verbal	Presenter: Philippa Slinger

Supporting Appendices:

Item:10	Maternity	Perinatal Quality Surveillance Saving Babies Lives Q4 Perinatal Workforce	*To receive and note*
Item:12	Patient & Quality	Safeguarding Adults & Children Q4 Patient Experience Q4	*To receive and note*
Item: 16	Strategy & Major Projects	Terms of Reference	*To receive and approve*

Minutes

University Hospitals Sussex
NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public at 10.00am on Monday 31 March 2025, held in the Washington Suite Boardroom, Worthing Hospital, Lyndhurst Road, Worthing and via Microsoft Teams Live Broadcast.

Present:

Philippa Slinger	Chair
Lucy Bloem	Non-Executive Director
Professor Jackie Cassell	Non-Executive Director
David Curley	Non-Executive Director
Philip Hogan	Non-Executive Director
Professor Paul Layzell CBE	Non-Executive Director
Bindesh Shah	Non-Executive Director
Dr George Findlay	Chief Executive
Dr Andy Heeps	Deputy CEO
Dr Maggie Davies	Chief Nurse
David Grantham	Chief People Officer
Nigel Kee	Chief Operating Officer
Jonathan Reid	Chief Financial Officer
Roxanne Smith	Chief Strategy Officer
Professor Catherine (Katie) Urch	Chief Medical Officer
Sandi Drewett*	Chief Culture Officer

*Non-voting member of the Board

In Attendance:

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

TB/03/25/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chair welcomed all those present to the meeting.

1.3 There were apologies for absence received from Professor Gordon Ferns. Wayne Orr was observing the meeting on the live stream but was unable to participate.

TB/03/25/2 DECLARATIONS OF INTERESTS

2.1 There were no interests declared.

TB/03/25/3 MINUTES OF THE MEETING HELD ON 6 FEBRUARY 2025

3.1 The Board received the minutes of the meeting held on 06 February 2025.

3.2 The minutes of the meeting held on 06 February 2025 were **APPROVED** as a correct record.

TB/03/25/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

4.1 No formal matters arising were noted.

TB/03/25/5 QUESTIONS FROM MEMBERS OF THE PUBLIC

5.1 No questions had been raised by members of the public.

5.2 The Chair confirmed that at the last meeting, the Board had received an open letter from Charlotte Smart on behalf of families connected with the events under investigation with Sussex Police as part of Operation Bramber. The Chair confirmed that this letter had been responded to in full. Efforts to arrange a meeting to discuss the letter have been made but a suitable date not yet made. The trust awaits options for further dates from Ms Smart if Ms Smart would like such a meeting. .

TB/03/25/6 CHIEF EXECUTIVES REPORT

6.1 George Findlay used the Chief Executive's report to provide a review of the past 12 months taking stock of the progress made and highlighting the challenges and achievements within the NHS. George thanked the Trust's staff for their dedication in their endeavour to deliver safe patient care and faster access to care and treatment

6.2 George reported that improvement to the Trust's planned care waiting list had continued. The overall waiting list had reduced by over 20% and the number of patients waiting over 65 weeks had fallen to the lowest level since the Covid-19 pandemic. George gave a particular update on the Cancer pathways and reminded attendees of the significance for patient experience of meeting the 28-day target to confirm whether patients have cancer, given most tests will be negative. The Faster Diagnosis Standard attainment was ahead of the 77% expectation. 62-days to treatment from urgent referral had seen improvement but was a continued area of focus and the Trust's Cancer waiting list had reduced to its lowest size.

6.3 George stressed the importance of using the Trust's finances wisely and gave an update on various capital projects to benefit patients across the Trust's sites. There had been confirmation from the new hospitals programme that the new Cancer Centre will continue to progress. The report included a summary of specific projects that included the Urgent and emergency care unit at Worthing due to open in August 2025, a Same Day Emergency Care centre at St Richards, a temporary mortuary facility and a comprehensive stroke centre were also building works underway. George added that Southlands had an important Community Diagnostic Centre in operation and opportunities to expand Southlands' theatre capacity to enhance timely treatment of low complexity cases had been explored.

6.4 In February, the Care Quality Commission (CQC) had made unannounced inspections of Maternity services at the Worthing and Royal County Sussex (RSCH) sites and the Urgent & Emergency Care services at RSCH. The issue relieving overcrowding in the emergency department and ensuring patient flow had been discussed at many board meetings. George confirmed that the CQC had shared those concerns and had written to the Trust in this regard. The Trust had responded and set up a 6-week accelerated improvement programme in support of the existing improvement programmes with the aim of delivering better outcomes. The CQC had accepted the plan and are working with the Trust to monitor this weekly.

6.5 George credited the innovative work taking place with partners to manage patients in need of unscheduled care in the community in an effort that ensure that care is received in the most appropriate facility rather than waiting in A&E. This had shown a 32% reduction in attendances from Care Homes and the Board had discussion about the wider benefits and testing a focused approach.

6.6 George summarised the progress on the 2025-2030 Trust Strategy that would come to the Board for approval in May.

6.7 Lucy Bloem raised a question about the challenge of patients with mental health needs having prolonged waits in the Trust's emergency departments (ED) and asked what progress had been made in ensuring they have timely access to therapeutic care and ensuring they are in a safe place when in our care. George explained the challenge with highest presentations in Brighton and while monitored closely and with improvement initiatives, waits remained unacceptable. Additional beds commissioned with system partners had so far showed limited impact. Maggie Davies added how enhanced healthcare support workers support these patients with Mental Health trust supervision and Katie explained the spectrum of care needs that patients had presented with and efforts to provide more tranquil area but stressed ED is not the appropriate therapeutic environment.

6.8 The Chair asked how the patient voice was sought in improvements to the RSCH ED given it would take time to redevelop the facility. George referred to the Healthwatch input to both new building plans and the accelerated 6-week improvement work. Andy Heeps gave an update on the rapid actions and described progress on the use of the corridor space, better flow through department and faster ambulance handovers.

6.9 The Board **NOTED** the Chief Executive Report

TB/03/25/7 UPDATE ON GENERAL SURGERY AT THE RSCH (including stock take on RCS actions)

7.1 Andy Heeps explained that a year ago the Trust Board had received the report from the Royal College of Surgeons (RCS) following their invited service review into General Surgery. Andy took as read the paper in the meeting pack that gave an update on the progress made since and added context to the work that had taken place.

7.2 A Surgical Assessment Unit had been established, and a Colorectal reception hub had been opened on the Worthing side to free up RSCH capacity. Higher Surgical Training had been re-introduced and the General Medical Council, had removed its enhanced monitoring status of foundation doctor training in general surgery. Andy reported that patient satisfaction levels had risen, and elective waiting lists had significantly improved. The working culture programmes and programmes reinforcing appropriate behaviours had also progressed.

7.3 Andy outlined the governance work in the programme through the Single Improvement Plan and the Improving Surgery Workplan. Andy credited the Division leadership triumvirate for their oversight and drive of the improvement. Governance oversight will go through the Quality Governance Steering Group. Katie Urch outlined the embedding of learning from areas of best practice that had contributed to the return of higher trainees with good feedback. Multi-disciplinary team (MDT) working with the Cancer division had meant the Trust is consistent with national standards. Recruitment to the consultant posts taking place would enable delivery of the three-tier rota meeting the RCS recommendation by early 2025/26.

7.4 The Board discussed the significance of the progress achieved through the programmes described. Flow issues that lead to outlying patients and inefficient ward rounds were discussed and Katie explained how the three-tier model would actively address this issue. The Board discussed whether negative media coverage was problematic to recruitment and were advised that the number and calibre of applications had been heartening with anecdotal feedback of the positive reputation of UHSussex enabling high specialty careers. Andy added that further work would follow around the bed base associated with the emergency need at RSCH and balanced with the other medical and surgical specialties. Subsequent updates to come back to Board should show the benefits realisation primarily timely cancer treatment and demonstrating productivity levels with the changes becoming near cost neutral.

7.5 The Board discussed whether cross-site learning across the Trust had been sufficiently considered. While the SAU and Colorectal moves and MDTs had been focussed work, the Board heard examples of how each MDT's development was becoming easier to implement than the ones before with prior learning applied.

7.6 The Board explored in their discussion the confidence that there was both a good understanding within the division about how the previous quality issues had developed, and an awareness of the Board to the indicators of deterioration. Focus on outcome data and quality and safety oversight had improved. The considerable progress was acknowledged. While some recommendations remain outstanding, further updates would report to the Board by exception.

7.7 The Board **NOTED** the General Surgery update.

TB/03/25/8 2025/2026 OPERATIONAL, EFFICIENCY AND CAPITAL PLAN

8.1 Jonathan Reid introduced the operational and financial plan for the upcoming year, including performance targets and financial goals. While Jonathan outlined the National process was not complete the internal process for developing working plans had taken place through detailed discussions in workshops from January 2025 alongside weekly planning meetings with Divisional leadership teams since November 2024. The main parameters of the plan had been agreed by with the Board and built on a stabilised financial run rate by the end of 2025/26 and steady improvement in key operational metrics.

8.2 Jonathan reported that a submission of the plan had been sent to NHS England that included an ambition for continued improvement in elective care performance of 6% overall and for a 10% improvement on Urgent Care metrics. The submitted plan was a deficit plan of -£39.2m for 2025/26. This built on a reported 2024/25 outturn deficit of -£30m after receiving £29.5m deficit support.

8.3 Nigel added that the plan consolidated the improvements of 2024/25 in performance in cancer and diagnostic standards. There remained a challenge to achieve the new diagnostics standards with ongoing work on the cost base. The Trust's Urgent and Emergency Care (UEC) performance had improved in 2024/25 relative to other Trusts and there was consideration whether the target set in the submitted plan for 2025/26 could be more ambitious given improvement plans. Elective Referral to Treatment plans for 5% improvement were felt to be challenging but achievable while not at the level sought by NHS England. Members confirmed they had scrutinised the plan and recognised the risks and mitigations underway and opportunities to accelerate.

8.4 The Chief Medical Officer and Chief Nurse confirmed that the pace of the plans was considered safe from a quality of care and patient safety perspective and

that quality impact assessments (QIA) had been enhanced in the associated financial planning. Katie explained QIAs would be applied to not only financial cost improvement plans but any service changes, permanent and temporary.

8.5 The Board acknowledged the Trust's submission contrasted with the break-even plans of other Trusts both nationally and in the Sussex system. The Chair confirmed the Board were content that the plans were stretching but at a level of performance and financial targets they had confidence in the Trust's ability deliver safely. The Chair of the Finance & Performance Committee added that the plan submitted was consistent with a trajectory towards sustainable finances and a break-even on run rate position to be achieved by the end of 2026/27.

8.6 Jonathan confirmed the full plan would come to the next meeting of the Board in public in May 2025. George Findlay added that there would be further discussions to place with NHS England regional and national teams and the outcome of those would be brought back.

8.7 The financial position remained challenged with additional key drivers of increased direct costs. Enhanced cost control measures had been introduced. across the Trust in an endeavour to stabilise the position and support the efficiency target. Additional measures were being managed linked to the development of a refreshed strategy, to address the underlying deficit.

8.8 The Board **NOTED** the Operational Efficiency and Capital Plan

TB/03/25/09 SINGLE IMPROVEMENT PLAN

9.1 Katie Urch provided an update on the time-limited Committee that was to assure delivery of NHS England undertakings, and Care Quality Commission (CQC) inspection responses. Following review of evidence and outcomes there was confidence that actions in had been completed with well mapped business as usual internal and external scrutiny arrangements.

9.2 CQC actions and those around Surgery services as referred to in the earlier item would have their own dedicated workstreams to monitor progress that would report into Quality Governance Steering Group and through to Patient & Quality Committee. UEC and Planned Care and Cancer actions would also continue with similar monitoring workstreams and had clear internal and external scrutiny arrangements.

9.3 At the request of the Board, while the programme had been confirmed to be closed, high level summary reports on the aggregated matters would continue to be brought to Trust Board. Chairs of the Board's Committees in attendance confirmed they were satisfied with the assurance arrangements to be devolved to their committees as described. Plans for a compliance function around CQC and regulatory actions had not yet been fully delivered, and Katie Urch outlined the plans to map the requirements for an efficient function while Divisions' assurance arrangements had been strengthened.

9.4 The Board **NOTED** the report and **APPROVED** the recommendation to dis-establish the Single Improvement Plan Committee and the plans for assimilation into business-as-usual arrangements with an element of bespoke Board reporting.

TB/03/25/10 STAFF SURVEY

10.1 David Grantham presented the staff survey update and took as read the report in the meeting pack and the referenced the detailed appendices that show

National trust comparator data. The overall picture for our 2024 results showed a broadly stable state and areas of improvement, notably in Women's and Children's and Surgery PRH/RSCH. The majority of WRES (Workforce Race Equality) metrics also indicated an improvement in score from 2023 with some areas better than the national average.

10.2 There was a worsening position in staff engagement with the primary driver for the reduction advocacy for the care that staff are able to provide, and that staff would be happy if a friend or relative needed treatment. David Grantham outlined some of the factors that had changed in July 2025 that had coincided with the identified drop in locally reported staff satisfaction. These included the introduction of vacancy controls and the commencement of continuous flow that spread the risk of crowding from the Emergency Departments to hospital wards.

10.3 David referred to discussions around the Board Assurance Framework where the Board had anticipated the difficult operational environment would mean it likely there would be limited improvement on staff engagement.

10.4 The People & Culture Committee in March had considered the People Plan 2025-26 and the People section of the 2025-2030 Trust Strategy together with the Survey data. This had offered an opportunity to challenge whether the elements that would make a difference to staff had been reflected in both. While there were likely to be limited changes, David suggested that some targeted engagement approaches might be amended to focus on particular professional groups and areas. The Committee had discussed opportunities how to communicate changes using internal arrangements and ensuring best practice was applied to those communications.

10.5 The Board discussed concerns that the scores related to the confidence of staff speaking up had deteriorated. The Board heard about plans to communicate positive experiences of using the Freedom to Speak up Guardian Services, provided by an independent provider, the Trust had put in place. It was acknowledged that there had been a national trend on these questions having fewer positive responses. Action plans had been put in place to support listening activities, supporting managers and teams around changes and demonstrating concerns have been heard and acted upon.

10.6 George Findlay stressed that the results were not what the Trust aspired to and reflected a year where difficult decisions had been taken. George referred to discussions with staff and the significance of correcting basic issues through reduced ED crowding and eliminating theatre list delays. The Board acknowledged the importance of linking the staff survey reflections to the Strategy implementation plans. David Grantham referred to positive discussions around consultant job planning and members acknowledged a need to focus on enabling the Trust to work differently because a default view to solve challenges with added head count would not be possible.

10.7 The Board **NOTED** the 2024-25 staff survey results and assurances from the People and Culture Committee that plans are in place for addressing issues identified as part of 25-26 planning.

TB/03/25/11 BOARD ASSURANCE FRAMEWORK REPORT

11.1 Glen Palethorpe introduced the Board Assurance Framework (BAF) that remained like the year-end position predicted at the start of Quarter 4. There had been no changes in oversight arrangements for the significant risks facing the organisation and the strategies in place to mitigate them. The

arrangements would be reflected in the Annual Governance Statement in 2024-25 Annual report.

11.2 Strategic Risks under their respective Patient First domains were confirmed to have been reflected in strategy discussions that had taken place in other meeting items. The Board discussed the need for a substantial refresh of the strategic objectives for 2025/26 and consequent risk management framework in line with the new strategic plan and would use Board Workshop opportunities to agree these.

11.3 The Board **NOTED** that the continued application of the Trust's BAF oversight processes applied by the Executives and the respective oversight Committees. The Board **NOTED** no change to the quarter 4 scores agreed by the Board. The Board **AGREED** that the Trust's 2024/25 annual report will reflect these risks and the actions taken over the year which were reported via the respective Committees to the Board.

TB/03/25/12 COMPANY SECRETARY REPORT

12.1 Glen Palethorpe introduced the Company Secretary Report, which reflected changes to the Trust Constitution and election activities for the Trust Governor roles. The routine review of the Constitution had led to only minor changes around language, removal of the Deputy Lead Governor role as that had been vacant for two years and provided clarity on expected Governor behaviours on the Council of Governors.

12.2 Glen confirmed that the election for the staff governor position for the Royal Sussex County Hospital site had concluded and the Board welcomed Zingiswa Thetho who had been returned. Public Governor elections would be underway for nominations from 2 May 2025 and Glen would hold information sessions for Members interested in becoming Governors.

12.3 The Board **APPROVED** the revisions to the Trust Constitution, noting that the Council of Governors had given their required approval to these revisions at their meeting in February. The Board **NOTED** the outcome of the Staff Governor election and the commencement of the elections for 4 public governors.

TB/03/25/13 OTHER BUSINESS

13.1 There were no further items for discussion.

TB/03/25/14 DATE OF NEXT MEETING

14.1 It was noted that the next meeting of the Board of Directors was scheduled to take place at **10.00** on **Thursday 08 May 2025**

Tamsin James
Board & Committees Manager
March 2025

Signed as a correct record of the meeting.

…….. Chair

..…… Date

NHS
University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	7.	**Meeting:**	Trust Board in Public	**Meeting Date:**	8 May 2025
Report Title:	Chief Executive's Report				
Sponsoring Executive Director:		Dr George Findlay, Chief Executive			
Author(s):					
Report previously considered by and date:					

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

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

Link to ICB (Integrated Care Boards) / Trust Annual Plan			
Link to ICB Annual Plan	N/A	Link to Trust Annual Plan	N/A

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

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

Regulatory / Statutory reporting requirement

Communication and Consultation:
N/A

Executive Summary:

Chief Executive Report

Since we last met, I have had the privilege of helping to judge this year's Patient First STAR Awards. Reading so many heartfelt nominations is both uplifting and inspiring, as well as a timely reminder, as another busy winter period ends, of the incredible care, commitment, and innovation taking place across the Trust all year round. I am extraordinarily proud to work with such talented, compassionate, and dedicated colleagues at University Hospitals Sussex, and it was great to engage with so many compelling accounts of people going above and beyond for our patients and each other.

Our annual staff recognition awards always showcase the best from our people, services, and hospitals – and this year is guaranteed to be no exception. More than 1,200 nominations were made across the 12

prize categories, and so it was no easy task to determine this year's winners and runners-up. Fortunately, our large judging panel includes a wide range of Trust leaders, governors, and staff representatives to help us distil the very best from a very competitive field. Our decisions will, of course, remain top secret until the awards ceremony on Friday 13 June, but we will be announcing all this year's finalists later this month.

They will all receive an invitation to our celebration event at the Pavilion Theatre in Worthing, kindly funded by our charity, My University Hospitals Sussex. We will also be sending celebratory messages and "Congratulations" postcards to every individual and team nominated. Knowing that someone has taken the time to put them forward for special recognition is a huge boost, and I look forward to seeing all this year's celebration notices on display as I visit teams and departments across the Trust in the coming weeks and months.

Visiting teams and departments is another real highlight of my role, and something all the members of the executive team make time to do each week. I regularly post about who I've met and where I've been on our Staff Facebook page, which has grown to include nearly 3,000 members since we launched the group a couple of years ago. In addition to my regular visits to our urgent and emergency care teams and other frontline colleagues, over the past month or so I've focused on spending time with other critical patient-facing teams such as our housekeepers, portering, catering, and security colleagues.

At St Richard's, we had a good conversation about the condition of much of our estate, and it was good to update teams on the extensive refurbishment programme taking place in stages throughout the hospital, modernising our public spaces and ensuring they meet our stringent infection prevention and control measures. At the Royal Sussex County Hospital, I visited colleagues in our new CCTV Control Centre and listened to the concerns about the violence and aggression staff can face and what we can do to address it better. Sadly, this is something most public sector organisations are contending with, and so we work closely with all our partners in Sussex to ensure a consistent and more effective approach. We are also part of Sussex Police's Operation Cavell, which supports healthcare staff and aims to reduce offences against them.

Partnership working is at the heart of improving services for people in Sussex and strengthening our current relationships and generating new ones with the voluntary sector, community groups, charities, and the business community is a key component of our new Trust Strategy that we will be discussing in detail at our next public board meeting in June. A huge amount of work has been taking place in recent months to finalise the document and ensure we have the best roadmap possible to guide and support our delivery of excellent care everywhere across the Trust over the next five years. I am looking forward to our public launch of the strategy in the coming weeks, getting started on its delivery, and realising the many benefits and improvements it heralds.

Congratulations - improvements, innovation, and achievements

University Hospitals Sussex won two HSJ Partnership Awards in March, and we were highly commended in another category. Consultant neurologist professor **Dennis Chan** and clinical nurse specialists **Kate Warren** and **Anna Koniotes** won Best Pharmaceutical Partnership with the NHS as part of a national pilot to provide more accurate diagnosis of Alzheimer's disease via cerebrospinal fluid (CSF) testing. **Colleagues from Clinical Education and Practice Development** were recognised by winning the Workforce and Wellbeing Initiative of the Year for our collaboration with The Bravest Path, which provides our staff with high-quality, evidence-based programmes designed to develop courageous, compassionate, and connected leaders. And the **3Ts Programme Team** were highly commended in the Healthcare Infrastructure Project of the Year for their management of patient and staff transfers into the new Louisa Martindale Building.

An 82-year-old opera singer from Lewes became the first person in the UK to receive a new type of heart valve implant thanks to a team from the Sussex Cardiac Centre at Royal Sussex County Hospital, led by

consultant cardiologist professor **David Hildick-Smith**. Charles Kerry has a serious condition called severe tricuspid valve regurgitation which causes blood to flow backwards instead of away from the lungs, but thanks to a research study and the work of lead research nurse Jessica Parker to enrol him, Charles avoided risky open-heart surgery and is hopefully the first of many to benefit from transcatheter tricuspid valve replacement (TTVR). A keen walker, Charles was back home the day after surgery, walking up a steep hill the following day, and now hoping to return to the opera stage very soon.

Patients across Sussex can now access a new, cutting-edge transplant procedure to help restore sight loss for patients with a damaged cornea. Consultant ophthalmologist **Mr Mayank Nanavaty** has enabled University Hospitals Sussex to be one of only five NHS trusts in the country to offer an artificial transplant that is proving to be a life-changing, state-of-the-art alternative for some patients. The technology used in the procedure, called EndoArt, is specifically designed for centres with expertise in complex corneal transplants, such as the Sussex Eye Hospital in Brighton.

St Richard's Hospital is the first in the South of England (outside London) to offer a life-changing urology procedure that helps patients with debilitating overactive bladder issues. Sacral nerve neuromodulation (SNM) was previously only available in London, but our patients can now receive effective treatment in Sussex thanks to consultant urologist **Dr Angela Birnie**, who has led the introduction of SNM at the Trust.

A new volunteer service, A Friend in Need, successfully launched at Royal Sussex County Hospital to provide companionship and emotional support to patients and their loved ones at the end of their life. Supported by the **Friends of Brighton and Hove Hospitals**, the service has trained 13 volunteers who have already supported more than 100 patients. Speaking at the launch event in the Heritage Space at RSCH, selfless volunteers spoke of the immense privilege they felt being able to spend time with people in their final days and hours, offering a comforting presence and listening ear to those who may be alone or in need of additional support.

Fast-acting nurses and healthcare assistants have been praised by a man whose life was saved during a badminton game at Moulsecoomb Leisure Centre. Nurses **Xerxes Carticiano** and **Theresa Balmores**, and healthcare assistants **Menard Tomas** and **Carlos Balmores**, leapt into action to provide CPR when a 47-year-old man collapsed on court, banged his head, and turned blue with no pulse. Their actions saved his life, and subsequently, surgery colleagues at Royal Sussex County Hospital fitted a device that acts as a pacemaker and a defibrillator. Their patient is now recovering at home and wants to learn CPR so he can help others if needed.

Parkinson's nurse consultant **Amanda Hulejczuk** was invited to St James's Palace to celebrate 35 years since the introduction of the first Parkinson's nurse. Amanda enjoyed afternoon tea with Her Royal Highness the Duchess of Gloucester, the Chief Executive of Parkinson's UK, and 26 other Parkinson's nurses from around the country. Amanda provides an invaluable service to our patients with Parkinson's, which is the fastest-growing neurological condition in the world, and currently, there is no cure.

We wish a very well-earned and happy retirement to cancer nurse specialist **Maggie Morley**, who, at the age of 72, decided to hang up her uniform after 55 years at Worthing and Southlands hospitals. Maggie joined as a 16-year-old nursing cadet in 1969 and for more than half a century has been a devoted colleague in surgery, intensive care, and Ear, Nose, and Throat teams. For the last 20 years, she has been a Head and Neck cancer nurse specialist, but she's not leaving us completely as she'll soon return as a volunteer!

We're installing new solar panels at St Richard's, Princess Royal, and Southlands hospitals following receipt of a £2.6 million grant from the Department for Energy Security and Net Zero. The investment not only supports our commitment to sustainability, but it will also reduce our energy bills by around £360,000 a year and enable us to redirect funds to frontline care.

Supporting our people

As described in previous reports we provide a comprehensive, broad-ranging and growing programme to provide support for colleagues across the organisation as well as thank, acknowledge, and recognise everything they do for our patients and each other. The programme covers physical, mental and financial wellbeing. Full details are available on our website at www.uhsussex.nh.uk/Wellbeing and below are some recent examples:

More than 4,500 colleagues were referred to our Staff Psychological Support Service (SPSS) over the past five years. Approximately 42% referred themselves, 43% were referred by managers, and 7% from Occupational Health. While 88% of referrals did not state a key reason, where this was stated 50% of referrals included anxiety and depression; 16% included issues relayed to work, such as work-related stress; while 4% referenced bullying, discrimination, harassment or violence. Feedback from staff about the service is positive and the data has been used to inform new Health and Wellbeing services for staff.

A new series of Lunch and Learn events started in April called **"Understanding Anxiety"**. The sessions, led by a trauma-informed hypnotherapist and neuro-linguistic programming master practitioner, are designed to help colleagues understand what causes feeling of anxiety, what coping strategies they can use, as well as practical techniques designed to manage anxiety levels and address its effects.

Each month, colleagues can benefit from complimentary **"Hypnotherapy and Mini Meditation"** sessions led by a clinical solution-focused psychotherapist and hypnotherapist. The sessions include tips and techniques to help staff deal with stress and anxiety, as well as easy-to-understand explanations of the neuroscience that explains how the brain works.

Our **Crisis Support Fund** helped more than a thousand colleagues last year, with more than £204,000 provided to staff with financial wellbeing issues, thanks to our charity My University Hospitals Sussex. The money is received in the form of £50 monthly supermarket vouchers, or one-off grants of up to £500 in vouchers for unexpected or significant items of expenditure, or support for a drop in income due to unexpected circumstances. We also work with Credit Union to provide staff with personal money management support and advice and all staff applying for grants receive a follow up referral to speak with an advisor.

Support for our **trans members of staff** has also never been more important, following the recent UK Supreme Court ruling concerning the definition of 'sex' in the Equality Act 2010. The ruling does have implications for our policies concerning single-sex wards, services and facilities, for both patients and staff. In response, the NHS is reviewing its national guidance to align with the Supreme Court's interpretation and statutory guidance is expected soon from the Equality and Human Rights Commission. We are committed to delivering safe, compassionate and lawful services for all patients and staff. We acknowledge the concerns the ruling has raised, particularly for our trans colleagues and patients, as well as recognising the need for women only spaces. Our review process will be inclusive and aim to ensure the is no discrimination, while adhering to the clarified legal definitions and national guidance. We will provide further information at a future board.

Interested to find out more

If you are interested to find out more, the news section of our website provides more detail and images related to many of the achievements and initiatives referenced above. Please visit www.uhsussex.nhs.uk/news. We are also active on social media. Please join the conversation, comment, like, and share by searching for @UHSussex on your favourite platform.

We also invite people living locally to join University Hospitals Sussex as a member, volunteer in our hospitals, or to develop their career with us. With seven hospitals across Sussex and numerous satellite

services, we are proud to be at the heart of the communities we serve. We wish to welcome others to our UHSussex family too. Visit www.uhsussex.nhs.uk/join-us - thank you.
Key Recommendation(s):
The Board is asked to **NOTE** the Chief Executive's Report.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	8.	**Meeting:**	Trust Board in Public	**Meeting Date:**	08 May 2025
Report Title:	Integrated Performance Report				
Sponsoring Executive Director:	Dr George Findlay, Chief Executive				
Author(s):	Executive Directors/Corporate Directors				
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	Yes	Approval / Agreement	N/A
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	N/A	Staff confidentiality	N/A
Patient confidentiality	N/A	Other exceptional circumstances	N/A

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

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

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

Regulatory / Statutory reporting requirement

The Trust has a statutory requirement to report performance to the board against the NHS National Oversight Framework.

Communication and Consultation:

Executive Summary:

I am pleased to introduce the Integrated performance report for University Hospitals Sussex. It shows our performance to March 2025 and sets out the progress we are making to deliver the Trust's Patient First Priorities, the NHS National Oversight Framework and the NHS Operating Plan.

Key Recommendation(s):

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

NHS
University Hospitals Sussex
NHS Foundation Trust

Integrated Performance Report

March 2025

NHS
University Hospitals Sussex
NHS Foundation Trust

Chief Executive Summary

NHS
University Hospitals Sussex
NHS Foundation Trust

Please see enclosed the performance report for University Sussex Hospitals. It shows our performance to March 2025 and sets out the progress we are making to deliver the Trust's Patient First priorities, the NHS National Oversight Framework and the NHS Operating Plan. My summary highlights our performance against some of the key metrics with more detail provided in the body of the report.

During Quarter 4 more than 30,000 patients provided feedback on the care they received within the Trust. 88.5% of those patients were satisfied that they had a good or very good experience in quarter 4, below our target of 90%. This is comparable to previous quarters of 24/25. Trust-wide ED average positive reported experience remained above the national average. The urgent and emergency care improvement plan continues to be implemented to improve the length of waits in our departments and user experience. Work is also underway in other parts of the patient pathway to identify opportunities to improve experience for our patients.

From a quality perspective, there has been continued improvement in the SHMI mortality rate within expected range to end December (with a small rise in December). There has been an increase in falls in January but this reduced in February to 294 IP falls. Our falls rate is 4.62 per 1000 bed days and marginally above the Trust rolling average of 4.3. With respect to Harm caused within our care, since the implementation of DCIQ, incident reporting has increased by 16%, this is a positive sign of a learning and safety culture. The latest reported month has seen a reduction in the rate of reporting to 54.69 per 1000 beddays, the same as the national average (2022) of 54.9 and 5.3 points away from the Trust target of 60.

Across quarter 4 the Trust experienced seasonal challenges in demand and urgent care flow. The Trust treated 71.5**%** of patients within 4 hours of attending all A&E departments in March 2025, a 1.3% improvement from Feb-25, and 2.4% improvement from Mar-24. All main sites saw improvement in Mar-24, with the exception of Worthing (61.9% compared to 63.6% Feb-25), marginal reduction of 0.1% for RACH. There was a 5.5% improvement SRH, to 65.1%, a 2.9% improvement at RSCH to 59.6%, and 2.3% improvement at PRH to 66.8%. National Performance was 75%. Over 60 minute handovers reduced March 2025 to 169 (2.4%) compared to 315 (4.9%) in Feb-25, and than 516 (7.2%) Mar-24. Patients 12 hours in A&E department decreased to 2662 patients in Mar-25 (7.03%) compared to Feb-25(8.8%) and lower than Mar-24 (7.6%).

For context UHSx was ranked 82nd out of 121 providers in March. Our hospitals continue to operate at a high level of occupancy at c94% which poses challenges to flow through the emergency pathway. We continue to work with system partners to address the large number of patients who are not able to leave our hospital when medically ready to do so.

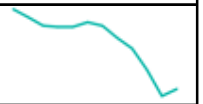
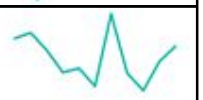
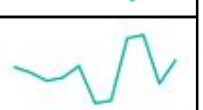
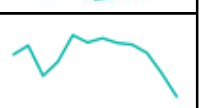
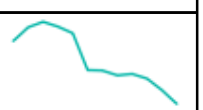
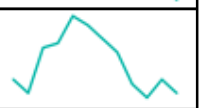
The Trust has remained in the national Tier 1 process for RTT and Cancer performance. Elective activity improved in quarter 4, compared to 2023/24. We continue to have some specialty specific challenges for RTT long waits however. The waiting list has continued to fall since September-23 which means that the Trust and system capacity solutions continue to reduce the amount of patients waiting as well as the longest waits. While the performance for the Trust remains challenging in certain specialties, mitigation plans continue to deliver improvements with the ambition to continue to reduce the waiting list and long waits in 2025/6.

The Trust's workforce / people KPIs ended 24/25 broadly stable or with improvement, although there remains much to do to further support staff and improve further, especially on sickness. The Trust identified priorities for action on culture and workforce in a 'people plan' for 24/25 and has continued to pursue these as it updated plans for 25/26.

The Trust originally submitted a deficit financial plan of £26.5m for 2024/25, which was revised to a deficit financial plan of £19.47m (excluding deficit support funding). The Trust received £19.47m of deficit support in October 2024, which further revised the financial plan for 2024/25 to breakeven. The actual deficit at March 2025 is £30.0m, against a breakeven plan, which is £30.00m adverse to plan. The Trust submitted a forecast of £40m to ICB colleagues in November 2024, which was achieved, and supplemented by a further £10m non-recurrent national income.

The Trust leadership continues to prioritise patient safety and staff well-being during seasonal pressures. There are positive movements in a number of key operational metrics in planned care, cancer and diagnostics which will continue to be a key part of the Trust's focus into 2025/26.

NHS
University Hospitals Sussex
NHS Foundation Trust

True North Metrics					
	Patient First Domain	Metric	Value	Target	Trend
Pt	Patient	Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good	88.6%	90.0%	
P	People	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	6.42	7.06	
S	Sustainability	Financial Stability - Variance from breakeven plan YTD	-30,000k	0k	
Q	Quality	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	104.7	100.0	
Q	Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	652		
SP	Systems & Partnerships	A&E and Emergency flow - % treated and admitted/discharged within 4 hours	67.0%	78.0%	
SP	Systems & Partnerships	Cancer - To achieve the 62 day standard (All referrals - National standard revised Oct 2023)	60.86%	70.00%	
SP	Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	119	0	
SP	Systems & Partnerships	RTT Elective care - >=65 Weeks	377	0	
SP	Systems & Partnerships	A&E and Emergency flow - Hour of discharge median will be 10am to 10.59am (home for lunch) (Trust Level)	14:45	11:00	
RI	Research & Innovation	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	24	35	

NHS
University Hospitals Sussex
NHS Foundation Trust

NHS
University Hospitals Sussex
NHS Foundation Trust

Patient

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

NHS
University Hospitals Sussex
NHS Foundation Trust

Patient First Domain
The patient true north is for patients to have excellent care every time. The patient true north is measured using the friends and family test (FFT). Based on available FFT data, the significant majority of patients (88.5% at the end of March 2025) are satisfied that they have a good or very good experience, based on more than 30,000 responses. This is comparable to the previous four quarters. Surveys are distributed for inpatients, outpatients, maternity and the emergency departments, in line with national requirements. Trust-wide ED average positive reported experience at 81% is trending close to the national average (latest national data published by NHSE 80% in January 2025). Patient reported experience of A&E closely aligns to 4-hour performance. A difficult quarter for patient experience at WGH is noted with deteriorating trajectory for patient experience in the ED. An improving trajectory is noted at RSCH with comments from patients indicating positive reports of the compassion and attentiveness of the staff but concerns about overcrowding and corridor care. Inpatient reported experience, with 92% of patients reporting their care as good or very good, remains slightly below the national average of 95%, with the exception of at PRH. However, this is mainly due to how the data is collected with some parts of the emergency floor included in inpatient data, with this confounding the result slightly downward as patients provide a lower score when they have experienced longer waits. Overall outpatient reported experience is 96.5% - above the national average of 94%. Maternity patient experience is just above national averages at 94%. The most prevalent theme in negative reviews is waiting, in particular for care and treatment in EDs, or for a bed, staff attitude and issues with appointments, such as delays and cancellations. As such, there is a correlation between our patient true north and urgent care performance, in particular the 4-hour standard. Other themes in negative experiences include appointment cancellations, staff attitude and behaviour, inpatient care and discharge. Our fundamental standards of care programme is raising inpatient care standards through audits on handwashing, falls, patient experience and nutrition, amongst others. A new visiting policy will support improved inpatient experience. Emergency department improvements are overseen by F&P breakthrough objectives with A&E performance correlating with patient reported experience. Urgent and emergency care improvement plans are now in place, with the aim of reducing 4 hour and 12 hour waits, and ambulance handover times.

NHS
University Hospitals Sussex
NHS Foundation Trust

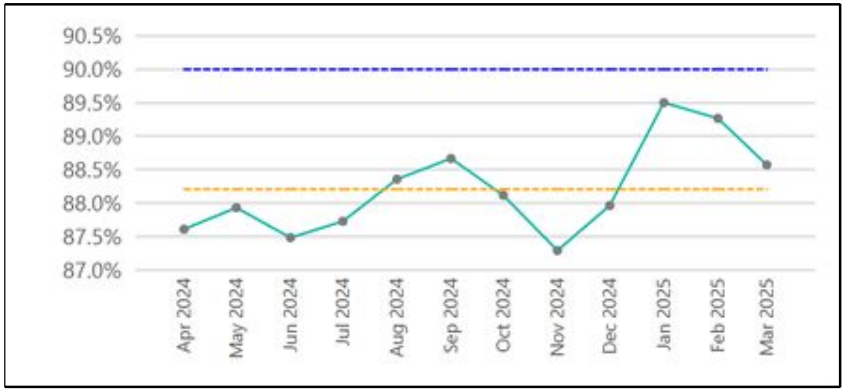
True North

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
87.6%	87.9%	87.5%	87.7%	88.4%	88.7%	88.1%	87.3%	88.0%	89.5%	89.3%	88.6%

Overview

The Friends and Family Test (FFT) involves a survey being distributed to ask patients to rate their care on a scale of very good (1) to very poor (5) and to give a reason for their score. The survey is grouped into four touchpoints – ED, maternity, inpatients and outpatients.
Based on available FFT data, the significant majority of patients (89.5% at the end of March 2025) are satisfied that they have a good or very good experience, based on more than 30,000 responses. This is comparable to the last four quarters.



What the chart tells us

Overall, Trust FFT positive rating remained approximately 88.5% in quarter. As such, the patient true north ambition of 90% was not met.
Trust-wide ED average positive reported experience is above the national average although the gap has closed.
Patient reported experience of ED closely aligns to 4-hour performance.
Maternity services rated above 90% for all sites. Average inpatient positivity was 92.5% against a national average of 95% and outpatients averaged 96% against a national average of 94%.
The most prevalent theme in negative reviews is 'waiting'.
Medicine divisions having lower overall positive ratings than other divisions due to ED data being included. When ED figures are not included, all divisions achieve a patient positivity rating of above 90%.

Intervention and Planned Impact

Emergency department improvements are overseen by F&P breakthrough objectives with ED performance correlating with patient reported experience. Urgent and emergency care improvement plans are now in place as part of the Trust's single improvement plan, with the aim of reducing 4 hour and 12 hour waits, and ambulance handover times.
To improve inpatient care, patient experience audits are being undertaken on the wards to identify concerns early for resolution as part of the fundamental standards of care programme. Changes to the visiting policy will support improved family engagement.

Risks/Mitigations

Themes in negative patient feedback continue to relate to waiting times on site, clinical treatment, communication and staff behaviours as detailed within the Patient Experience Strategy. As such, the key risks to patient reported experience are ED performance and care and communication by clinical staff.

University Hospitals Sussex
NHS Foundation Trust

Watch Metrics for Patient

Metric	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Patient experience - Number of complaints	132	125	116	121	126	143	113	106	107	138	154	172
Patient experience - Total open formal complaints	434	437	412	374	352	343	316	304	294	322	340	369

NHS
University Hospitals Sussex
NHS Foundation Trust

People

	Metric	Target
True North	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	7.06

University Hospitals Sussex
NHS Foundation Trust

Patient First Domain
The Trust's workforce / people KPIs ended 24/25 broadly stable or with improvement, although there remains much to do to further support staff and improve further, especially on sickness. The Trust identified priorities for action on culture and workforce in a 'people plan' for 24/25 and has continued to pursue these as it updated plans for 25/26. As expected, the challenges the Trust faced in 24/25 and some of the changes necessary to deliver operational performance did impact morale and motivation, reflected in a reduced engagement score from July 2024. This was influenced by staff's perception of the quality of care they have been able to provide, and coincided with changes taking place in operational practice to manage demand, controls on recruitment and Trust spending being introduced, and a national narrative that the NHS 'is broken', coupled with local publicity over operation Bramber. The objective was to at least maintain and as far as possible improve the Trust's people metrics (to the equivalent of peers) over 24/25. This was broadly achieved for performance metrics but there remains a gap to peers in elements of the staff survey and its 'people promise' scores. The out-turn is a stable platform on which to build improvement. This will be done under the People theme of the new Trust strategy and the delivery plans to support that.

NHS
University Hospitals Sussex
NHS Foundation Trust

True North

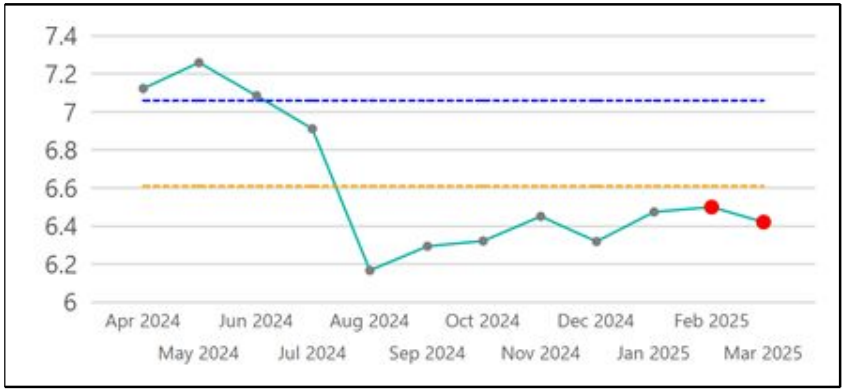
Metric: Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
7.12	7.26	7.09	6.91	6.17	6.29	6.32	6.45	6.32	6.47	6.50	6.42

Overview

The Trust's People True North is to have the most engaged staff and students in the NHS.

The Trust measures engagement using a monthly staff survey and applying the same methodology as the national NHS staff survey to produce a composite 'engagement score'. This reflects the extent to which staff respond positively about their motivation and involvement at work and sense of advocacy for the organisation (do they speak well of it?).



What the chart tells us

The Trust had seen a staff engagement score above the national average for the first quarter of the 2024-25 year, with a high of 7.26 (out of 10) in May 2024 but it declined to below 7.0 from July onwards (Q2-4 score range: 6.17 to 6.91). The year ended with a score of 6.42 in March 2025, compared to 7.28 in March 2024.

In the 2024 national NHS Staff Survey, our staff engagement score was 6.59 (out of 10), compared to the national acute Trust average of 6.84. While our score has declined slightly since 2021, the gap to the national average has stayed consistent.

Intervention and Planned Impact

The 2025-26 People Plan sets out the priorities from across the People Directorate divided into 3-Year programmes (Culture Programme comprising 6 workstreams – Psychological Safety & Safety Culture, Reward & Recognition, Leadership & Management, Values & Behaviours, OD infrastructure and Strategic Alignment; a Workforce Inclusion Plan; Health & Wellbeing Plan; and Integrated Education Plan) and an extensive range of 12 to 18-month improvement projects, aligned to the 7 national People Promise domains.

The 2025-26 People Plan priorities will be mapped against the People Ambition action areas of the 2025-30 Trust Strategy to ensure they are aligned and that the People Plan will support delivery of the Trust Strategy (due to launch Q1 2025-26).

NHS
University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
There are many competing demands on Divisional leadership teams' time, potentially detracting from the delivery of staff engagement action plans. HRBPs have developed plans with Divisions with a focus on the top 5 key high impact actions for 2025-26 to make delivery simpler. Improved clarity about the future of the Trust following the development of 2025-30 Trust Strategy with a wide range of stakeholders. Development of 2025-6 People Plan aligned to Trust strategy to ensure that sufficient focus and improvement effort is made corporately towards each of the People Promises and staff survey. Delivery of 2025-6 Trust's Business and Workforce Plan is challenging and therefore effective communication about the necessary changes will be critical.

NHS
University Hospitals Sussex
NHS Foundation Trust

Driver

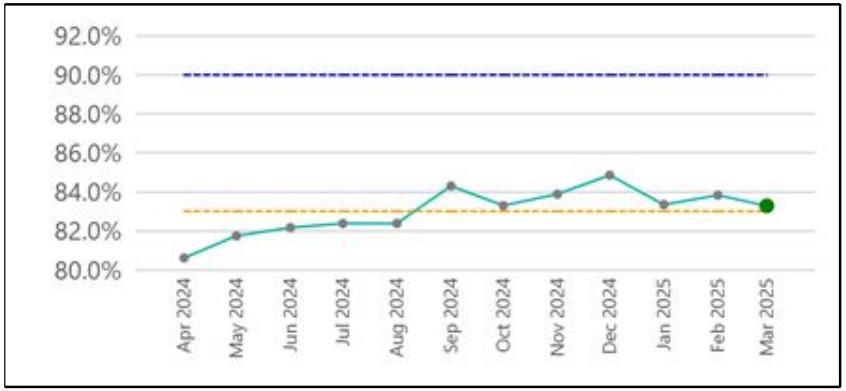
Metric: Training & development - Appraisals completed

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
80.6%	81.8%	82.2%	82.4%	82.4%	84.3%	83.3%	83.9%	84.9%	83.4%	83.8%	83.3%

Overview

The metric reports the proportion of eligible non-medical staff who have had an Appraisal recorded as complete within the previous 12 months.

Evidence shows that well-conducted appraisals have significant positive effects on staff engagement, which in turn has a positive association with patient experience and clinical outcomes. Appraisal compliance is also a key metric for the CQC.



What the chart tells us

The Trust Non-Medical Appraisal rate fell slightly from 83.7% in February 2025 to 83.0% in March 2025. However the overall trajectory remains positive and compliance has been consistently above 80.0% since March 2024, although remains below the 90% target.

By Division, compliance ranges from 90.0% in CFO Division (+7.7% points from February) to 67.7% in CGO Division (-8.2% points). Clinical/Operational Divisions show a narrower range: from 87.8% Facilities & Estates and 87.1% in Surgery (RSCH/PRH) to 79.0% in Medicine (RSCH/PRH).

By Staff Group, all groups are above 80.0% compliance other than Healthcare Scientists (76.4%), although there has been a 2.9% point increase since February.

Intervention and Planned Impact

HR Business Partners are continuing to support Divisional Management Teams to support uptake and identify variances: at Cost Centre level, 303 teams (43%) are > 90% compliance target, while 165 teams (24%) are < 70% compliance. Corporate Divisions are encouraged to continue to focus on appraisals. Sustained effort will be required to maintain > 80% compliance.

2024 NHS Staff Survey data show that UHSussex has a higher rate of appraisal (all staff) than the national NHS benchmark, however quality of appraisal requires focus. This is informing the development of the refreshed Non-Medical Appraisal process (to be piloted with Facilities & Estates Division).

NHS
University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
Given the positive association between appraisal, engagement, experience and outcomes the risk of underperformance against the appraisal metric are to those metrics as well as compliance with staff and regulators' expectations. Mitigations are as set out in Interventions – continued focus by Divisional and Corporate Management Teams, supported by HR Business Partners, with targeted support at Cost Centre manager level.

NHS
University Hospitals Sussex
NHS Foundation Trust

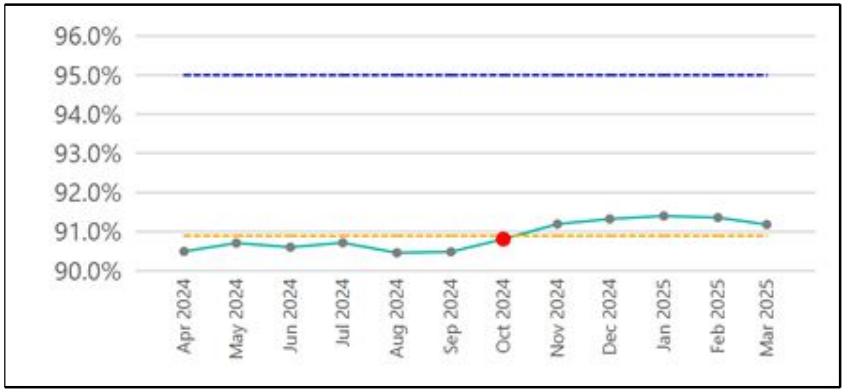
Driver

Metric: Training & development - STAM Weighted Average

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
90.5%	90.7%	90.6%	90.7%	90.5%	90.5%	90.8%	91.2%	91.3%	91.4%	91.4%	91.2%

Overview

UHSussex has set a target for all Statutory and Mandatory (STAM) training to have a compliance rate of 90%. The report shows the breakdown of the STAM weighted average (ie the avergae leve of compliance across subjects). This training is important in ensuring the safety of patients, staff and the public.



What the chart tells us

The UHSussex STAM compliance rate continues to be strong, with a rate of 91.2% in March, and rates of over 90% for twelve months in a row.

Compliance rates for Medical staff continue to be a bit of an outlier but are rising and now stand at 81.3% (the sixth month in a row within the 80% range), all other groups are compliant.

Divisionally, 4/17 divisions are below the 90% compliance rate (Chief Executive, Specialist, Medicine and Surgery across RSCH/PRH) although all in the range of 85-89%.

Intervention and Planned Impact

The maintained rate of compliance has been achieved through targeted staff reminders when they hit the three-month expiry period. Staff are being encouraged to complete before they expire. There is also capacity mapping exercise that is taking place to ensure that we are providing the right number of places across our sites, and this has worked with M&H training which has seen a sustained increase in compliance over the last few months.

Resus training continues to underperform but this has been addressed through being less rigid in approach i.e. you can now undertake the practical before theory which has seen better sign up and attendance rates are slowly starting to rise. We are now looking at delivering some training in situ in departments or as part of wider simulation training.

NHS
University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
There is a piece of work due to go live on 1st May 2025 which will enable the passporting of STAM across the NHS in England. This has been developed to save staff having to repeat training each time they move. This in time should keep compliance rates at a good level and reduce the burden of undertaking training on the individual and the service. Further to this, the national review has reviewed all modules, and some certification periods amended. This will give us a short window in which compliance rates should be sustained as these changes take effect. Oliver McGowan Part 2 training remains a risk as the ICB are still yet to commission a provider to enable this training.

NHS
University Hospitals Sussex
NHS Foundation Trust

Driver

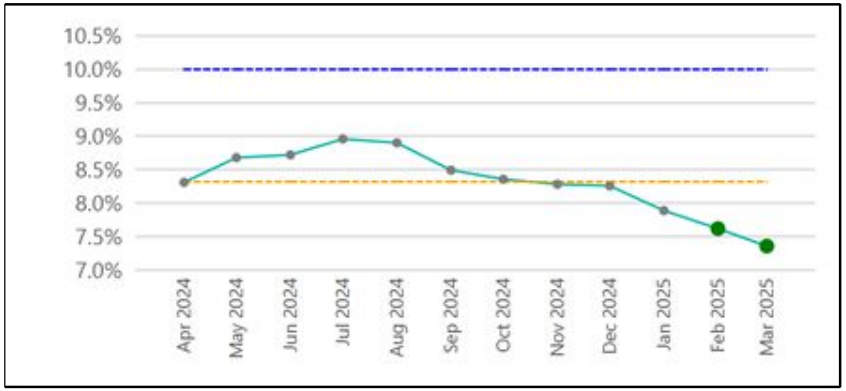
Metric: Workforce capacity - Vacancy Factor (Substantive contracted FTE) - monthly

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
8.3%	8.7%	8.7%	9.0%	8.9%	8.5%	8.4%	8.3%	8.3%	7.9%	7.6%	7.4%

Overview

The vacancy rate expresses as a percentage of the Trust's overall budgeted establishment in month the proportion of posts that are vacant.

The budgeted establishment stands at 17,269 FTE (down 2 FTE in a month but up 302 FTE in the last year). Compared to this staff in post is now 15,998 FTE (up 42 FTE in a month and up 374 FTE in the last year).



What the chart tells us

The overall vacancy rate is 7.4%, the lowest level seen since Feb-24. The Trust has 1,271 FTE vacancies, -72 FTE in the past year.

Organisational growth has slowed; this due to enhanced workforce controls for non-clinical staff and clinical staff at 8a+.

The Trust continues to reduce HCA vacancy factor (-8%). There has been a reduction in band 5 RN vacancies (-1.2%).

Healthcare Science continues to run at high vacancy rate; this due to challenges with recruiting.

By staff group , high rates within Estates & Ancillary (15.3% from 16.1% Feb-25), and Healthcare Science (16.2% from 15.8% Feb-25).

Highest vacancies are Registered Nursing at 316 FTE (down 38 FTE from Feb-25), Admin & Clerical at 244 FTE (up 17 FTE from Feb-25) and Estates and Ancillary at 215 FTE (down 11 FTE)

Intervention and Planned Impact
Paper to be presented at May People and Culture Committee addressing the resourcing required to deliver the 25/26 workforce plan and outlining strategies to recruit to specialist areas including those identified for growth in the workforce plan. Increased RN and HCA open days. Enhanced medical renumeration scheme approved by FRDB to support recruitment to areas with high-cost premium spend. Sponsorship of HCAs with non-UK nursing qualification being considered to attract experienced band 3 candidates.
Risks/Mitigations
Availability of RN candidates to support transition from bank/agency into substrative roles, mitigated by enhanced recruitment strategies. Shortage of experienced band 3 HCAs, mitigated by potential sponsorship of candidates with non-UK nursing qualifications and review of band 2/3 workforce profile. Hard to recruit to consultant posts, mitigated by enhanced medical renumeration scheme. Capacity to recruit at scale to deliver the 25/26 workforce plan, mitigated by recent appointment of experienced Head of Resourcing and agreement to replace band 6 Resourcing Manager that was previously frozen.

NHS
University Hospitals Sussex
NHS Foundation Trust

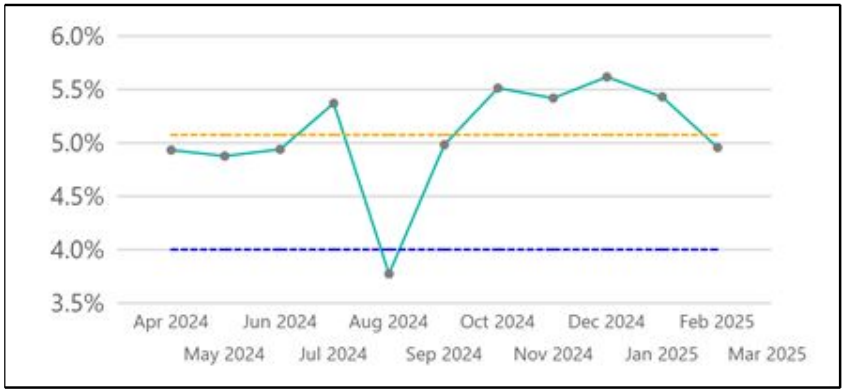
Driver

Metric: Workforce efficiency - Absence Sickness in month

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
4.9%	4.9%	4.9%	5.4%	3.8%	5.0%	5.5%	5.4%	5.6%	5.4%	5.0%

Overview

This metric shows the Trust's in month sickness absence rate as a percentage of the staff employed.



What the chart tells us

Following a peak in December 2024 the in month sickness absence rate has reduced during January and February 2025. March data is not yet available. A deeper analysis of the sickness data for 2024 has shown that whilst absence increased during the year the number of staff sickness episodes did not, therefore we are seeing a trend of the average length of an absence increasing.

In January 2025 the Sussex ICB region had the highest sickness rate across the south coast ICB regions. Within Sussex ICB, UH Sussex is showing as the second lowest for sickness and is mid-table for the proportion of absence related to mental health in the Sussex region albeit it still represents the highest reason for absence in the Trust.

Intervention and Planned Impact

A detailed update was presented to the People and Culture Committee setting out the improvement actions to reduce absence in 2025-6.

A dedicated team in HR continue to support the management of long term sickness absence and "hot spot areas " and from 5 May 2025 will also support short term absence. An updated Health & Wellbeing Policy has been approved and published.

The Nursing and Midwifery Workforce Steering Group, supported by HR, is targeting the management of absence in areas that will achieve a reduction in both sickness absence rates and bank and agency costs. Progress to date is positive.

Review of Occupational health services internally and with the ICB.

A multiprofessional workshop was held on 6 March 2025 to focus on mental health and from that a MH action plan is being developed. supporting mental ill health.

NHS
University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
High sickness rates impact on staff health and wellbeing, staffing levels, patient continuity of service, morale and resourcing costs. Therefore a detailed plan to reduce absence has been developed. Previous interventions have had an impact on reducing sickness levels but this has not been sustained across a challenging autumn/winter period. The new sickness absence plan will be monitored with Divisions through the fortnightly Operational Delivery Group meetings. Further governance arrangements are in place to both monitor sickness absence with daily absence information being shared and to control the impact on services e.g. ensuring safe staffing levels are in place whilst controlling costs.

NHS
University Hospitals Sussex
NHS Foundation Trust

Watch Metrics for People

Metric	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Turnover (12 month)	7.4%	7.4%	7.3%	7.2%	7.1%	6.9%	6.9%	7.5%	6.8%	6.8%	6.8%	6.6%
Workforce capacity - FTE Budgeted	17083	17137	17141	17162	17239	17310	17366	17347	17261	17265	17271	17269
Workforce capacity - FTE Substantive contracted	15663	15649	15646	15624	15704	15840	15914	15910	15835	15903	15955	15998
Workforce capacity - FTE Substantive contracted variance from Budget	1420	1488	1495	1538	1535	1470	1452	1437	1426	1362	1316	1271
Workforce capacity - Number of leavers	76	91	89	116	169	105	113	195	107	95	97	108
Workforce capacity - Number of Starters	175	113	106	142	488	253	241	148	99	207	191	160
Workforce efficiency - Absence 12 month sickness rate	5.2%	5.2%	5.3%	5.4%	5.2%	5.4%	5.4%	5.4%	5.4%	5.4%	5.4%	
Workforce efficiency - Absence Total in month.	16.1%	16.3%	15.5%	15.9%	13.9%	15.7%	16.5%	16.5%	16.1%	16.2%	15.7%	

University Hospitals Sussex
NHS Foundation Trust

Sustainability

	Metric	Target
True North	Financial Stability - Variance from breakeven plan YTD	0K
Breakthrough	Productivity Metric - Elective Recovery Fund Performance Actual	107.0%

Patient First Domain

The Trust's True North Domain is 'living within out means providing high quality services through optimising the use of resources' which is measured through the metric of delivering the Trust's Financial Plan.

The delivery of the Trust's financial plan has 6 key components:

1. Income & Expenditure (I&E) Performance achieving the agreed I&E plan;
2. Cash: maintaining sufficient cash balances;
3. Capital: achieving the agreed capital plan;
4. Efficiency: achieving the required efficiency programme;
5. Productivity; and
6. Agency 3.2% ceiling

Integrated Care Boards (ICBs) have a statutory duty to contain expenditure within the limits directed by NHS England, with a requirement to deliver System financial balance. In recognition of the scale of elective recovery challenge and quality agenda, and allowing for time to embed mitigations, the Sussex ICB financial revenue plan limit for 2024/25 is a £50m deficit. There is a clear expectation the deficit is mitigated in full by 2025/26.

NHS
University Hospitals Sussex
NHS Foundation Trust

True North

Metric: Financial stability - Variance from breakeven plan YTD

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
YTD Actual	7.21	16.04	24.30	31.10	33.92	34.91	17.85	22.15	26.64	31.13	35.61	30.00
YTD Plan	6.52	12.44	17.61	23.93	26.76	29.47	11.12	10.93	11.55	8.19	3.05	0.00
	-0.69	-3.60	-6.69	-7.17	-7.16	-5.44	-6.73	-11.22	-15.09	-22.94	-32.56	-30.00

Overview

The Trust originally submitted a deficit financial plan of £26.5m for 2024/25, which was revised to a deficit financial plan of £19.47m (excluding deficit support funding). The Trust received £19.47m of deficit support in October 2024, which further revised the financial plan for 2024/25 to breakeven.

The actual deficit at March 2025 is £30.0m, against a breakeven plan, which is £30.00m adverse to plan. The Trust submitted a forecast of £40m to ICB colleagues in November 2024, which was achieved, and supplemented by a further £10m non-recurrent national income.

The cash position is £3.08m, £16.94m worse than plan. This is driven by an unfunded year-to-M11 deficit against plan of £32.56m and a £16.33m reduction in creditors, offset by £14.0m of revenue support PDC funding and £17.95m of capital depreciation funding.

Capital expenditure for the 2024/25 financial year is £48.27m, in line with the plan.

Efficiency performance for the year was £76.03m, which was £13.48m behind plan for the year.

The agency ceiling for 2024/25 is set at 3.2% of total pay expenditure (a reduced target from 3.7% in 2023/24). Agency expenditure for the year is £33.06m, 2.95% of total pay, £2.94m below the ceiling.

NHS
University Hospitals Sussex
NHS Foundation Trust

2024/25 M12 £m	Annual Plan	YTD		
		Plan / Ceiling*	Actual	Variance Fav/(Adv)
I&E (Surplus) / Deficit**	19.47	19.47	49.47	(30.00)
I&E (Surplus) / Deficit***	0.00	0.00	30.00	(30.00)
Cash	20.02	20.02	3.08	(16.94)
Capital	81.90	85.53	85.52	0.01
Efficiency	89.51	89.51	76.03	(13.48)
Agency Ceiling	30.12	36.00	33.06	2.94

* The agency ceiling is a % of pay expenditure so flexes with actuals
** Excluding £19.47m deficit support
*** Including £19.47m deficit support

What the chart tells us

The actual deficit is **£30.00m**, which is **£30.00m** adverse to plan.

Key drivers of the adverse variance to plan are: the efficiency delivery below plan (£13.48m), expenditure on diagnostics, high cost drugs and devices funded by fixed income (£11.3m), expenditure to support patients with mental health needs (£4.6m), expenditure on Band 2 to Band 3 uplifts (£3.4m). These key drivers have been partially offset by non-recurrent mitigations.

The adverse cash position is impacting the Trust's ability to pay its creditors in line with the better payment practice code (BPPC).

Intervention and Planned Impact

The 2024/25 financial year has now been completed. However the exit run-rate above plan will have an ongoing impact on the 2024/25 financial year.

The Trust is in the process of developing the actions which are required to support the delivery of the 2025/26 plan, which include:
Continuation and further strengthening of the enhanced control environment and pay controls;
An increased focus on compliance with financial controls and compliance reporting; and
Full identification of the Efficiency Programme, which will need to be developed and matured at pace to ensure full-year delivery of the target.

NHS
University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations

The actual reported deficit for the 2024/25 financial year is £30m, which is recognised and supported by the Sussex Integrated Care Board (ICB).

This financial position reflects the draft accounts submitted to NHSE and the Trust's external auditors on 25th April. No further changes are anticpated. The final accounts will be presented to Audit committee and Trust Board in June 2024, once the year end audit is completed.

The Trust has submitted a initial deficit plan of £39.2m for the 2025/26 financial year and is in the process of re-submitting the plan for the 2025/26 financial year. The submitted plan requires delivery of a challenging £85.3m efficiency programme alongside delivery of operational targets.

Pay costs are a significant component of the Trust's expenditure and also a significant driver of financial performance. The Trust will need to consider the current level of pay rates and also instigate headcount/establishment reductions to ensure delivery of the financial plan and address areas of growth, in line with national expectations and actions taken by other provider Trusts.

Breakthrough

Metric: Productivity measured by the income value of activity delivered in 24/25, compared to the 19/20 baseline

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	FY
24/25 Actual	118%	117%	123%	113%	115%	117%	118%	114%	116%	114%	121%	121%	**117%**
24/25 Target	122%	119%	120%	119%	123%	114%	112%	107%	120%	115%	115%	113%	**116%**
23/24 Actual	104%	109%	102%	99%	101%	103%	104%	104%	107%	106%	107%	112%	**104%**

** To note prior month performance is updated post data freeze.*

NHS
University Hospitals Sussex
NHS Foundation Trust

Overview

The Elective Recovery Framework (ERF) target for the Trust is 109% (income value of activity earned above the 19/20 baseline). The 24/25 Trust plan is to deliver 115.6% of the 19/20 baseline, reflecting the income value of activity to meet the requirement of zero 65 week waits.

This income performance is to be taken in conjunction with activity performance data. The performance data provides clarity of attainment of the 65-week wait performance, as consideration of increased coding depth can result in higher income performance without a corresponding attainment in performance targets.

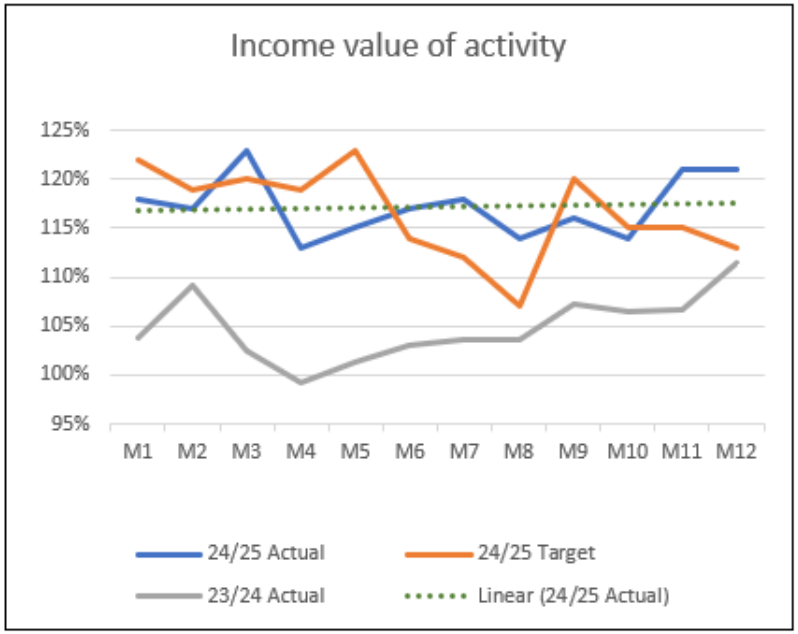
The plan was set on the principle that overperformance will be paid at tariff, for income achieved above the 109% target and conversely, income could also be clawed back, if performance falls below the 109% target.

The 24/25 ERF performance at month 12 is 117% compared to the 19/20 baseline. This equates to a **+£22.81m v**alue variance compared to the 109% ERF Target.

The required ERF performance in the plan was 116% YTD, performance was therefore 1% above this target, resulting in the Trust reporting c £2.1m income above plan.

In January is was advised that a year end ERF ceiling would be allocated to ICB's based on forecast performance submitted at month 8 including payment relating to activity performance in 23/24. The Trust forecast was £31.5m above plan and the actual payment was c£32m. The final position (freeze data) for M12 will not be finalised until end May, whilst any overperformance is unlikely to be paid, there remains a risk that underperformance could be clawed back.

NHS
University Hospitals Sussex
NHS Foundation Trust



What the chart tells us

Outturn performance for the 24/25 financial year is **117%** in comparison to the 2019/20 baseline target (100%). This means that the income value of activity was 8% above the 109% target, resulting overperformance of £22.81m.

The plan is phased by working days to reflect the income value of the activity performance required to meet the planned income target of 115.6%.

The chart also shows the 23/24 ERF performance, noting that last year was significantly impacted by a number of incidences of Industrial Action (IA).

Productivity initiatives, introduced in M8 last year have continued into 24/25, underpinning the higher ERF performance required to meet current year targets.

To note: NHSE have shared 24/25 ERF baselines reflecting movements from draft baselines,

Intervention and Planned Impact

Throughout 24/25, weekly planned care meetings monitored delivery against the required performance trajectory, with oversight having been provided at fortnightly Operational Delivery Group meetings. Internal productivity and increased coding depth and capture has been sustained throughout the year with income being reported at £2.1m above plan.

The fixed ERF ceiling implemented by NHSE could result in an impact when the freeze data is shared at the end of Q1 25/26, as overperformance will not be paid. Maintaining a focus on ensuring all activity is captured and coded is a good discipline and will continuing into 25/26, informing future forecasts.

Independent Sector capacity has been secured to support delivery in specialties with capacity constraints, affordability of utilising insourcing and outsourcing is considered.

NHS
University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations

ERF baseline & actuals - NHSE advised that a year end ERF ceiling would be allocated to ICB's based on forecast performance submitted at month 8, with adjustments made in part for the prior year appeal. Payment has been received as expected, however there is a further risk that activity increases in the later part of Q4, which supported the achievement of 65 week wait targets, will not be funded in 25/26 if activity exceeds the System ceiling. If the Trust was to not achieve the ceiling, there is a risk of income being clawed back in 25/26.
To mitigate against these risks, the discipline of increased data capture and coding improvements continued throughout the year and, initiatives to understand and increase productivity through theatres are continuing into 25/26.

NHS
University Hospitals Sussex
NHS Foundation Trust

Quality

	Metric	Target
True North	Safety - Reduction of 5% in preventable harm - UHSx approved	
True North	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	100.0
Breakthrough	Safety - To reduce falls whilst in the care of UHSussex by 30%	202
Patient First Domain		
The Quality True North for harm at UHSussex is 'Zero harm occurring to our patients when in our care', with a target to reduce the number of all harms categorised as 'low, moderate, severe harm and death' by 5%.		

University Hospitals Sussex
NHS Foundation Trust

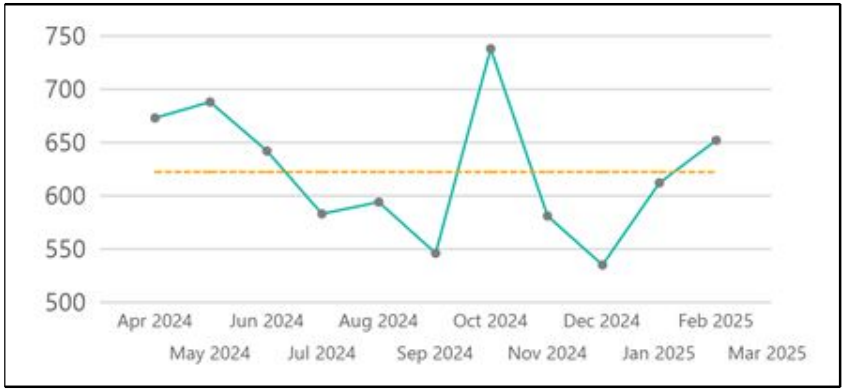
True North

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
673	688	642	583	594	546	738	581	535	612	652

Overview

The submitted monthly incident report & harm grading (in actual numbers) for the quality scorecard via DCIQ (as graded by the reporter) requires a review, investigation and assessment for accuracy by the investigating managers. Due to capacity and or complexity, this can often take time (longer than the in-month reporting period) so in numbers, the reported (predicted in month) harm versus the final actual harm graded by the NHSE Learning From Patient Safety Events system (LFPSE) definition- has significant variation.
Therefore for the monthly reporting cycle for the quality scorecard, True North, QGSG and Quality Committee reports, in order to present ratified data we will now be reporting one month in arrears. So for April, we will provide a more accurate picture of approved harms from incidents reporting per 1000 beddays for February. This follows the same methodology as FFT.
The quarterly reports provide the ratified and more accurate data on actual harms. In addition LFPSE has published revised harm criteria and the training for this update is currently commencing in in conjunction with the Duty of Candour training on IRIS launched in October.
However of note, the reporting for the Patient Safety Incident Reporting Framework (PSIRF) provides the more recent live data and dashboards for the Trust scorecard from March 2025.



What the chart tells us

February has seen a Trustwide decrease in the rate of reporting to 54.69 (per 1000 beddays) = to the NRLS *2022 national average of 54.9 and inching towards the Trust target of 60.
February evidenced a sustained trend in the month-on-month stability in reporting. (3144 reported in February) and a rise in the reporting of low harm (641/652) = 98.3% of actual harm**).

*National Reporting and Learning System replaced in 2024 with NHSE Learning from Patient Safety Events (LfPSE) - no current benchmark available or established.
**Awaiting final approval and finally approved on DCIQ only- low/moderate/severe/death (excludes no harm/near miss and pressure damage present on admission)

NHS
University Hospitals Sussex
NHS Foundation Trust

Intervention and Planned Impact
The Go-Live for the reporting of incidents module was launched in February 2024. Training and comms underway. Trust has purchased the DCIQ extraction tool for the BI team to allow for an accurate and seamless data feed. DCIQ suite of training materials and videos now available on IRIS. Patient Safety Investigation Face to Face training modules commenced. Duty of Candour and Just Culture Training module go-live on IRIS- October 24 Patient Stories produced and the learning presented at the Patient Safety Group.

Risks/Mitigations
Noted increase in complexity and media focus Increase in Freedom of Information requests from media Increase in requests for safeguarding/court of protection applications Workforce capacity risk legal and budget increase noted in legal teams (Risk Register ref: 1257) Significant cost pressure to Trust from legal advocacy and representation for inquest There has been a noted rise in incidents presenting to PSIRG regarding patient harm from patient deterioration and lost to follow up, cancer, surgery delays, patient flow, waiting times for neurosurgery/ophthalmology. Mental Health: High risk remains in both emergency departments and paediatric areas with Tier 4, LA and specialist placement.

University Hospitals Sussex
NHS Foundation Trust

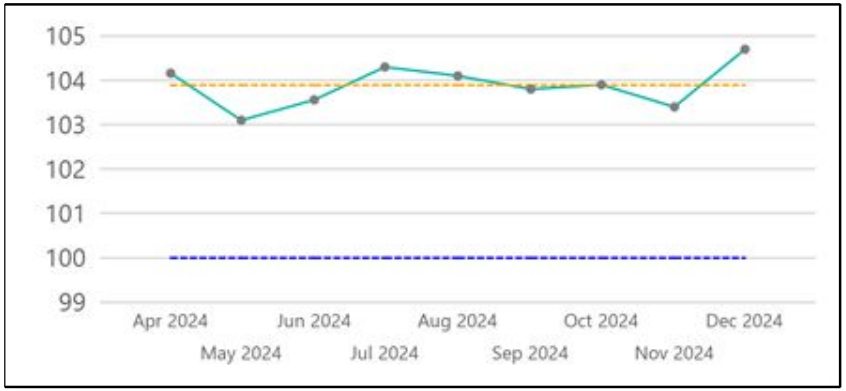
True North

Metric: Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
104.2	103.1	103.6	104.3	104.1	103.8	103.9	103.4	104.7

Overview

No Data



What the chart tells us

The SHMI for UHSx 104.74 (January 2024 - December 2024). This result is not an outlier using 95% over-dispersed funnel plot limits, but it is an outlier based on the stricter 95%Poisson method.
The In-hospital SHMI is 106.35.
The Out-of-Hospital SHMI is 101.22.
The SHMI at PRH, Worthing and St Richards are within the expected confidence limits, however, the SHMI at RSCH (114.58) is an outlier being above the 90% upper control limit on an over-dispersed funnel plot.

Intervention and Planned Impact

The Clinical Effectiveness Team is piloting a standardised response when the SHMI LCL is above 100 for a diagnostic group or specific hospital site.
This standardised response will be used to review some of the current outliers in head and neck cancer; melanomas of skin; pancreatic and breast cancer.

Risks/Mitigations

No Data

NHS
University Hospitals Sussex
NHS Foundation Trust

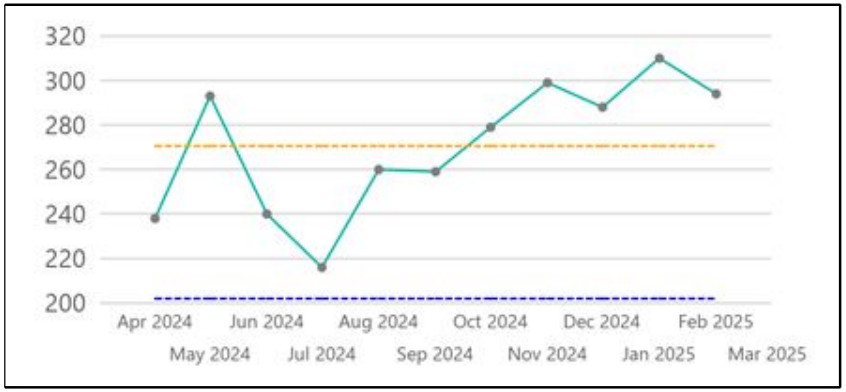
Breakthrough

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
238	293	240	216	260	259	279	299	288	310	294

Overview

The quality true North for harm in our organisation is zero. Harms contribute significantly to poor patient experience, outcomes and staff experience. Falls are a top contributor in terms of harm across UHSussex.



What the chart tells us

Overall, there were 258 falls with a falls rate of 4.62 per 1,000 bed days this is slightly above the Trust rolling average of 4.32. Falls with harm have increased with 9 moderate and 4 severe however 71% of falls in month, resulted in no harm to the patient.

Intervention and Planned Impact

- A thematic review is in progress focusing on severe/fatal falls to identify trends. This will be concluded in May 2025.
- Post-fall management booklet has been created and is now being trialled across pilot areas.
- Deconditioning Awareness week in May is being planned which with clinical teams
- ED documentation is being reviewed for all HFC risk assessments this includes falls risk assessment and trolley rail assessment.
- Additional Hoverjacks (equipment used to move patients) have now been allocated across UHSussex to replace or add to current stock.

Risks/Mitigations

KPIs have been set for falls per 1000 bed days across UHSussex at 4.2 or less. The harm free care and education team will continue to work with Sites and Divisions to support quality improvement workstreams. The Divisions have been driving up improvement opportunities by focusing on the top themes such as completing falls and bedrail risk assessments and undertaking lying / standing blood pressures. This has enabled the identification of actual / potential issues earlier so that mitigations can be put in place. Rate of falls per 1000 bed days will continue to be monitored via the weekly Harm Free Care Group, monthly QGSG and two monthly FSoC patient safety group.

University Hospitals Sussex
NHS Foundation Trust

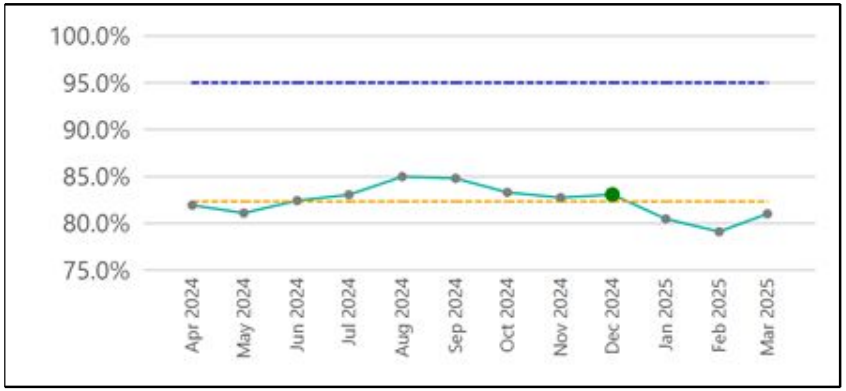
Driver

Metric: Safer Staffing - Average fill rate - care staff (day shifts)

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
81.9%	81.1%	82.4%	83.0%	85.0%	84.8%	83.3%	82.7%	83.1%	80.5%	79.1%	81.0%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Care Hours Per Patient Per Day (CHPPD) trust wide has seen a gradual increase from 7.0 in December 23 to has remained consistent at 7.8 in March 25. In the model hospital data published in March 25 the trust has moved into quartile 2 for registered nurses and dropped to quartile 1 for care staff.



What the chart tells us

The chart shows the fill rate % for care staff for the day shifts each month. Care staff has seen a dip in the fill rate in January and February 25 across all sites. All sites have seen a small improvement in March 25 which aligns with an improvement in the vacancy position. 8.8 % reduced to 8.0%. As a site St Richards has the lowest fill rate, and a deep dive is underway to understand the factors influencing this and bespoke recruitment planned for bank HCA's at SRH.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce that is appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and reporting the associated workforce. The Deputy Chief Nurse (DCN) for Workforce along with the clinical workforce team undertook establishment reviews using the safer nursing care tool (SNCT) for all inpatient areas. The SNCT is a system designed to guide decisions about nurse staffing requirements on hospital wards, in particular the number of nurses to employ (establishment). In total 69 wards/clinical areas were covered across the Trust. Those not included within the SNCT audit were neonatal, theatres, and critical care. The data collection took place in Nov 2024 across all inpatient wards for 30 days and all Emergency departments completed their data collection over 12 days twice daily as per the guidance from the toolThe establishment reviews took place between Dec and Feb 2025. This data was then triangulated with CHPPD and quality metric for each department. A full report will be submitted to board in May as part of workforce safeguards governance.

NHS
University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
There are currently 8.0% Band 3 care staff vacancies and turnover of 7.54% for Health care Assistants across UHSussex, the recent work rebanding the HCA workforce should positively impact HCA retention further. From the 1st of April we have transitioned band 2 HCAs into Band 3 posts to align with the national job profiles. We will continue to recruit HCA's that are new to care but they will only remain a band 2 for 6 months while they undertake further training and complete their care certification. We continue to have a robust recruitment calendar attracting band 2 and band 3's. Recruitment of all band 3 Maternity Support Worker (MSW) has been centralised which has allowed a more robust recruitment pipeline and allowed us to create a waiting list for some areas.

NHS
University Hospitals Sussex
NHS Foundation Trust

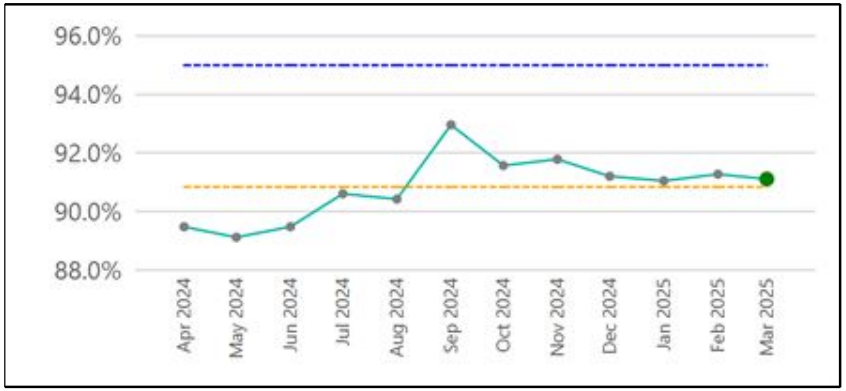
Driver

Metric: Safer Staffing - Average fill rate - care staff (night shifts)

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
89.5%	89.1%	89.5%	90.6%	90.4%	93.0%	91.6%	91.8%	91.2%	91.0%	91.3%	91.1%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Care Hours Per Patient Per Day (CHPPD) trust wide has seen a gradual increase from 7.0 in December 23 to has remained consistent at 7.8 in March 25. In the model hospital data published in March 25 the trust has moved into quartile 2 for registered nurses and dropped to quartile 1 for care staff.



What the chart tells us

The chart shows the fill rate % for care staff for the night shifts each month. The fill rate at night is better than the day and has consistently been over 91% since October 24. Like the day rate the fill rate is lowest at St Richards hospital. RSCH has achieved the highest fill rate and is consistently over 95% noting RSCH has no HCA vacancies. Please note the fill rate is better than the day fill rate due to night pay enhancements.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce that is appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and reporting the associated workforce. The Deputy Chief Nurse (DCN) for Workforce along with the clinical workforce team undertook establishment reviews using the safer nursing care tool (SNCT) for all inpatient areas. The SNCT is a system designed to guide decisions about nurse staffing requirements on hospital wards, in particular the number of nurses to employ (establishment). In total 69 wards/clinical areas were covered across the Trust. Those not included within the SNCT audit were neonatal, theatres, and critical care. The data collection took place in Nov 2024 across all inpatient wards for 30 days and all Emergency departments completed their data collection over 12 days twice daily as per the guidance from the tool. The establishment reviews took place between Dec and Feb 2025. This data was then triangulated with CHPPD and quality metric for each department. A full report will be submitted to board in May as part of workforce safeguards governance.

NHS
University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
There are currently 8.0% Band 3 care staff vacancies and turnover of 7.54% for Health care Assistants across UHSussex, the recent work rebanding the HCA workforce should positively impact HCA retention further. From the 1st of April we have transitioned band 2 HCAs into Band 3 posts to align with the national job profiles. We will continue to recruit HCA's that are new to care but they will only remain a band 2 for 6 months while they undertake further training and complete their care certification. We continue to have a robust recruitment calendar attracting band 2 and band 3's. Recruitment of all band 3 Maternity Support Worker (MSW) has been centralised which has allowed a more robust recruitment pipeline and allowed us to create a waiting list for some areas.

NHS
University Hospitals Sussex
NHS Foundation Trust

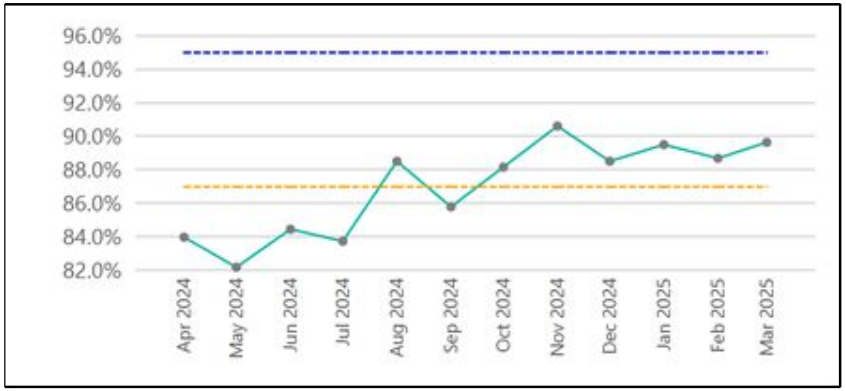
Driver

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
84.0%	82.2%	84.4%	83.7%	88.5%	85.8%	88.2%	90.6%	88.5%	89.5%	88.7%	89.6%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Care Hours Per Patient Per Day (CHPPD) trust wide has seen a gradual increase from 7.0 in December 23 to has remained consistent at 7.8 in March 25. In the model hospital data published in March 25 the trust has moved into quartile 2 for registered nurses and dropped to quartile 1 for care staff.



What the chart tells us

The chart shows the fill rate % for Registered Nurses/Midwives for the day shifts each month. Registered Nurses/Midwives fill rate has seen a gradual improvement since March 24 to peak in November 24 at 90.6%. The fill rate has remained consistent for the last 3 months averaging between 88.7 and 89.6%. The fill rate has improved on all sites in March and is consistent with the improving vacancy position for band 5 nurses at 8.5%, in addition RN agency usage has reduced by 11.2% and RMN by 15.9% in the last quarter of 24/25.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce that is appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and reporting the associated workforce. The Deputy Chief Nurse (DCN) for Workforce along with the clinical workforce team undertook establishment reviews using the safer nursing care tool (SNCT) for all inpatient areas. The SNCT is a system designed to guide decisions about nurse staffing requirements on hospital wards, in particular the number of nurses to employ (establishment). In total 69 wards/clinical areas were covered across the Trust. Those not included within the SNCT audit were neonatal, theatres, and critical care. The data collection took place in Nov 2024 across all inpatient wards for 30 days and all Emergency departments completed their data collection over 12 days twice daily as per the guidance from the tool. The establishment reviews took place between Dec and Feb 2025. This data was then triangulated with CHPPD and quality metric for each department. A full report will be submitted to board in May as part of workforce safeguards governance.

University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
There are currently 8.5% Band 5 Registered Nurse vacancies which is a decrease from 13.1% (March 24) for Band 5 nurses. Notably, there has been a significant focus on domestic recruitment during the 2024/2025. Through focused engagement with our student nurses and midwives, we have seen an increase in students joining the workforce. Trust engagement with all students commences in year one of their training and students are giving the option of working on bank within the trust. Our proactive recruitment strategies have also effectively secured newly qualified nurses from universities across England. With the changes in the SIFE requirements (Supporting information from employers) has seen an increase in applicants who have an international qualification and are already resident in the UK. Furthermore, we have welcomed 17 Register Nurse Degree apprenticeship in 2024 and a further 25 qualify in July 2025. 32 students nursing associates completed their training during the 2024/2025 period, joining the workforce as registrants. Our aim is to commence training for 100 student nursing associates between Sept 2025 and Feb 2026 as part of our focus on growing our own and developing our Heath Care assistant (HCA) workforce. Turnover of 4.0% for band 5 and band 6 registrants. The impact of this is that there is an improvement to fill absence and escalation shifts.

University Hospitals Sussex
NHS Foundation Trust

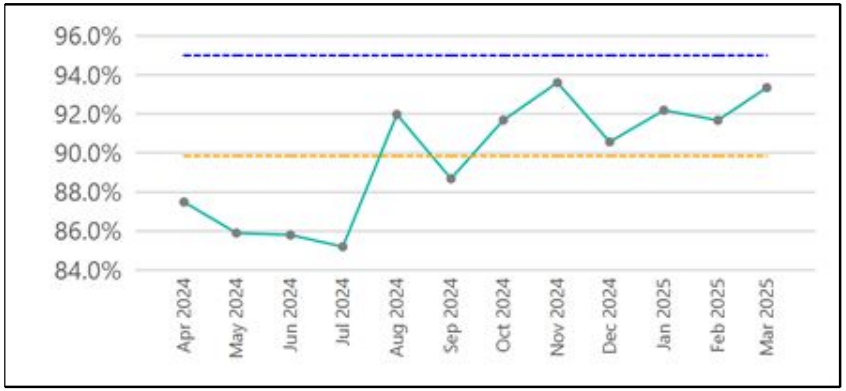
Driver

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
87.5%	85.9%	85.8%	85.2%	92.0%	88.7%	91.7%	93.6%	90.6%	92.2%	91.7%	93.4%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Care Hours Per Patient Per Day (CHPPD) trust wide has seen a gradual increase from 7.0 in December 23 to has remained consistent at 7.8 in March 25. In the model hospital data published in March 25 the trust has moved into quartile 2 for registered nurses and dropped to quartile 1 for care staff.



What the chart tells us

The chart shows the fill rate % for Registered Nurses/Midwives for the night shifts each month. The fill rate is gradually increasing each month across all sites in line with the improved vacancy position. The fill rate is better than the day fill rate due to night pay enhancements. The fill rate at Princess Royal hospital (PRH) is consistently the highest in all our sites achieving above 95% over the 3-month period. Band 5 vacancies at PRH is lowest in the trust, and 75% of areas at PRH are agency free.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce that is appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and reporting the associated workforce. The Deputy Chief Nurse (DCN) for Workforce along with the clinical workforce team undertook establishment reviews using the safer nursing care tool (SNCT) for all inpatient areas. The SNCT is a system designed to guide decisions about nurse staffing requirements on hospital wards, in particular the number of nurses to employ (establishment). In total 69 wards/clinical areas were covered across the Trust. Those not included within the SNCT audit were neonatal, theatres, and critical care. The data collection took place in Nov 2024 across all inpatient wards for 30 days and all Emergency departments completed their data collection over 12 days twice daily as per the guidance from the tool. The establishment reviews took place between Dec and Feb 2025. This data was then triangulated with CHPPD and quality metric for each department. A full report will be submitted to board in May as part of workforce safeguards governance.

NHS
University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
There are currently 8.5% Band 5 Registered Nurse vacancies which is a decrease from 13.1% (March 24) for Band 5 nurses. Notably, there has been a significant focus on domestic recruitment during the 2024/2025. Through focused engagement with our student nurses and midwives, we have seen an increase in students joining the workforce. Trust engagement with all students commences in year one of their training and students are giving the option of working on bank within the trust. Our proactive recruitment strategies have also effectively secured newly qualified nurses from universities across England. With the changes in the SIFE requirements (Supporting information from employers) has seen an increase in applicants who have an international qualification and are already resident in the UK. Furthermore, we have welcomed 17 Register Nurse Degree apprenticeship in 2024 and a further 25 qualify in July 2025. 32 students nursing associates completed their training during the 2024/2025 period, joining the workforce as registrants. Our aim is to commence training for 100 student nursing associates between Sept 2025 and Feb 2026 as part of our focus on growing our own and developing our Heath Care assistant (HCA) workforce. Turnover of 4.0% for band 5 and band 6 registrants. The impact of this is that there is an improvement to fill absence and escalation shifts.

NHS
University Hospitals Sussex
NHS Foundation Trust

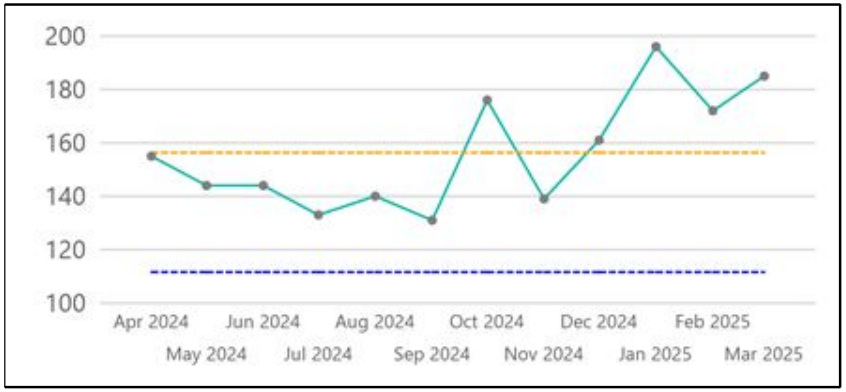
Driver

Metric: Safety - Grade 2+ pressure ulcers

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
155	144	144	133	140	131	176	139	161	196	172	185

Overview

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



What the chart tells us

Overall, there have been 173 patients with a hospital-acquired Category 2 and above pressure ulcer. The current HAPU category two and above per 1000 bed days is 3.04 per. Overall, the Trust data remains above the mean average and upper control limit for both the number of patients with pressure ulcers and the number of pressure ulcers per 1,000 bed days.

Intervention and Planned Impact

- Compass BI indicates that 77.2% of Pressure Ulcer Risk Assessment (Purpose T) are completed within 6 hours of admission. This is an increase from previous months.
- The revised aSSKINg care bundle is now live on patient track across all sites.
- The Intentional Rounding has been standardised and is now used across all sites
- A new rapid review template for pressure damage has been developed and implemented
- The TVN team is developing a teaching/education plan for pressure ulcer awareness for 2025/26. The first sessions will commence in April.

Risks/Mitigations

- There has been a rise in moisture-related moisture-related pressure damage. The FSoC pressure damage working group has now been combined with the continence group, and a work programme is being crafted.
- The divisions have been driving improvement opportunities by focusing on the top themes, such as completing pressure damage and nutritional risk assessments on time, to allow for earlier identification of potential issues. This will be monitored via the Weekly harm-free care meeting chaired by the HON for Harm-Free Care to discuss all category two and above HAPU.

NHS
University Hospitals Sussex
NHS Foundation Trust

Watch Metrics for Quality

Metric	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Clinical outcomes/effectiveness - Timeliness of observations against targets (NEWS2)	66.9%	68.3%	68.5%	69.2%	70.2%	72.0%	73.5%	74.7%	73.1%	72.9%	74.3%	75.7%
HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	16	16	18	12	14	24	23	15	25	20	11	15
HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	13	21	20	24	18	26	25	16	14	17	24	22
HCAI - Number of hospital attributable Klebsiella species cases (HOHA/COHA)	6	11	3	6	9	6	8	6	4	4	5	3
HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)	1	1	1		1					1		
HCAI - Number of hospital attributable MSSA bacteraemia cases (HOHA/COHA)	6	12	6	8	6	8	12	13	13	12	8	12
HCAI - Number of hospital attributable Pseudomonas cases (HOHA/COHA)	6	2	5	3	5	1	4	4	3	6	1	4
Safety - % of Deaths with Comfort Obs in Place	79.0%	75.2%	70.8%	74.6%	76.6%	77.2%	76.4%	69.8%	72.8%	80.2%	73.6%	74.5%
Safety - Total moderate, severe or death incidents	91	87	76	93	89	106	77	97	97	109	83	106

NHS
University Hospitals Sussex
NHS Foundation Trust

Systems & Partnerships

	Metric	Target
Breakthrough	A&E and Emergency flow - Hour of discharge median will be 10am to 10.59am (home for lunch) (Trust Level)	11:00
True North	Cancer - To achieve the 62 day standard (All referrals - National standard revised Oct 2023)	70.00%
True North	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	

NHS
University Hospitals Sussex
NHS Foundation Trust

Patient First Domain
The Systems & Partnerships True North domain of 'delivering timely, appropriate access to acute care as part of a wider integrated system' is measured through the key national emergency and elective care NHS Constitutional access standards: • A&E: treatment and admission or discharge within 4 hours; • Referral To Treatment (RTT) definitive treatment within 18 weeks; • Cancer: diagnosis and treatment within 62 days; and • Diagnostics: investigation undertaken within 6 weeks Performance remained challenged in Q4 2024/25, but there has been notable improvement across all areas. UHSX remains in Tier 1 as part of the NHSE oversight framework for RTT, cancer and diagnostics. The Trust is in Tier 2 for emergency performance. 65-week waits have continued to improve, and the Trust is no longer the highest in the highest in the country. 78-week waits also reduced; both measures are now at the lowest they have been since UHSX was formed. 104-week waits improved to just 4 in March. However, the Trust did not achieve its ambition to eliminate such long waits; too many patients are still waiting too long for treatment. The overall RTT waiting list continues to reduce and is now the lowest it has been since May-22. Cancer performance improved in both the 28-day 'faster diagnosis' standard (FDS) and 62-day cancer waiting time standards. FDS performance was second best in the south east region and above the 77% target. The trust expects to deliver its 62-day improvement trajectory and reach 70% performance for Apr-25. The backlog of over 62-day prospective waits decreased to the lowest level UHSX has ever reported. NHS England's regional team has recommended UHSX moves from Tier 1 to Tier 2 in recognition of progress made and relative performance. Diagnostics performance improved in Q4, and is now better than at any point since the Covid-19 pandemic. The total Diagnostic waiting list and backlog both reduced and the Trust's performance is now better than the national and regional median position. However, the Trust did not meet the 8% DM01 objective. A&E performance (including Minor Injury Units and Walk In Centres) was 71.5% in Mar-25, which was an improvement compared to both Feb-25 and the same period 12 months ago.

University Hospitals Sussex
NHS Foundation Trust

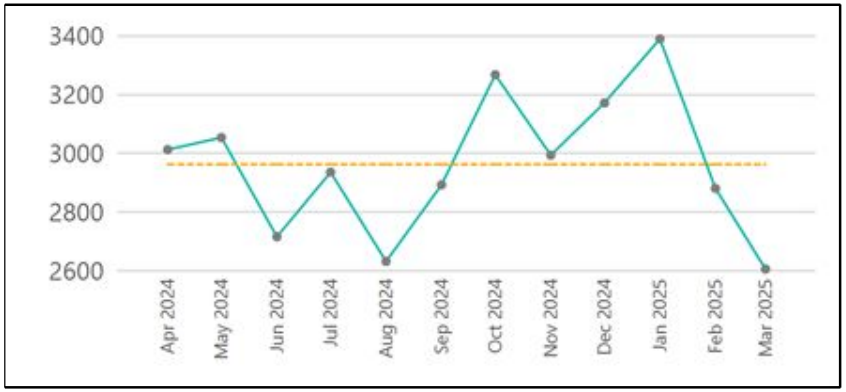
True North

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
3013	3054	2716	2936	2632	2893	3268	2994	3172	3390	2881	2606

Overview

From a peak in Dec 24 there has been a decrease in the number of 12 hr breaches. Patients 12 hours in A&E department decreased to 2662 patients in Mar-25 (7.03%) compared to Feb-25(8.8%) and lower than Mar-24 (7.6%).



What the chart tells us

Performance is most challenged at RSCH. There were 14.7% of RSCH attendances in department more than 12 hours in Mar-25, but this is an improvement to 17.4% Mar-24.

Intervention and Planned Impact

The introduction of continuous flow throughout the day has resulted in less patients being held in ED corridors and more patients moved to the wards where they wait until a patient is discharged or the patient being discharged that day is sat out and the admitted patient placed in the vacated bed space. The use of the discharge lounge is being tightly managed to ensure more patients move there earlier in the day thereby freeing up space earlier in the wards.

Risks/Mitigations

The risk is that continuous flow does not happen and slow does the flow out of ED. This is being monitored by the Hospital leadership teams to ensure that continuous flow does happen and managers of the day liaising with their wards to ensure that the early movement required is achieved.
Numbers through the discharge is being monitored as well as the numbers being moved by the continuous flow model is mapped and maintained through the day.

NHS
University Hospitals Sussex
NHS Foundation Trust

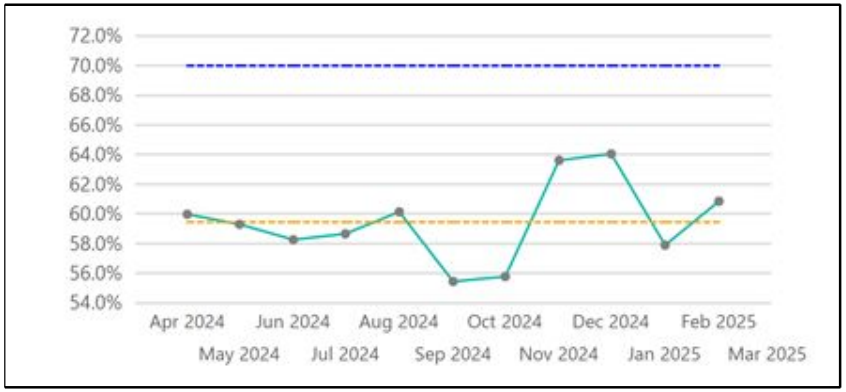
True North

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
59.98%	59.31%	58.27%	58.67%	60.15%	55.45%	55.78%	63.62%	64.05%	57.90%	60.86%

Overview

Cancer 62-day performance is a constitutional standard, with a target of 85% of patients to be referred and commence first definitive treatment within 62 days.
Please note that the constitutional standard changed in Oct-23 to include patients from all referral sources, having previously covered only urgent GP referral only.
UHSX has committed to improving performance to 70% by Mar-25, in line with national planning guidance.



What the chart tells us

The chart shows the % of patients who commenced treatment each month within 62 days. Cancer information runs a month in arrears, to allow for collation of shared pathways with tertiary providers and improve the accuracy of reporting.
Feb-25 performance was 60.6%, compared to 57.8% in Jan-25 and national standard of 85% and 70% target.

Intervention and Planned Impact

The trust has developed recovery plans for each challenged tumour-site. These are being overseen through enhanced governance led by the COO, MD (planned care), and Deputy MD (Cancer) and supported by the Surrey and Sussex Cancer Alliance.
Tumour site plans are focused on improving diagnostic and treatment capacity, shortening the front of the pathway and reducing the backlog. 62-day performance will only materially improve once the backlog has been reduced and sustained at a lower level.
NHS England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress.
The Trust has been awarded additional financial support by NHS England to recover cancer performance as part of the 'Tier 1' regime.

NHS
University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
Risks to deliver of the 62-day standard include: Management bandwidth to engage, given scale of challenges in other areas (for example A&E and RTT). This is being mitigated through use of additional PMO and analytical support from Surrey and Sussex Cancer Alliance. Diagnostic capacity challenge - mitigated by securing funding from the cancer alliance and Tier One for extra capacity. Navigator roles to ensure pathways are closely observed - alliance funding for high-risk pathways now secured so that detailed navigator overview is in place.

NHS
University Hospitals Sussex
NHS Foundation Trust

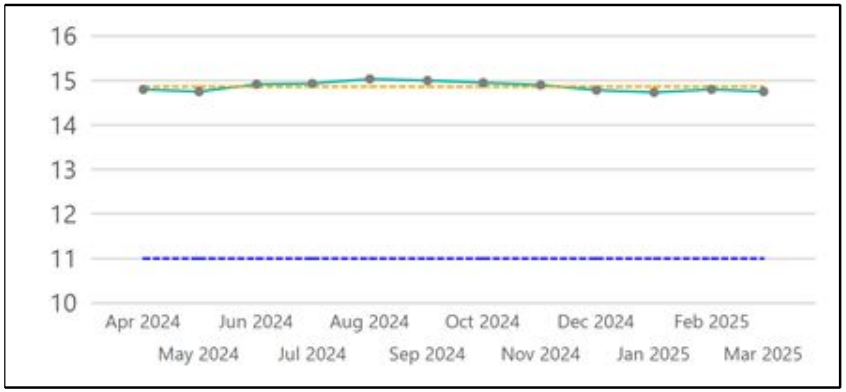
Breakthrough

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
14:48	14:45	14:55	14:56	15:02	15:00	14:57	14:54	14:47	14:44	14:48	14:45

Overview

There has been no variation across the first quarter of the year with MHD remaining at 14:45.



What the chart tells us

There has been no significant change in the MHD and the aim of before 11am is not being achieved.

Intervention and Planned Impact

Monitoring of the MHD has transferred from an SRO BO project to a metric being monitored at divisional SDR. This is to drive greater divisional ownership of this metric and to focus on specific factors impacting the division to bring forward the time of discharge.

Risks/Mitigations

There is no Trust lead for this project
The accountability has transferred to the divisions as this is where the focus is required to effect change. The MHD is discussed monthly at SDR providing exec oversight into action plans to bring this metric forward.

University Hospitals Sussex
NHS Foundation Trust

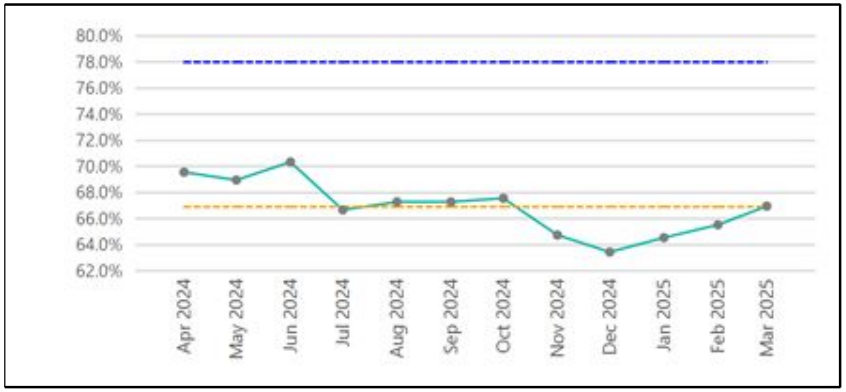
Driver

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
69.6%	69.0%	70.3%	66.7%	67.3%	67.3%	67.6%	64.7%	63.4%	64.5%	65.5%	67.0%

Overview

Performance has improved in the first Quarter of 2025 with greater improvement being seen across the EDs within RSCH and PRH. There has been a 1.3% improvement from Jan-25 to March 25 and 2.4% improvement from Mar-24.
For context in March UHSx ranked 82nd out of 121 submitting Trusts with A&E departments.



What the chart tells us

There has been a steady recovery from Dec 24 however performance is varied across all sites and the position at RACH and SEH is improving the overall UHSx value.

Intervention and Planned Impact

The UEC improvement programme has cross trust schemes with workstream SROs.
Weekly meetings with the medicine divisions continue to focus on PDSA approach with grip and control a common theme.
Improvements have been seen however caution needs to be applied as this could be a seasonal effect.

Risks/Mitigations

The cross Trust workstreams may not impact 4 hrs in the immediate future which will not realise the movement needed to achieve 78% of pts seen in 4 hrs
The quick wins and cross trust workstreams will all have trajectories and expected impacts to establish what plans are achieving their aim.

NHS
University Hospitals Sussex
NHS Foundation Trust

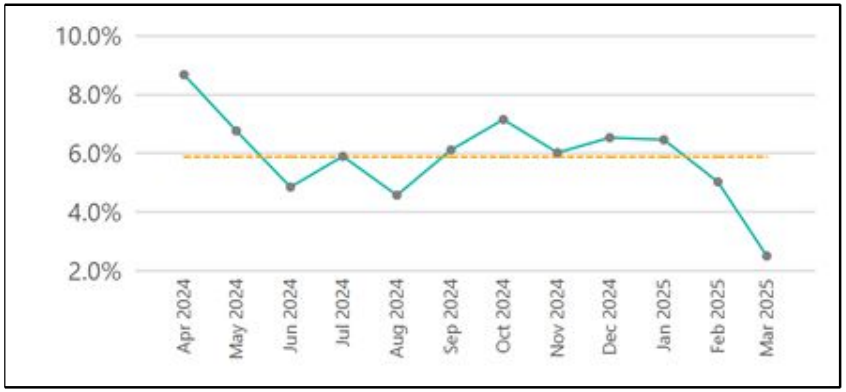
Driver

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
8.7%	6.8%	4.9%	5.9%	4.6%	6.1%	7.2%	6.0%	6.5%	6.5%	5.0%	2.5%

Overview

There is an improvement in the number of handovers being delayed for more than 60 mins. This is across all of the EDs however the majority of the 60 mins delays are at RSCH but there has been a significant improvement over the last 3 months.



What the chart tells us

Over 60 minute handovers reduced March 2025 to 169 (2.4%) compared to 315 (4.9%) in Feb-25, and than 516 (7.2%) Mar-24.
RSCH remains an outlier however there has been an improvement of 10% in January down to 4.4% in March

Intervention and Planned Impact

The introduction of continuous flow and fit to sit has enabled crews to hand over in am more timely fashion. There is an increased awareness of the requirement to not hold ambulances and escalate within the team when waits are increasing to implement an immediate action plan to allow for offloading.

Risks/Mitigations

Department crowding from offloading ambulances remains a risk. However the assessing patients suitability to be transferred to a chair as well as continuous flow reduces the risk of overcrowding.

University Hospitals Sussex
NHS Foundation Trust

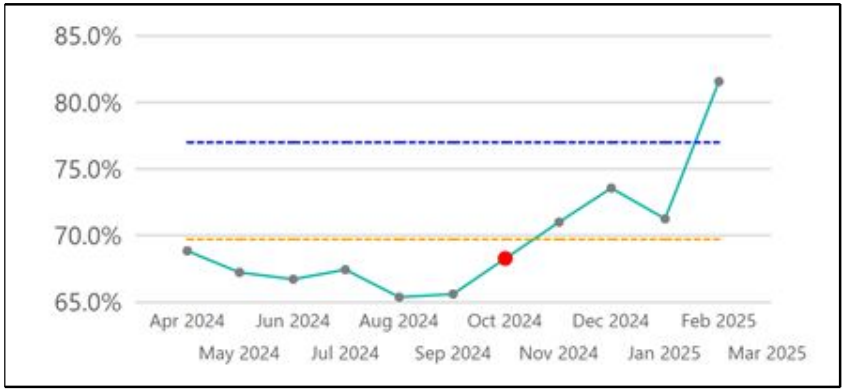
Driver

Metric: Cancer - 28 day faster diagnosis standard

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
68.85%	67.24%	66.73%	67.44%	65.38%	65.61%	68.28%	71.02%	73.57%	71.27%	81.58%

Overview

The 28-day faster diagnosis standard (introduced Jul-19) is an important target for patient experience and forms part of expedient cancer pathways. The national standard sets a maximum 28-day wait for communication of a cancer diagnosis or ruling out of cancer for patients referred urgently for investigation of cancer (including those with breast symptoms) and from NHS cancer screening, with a 77% target for 2024/25.
UHSX has committed to achievement of 77% by March 2025, in line with national planning guidance ask.



What the chart tells us

FDS performance improved in Feb-25 to 81.6% from 71.3% in Jan-25. This is above the 77% target and the best performance over the last 12 months.

Intervention and Planned Impact

The FDS performance has been most significantly impacted by Breast, Colorectal, Gynaecology, Skin, UGI and Urology.
•Breast performance is mainly affected by triple assessment capacity at the front of the pathway.
•Colorectal performance is mainly affected by vacant nursing posts managing the assessment and onward referral for first diagnostic leading to batches of referrals hitting Endoscopy in particular, unable to perform scopes in pace with batched referral demand.
•Gynaecology performance is mainly affected by the shortage of sonographer USS capacity and hyst delays.
•Haematology performance is mainly affected by late referrals across from other tumour sites.
•UGI performance is currently affected by delayed endoscopic and radiological diagnostics.
•Urology performance is mainly affected by delays to biopsy and OP capacity.
Tumour site improvement plans to address these issues are in place.
NHS England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress, and support with recovery including £1.1m of schemes to improve cancer wait times.

NHS
University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
Risks to deliver of the 28-day FDS include: Increased demand - mitigated by working with primary care colleagues to clarify referral pathways in high demand areas - for example, established a post menopausal bleeding on HRT pathway. Diagnostic capacity challenge - mitigated by securing funding from the cancer alliance for extra capacity Navigator roles to ensure pathways are closely observed - alliance funding for high-risk pathways now secured so that detailed navigator overview is in place.

NHS
University Hospitals Sussex
NHS Foundation Trust

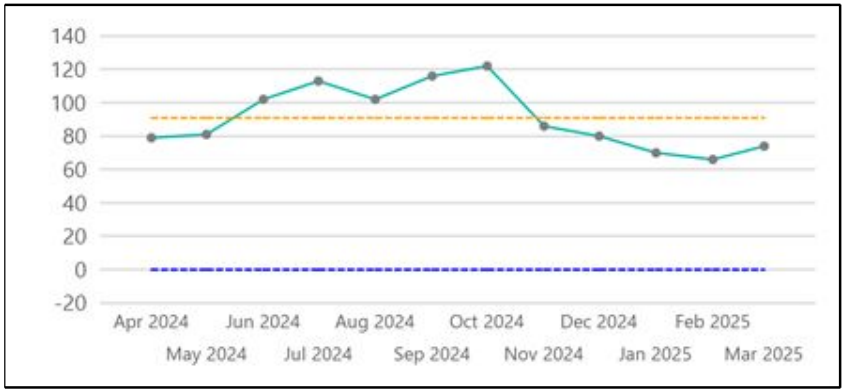
Driver

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
79	81	102	113	102	116	122	86	80	70	66	74

Overview

Cancer Waiting Times operational standards have been designed to take in to account the practicalities of managing very complex diagnostic pathways, patients who are temporarily clinically unfit for cancer treatment, and those who choose to defer their diagnosis or treatment for personal reasons.
A small proportion of patients will have a recorded waiting time of more than 104 days, usually for these reasons (i.e. 6 weeks beyond a breach of the 62-day standard).
Patients with a long waiting time need both proactive and retrospective management so that avoidable non-clinical factors can be identified and separated from clinically appropriate management, and patient choice. Equally, providers should have effective processes in place to review such patient pathways and escalation approaches for delays which may have direct clinical significance and/or have resulted in a harm event for the delayed patient concerned.



What the chart tells us

There has been an increase in over 104-day waits from 66 in Feb-25 to 74 in Mar-25, but this remains low compared to the historical position.

Intervention and Planned Impact

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

Risks/Mitigations

Patient choice and complexity pose the greatest risk to 104-day waits. These should be mitigated through proactive forward-planning and effective communication.
Diagnostic capacity is a risk for the Trust as patients progress through their cancer pathways, and with similar pressure at this stage of treatment from the RTT recovery programme and emergency pathways.

NHS
University Hospitals Sussex
NHS Foundation Trust

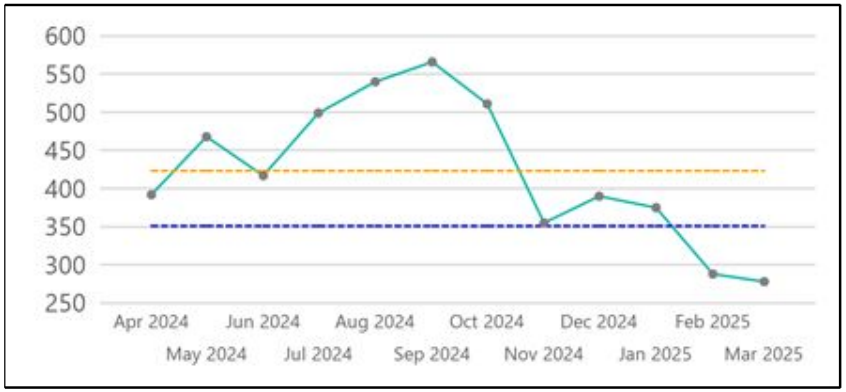
Driver

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
392	468	417	499	540	566	511	355	390	375	288	278

Overview

The NHS operating framework 24/25 requires Trusts to improve 62-day performance to 70% by Mar-25. To deliver this, UHSX has to maintain a backlog below it's 'fair share' target of 351.



What the chart tells us

62-day prospective waits decreased from 278 in Mar-25, compared to 288 in Feb-25. This is the lowest backlog position since UHSX was formed.

Intervention and Planned Impact

To return to fair share target backlog, 62-day prospective waits need to be reduced in skin, lower GI and gynae.
Tumour site recovery plans have been agreed for each of these, and form part of our H2 cancer recovery plan. This is being overseen by COO, and supported by Surrey and Sussex Cancer Alliance (who are providing PMO capacity as well as pathway analysis to drive improvement).
NHS England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress.
The Trust was awarded additional financial support to help recovery cancer performance as part of the 'Tier 1' regime.

Risks/Mitigations

Management bandwidth to engage, given scale of challenges in other areas (for example A&E and RTT). This is being mitigated through use of additional PMO and analytical support from Surrey and Sussex Cancer Alliance.
Diagnostic capacity is a risk for the Trust as patients progress through their cancer pathways, and with similar pressure at this stage of treatment from the RTT recovery programme and emergency pathways. This has been mitigated through additional Tier One funding for diagnostic capacity.

NHS
University Hospitals Sussex
NHS Foundation Trust

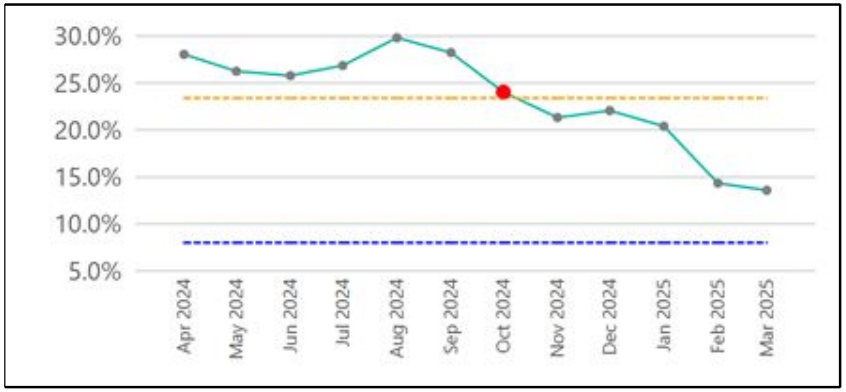
Driver

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
28.0%	26.3%	25.8%	26.9%	29.8%	28.2%	24.0%	21.3%	22.1%	20.4%	14.3%	13.6%

Overview

Diagnostics are an important element of elective care for patient care and are an essential part of decision-making towards definitive treatment. Performance is measured using the 'DM01' standard, which tracks waits across 15 diagnostic tests, ranging from imaging modalities, to physiological measurement, to endoscopic investigations.
The 2024/5 operating framework includes ambition to achieve no more than 8% of over 6-week waits by end March-25.



What the chart tells us

UHSX achieved 13.6% in Mar-25 against the DM01 standard, compared to 8% target. This was the Trust's best reported performance since the Covid pandemic.

Intervention and Planned Impact

Targeted recovery plans - with support from ICB - have been agreed for each of the most challenged modalities.
Delivery of plans being overseen weekly though planned care governance and oversight meeting.
Director of Performance overseeing review of data quality and reporting practices, to ensure in line with national guidance.

Risks/Mitigations

There remain risks around the amount of additional diagnostic capacity required to support emergency, cancer and RTT recovery.
Capacity for cardiac imaging and enhanced sedation endoscopy is limited, and reliant on fragile workforce.

NHS
University Hospitals Sussex
NHS Foundation Trust

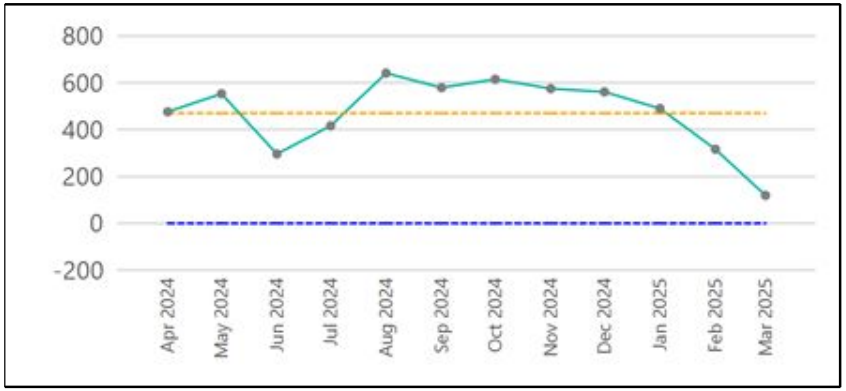
Driver

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
476	553	296	416	641	579	615	575	561	490	316	119

Overview

Elective waiting times are a key constitutional target. Elective Waiting times materially increased as a result of the covid pandemic. The national operating framework required the elimination of 78 week waits by the end March-23. The 2024/25 target is to go further and look to reduce the number of 65 week waits to zero by the end Sep-24. Due to challenges in the achievement of these targets, the Trust was placed in Tier 1 by NHSE in Sep-23, with enhanced CEO review with NHSE Executive on a fortnightly basis to oversee recovery. UHSX agreed a Mar-24 target of 298 78-week waits through the Tier 1 process. UHSX has committed to eliminating waits of 78 weeks in H2 2024/25.



What the chart tells us

The chart shows the number of patients who are waiting over 78 weeks at the end of each month. At the end of Mar-25 there were 119 patients waiting over 78 weeks, an improvement from 316 in Feb-25. This is lowest Trust has reported since the Covid-19 pandemic.

Intervention and Planned Impact

Divisions have developed recovery plans by specialty to target reduction of 65-week waits (which includes all 78-week waits). These are tracked closely on a weekly cycle to ensure adherence to plan, with additional actions if the recovery is off track.
The Trust has enhanced governance with thrice weekly oversight by COO and MD (planned care and cancer). There is weekly oversight of system capacity and how this is being used to support improvement in UHSX, chaired by MD. The Trust also has fortnightly meetings with CEO and NHS executive to oversee progress as part of 'Tier 1' regime.
These interventions will continue as the Trust works to deliver zero 78-week waits.

University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
PTL shape and growth: The growth in the PTL since the pandemic means there is an increased number of patients in the 78ww risk cohort, and the Trust has to treat an increased number of patients to avoid increasing numbers of 78ww. There are some highly complex pathways and specialist capacity constraints, which have created risk in minimising 78 week numbers. Increases in urgent or suspected cancer referral demand (which take precedence in terms of clinical priority) also constrain residual routine waiters capacity. There was a 9% growth in cancer referrals in 2023 v 2022.

NHS
University Hospitals Sussex
NHS Foundation Trust

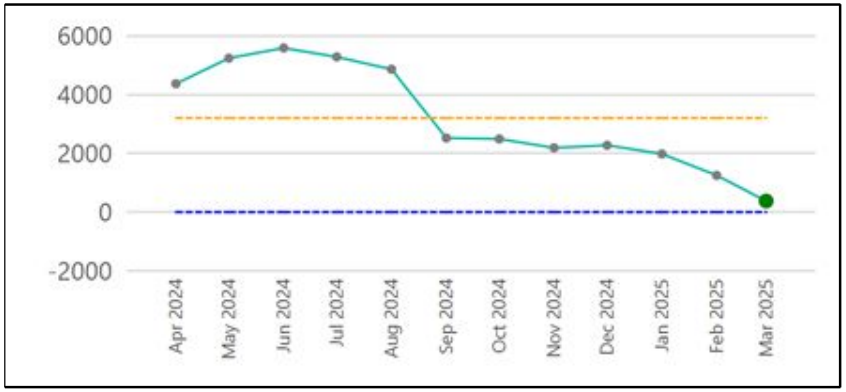
Driver

Metric: RTT Elective care - >=65 Weeks

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
4374	5245	5592	5288	4866	2525	2492	2189	2278	1982	1251	377

Overview

Elective waiting times are a key constitutional target. Elective Waiting times materially increased as a result of the covid pandemic. The 2024/25 national target is to reduce the number of 65-week waits to zero by the end Sep-24. UHSX did not achieve this, and has agreed an H2 plan to reach zero 65-week waits by Mar-25.
Due to challenges with 65-week wait performance, the Trust has been placed in Tier 1 level support by NHSE.



What the chart tells us

The number of patients waiting over 65 weeks decreased from 1,251 in Feb-25 to 377 in Mar-25. This is the lowest total for the Trust since the Covid pandemic.

Intervention and Planned Impact

UHSX has, along with ESHT & QVH, jointly agreed a plan to reach zero for H2. This is based on:
1. Opening forecast of ~6100 on 'do nothing more' basis (Forecast as of 29/09)
2. UHSX increasing activity further (both through productivity & WLI/insourcing) to close by further ~2,900; UHSX is being supported by the national Getting It Right First Time team over the next 6 months to achieve this.
3. ESHT and QVH using their capacity to treat 2,081 and 550 UHSX patients from the cohort respectively.
4. Independent Sector capacity being used to close the gap to zero.
UHSX Specialty-level plans for H2 have been agreed, and are currently subject to check and challenge.
Patients have now been transferred to ESHT & QVH, and UHSX is focused on delivering internal plans to reach zero.
UHSX CEO is lead for this plan across Sussex. UHSX MD is operationally leading delivery on behalf of the three NHS providers.
Sussex system support is being overseen through weekly system capacity meeting, chaired by MD, with weekly oversight from COOs.
Tier One oversight for RTT will now be of the whole Sussex System and not just UHSX.

University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
Urgent and emergency pressures have exacerbated risk associated with 65 week waits over the past 12 months. Increases in urgent or cancer demand (which take precedence in terms of clinical priority order) also constrain capacity for routine waiters capacity. UHSX is reliant on system working and capacity being available at other providers (both independent sector and NHS) in order to deliver this objective.

NHS
University Hospitals Sussex
NHS Foundation Trust

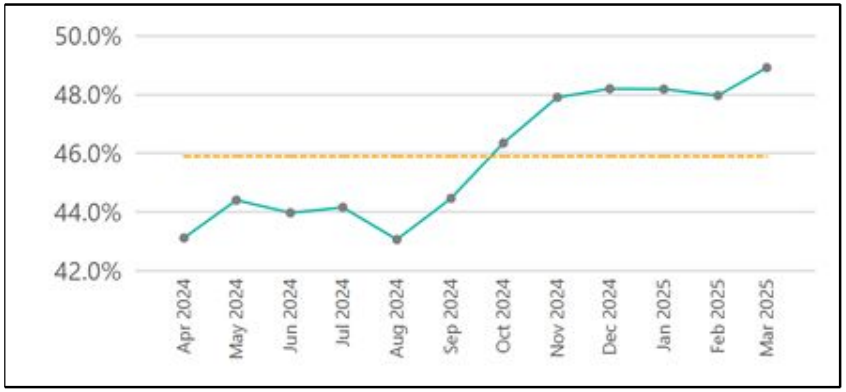
Driver

Metric: RTT Elective care - 18 Week Performance

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
43.12%	44.41%	43.98%	44.16%	43.07%	44.47%	46.35%	47.91%	48.20%	48.19%	47.97%	48.92%

Overview

Under Referral to Treatment (RTT) incomplete pathways constitutional target, 92% of patients should be waiting under 18 weeks to commence first definitive treatment following GP or consultant referral.
Incomplete performance was affected by Covid-19 pandemic due to a reduction in capacity in order to treat covid patients, which led to growth in the RTT backlog and total waiting list.
Reducing long waiters (104+,78+ and 65+ week waits) had superseded the 18-week target as acute Trusts look to tackle the very longest waits as part of staged recovery to reduced waits for elective care.



What the chart tells us

The chart shows the % of incomplete pathways that have waited less than 18 weeks to start definitive treatment. This had shown steady decline following Covid impact on planned care activity and waits, and as demand (in terms of clock starting events) has outstripped supply (clock stops/removals for other reasons from the waiting list). However, the Trust's performance is improving again as the total waiting list come down.
Performance was 48.9% in Mar-25, an improvement on Feb-25 (48.0%) and the best performance in over 24 months.

Intervention and Planned Impact

Key actions include:
1. Increasing activity delivered, through:
• improved productivity and pathway redesign. For example reducing unnecessary follow ups by increasing use of Straight to Test pathways and PIFU (Patient Initiated Follow Up)
• Increased weekend working
• Increased use of independent sector
• Mutual aid within Trust sites, across Sussex ICB catchment and where possible from beyond the Sussex System
2. Improved waiting list management, with refreshed standardised RTT meetings with operational teams to ensure access policy rules are followed and applied, ensure patients are booked in turn, and ensuring outcomes are captured on the information systems.
3.Enhanced planned care oversight and governance structure with divisional leadership led by MD (planned care) and Director of Performance, with divisions held accountable for improvement focused on all stages of treatment not just longest waits
4. Central validation of pathways over 12 weeks and continued DQ process re waiting list reporting, supported by technological transformation (including robotic process automation)

Risks/Mitigations
There are also some highly complex pathways, and specialist capacity constraints (eg in neurosurgery/spinal care), which have created risk in minimising longest waits. Increases in urgent or cancer demand, which take precedence in terms of clinical priority order can also constrain residual routine wait capacity. Financial constraints limit the amount of activity that can be delivered outside of plain time.

NHS
University Hospitals Sussex
NHS Foundation Trust

Watch Metrics for Systems & Partnerships

Metric	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
A&E and Emergency flow - % Patients with a 21+ day length of stay	9.0%	8.4%	8.3%	8.8%	8.1%	8.2%	8.3%	8.0%	8.6%	8.5%	8.4%	8.6%
A&E and Emergency flow - A&E 4 Hour Breaches	10737	11882	10667	10657	9987	9912	10368	11213	11511	10654	9717	10781
A&E and Emergency flow - A&E Attendances	35274	38278	35964	31974	30525	30296	31961	31801	31483	30044	28185	32625
A&E and Emergency flow - Ambulance Handovers	7303	7556	7278	7380	7444	7387	7719	7681	7643	7722	6794	7487
A&E and Emergency flow - Ambulance Handovers - % Under 15 mins	16.7%	76.6%	14.8%	15.4%	16.5%	68.7%	43.3%	43.7%	22.9%	16.3%	63.4%	61.1%
A&E and Emergency flow - Average LOS (Excl LOS 0)	7.7	7.7	7.6	7.8	7.5	7.6	7.3	7.2	7.7	7.8	7.4	7.6
A&E and Emergency flow - Bed Occupancy	1820	1819	1799	1782	1765	1801	1818	1836	1788	1887	1953	1901
A&E and Emergency flow - Emergency Admissions > 1 LOS	5475	5632	5426	5479	5477	5491	5813	5704	5684	5786	5103	5592
A&E and Emergency flow - Mean Waiting Time	345	339	315	325	310	329	348	353	362	374	352	315
A&E and Emergency flow - Time to treatment in ED (Median time to treatment mins)	63	72	62	70	67	68	64	67	94	95	101	101
A&E and Emergency flow - Time to Triage in ED - % seen within 15 mins	63.5%	60.2%	64.6%	62.5%	66.7%	62.1%	62.1%	61.2%	61.2%	61.0%	64.4%	64.7%
Cancer - Two week rule performance	67.5%	63.2%	58.8%	66.2%	62.8%	67.3%	72.6%	70.8%	83.8%	85.8%	93.7%	
Diagnostics - 6 week backlog	6036	5458	5331	5481	6044	5645	4895	4118	4135	3704	2679	2464
Diagnostics - Activity	37418	38711	38494	39960	35950	37660	41063	41707	36485	40439	37528	40736
Diagnostics - Waiting List size	20518	19712	19459	19127	19095	18688	19130	18285	17861	17526	18028	17528
Elective care - Activity compared to 2019/20	114.6%	116.3%	116.5%	105.9%	106.9%	105.7%	112.1%	110.4%	113.2%	110.0%	113.4%	149.7%
RTT Elective care - >= 52 Weeks	16480	16941	16157	15052	14168	10976	9965	9200	8278	7848	7437	6923
RTT Elective care - >104 Weeks (NHSi Criteria)	4	4	4	4	2	4	6	6	6	8	5	4
RTT Elective care - Clock Starts	20563	21290	19011	20716	17698	17468	20540	18977	17157	21547	18690	19576
RTT Elective care - Clock Stops	21765	22277	23470	24053	20976	22814	25072	23236	19764	23415	21490	22711
RTT Elective care - Waiting list size	142917	141517	136410	133732	130232	123868	119791	117899	121127	118530	114850	114131

University Hospitals Sussex
NHS Foundation Trust

Research & Innovation

	Metric	Target
True North	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	35

NHS
University Hospitals Sussex
NHS Foundation Trust

Patient First Domain
Data for Quarter 4 of 2024-25 for Acute Trust ranking in terms of total recruitment to studies on the NIHR portfolio. The Trust currently stands at 49th (April 25) putting it outside of the top 20% of recruiting Acute Trusts over the past 12 months. 5,112 (April 25) patients have been recruited to NIHR portfolio studies in 2024/25, however the breakthrough objective of increasing recruitment by 10% year on year has not been achieved. The annual target for 2024/25 of 8328 was artificially inflated due to the anomaly in recruitment figures for 2023/24. Over 3000 patients were recruited to three studies in 2023/4, one of which the GB3 study in maternal health recruited over 2000 patients. There were less large recruiting studies available to participate in on the NIHR portfolio for 2024/25. Through divisional research growth plans, the Trust is focusing upon increasing the number of open interventional studies and commercially sponsored interventional studies this year as a driver for increasing patient treatment access and options.

University Hospitals Sussex
NHS Foundation Trust

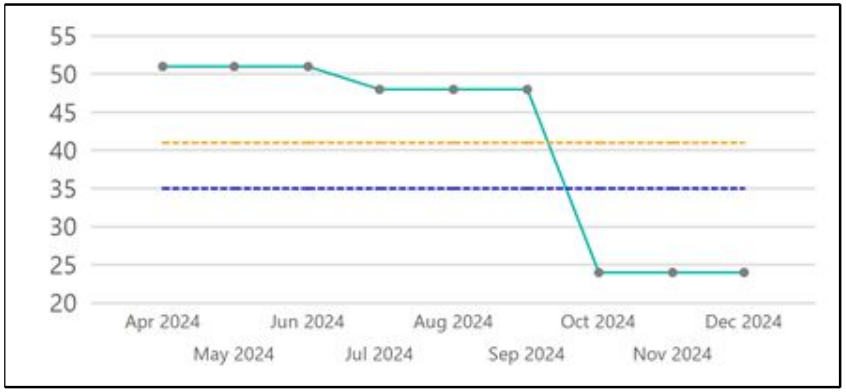
True North

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

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
51	51	51	48	48	48	24	24	24

Overview

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



What the chart tells us

This chart shows shows the 12-month rolling Acute Trust ranking in terms of total recruitment to studies on the NIHR portfolio. The Trust currently stands at 49th (April 2025) putting it outside the top 20% of recruiting Acute Trusts over the past 12 months.

Intervention and Planned Impact

The Trust is developing research and innovation in line with the R&I Strategy.

- We have appointed Divisional Research Directors to support the embedding of research. These roles are helping to promote research in the division through divisional targeted research growth plans.
- Prioritised work is underway to secure estates for the reprovision of the Clinical Research Facility on RSCH site which is essential to the growth in delivery of commercial clinical research.
- The Trust has been selected to host a new NIHR Commercial Research Delivery Centre (CDRC), this will be a Centre of excellence, offering additional commercial research delivery capacity to existing health and care organisations in Sussex. CRDCs will accelerate the delivery of commercial clinical research for the benefit of the health and wealth of the nation
- R&I strategic workstreams are also developing research communication and engagement approaches, research training and education and a programme supporting UHSx research groups and clinical academic career opportunities.

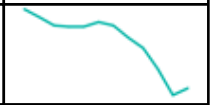
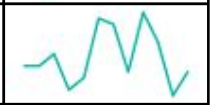
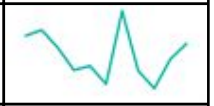
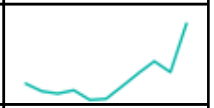
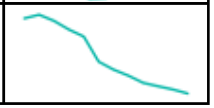
NHS
University Hospitals Sussex
NHS Foundation Trust

Risks/Mitigations
The UHS Future 2030 strategy reflects the strategic potential of R&I to drive transformations of services and care at UH Sussex. Securing estates for the reprovision of the Clinical Research Facility to a high quality and accreditable standard is the key risk to delivering the Trusts R&I ambition. Existing clinical research facilities are not adequate to support the breath and scale of trust wide participation in research needed to achieve our strategic ambition. This is now a major capital project. Workforce and service department capacity to deliver research is also a risk to the delivery of the Trust's research ambition – detailed work with Divisional Directors for Research will help to better clarify the risks and mitigations for each division and support services. Job planning guidance for research PAs has been agreed and disseminated. A lack of integration of UH Sussex Research and Innovation with wider Sussex health and care systems and universities is also a risk to the delivery of our R&I ambition. We must continue to drive the success of the Sussex Health and Care Research Partnership working with partners across the Integrated Care System and academic partners to build research which addresses the needs of our population and patients and develops our future research leaders, investing in shared infrastructure such as the Clinical Trials Unit, Training Hub, and Joint Clinical Research Office.

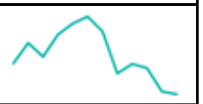
NHS
University Hospitals Sussex
NHS Foundation Trust

Watch Metrics for

Metric

Oversight Metrics				
Patient First Domain	Metric	Value	Target	Trend
People	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	6.42	7.06	
Sustainability	Financial Stability - Variance from breakeven plan YTD	-30,000k	0k	
Quality	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	104.7	100.0	
Quality	HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	15	2	
Quality	HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	22	6	
Quality	HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)	1	0	
Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	652		
Systems & Partnerships	Cancer - 28 day faster diagnosis standard	81.58%	77.00%	
Systems & Partnerships	RTT Elective care - >= 52 Weeks	6923	14000	

NHS
University Hospitals Sussex
NHS Foundation Trust

Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	119	0	
Systems & Partnerships	RTT Elective care - >=65 Weeks	377	0	
Systems & Partnerships	RTT Elective care - >104 Weeks (NHSi Criteria)	4	0	
Systems & Partnerships	Cancer - Number of patients waiting over 62 days for treatment	278	351	
Systems & Partnerships	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	2606		

University Hospitals Sussex
NHS Foundation Trust

Oversight Metric Summary

Current segmentation

The Trust remains in Segment 3 of the National Oversight Framework (NOF) and continues to engage with NHS England and the ICB through their formal oversight processes. The lead for the oversight of the Trust's performance remains with the ICB and the Trust through quarterly meeting provides assurance on its delivery of its annual plan.

Drivers of the segmentation

During Q4 the Trust has continued to focus on Emergency Care, Cancer and Planned Care delivery. The Trust remains within Tier 1 oversight for Cancer and Planned Care performance and is in Tier 2 oversight for Emergency Care performance seeing enhanced performance oversight continue with NHS E. The Trust whilst continuing to make significant progress in reducing its overall RTT waiting list numbers and meeting its planned care performance plan did not achieve zero patients waiting over 65 weeks. The Trust significantly improved its cancer faster diagnostic performance but in respect of emergency care performance the Trust has not made the performance gains it expected to within the quarter.

The Trust met its revised deficit plan for 2024/25 and whilst actions were taken over the second half of the year the Trust's underlying run rate remains adverse to balanced position. Thes risks have been articulated within the developing 2025/26 operational and financial plan. The Trust is engaging with both the ICB and NHS E in respect of its 2025/26 plan and the level of financial, operational and workforce risks contained within it.

The Trust continues to deliver against it's Single Improvement Plan which contains the action plans which when completed will satisfy the undertakings which the Trust entered into with NHS England. The monitoring of the delivery of these improvements has been reported to the Board and at its meeting in February agreed that the dedicated NED chaired Board Committee oversight was no longer required as the oversight of the remaining actions were mapped to the Board's routine governance committees. The overall plan delivery continues to be overseen by the Vhaief Medical Officer and progress with the few remaining actions is reported routinely to the ICB and NHSE as part of the provider assurance framework meetings.

The Board Assurance Framework, as reported to the Board on 31 March, reflected the continued level of elevated risk across the Trust's strategic objectives with 7 of the 10 strategic risks not achieving their target score as had been reported would be the case in the reporting at the start if quarter 4.

Implications of this segmentation

Segment 3 allows the Trust to have access to external advice and support which has included support to aid with the improvement of UEC performance and support for increased capacity and capability to address the Trust's cultural improvement work within the Single Improvement Plan.

Actions being taken to move from segment 3

Whilst the Trust has delivery much of the developed single improvement plan which itself captures the actions being taken in respect of the specific concerns highlighted by the CQC and the undertakings in respect of operational performance and finance given the elevated degree of risk and the risk within the Trust's developing operational and financial plan for 2025/26 the Trust does not expect to exit segment 3 in the first part of 2025/26.

The Board either directly or through its Patient and Quality, People and Culture and Finance and Performance Committees continues to exert oversight of the delivery of the improvement plans established along with securing feedback from the routine NHS E tiering oversight meetings on any areas that can be progressed more effectively.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	9.	**Meeting:**	Trust Board in Public	**Meeting Date:**	08 May 2025
Report Title:	Single Improvement Plan: Report to Trust Board				
Sponsoring Executive Director:	Professor Catherine (Katie) Urch, Chief Medical Officer				
Author(s):	Nicole Chavaudra, Single Improvement Plan SRO				
Report previously considered by and date:					

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

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

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

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in overall poorer patient experience and potential for adverse reputational impact.
Sustainability	Yes	2.1 We fail to deliver the in-year financial plan; alongside the requirement to return to a breakeven run-rate by M12 2025/26 and secure medium-term sustainability
People	Yes	3.2 We will not achieve our strategic aims and realise the benefits of merger, including improving patient safety and recruiting and retaining talent unless we take action to; develop a clear strategy, invest in and prioritise focussed work on culture change from 'Board to Ward' including developing our leaders to be engaging, inclusive and empathetic, aligning sub-cultures and addressing cultural gaps and reducing cultural variation
Quality	Yes	4.1 We are unable to demonstrate compliance with regulatory and quality standards 4.2 We are unable to deliver any safe and harm free care
Systems and Partnerships	Yes	5.2 We are unable to deliver and demonstrate consistent compliance with the 24/25 operational plan and NHS constitutional standards resulting in an adverse impact on patient care and the Trust's reputation and financial position.
Research and Innovation	N/A	

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

Regulatory / Statutory reporting requirement
R
Communication and Consultation:
None
Executive Summary:
Approved in June 2024, the Single Improvement Plan (SIP) is a fixed term plan, with associated governance, developed in response to the required undertakings. A process of alignment of the SIP with the emergent Trust strategy has begun, and a paper setting out the proposed roadmap for assimilation of the improvements within substantive governance was approved in February 2025. As such, in accordance with the terms of reference, the SIP committee and steering group have dis-established and a plan for business-as-usual governance enabled. During the reporting period, the status of the work stream actions is noted and plans for future reporting of the SIP priorities within the Trust and externally are detailed. It is noted that reasonable progress has been made during the reporting period including the reduction in the waiting list, progress against CQC actions and assimilation of plans into business-as usual governance. There is limited assurance against actions in some work streams which are off track, however these have established plans and governance arrangements to enable delivery. Priorities for the next reporting period are establishing new reporting arrangements and enabling assimilation of the improvement plans into the new strategy arrangements in Q1 2025/26.
The Board is asked to: i. **NOTE** the report

Report Title	Single Improvement Plan: Report to Trust Board
Executive Sponsor	Professor Catherine Urch, Chief Medical Officer
Report Author	Nicole Chavaudra, Single Improvement Plan SRO
Date	May 2025

1. Introduction and context

Approved in June 2024, the Single Improvement Plan (SIP) is a fixed term plan, with associated governance, developed in response to the required undertakings. Whilst it does not represent the totality of the Trust's improvement efforts, it provides a cohesive response to the critical, current issues and priorities for the trust to meet the expectations of our patients, staff and regulators over coming months. This has been developed over a period of nine months, in collaboration with ICB and NHSE, who have confirmed that the plan meets their expectations. The plan will inform the new Trust Strategy to establish our roadmap for the years to come.

The plan, which evolved since its approval, includes the following domains: CQC; quality improvement; culture; surgery; planned care; cancer; urgent and emergency care; equality, diversity and inclusion (EDI); specialised services; maternity; well-led; and finance. These are overseen by the SIP committee.
A process of alignment of the SIP with the emergent Trust strategy has begun, and a paper setting out the proposed roadmap for assimilation of the improvements within substantive governance was approved in February 2025.

The committee has also considered an analysis of the undertakings, identifying that the requirements have been substantially satisfied. As such, in accordance with the terms of reference, the SIP committee and steering group have endorsed their dis-establishment and a plan for business-as-usual governance enabled.

Reporting to the Board and to the Integrated Care Board (ICB) and NHS England (NHSE) is maintained until the ambitions of the SIP are fully assimilated into deployment arrangements for the new Trust strategy.

2. Analysis - Progress and performance over the previous reporting period

Performance against the key metrics is described in Appendix A.

During the reporting period, the status of the work stream actions against the plan is detailed in Appendix B, and summarised as follows:

- **CQC:** All well-led inspection actions are completed and an independent review of well-led is now underway; from the 2023 inspection, a steering group is established and of the 97% of all actions have been completed.
- **Quality improvement**: All actions and targets are met, with the exception of clinical guidelines. The target was 90% compliant but this target is not due until March 2026. Current performance is 41.7%.
- **Surgery:** A surgical Operating model has been developed and proposed to the Trust Executives. Implementation of the SOM will now be completed as part of the Trust wide Target Operating Model (TOM), a new piece of work commencing Q1 25/26 that will incorporate a wider scope across more specialities in the Trust, including clinical and corporate areas.
- **Planned care and cancer:** Under focused support from GIRFT, recovery plans are in place for each speciality. The Trust is under tier 1 reporting and has delivered 117% of ERF activity – 65week wait target is expected to be achieved in July 2025 and continued improvements are being made. The faster diagnosis standard was met with current confirmed position 81.6% in March 2025. The Trust currently under Tier 1 reporting with support from the cancer alliance.
- **Urgent and emergency care (UEC):** site-based plans are in place and the new UEC oversight approach is embedded in line with the plan. Actions outstanding include reconfiguration of UEC at RSCH. Current performance: 4-hour performance 66.9% (Mar 25) against a 78% standard. 12-hour breaches 2, 606 (Mar 25), 7.9% of attendances.
- All **maternity, EDI, specialised services** and **culture** actions are completed.

Reasonable progress has been made during the reporting period including the reduction in the waiting list, progress against CQC actions and assimilation of plans into business-as usual governance. Work streams which are off track, including UEC and clinical guidelines have established plans and governance arrangements to enable delivery. Priorities for the next reporting period are enabling further progress against outstanding ambitions and enabling assimilation of the improvement plans into the new strategy arrangements in Q1 2025/26.

3. Recommendations

It is recommended that the Board:

i. NOTE the content of the report.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	11.	**Meeting:**	Trust Board in Public	**Meeting Date:**	8 May 2025
Report Title:	Research, Innovation and Digital Strategy Assurance Committee Chair's Report to Board				
Sponsoring Non-Executive:	Jackie Cassell, Non-Executive and Committee Chair				
Author(s):	Jackie Cassell, Non-Executive and Committee Chair				
Report previously considered by:					
Purpose of the report:					
Information	Yes		Assurance		Yes
Review and Discussion	N/A		Approval / Agreement		N/A
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality	N/A		Staff confidentiality		N/A
Patient confidentiality	N/A		Other exceptional circumstances		N/A
Link to ICB / Trust Annual Plan					
Link to ICB Annual Plan	Yes		Link to Trust Annual Plan	Yes	
Implications for Trust Strategic Themes and any link to Board Assurance Framework risks					
Patient	N/A				
Sustainability	N/A				
People	N/A				
Quality	N/A				
Systems and Partnerships	N/A				
Research and Innovation	Yes		Links to risks 6.1 and 6.2		
Link to CQC Domains:					
Safe	Yes		Effective		Yes
Caring	Yes		Responsive		Yes
Well-led	Yes		Use of Resources		Yes
Regulatory / Statutory reporting requirement					
Communication and Consultation:					

Executive Summary:

The Research, Innovation and Digital Committee met on the 29 April and was quorate, as it was attended by four Non-Executive Directors and four executives, including the executive leads for the Committee these being the Chief Strategy Officer and Chief Medical Officer.

In attendance at the meeting were also the Chief Information Officer, the Clinical Research Director, the Director of Operations Research and Innovation, and the Clinical Medical Officer from Kent Surrey and Sussex Health Innovation Network. For the respective items the Trust's Data Protection Officer, EPR programme lead and the Head of Programmes & Projects (IT).

The Committee **received** its scheduled reports in accordance with its cycle of business. The key elements of the Committee are included within the report.

Research and Innovation & Digital Steering Group Chair's report The Committee received the report that introduced the areas discussed in detail within its meetings in February and April 2025. The update assured the Committee that the work of the Steering Group is aligned to the main key risks which as had been previously discussed at the Committee were aligned to the BAF as reported to the Board in March 2025. The Committee discussed the work overseen by the Steering Group in relation to strengthening of research infrastructure and the development of the clinical research hub and spoke model through collaborative work with BSMS and SPFT.

The Committee asked that within future reporting there is a clear road map of milestones to meet the Trust's research ambitions.

Research and Innovation Quarterly Performance Report. The Committee **received** the report which provided updates against the summary scorecard covering 21 areas linked to patient participation; efficiency and effectiveness; staff involvement and innovation. The Committee noted that whilst the overall level of research participation had reduced, this was influenced by the closure of some large studies while there had also been an increase in the level of specialties taking part in research, in line with the ambition to diversify the research portfolio. The Committee **noted** the work being undertaken to improve the levels of research activity becoming routinely part of the work of medical and clinical staff and in particular as consultants are recruited into the Trust.

Digital & Data Strategic Delivery Plan for 2025-30

The Committee considered the updated document following feedback at the last Committee meeting and **agreed the principles** contained within the document which confirmed this as a key pillar of the wider Trust Strategy. The Committee reflected on the successful level of staff engagement that underpins this document and the clarity of the five themes the delivery plan is grouped around.

In support of this the Chief Information Officer (CIO) provided information on the work being undertaken to expedite digital transformation ahead of the planned Electronic Patient Record implementation for 2027. The Committee **supported** the CIO proposal to draw in external support from the Health Innovation network (HIN) which could enable the Trust to make rapid step changes to clinical pathways, productivity and efficiency that will support the Trust's Strategy and annual plan.

Complementing this item the Committee received its scheduled report on digital projects underway. The Committee **continued to note** the significant demand on the IT team and link between this update and the proposal from the CIO to secure enhanced support, while developing governance and structures to optimise prioritisation.

Digital Security & Protection Toolkit Update

The Committee **NOTED** an update on the Trust's submission for compliance to the 2024/25 Data Security Protection Toolkit compliance under the Cyber Assurance Framework. The Committee discussed the risks and mitigation actions to enable a maximally compliant assessment to be made at the end of June and was assured that the anticipated level of compliance is achievable in the time frame.

Electronic Patient Record (EPR) Programme and Projects Reports

The Committee **noted** that the EPR ITT has been published and the team are working to secure the requisite numbered of clinical evaluators. The Chief Medical Officer informed the Committee that work is underway to support with creating clinical time for this work. The Committee **endorsed** this support. The Committee noted the work being undertaken in preparation for the EPR including the continuation of the electronic document management system roll out.

Risk registers

The Committee **noted** the correlation between the highly scored research, innovation and digital risks and the reports and discussions had at the meeting.

Key Recommendation(s):

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

The Board is also asked to **NOTE** the Committee's agreement to the Digital & Data Strategic Delivery Plan for 2025-30.

University Hospitals Sussex NHS Foundation Trust

RESEARCH, INNOVATION AND DIGITAL STRATEGY ASSURANCE COMMITTEE CHAIR'S HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**29 April 2025**	**Chair**	Jackie Cassell	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Research and Innovation Strategy Delivery			
Research & Innovation Strategy Steering Group: Chair's Report	**Presenter** Chief Medical Officer Clinical Research Director	**Purpose** To note	**Outcome /Action taken** Noted. (no steering group meeting in January 2025).
Research & Innovation quarterly performance report	**Presenter** Chief Medical Officer/ Clinical Research Director	**Purpose** To note	**Outcome /Action taken** Noted
Research & Innovation Workstream Updates	**Presenter** Chief Medical Officer Clinical Research Director	**Purpose** To note	**Outcome /Action taken** Noted.
Delivering Health Innovation – digital delivery partner proposal	**Presenter** Chief Information Officer	**Purpose** To Note	**Outcome /Action taken** Noted
Digital			
Digital and Data Strategic Delivery Plan 2025-2030	**Presenter** Chief Strategy Officer/ Chief Information Officer	**Purpose** To discuss and agree	**Outcome /Action taken** The Committee agreed the document
Digital Security & Protection Toolkit Update	**Presenter** Chief Information Officer	**Purpose** For assurance	**Outcome /Action taken** Noted the assurance provided that a complaint self-assessment submission will be made
AI opportunities	**Presenter** Chief Information Officer	**Purpose** For discussion	**Outcome / Action taken** The Committee engaged with the discussion on the opportunities and Trust governance oversight of the evaluation of these
Digital Transformation Updates	**Presenter** Chief Information Officer	**Purpose** For information	**Outcome /Action taken** Noted the continued level of demand on the team
Electronic Patient Record Programme and Projects Reports	**Presenter** Chief Information Officer	**Purpose** For information	**Outcome /Action taken** Noted the publication of the ITT and the work being undertaken to secure sufficient clinically evaluators
Risk			
Research, Innovation and Digital Risk Registers	**Presenter** Chief Medical Officer/ Clinical Research Director/ Chief Strategy Officer/ Chief Information Officer	**Purpose** To discuss and note progress	**Outcome /Action taken** Noted the correlation of these with the discussions and papers received at the meeting

University Hospitals Sussex NHS Foundation Trust

Actions taken by the Committee within its Terms of Reference	
The Committee agreed its cycle of business for 2025/26 noting that as the Trust's strategy is launched this may see some changes over the year.	
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)	
The Committee requested that the research ambition delivery road map come back to a future meeting.	
Items referred to the Board or another Committee for decision or action	
Item	**Who / when**
There were no specific matters referred to the Board or another Committee	Not applicable

NHS
University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	12.	**Meeting:**	Trust Board in Public	**Meeting Date:**	8 May 2025
Report Title:	Patient & Quality Assurance Committee Chair report to Board				
Sponsoring Executive Director:	Lucy Bloem, Committee Non-Executive Chair				
Author(s):	Lucy Bloem, Committee Non-Executive Chair				
Report previously considered by:					

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

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

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

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	Links to risk 1.1
Sustainability	N/A	
People	N/A	
Quality	Yes	Assurances in relation to risk 4.1 and 4.2
Systems and Partnerships	N/A	
Research and Innovation	N/A	

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Patient & Quality Assurance Committee had met three times since my last report and this report covers three meetings in February, March and April 2025. The meetings were quorate, attended by at least two Non-Executive Directors and two executives. In attendance at the meetings were the Chief Nurse and/or Chief Medical Officer, the Deputy Chief Nurse for Quality and the Director of Patient Experience, and the Director of Clinical Outcomes & Effectiveness. The Chief Nurse gave apologies to the March meeting and was represented by their deputies. In addition, other key personnel attended the meeting as appropriate to present specific papers concerning Infection Prevention & Control, Safeguarding and Estates.

During the quarter the Committee received its planned items including reports on the quality scorecard, Infection Prevention & Control the perinatal quality surveillance dashboards, Patient Safety and Duty of Candour reports as well as the Patient Experience assurance report. The Committee also received quality assurance reports, and reports from the Committee's reporting group: Quality Governance Steering Group (QGSG).

Particular focus in this period has been given to the development of an Estates Improvement Group that is focussed on some of the long-standing issues including backlog maintenance, ventilation, water and the

building fabric, which will also have oversight of the Equipment/Devices work programme that has been established in response to CQC actions and will report through the Quality Governance Steering Group to Quality and Patient Committee.

Patient Experience

The Q4 Patient Experience Report was received. The Committee **NOTED** that based on available Friends and Family Test (FFT) data, 90.2% of patients responding in Q4 were satisfied that they have a good or very good experience, which was comparable to Q3 and the previous year. The committee recognise the lowest satisfaction ratings continue to be associated with waiting times, the Emergency Department and appointment and waiting list management.

The Committee **NOTED** a marked increase in Complaints in Q4, the highest number in any quarter since 2021. The Committee discussed the work to better understand the issues driving complaints and heard about analysis taking place at speciality level and the arrangements that link complaint feedback into Medical Leadership and appraisals.

The Committee was **ASSURED** by the central complaints management system with the highest number of complaints closed this quarter since 2021 and a significant reduction in the complaints open greater than 6 months. The Committee heard that there continue to be issues with the timeliness of information responses in some Divisions and that there is a correlation with Divisions quality staff resourcing.
he special support in place to focus on timely closure of complaints will cease and responsibility will be restored to Divisions, the committee will monitor the impact of this. The committee also continues to be **ASSURED** on the quality of responses as the Health Service Ombudsman continues to uphold a very low rate (less than 0.5%) of the escalations they receive. The Committee heard that the new Visiting Policy that significantly extends visiting hours from 10am to 8pm had been implemented and is hopeful that this will improve patient experience.

Patient Safety

At the March meeting the Committee **NOTED** the Q3 Patient Safety Incident Report. The Committee **NOTED** that there are emerging themes of matters coming to the Patient Safety Incident Review Group within moderate and severe harms are lost to follow up/treatment delay particularly in ophthalmology, mental health experience in the acute setting and rises in incidents relating to falls, skin pressure and moisture damage. The Committee took **ASSURANCE** from the continued progress on trajectory to report 60 patient safety incidents per 1000 hospital bed days that has been benchmarked as reflective of a positive reporting culture. The current reported rate is 54.69 per 100 bed days which is in line with the NRLS benchmark (2022). The Committee was **ASSURED** by the compliance with patient safety and medicine alerts issued through the Central Alerts System and acknowledged the oversight by Medicines Management Group. However, the number of overdue Patient Safety Incidents Reports is increasing monthly which again is linked to Divisional capacity but mitigations are in place with enhanced support and training.

The committee were updated on the reported Never Events in the last quarter but noted these remained a relatively low number for a Trust of this size. The Committee discussed the events which are being reviewed but not that there were no themes identified and that they had resulted in no or low harm. The Committee **NOTED** that the Trust has fully transitioned to the new investigation and reporting framework and that in this initial period there had been an increase in overdue parts of the process. As with Patient Experience, the Committee heard the improvement programme to integrate governance arrangements within Divisions seeks to ensure the appropriate resource and facilitate timely reporting to support it.

The Q3 Duty of Candour (DoC) Report was received, and the Committee was assured by detailed compliance monitoring with the 3 elements of the candour processes. While the Trust has very high compliance for the first 2 elements and is focussing on the third element of feeding back on investigations and discussion of reports with family. The overall average compliance score of the 3 components increased to 89.3% (Q2 87.6%). Compliance with the third stage had remained challenging for some divisions, however, it had been recognised that some investigations were complex and may take longer as a result. The Committee also received reports on Inquests and prevention of future death (PFD) notices and how the learning is taken from these into the Trust. The Committee **NOTED** the continued impact of the increase in the number and duration of inquest proceedings, particularly those with significant media profile, were having on staff and providers of the support being given as well as the reputational and financial impact.

Quality Assurance

The Director of Clinical Effectiveness supplied an interim Quality Assurance update report pending the full report **TO COME BACK** with the Q4 Clinical Outcomes and Effectiveness report on NICE guideline reviews, Technology Appraisals, National audits participation and assurance on changed practice and quality improvement for patients, NCEPOD, Clinical guidelines GIRFT review and action plans, Mortality reporting / Learning from Deaths. Following up on an item for attention from my last report, the update on the **TO COME BACK** assurances around the Sepsis subgroup with implementation of the updated policy will need to be included in my next report.

The Committee reflected on the progress across the breadth of this area that had been achieved over the past year and whilst there remain, sometimes significant gaps in compliance, for example in clinical documentation there is a clear understanding of the gap, and both plans and governance in place to address these. The committee **NOTED** the update that the NICE Guidance backlog had reduced and there was a focus on improvement plans to get towards full compliance. The Trust had participated in 97% of relevant clinical audits and the 19 at risk due to data or staffing issues having plans being put in place to progress these and 7 audits now had Quality Improvement plans in place. Again, the Divisional capacity to support this work programme is a challenge. I am pleased report there are no SJR's outstanding over 90 days or 60 days from referral

Safeguarding

In April, the Committee welcomed the substantive Associate Director of Safeguarding. The Committee received the Q4 Safeguarding Children and Safeguarding Vulnerable Adults reports for 2024/25. The Committee **NOTED** the progress on specialised Level 3 training and work taking place with Divisions to broaden uptake of this training. The target had been to achieve 85% compliance by end of year that had almost been achieved. The Committee recognises that patients with primary mental health needs staying in our emergency departments is a considerable risk to the Trust and the Safeguarding team are well sighted on their stay in the department. The committee were updated on the challenges relating to the care of Children and young people with mental health needs and long stays whilst waiting for care.

Executive efforts to request a summit with System partners on the issue of Children and Young People with mental health and emotional care needs has not yet led to a meeting date so I reiterate my earlier **ESCALATION** on this aspect. The committee were updated on system changes for data security by the Local Authorities which requires the Trust to adapt its way of working to have access to the relevant data.

The Committee welcomes the progress in rolling out the impactful and well received Communication and Interaction Training (CAIT) supporting staff to manage distressed behaviour and recognise unmet needs which enables staff to de-escalate situations and may help to retain staff who might otherwise leave if feeling

untrained to deal with the increasingly challenging and emotionally impactful work. The Committee **NOTED** the positive maternity service developments in safeguarding including the arrangements to prevent baby abduction.

Quality Impact Assessments

Following discussion at the Committee in previous quarters, an update on the quality impact assessments (QIAs) process was received with the reflection that the application of QIAs had been limited to financial saving plans on the 2024/25 efficiency programme. The Committee received and commented on a draft Trust policy on the use of QIAs to broaden the scope of the types of Trust Service to which they are applied and the Committee looks forward to receiving updates to future meetings.

Care Quality Commission (CQC) action plans

At the March meeting, the Committee reviewed the outstanding actions from previous CQC reports and further discussed the approach to the appropriate status recording.

The Committee **NOTED** the completed work programme and associated disestablishment of the Single Improvement Programme (SIP) Committee and gave our thanks to the Improvement Director who has supported the quality assurance of evidence.

In relation to actions arising from the 2023/24 report, the Trust had completed or moved into business as usual/work programmes 133 of 137 sub-actions. The Quality and Patient Committee NEDs undertook a review of a selection of actions to gain assurance of the process and evidence logged to sign-off the actions.

A proportion of the most-do/should-do actions have been completed, whilst others have been completed but recorded as “business as usual” (BAU) recognising the requirement for ongoing monitoring through established BAU governance processes and the committee will receive updates on these.
As referenced above for medical devices, work programmes have been put in place for those actions which were not achievable by the end of March 2025 including the implementation of electronic records and some relating to medicines safety, ventilation, staffing and medical devices management and will have oversight from the CQC Improvement Steering Group. The remaining outstanding sub actions in Q4 were: data for out of hours discharges being collated and acted upon; reducing the number of times patients are moved; and Infection Prevention and Control plans to roll out deep dives. The Committee **NOTED** that the Infection Prevention & Control update given to the April meeting reflected the deep dive planning.

I have highlighted to my fellow Committee Chairs a request that Committees with oversight of CQC actions in their respective remit continue to ensure their consideration of report visibility and corroboration of assurance that those items had been addressed and closed or are clear about their ‘in progress’ state. CQC reports from the Worthing Children and Young People inspection in 2024 and the recent RSCH and Worthing Maternity and RSCH ED inspections are awaited.

Facilities and Estates

In response to the quality impact of the risks and issues that are being identified relating to facilities and estates, the Chief Finance Officer as executive lead for Estates has attended further meetings of the Committee in Q4. The Committee **NOTED** the compliance dashboard maintained by the Estates team and learning from the Maternity Improvement Group will be used to develop the ‘Estates Improvement Group’ (EIG). The EIG has an action **TO BRING BACK** clear governance arrangements that also illustrate their links to the health and safety, finance and clinical forums and a milestone plan.

At the Committee's March Meeting, the Director of Estates & Facilities **NOTED** the Ventilation Safety Group Chair's report which noted positive steps forward with a multi-disciplinary approach to review the ventilation action plan. Key issues had been identified by the Group, however further operational clinical engagement was required to enhance discussions. A more rigorous permit to work process had been established across the Trust, ensuring appropriate timescales to undertake repairs in collaboration with Surgery divisions.
The Committee **NOTED** the Chair's Report from the Water Safety Group meeting and acknowledged it was less mature than the Ventilation Group, but it had established a process for identifying high risk areas of work and an action plan was being finalised

The Medical Devices Group had been re-launched in March 2025 with good representation across divisions. The Group's Terms of Reference had been revised and the Committee **NOTED** that the Estates Improvement Group would have oversight of the Medical Devices Action Plan. The Committee also received assurance from the Quality Improvement Director that the action plan covered all aspects of the CQC recommendations.

Infection Prevention and Control (IPC) Quarterly Report

At the February meeting, the Committee received the IPC report containing the validated data from Q3 2024-25. While the Q4 Report is due at the next meeting the Trust had seen a rise in health care associated infections: MRSA, E.coli, P.aeruginosa and C.difficile were above trajectory. C.difficile had exceeded the threshold for the year. Klebsiellas remain below target. Information from the national epidemiology commentary demonstrates that this aligned with the national picture.

At the April meeting, an interim report referring to February data was provided to the Committee and showed an unprecedented further spike in norovirus with an update that this also aligned with the national picture. The Committee had a detailed discussion about the implications for Theatre planning to accommodate the necessary estate works and IPC accreditation.

Fundamental Standards of Care

The Committee welcomed the first quarterly report on Fundamental Standards of Care (FSOC) across hospital wards. This represented good progress since the go-live in March 2024 in compliance against the completion of audits and the ability of ward teams to view a dashboard in key metric areas. This is now being rolled out in RSCH ED followed by our other ED's. Particular areas of progress included how Martha's Rule (access to second opinion for deteriorating patient concerns) had progressed with four pilot areas across RSCH and PRH for phase 2.

Visibility of fall and pressure ulcer rates and enabling analysis and recognition of issues including increase in medical device related pressure damage, management of moisture damage and gaps in medical photography service; Zero preventable Pulmonary Embolisms in month; Rollout of the Mouth care and Sepsis policies that were updated and the Monthly Nursing Quality Assurance Meeting had commenced. The Committee reflected on the previously reported inconsistency in hand hygiene data between IPC observed scores and division reporting that highlight the extent of assurance that can be taken. The committee asked for future plans to be shared where this is live in the Trust and analysis of the quality and safety assurance that can be taken.

Perinatal

At each meeting the Committee **RECEIVED** reports in respect of the Trust's Perinatal Quality Surveillance Reports & Dashboards for all four of its maternity units, which included the Ockenden data sets within the current dashboards. The Trust **NOTED** it had achieved the NHSE ambition set in 2017 to reduce the

stillbirth rate by 50% by 2025 with the aspiration of 2.5/1,000 births. The service has exceeded this target achieving 1.05/1000 births.

The Committee **NOTED** peri-natal mortality and brain injury rates have reduced at UHSussex to reaching less than half the national average. The Committee reflected on this showing the positive impact of the Saving Babies Lives safety bundle and the benefit of the focussed leadership and clinical governance in the Women & Children's Division that has shown the potential for safety through what has also been recognised to have had substantial investment.

The Committee **NOTED** the contents of the reports and **APPROVED** the latest scorecards that are provided to the Board.

The Committee considered each of the dashboards across each of the domains of; learning from incidents; training; and the voice of the service user. The Committee **NOTED** progress within the considerable Maternity Improvement Plan, improved vacancy position within the clinical teams and increased capacity of leadership teams has been pivotal in this progress. There is much to still achieve, however, momentum and trajectory are very encouraging. The Committee **RECEIVED** the Q4 Maternity Serious Incident Report and were **ASSURED** the serious incidents had been investigated fully and lessons learnt across the Trust. It was also assured by the reported full implementation of the Saving Babies Lives care bundle and the quality improvement plans in place.

The Committee received updates on progress towards the Trust's year 6 CNST Maternity Incentive Scheme submission. The Committee **NOTED** the progress toward seeking a solution not yet found for theatre access for C-Sections. The Committee sought assurance that theatre access is being addressed at all levels and will continue to look to further updates from the executives.

<u>Divisional Deep Dives</u>
These deep dives enable the committee to understand quality and safety risks and challenges faced by the Divisions at a more granular level and triangulate this with the standard reports received by the committee to gain assurance. As Chair I take the opportunity to visit the Divisions presenting to gain first hand insight into the achievement and challenges and to talk to staff to triangulate the reporting received.
At the February meeting the Committee had a deep dive into **Specialist Division's** challenges

The Committee was able to **NOTE** that the division had established a clear and defined governance structure as illustrated in the report and positive culture of reporting with levels of patient safety and incident reporting rising over time. There had been an increase in moderate and severe harms, all of which had been addressed and closed. The complexity was noted for this division as patient safety investigations often require input from more than one division and added patient concern linked to the historic cases that are the subject of police Operation Bramber which had led to delayed closure of investigations with particular impact on the specialties of Neurosurgery, Major Trauma, Spinal and Plastics.
The Division had undertaken considerable work focussed on patient experience with a proactive approach taken with recognition of the added apprehension patients otherwise have due to the publicity around Operation Bramber.

There had been good progress on Quality Assurance in the Division backlog of NICE guidance and ensuring active participation in audits. It had been identified that some Directorates within the Division had struggled to identify the necessary Quality resource to make the work robust and sustainable. Similarly, further improvement was needed in engagement to ensure timely risk register reviews, this had been recognised as an area requiring further work.

The Committee discussed the drop in stroke care accredited standards (SSNAP). The performance in key domains had been constrained by the current configuration and workforce establishments, notably in therapies, as well as criteria for Early Supported Discharge. There had been universal poor performance against Standard 2 (Stroke Unit) which related to the difficulty in admitting a patient to a stroke ward within 4 hours given pressures in the emergency departments. The Committee understands that plans for the Major Projects governance includes a focus expected on stroke service reconfiguration and the committee recommended a quality focussed paper accompanies this. An update on the quality improvement plan for the care of stroke patients is **TO BE BROUGHT BACK** in Q3.

Risks

The Committee reviewed the Trust's key risks with the potential to impact on quality and noted those with the highest current score and their alignment to the areas that the Committee had continued to scrutinise for assurance. The Committee recognised a continued increase in the number of the highest scoring risks. In part these reflect disaggregation of previous risks from Emergency Department crowding and associated corridor care at different hospital sites and reflecting differential patient harm or patient experience implication Challenged capacity for scanning due to national workforce pressures had also been recognised by multiple divisions. The implications of caring for patients whose primary needs are mental health or emotional issues i the inappropriate care setting is recognised among the Trust's highest scoring risks.

Quality Governance Steering Group (QGSG) and Quality Scorecard

The reports from QGSG included divisional summaries, as well as safety and quality domain summaries plus updates against the CQC action plans. The Committee welcomed the plan to address the risks around Trust Mortuary facilities and compliance with HTA/Fuller requirements following up on issues highlighted in my previous report. It was NOTED detailed reports had been received via QGSG around Medicine safety and progress in Harm Reviews had been made with the cancer harm review process Reflecting on the Risk Register update and division reports to the QGSG the Committee **NOTED** the top risk themes and the addition of a top rated risk relating to provision of Mental Health Services for Children and Young People.

At the March meeting, the Committee **NOTED** the acknowledgement from the Royal College of Surgeons on the updates given by the Trust in response to actions taken to address the recommendations made in their report issued on 17 January 2024. The report was on the general surgery department, with a focus on emergency general surgery, upper gastrointestinal surgery and lower gastrointestinal surgery, following the RCS England invited service review commissioned by the Trust and undertaken on 24-26 May 2023 that was taken to Trust Board. This showed all urgent patient safety recommendations and service improvement recommendations had been responded to.

It was **NOTED** that the quality management resources to support the Divisions has been delayed awaiting the outcome of the target operating model work. The committee asked for an impact assessment at the next meeting as this will affect the ability of Divisions to comply with quality and safety standards and embed learnings from the processes as outlined in my report.

Referrals to other Committees

There were no formal referrals to other Committees during this period

Key Recommendation(s):

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

The Board is also invited to **NOTE** the following items were received and are commended to the Board:

- Perinatal Quality Surveillance Update (to receive and note)
- Saving Babies Lives Q4
- Perinatal Workforce Report
- Patient & Quality Learning from Deaths Q3 (to receive and note)
- Patient Experience Report Q4
- Safeguarding Children & Safeguarding Vulnerable Adults Report Q4

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**25 February 2025**	**Chair**	Lucy Bloem	**Quorate**	Yes
Meeting Date	**25 March 2025**	**Chair**	Lucy Bloem	**Quorate**	Yes
Meeting Date	**29 April 2025**	**Chair**	Lucy Bloem	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Focus, Operation and Priorities of the Committee						
QGSG reports	**Feb**	**Mar**	**Apr**	**Presenter** Chief Medical Officer/ Dep. Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted.
Quality Dashboard (excluding Maternity) Safety, Effectiveness Experience, Mortality	**Feb**	**Mar**	**Apr**	**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted.
Patient Experience Report Assurance Report Q4 2024/25 Report (Apr)			**Apr**	**Presenter** Director Patient Experience & Engagement	**Purpose** For information	**Outcome /Action taken** Noted
Safe, Effective, Caring, Well Led and Responsive						
Patient Safety Assurance Report Q3 2024/25 (Mar) Patient Safety updates and MedicoLegal Update (Feb/Mar)		**Mar**	**Apr**	**Presenter** Chief Nurse / Deputy Director Patient Safety & Learning	**Purpose** For information	**Outcome /Action taken** Noted
Infection Prevention & Control Assurance Q3 2024/25 Report (Feb) M11 Update (Apr)	**Feb**		**Apr**	**Presenter** Director Infection, Prevention & Control	**Purpose** For assurance	**Outcome /Action taken** Noted.
CQC Update / Action Plans	**Feb**	**Mar**	**Apr**	**Presenter** Chief Nurse/ Director of Patient Safety & Learning	**Purpose** For information	**Outcome /Action taken** Noted
Safeguarding Adults and Children 2024/25 Q4 Report			**Apr**	**Presenter** Chief Nurse/ Director of Safeguarding	**Purpose** For assurance	**Outcome /Action taken** Noted.
Divisional Spotlights: Specialist	**Feb**			**Presenter** Division Chief of Service/ Director of Nursing	**Purpose** For information	**Outcome /Action taken** Noted. SSNAP issues explained action closed. **Action** to provide update on quality improvement plan for care of stroke patients by Aug'25
Quality Assurance Report Including Clinical Outcomes & Effectiveness Group Reports			**Apr**	**Presenter** Chief Medical Officer/Director of Clinical Outcomes & Effectiveness	**Purpose** For assurance	**Outcome /Action taken** Noted

Facilities and Estates Ventilation, Water and Medical Devices updates Backlog Maintenance (Feb) Estates Improvement Group (Terms of Reference) (Mar)	**Feb**	**Mar**		**Presenter** Director of Estates and Facilities / Chief Finance Officer	**Purpose** For information	**Outcome/Action taken** Noted. Approved Estates Improvement Group terms of reference (Mar)
Quality Impact Assessments		**Mar**		**Presenter** Chief Medical Officer / Chief Finance Officer	**Purpose** For discussion	**Outcome /Action taken** Noted. Expanded QIA Scope in new Policy (to June)
Deep Dive - Facilities & Estates (Feb) CQC Action Delivery (Mar)	**Feb**	**Mar**		**Presenter** Chief Finance Officer / Dir Facilities & Estates Chief Nurse/ Director of Improvement (Quality)	**Purpose** For assurance	**Outcome /Action taken** Noted.
Perinatal Quality Surveillance Report and Dashboards Q3 2024-25 (Feb). Updates on Jan'25/Feb'25 data (Mar/Apr)	**Feb**	**Mar**	**Apr**	**Presenter** Director or Midwifery / Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
CNST Maternity Incentive Scheme Year 6 Declaration update. Update on Year 7	**Feb**			**Presenter** Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Maternity Claims Scorecard Q3 2024/25	**Feb**			**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted
Perinatal Mortality Review Tool (PMRT) Q3 2024/25	**Feb**			**Presenter** Director of Midwifery/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Maternity Patient Safety Outcomes Report inc Serious Incidents Q4 2024/25			**Apr**	**Presenter** Director of Midwifery/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Perinatal Workforce Report			**Apr**	**Presenter** Director of Midwifery/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Foetal Wellbeing / Saving Babies Lives Review Quarterly Report Q3 2024/25		**Mar**		**Presenter** CNO/ Director of Midwifery/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Risk						
Trust Risk Register relating to Patient & Quality (* Summary of changes only, between Quarterly meetings)	**Feb***	**Mar***	**Apr**	**Presenter** Chief Medical Officer / Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted

Actions taken by the Committee within its Terms of Reference	
The Committee received Patient Experience Quarterly Reports and the Annual Inpatient Survey The Committee received the Safeguarding Quarterly Report The Committee received the Patient Safety Incident & Duty of Candour and Medico-Legal Quarterly Report The Committee received the Medicines Management Quarterly Report	
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)	
▪ Infection Prevention and Control Q4 Report ▪ Endoscopy Accreditation (JAG) Action Plan (delayed to QGSG May 2025) ▪ Plan for Health Inequalities Reporting (Quarter 1 2025/26) ▪ Quarterly Quality Impact Assessments summary to be provided to the Committee to provide evidence and assurance of the QIA process and highlight escalations where necessary (Quarter 1 2025/26). ▪ Update of the Committee sub-group reporting structure and oversight arrangements.	
Items referred to the Board or another Committee for decision or action	
Item	**Date**
The Quality Committee invites the Board to **NOTE** the following: The Board is also invited to **NOTE** the following items were received and are commended to the Board: - Perinatal Quality Surveillance Update (to receive and note) - ATAIN & Transitional Care (to receive and note) - Patient & Quality Learning from Deaths Q3 (to receive and note) - Safeguarding Reports Q4 (to receive and note) - Patient Experience Report Q4 (to receive and note)	**May 2025**

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	13.	**Meeting:**	Trust Board in Public	**Meeting Date:**	08 May 2025
Report Title:	People and Culture Assurance Committee Chair's Report				
Sponsoring Executive Director:	Paul Layzell, Non-Executive Director				
Author(s):	Paul Layzell, Non-Executive Director				
Report previously considered by:					

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

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

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

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	N/A	
Sustainability	N/A	
People	Yes	People Risks 3.1 and 3.2
Quality	N/A	
Systems and Partnerships	N/A	
Research and Innovation	N/A	

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The People and Culture Assurance Committee met on the 25 March and on the 30 April 2025. The Committee was quorate at both meetings as was attended by at least two Non-Executive Directors and two Executives Directors. In attendance at these meetings were the respective report presenters including the Director of Human Resources, Director for Integrated Education, and the Associate Director of Leadership, Culture and Development. The Director of Workforce Planning & Deployment attended the March meeting.

The April meeting was a full quarterly assurance meeting and covered all areas within the Committee's remit and received, discussed and noted the expected papers that are listed at the end of this report.

At the start of the March meeting the Committee chair reflected on the need for timely paper delivery and for increased focus on the key messages being conveyed within the papers.

At the March meeting the Committee received its planned items including the 2025/26 People Promise Priorities, the NHS National Staff Survey results, the EDI year 3 strategy, an update on the Trust's Cultural Programme along with the People Compliance Assurance Framework and a deep dive review into staff sickness. The Committee also structured its meeting agenda to allow for papers providing follow up information on the recruitment and deployment of locally employed doctors, speciality and specialist doctors and fixed term consultants and a paper on the outcome of NHS England Quality Improvement of the Trust's knowledge and library services confirming compliance with all the expected standards.

The key areas of focus for the Committee at its March and April meetings are listed below, noting the full breath of the meeting's activity are included in a table at the end of this paper.

People Performance Overview Report.

The Committee continued to **receive** a report from the Chief People Officer providing a high level summary of the work undertaken across the Trust within the people domain. The report also allowed the Committee to consider the focus of the papers being presented to the meeting and receive an overview of the Trust's people metrics scorecard. The Committee noted the wider national work covering the workforce productivity arena.

The Committee considered the People scorecard and that many of the metrics showed stable performance in the quarter but with a continuing rise in sickness levels and a recovering position relating to staff engagement from a drop in August 2024.

The Committee **noted** the update and the background it provided to the rest of the meeting items.

Also at the April meeting there was recognition that the Operational and Financial Plans for 2025-26 and the Trust Strategy 2025-30 may have implications for certain People Performance measures becoming particularly pertinent for Committee scrutiny and an item around potential adjustments would be **brought back**. There was particular reference to Job Plans and appraisals, with work taking place at pace and that these discussions give an opportunity to restate Trust values and confirm expectations.

People Promise Priorities 2025/26

The Committee in March **received** a report on the Trust's people plan priorities and how these map to the Trust's people promises. The Committee **noted** the alignment of these priorities with the outcomes of the staff survey, and was **assured** that the people plan and people promises will be aligned to the Trust's 2030 strategy prior to its finalisation. At the April Meeting, the Committee noted that work had taken place to refresh reporting arrangements and improvement project progress.

The Committee asked about the plan for the reporting of the monitoring of the delivery of these promises and **was provided with assurance** that that the Committee will receive routine reporting through a multi dimensional scorecard against each promise. The Committee acknowledged the assurances and asked for a schematic **to be brought back** that reflected some of the broader assurances around the people and culture work connected to both people strategic objectives where these sought to support other elements of the Trust strategy.

Health and Wellbeing Update

The Health & Wellbeing programmes provide a key enabler for the new Trust Strategy and reflect the commitment to support our staff to be healthy and happy at work. At the April meeting, the Committee **noted** that work on Reward & Recognition and Violence Prevention had further progressed in 2024/25 through the Culture Programme, led by the Chief of Culture & OD. The Committee **noted** the report that gave an update on Year 3 delivery of the Trust's plan, including progress against agreed priorities, triangulation with Health & Wellbeing elements of the 2024 NHS Staff Survey, and forward planning for reassessment against the NHS Health & Wellbeing Framework. In particular, the Committee discussed the triangulation of staff survey data with local measures with particular discussion with clinical members on the factors around workplace stress, what can be done to mitigate these and how the new Strategy should help.

Update on Post-Merger Employment Harmonisation Issues

Since University Hospitals Sussex was formed by merger in 2021-22, the Trust had addressed a number of complex legacy harmonisation issues through a series of strategic initiatives, including organisational restructuring, policy standardisation, and targeted staff group role/banding reviews. The Committee **noted** the progress made, acknowledging the operational and cultural complexities.

NHS University Hospitals Sussex NHS Foundation Trust

NHS Staff Survey

The Committee **received** the report at the March meeting, noting that the outcomes had plateaued since last year. The Committee reflected on the Trust's results and national benchmark comparisons and considered those areas which had seen the most reduced score for 2024 and the plans for development of focused improvement plans, along with a reflection on those areas where improvements had been seen and the potential link to the work having been undertaken in respect of the Trust appraisal processes.

The Committee **noted** the work being undertaken and the discussion that will be had at the Board in March and the developing plans to utilise the feedback for improvement and discussed how the Board will be able to test how these improvement actions support the people dimension of the Trust's 2030 strategy.

Integrated Education Update

The Committee in its meeting in April received **assurance** that the trainer survey results are incorporated into the Trust's improvement plans. Insights were provided from the National Education and Training Survey (NETS) capturing multiprofessional feedback from all undergraduate and postgraduate healthcare learners on placement or in training posts and while the participation rate was low and coincided with learner rotation, it had been triangulated with other survey results highlighting opportunities for improvement. The Committee noted Medical Leadership posts in medical education had been fully appointed to.

The Committee asked for a future item on the quality assurance arrangements for education programmes.

The Committee noted that work was underway to develop an educational partnership that would complement our existing partnerships. The new partnership targeted specific areas to help educational provision for our staff not covered elsewhere, The Trust is awaiting final confirmation of the new, additional arrangement and it is expected that this will be confirmed in early summer 2025.

Compliance Assurance Framework

The Committee at its March meeting **received** the developed people compliance assurance framework. The Committee was updated as to the underpinning processes of management checks and audit assurances that feed into the assured confidence levels recorded within the document. The Committee also heard from the people team as to how this reviewed by the various operational management teams to ensure it gives a timely focus for their improvement work. The Committee **secured confidence** of the management processes applied and how this is captured within the detailed framework.

The Committee discussed with the Chief People Officer the value of receiving a summary giving an overview of the strength of assurance held by management and report by exception the gaps or where assurance is showing weak systems of control. The preparation of this routine reporting was agreed.

Nursing and Midwifery Safer Staffing Report Jan 2024 – Jan 2025

In April the Committee received a report that provided a review of ward staffing levels across all inpatient ward areas using the Safer Nursing Care Tool. The committee was **assured** that the SCNT had indicated that staffing levels were predominantly sufficient while in some cases had been achieved through additionality (bank or agency) for which outturn funding has been given for each division in 2025/26.

EDI year 3 strategy refresh

The Committee at its March meeting was updated by the Head of Inclusion on the report provided. The Committee reflected that the paper showed the plans for the 3rd year priorities of the Trust's EDI Strategy. The Committee provided feedback on the document especially in respect of the ambition and the potentially extensive level of metrics included within the document, which the Head of Inclusion agreed to incorporate

into the final document as it is aligned to the developing wider 2030 Trust Strategy. The Committee **noted** the plan covered the 6 high impact actions from NHS England and a local 7th priority aligned to digital inclusion for the Trust's staff. The Committee **agreed** to the establishment of a Workforce Inclusion Steering Group to oversee the delivery of this work and for this group to provide a routine report to the Committee.

Sickness Absence Update

The Committee in its March meeting **received** a report which provided insight into the Trust's staff sickness levels. Whilst 2023 sickness absence levels had fallen and risen in 2024, these were comparable to other NHS providers in the system, but higher than the SE region overall.

The Committee considered the actions being proposed to support staff to return to work with a focus on short term sickness and support to staff to enable them to remain at work and was **assured** by the update from the Director of Human Resources how these actions align to the people plan and promises.

Culture Update

The Committee **received** updates on the work led by the Chief Culture and Organisational Development Officer and Director of Integrated Education who is the workstream SRO. The Committee was **updated** on the six workstreams and **noted** the work undertaken to transition from the work within the single improvement plan to the business as usual processes with regular reporting to the Committee.

The Committee reflected on the recorded risks to the programme and asked these be reviewed to better align to the BAF strategic cultural risk.

At the April meeting the Committee acknowledged the highlight report remains work in progress while recognising deliverables will be on medium to long term timescale but is important for the board to have the oversight it needs.

At the April meeting, there was a deep dive into the internal communications and infrastructure arrangements that are key to the Culture programme. The Committee heard about the enthusiasm for the new intranet site and had a discussion about key ways in which staff engaged with Trust messaging. The Committee **noted** the recommendations, analysis and proposed actions and **asked for an update** in Quarter 3.

Risk Register relating to people

The Committee at both its meetings received and **noted** the key people related risks

Referrals to other Committees

The Committee considered the reports and presentations it received at its meetings and **agreed** there were no matters it needed to refer to any other Committees.

Key Recommendation(s):

The Board is asked to **NOTE** the assurances received at the Committee and the Committee's input into the developing EDI 3 year priorities and feedback into the structure and content of the compliance assurance framework reporting.

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	25 March 2025	**Chair**	Paul Layzell	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting			
People Performance Overview including People Scorecard	**Presenter** Chief People Officer	**Purpose** For discussion and assurance	**Outcome /Action taken** Utilised the overview to bring focus to the meeting. Noted the recorded performance showing a broadly stable level of performance across the broad range of indicators.
People Promise Priorities 2025/26	**Presenter** Director of Human Resources Management People Promise Manager	**Purpose** For discussion and agreement	**Outcome /Action taken** Reviewed the proposed people promise priorities for 2025/26 and the linkage of these to the Trust's overarching people plan. The Committee recognised the work to be undertaken to align the respective people plan with the Trust 2030 strategy.
National Staff Survey Results	**Presenter** Chief People Officer	**Purpose** For discussion	**Outcome /Action taken** Received the report which showed a broadly plateaued picture regarding the scores, with the notable exception of working flexibly where staff indicated they were better supported in this area than in the prior year and the areas of advocacy for care that the staff are able to provide and recommending the Trust as a place to work were reduced.
People Compliance Assurance Framework	**Presenter** Chief People Officer	**Purpose** For discussion and assurance	**Outcome /Action taken** Noted the development of the framework and the underpinning processes. The Committee also provided information on the developing committee reporting scorecard.
EDI year 3 strategy refresh	**Presenter** Head of Inclusion	**Purpose** for discussion and input	**Outcome /Action taken** The Committee received the report providing information on Trust's year 3 EDI plan and were assured over its alignment to the National EDI priorities and duties under the

			Public Sector Equality Duties linked to the Equality Act 2010. The Committee agreed to the establishment of a Workforce Inclusion Steering Group to oversee and report delivery against these priorities.
Sickness Absence update	**Presenter** Director of Human Resources Management	**Purpose** For discussion	**Outcome /Action taken** Received an update on the current sickness absence rates, analysis of these, and the current Trust system of internal control to manage sickness absence The committee secured confidence in the improvement actions and their alignment to the overall aim of reducing the absence levels and supporting staff well being and ability to remain at work.
Cultural Programme Update	**Presenter** Chief Culture and Organisational Development Officer	**Purpose** For information and noting of actions being taken	**Outcome /Action taken** Noted and took confidence that the feedback from the work has driven the Employee value proposition for inclusion within the Trust's developing strategy
Risk Map of Post Merger People Process Harmonisation issues	**Presenter** Chief People Officer Chief Culture and Organisational Development Officer	**Purpose** For information and assurance	**Outcome /Action taken** Noted that a further report will come back to the Committee.
Update on the recruitment and deployment of locally employed doctors, speciality and specialist doctors and fixed term consultants	**Presenter** Director of Workforce Planning And Head of Medical HR	**Purpose** For information	**Outcome /Action taken** Noted the report provided confidence that the agreed actions reported to a previous committee remain on track.
NHS England quality improvement report on Knowledge and Libraries	**Presenter** Director of Integrated Education	**Purpose** For information	**Outcome /Action taken** Noted that the Trust is complaint with all the 16 essential indicators within the NHS E framework.

Meeting Details					
Meeting Date	30 April 2025	**Chair**	Paul Layzell	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

People Performance Overview including People Scorecard	**Presenter** Chief People Officer	**Purpose** For discussion and assurance	**Outcome /Action taken** Utilised the overview to bring focus to the meeting. Noted the recorded performance showing a broadly stable level of performance across the broad range of indicators.
Alignment of Annual People Plan and People Promise Priorities 2025/25 with Trust Strategy	**Presenter** Chief People Officer	**Purpose** For discussion and assurance	**Outcome /Action taken** Noted the mapping and alignment of the Annual People Plan and People Promise Priorities 2025-26 with Trust Strategy and assurance that the 25-26 planned activities and programmes are aligned. Action to bring a schematic on assurances
Health and Wellbeing Programme Update	**Presenter** Chief People Officer	**Purpose** For discussion and noting	**Outcome /Action taken** Noted the update that confirmed Reward & Recognition and Violence Prevention workstreams had further progressed in 2024/25
Post-Merger Employment Harmonisation Issues Update	**Presenter** Director of Human Resources	**Purpose** For discussion and assurance	**Outcome /Action taken** The Committee **noted** the ongoing project work.
Culture Programme Communications & Engagement Update	**Presenter** Chief Culture and OD Officer / Director of Communications & Engagement	**Purpose** To discuss, provide assurance and agree action	**Outcome /Action taken** Noted the update. The highlight report remains work in progress Noted the recommendations, analysis and proposed actions and asked for an update around the Comms work to be brought back in Quarter 3.
Integrated Education Update Including Chichester University Partnership - National Education and Training Survey (NETS) 2024	**Presenter** Director of Integrated Education	**Purpose** To discuss, provide assurance and agree action	**Outcome /Action taken** Noted the update including the NETS training survey results and triangulation. Action to arrange a future item considering Quality Assurance of Education programmes.
Patient First Improvement Programme Update		**Purpose** To note and provide assurance	**Outcome /Action taken** Noted the assurance provided

Guardian of Safe Working Hours Annual report 2024/25 (including Q4 2024/25 reporting)		**Purpose** To note and provide assurance	**Outcome /Action taken** Noted the assurance provided
Nursing and Midwifery Safer Staffing Report Jan 2024 – Jan 2025*		**Purpose** To discuss and recommend the report goes to Trust Board	**Outcome /Action taken** Noted the report that provided a review of ward staffing levels across all inpatient ward areas using the Safer Nursing Care Tool. Will report to Trust Board
Medical Appraisal Update*		**Purpose** To note and provide assurance	**Outcome /Action taken** noted the update and assured that medical appraisal rates are improving.
Terms of Reference review of Committee Terms of Reference, including: - Committee Annual Schedule of Business 2025/26	**Presenter** Chair	**Purpose** To Agree	**Outcome /Action taken** The Committee agreed the terms of reference are sufficient for 2025-26. Noted the schedule of business
Updates from reporting groups - JNCC - JLNC - Nursing and Midwifery Group - EDI Committee	**Presenter** Chief People Officer	**Purpose** For discussion and noting of actions being taken	**Outcome /Action taken** The Committee noted the updates and took confidence that there were no specific actions escalated from any of these groups
Updates on Integrated Care System	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** The Committee noted the update
People Risks update	**Presenter** Chief People Officer	**Purpose** To note	**Outcome /Action taken** The Committee noted these

Actions taken by the Committee within its Terms of Reference
The Committee **AGREED** to the establishment of a Workforce Inclusion Steering Group to oversee the delivery of this work and for this group to provide a routine report to the Committee.
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)
Report on adjustments to People Performance measures in light of Trust Strategy and Operational Plan Schematic on People Promises Assurances to come back to Committee. Internal Communications Update as part of Culture Programme in Quarter 3 2025/26
Items referred to the Board or another Committee for decision or action
Item
The Committee agreed there were no specific items referred to another Committee for action.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	14.	**Meeting:**	Trust Board in Public	**Meeting Date:**	08 May 2025
Report Title:	Finance & Performance Assurance Committee Chair's report to Board				
Sponsoring Director:	Philip Hogan, Committee Chair, Non-Executive				
Author(s):	Philip Hogan, Committee Chair, Non-Executive				
Report previously considered by:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	N/A
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	N/A	Staff confidentiality	N/A
Patient confidentiality	N/A	Other exceptional circumstances	N/A

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

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	N/A	
Sustainability	Yes	Assurances in relation to risk 2.1, 2.2 and 2.3
People	N/A	
Quality	N/A	
Systems and Partnerships	Yes	Assurances in relation to risk 5.1, 5.2 and 5.3
Research and Innovation	N/A	

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Finance & Performance Assurance Committee (FPC) brings together matters within the Trust's Patient First Sustainability and Systems & Partnerships Domains and has met in February, March and (1st) May (the latter being the April Meeting). Each Meeting was quorate, and the April meeting was a full quarterly committee and covered all areas within the FPC's remit and received, discussed and noted the expected papers that are listed behind this report.

The papers related to the Trust's Sustainability True North, a Quarter 4 finance report, the Efficiency Programme, the Capital Programme, Operational Performance including the performance against constitutional standards, Commercial team activities including procurement, an ICS finance update and discussion of key risks.

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

True North Financial Performance Report - Quarter 4 2024/25 Financial position

At each meeting, the FPC received a report from the Chief Financial Officer on the financial position against the Trust's Deficit financial plan. The report showed that the Trust had month on month and year to date adverse variance against the plan.

The FPC discussed and **NOTED:**

- In the year to M12 the Trust incurred an actual deficit of £49.5m. The Trust has received £19.5m of deficit support funding, leaving an unfunded deficit of £30.0m; this is in-line with the agreed forecast position.
- Continuing the performance from Q3, consistent month on month deficit performance within -£4.5m through months 10 and 11 had enabled that agreed forecast position to be achieved.
- The enhanced grip and control measures enacted since quarter 1 that form part of the financial recovery process had continued to slow run-rate increases. The Committee has received detailed Grip and Control reports at each meeting with particular focus on workforce including bank and agency usage. Proposals for additional reporting on compliance with controls were also considered.
- The most significant in-month and year to date drivers of the adverse position to the plan were: Additional costs of support for patients with mental health needs, high cost drug expenditure in excess of the block contract including the net impact of unfunded change to Insulin Pump usage resulting from NICE guidance, and open escalation beds above the funded capacity.
- At month 12 the efficiency programme in-month delivery of £28.19m was £16.24m favourable to plan. This brought full-year delivery to £76.03m, £13.48m adverse to plan. The enhanced grip and control arrangements had led to a reduction in whole time equivalents worked across the Trust, however the pay bill had continued to increase. Agency costs remained below the agency ceiling but are still prevalent in hard to recruit and challenged specialities and spiked in M12 with the cause still to be understood. Pay expenditure at year to M12 was £16m adverse to plan, driven by £3.1m adverse variance against anticipated pay efficiencies and Healthcare assistants banding uplift costs.
- As a result of this support, the Trust has been able to stretch its cash resources. Hence while the BPPC performance has dropped since 2023/24 from maintaining a level close to the notional 95% target to 76% in March 2025, the drop has not been as steep as it would have been without this support. The Trust has modelled various scenarios for manging supplier payments showing projections with and without deficit cash support. These are shown in the trade creditors with and without deficit support graph. Without cash support, trade creditors are forecast to rise over £74m by 24 June 2025, from a balance of c£52m forecast creditors as at 31 March 2025.
- The Cash position is below plan. Cash management has remained a key area of focus as the year progressed and further cash support has been sought from NHS England. The Trust's cash application for March 2025 was not approved on the basis the Trust received additional funding allocations from the ICB.
- The better payments practice code performance had fallen below the target level and remained below the target level in Q4 although performance had steadied since January with the received cash support and the FPC was provided with assurance local small enterprises did not suffer detriment.

At each meeting, the FPC spent considerable time discussing the financial position and recovery plans and discussed and **NOTED**:

- Work on financial improvement and recovery continued in the previously reported areas:
  - Stabilising the financial position, preventing further deterioration with enhanced spend controls.
  - Bridging the gap in the financial position – with Trust wide Financial Recovery Workstream opportunities evaluated and implemented with support from the efficiency team.

- Addressing the underlying deficit - undertaken as part of the strategy development work.

The Committee noted the continued governance arrangements for close oversight of the key issues through the Financial Recovery Delivery Board with several focussed sub-groups including for coding and cash.

Capital Investment Progress Report Quarter 4

The FPC **RECEIVED** the Q4 update against the Trust's 2024/25 capital plan and the forecast outturn.

The FPC **NOTED:**

- The programme had been underspent in earlier reports to the committee but by M12 the full £92 million funds available had been spent in year save for a £10k variance.
- The risk associated to the timing risk of the delivery of the project to connect to the Worthing Heat Network had been overseen by the Capital Investment Group Monthly meetings with oversight of the Chief Financial Officer. This remains the primary basis for the underspend risk and had to be significantly mitigated by other programmes. Work to manage the risks to the grant funding timescales have been discussed by the Board since the last Committee report. The FPC received a progress update at the April Meeting and continue to closely monitor impact on 2025/26.

2025/26 Operational and Financial Planning

At each meeting, the FPC has given particular focus to the plans for 2025/26 including the commitments for operational activity and performance, workforce, capital and efficiency delivery. At the April Meeting, ahead of a required submission date ahead of this Board meeting, the Committee invited other Board Members to a detailed discussion of the 2025/26 Operational and Financial Plan. The Committee **AGREED** to endorse a refreshed submission of a plan that is balanced to be submitted to NHS England. The Board is asked to ratify this decision.

ICS Update

The March and April meetings of the FPC **RECEIVED** an update on the Integrated Care System (ICS) financial position and the proposed system wide work to review how the system improves its services to our population in line with the national initiative to move towards more integrated care, improved prevention and primary care services, reduced health inequalities, better outcomes and a sustainable financial position. Discussed in the planning work, there has been increased financial recognition of mental health and no criteria to reside patients in UHSussex hospitals as a system challenge that the Trust had to date been exposed to.

The Sussex Strategy Committees in Common met in early February where there was discussion of priority areas of work for collective support following the analysis work outlined in the previous report.

Operational Performance

Each meeting the FPC **RECEIVED** a detailed report on the Operational performance of the Trust including the constitutional standards set by NHSE.

The FPC **NOTED:**

- All the performance reports and action plans are subject to significant internal and external scrutiny because of the Tier 1 and 2 oversight arrangements currently imposed on the Trust. The Trust remains in Tier 1 oversight for RTT and Cancer performance and in Tier 2 oversight for Urgent Care. Improvement performance progress in Cancer and Diagnostic has indicated their oversight may exit

- Overall Trust performance against all the constitutional standards remained challenging and whilst some progress has been made against UEC targets this has not always been sustained, The Trust was generally below national targets. At the April meeting, a refocussing of plans was suggested.
- The Trust continues to make good and significant progress on the waiting lists and is sighted on how each is closely managed and the events and situations that gave rise to original waiting list growth are understood. The Committee acknowledged that the profile of the waiting list means the numbers waiting over 65week waits will increase at times but at M12 the trust had exceeded its trajectories and had continued to reduce both the overall waiting list and the longest waiting patients.

Commercial Progress Report Quarter 4

The FPC **RECEIVED** a comprehensive report on the commercial activity in Q4 at the April meeting that included an update on the work to deliver the existing commercial strategy. A new Commercial Director had identified further opportunities to accelerate progress and **NOTED** the innovation pipeline. The Committee discussed around for strengthened governance arrangements around Retail and discussed the Trust's wholly owned subsidiary company arrangements. I am the Trust's representative on the Pharm@Sea Board. The FPC **NOTED** that the Procurement & Supply Chain strategy aligns with the new Trust Strategy.

3Ts

At the February meeting, the FPC had a detailed update on the overall 3Ts programme and welcomed news that the Phase 2 Sussex Cancer Centre would continue to receive New Hospitals Programme support with the expectation that the new Cancer Centre would commence its operations in 2029. The Committee **NOTED** the continued progress of the scheme including the ongoing work to assure the capital and revenue costs and affordability.

Risks

The FPC **AGREED** the reports and discussions accorded with the key risks and their linkage to its oversight of the Board Assurance Framework strategic risks allocated to it triangulated with the reports received.

Referrals to other Committees

The FPC considered the reports and presentations it received at each meeting and **AGREED** there were no matters that they wished to refer to other Committees.

Key Recommendation(s):

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

The Board is asked to **RATIFY** approval of the refreshed Submission of the Trust Plan for 2025/26 to NHS England

FINANCE & PERFORMANCE COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Date	**27 February 2025**	**Chair**	Philip Hogan	**Quorate**	Yes
Meeting Date	**27 March 2025**	**Chair**	Philip Hogan	**Quorate**	Yes
Meeting Date	**1 May 2025 (April meeting)**	**Chair**	Philip Hogan	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Sustainability True North Financial Performance Report Quarter 4 2024/25 - Updates Provided in Feb 2025 for Month 10 & Mar 2025 for Month 11	**Feb**	**Mar**	**Apr**	**Presenter** Chief Finance Officer	**Purpose** For assurance	**Outcome /Action taken** Noted M12 position and delivery that was in line with the agreed forecast position. Noted board briefing on Annual Accounts to address technical M12 adjustments
Efficiency & transformation Programme. Efficiency Report Quarter 4 2024/25 - Updates Provided in Feb 2025 for Month 10 & Mar 2025 for Month 11	**Feb**	**Mar**	**Apr**	**Presenter** Chief Finance Officer / Efficiency Director	**Purpose** To inform the committee on the update on the 2024/25 plan delivery	**Outcome /Action taken** Noted significant full year 2024/25 delivery of core plan and bridging plan Noted maturity and phasing of savings plans and risks to delivery for 2025/26. Noted Considerable opportunity identified against core efficiency target of £50m. **Action** for Depth of Coding workstream to report to the Committee
Capital Investment Progress Report Update on Capital Plan for 2024/25	**Feb**	**Mar**	**Apr**	**Presenter** Director of Capital Planning	**Purpose** To update on the implementation of the 2024/25 capital plan & set out actual position at Q4 end.	**Outcome /Action taken** Noted. Risk of underspend had been substantially mitigated. Worthing Heat Network remained the main area of slippage at M12 and noted ongoing work to mitigate impact on 2025/26.
ICS System Update Report		**Mar**	**Apr**	**Presenter** Chief Finance Officer/ Chair of Committee	**Purpose** For information	**Outcome /Action taken** Noted system partner implications in national context. No updates on Committees in Common
Commercial Progress Report Q4 2024/25 including Procurement Update			**Apr**	**Presenter** Chief Finance Officer	**Purpose** To Note	**Outcome /Action taken** Noted activity undertaken by the commercial directorate and upcoming areas of opportunity.

Systems & Partnership True North Operational Performance ▪ Performance Scorecard ▪ Report on Constitutional Standards	**Feb**	**Mar**	**Apr**	**Presenters** Director of Performance and BI / Managing Directors (Feb) Chief Operating Officer (Mar/Apr)	**Purpose** For information	**Outcome /Action taken** Noted progress in elective recovery, diagnostics, and cancer pathways. The level of improvement in urgent & emergency care remains insufficient. **Action** for refocussed UEC plans to be brought back. Discussed that there has been complimentary assurance from Tiering in Cancer/Diagnostics so we need to decide if bolstered assurances are needed over the actions taken as oversight is exited
Deep Dive into Cancer / Diagnostics		**Mar**		**Presenters** Chief Operating Officer	**Purpose** For information	**Outcome /Action taken** Noted
3Ts update		**Mar**		**Presenters** Chief Operating Officer	**Purpose** For information	**Outcome /Action taken** Noted Sussex Cancer Centre – Capital & Revenue Update. Noted continued progression and timescales for national approval. Closed 3Ts benefits realisation action
2025/26 Operational and Financial Planning Operational, Efficiency and Capital Plan 2025/26 (Mar)	**Feb**	**Mar**	**Apr**	**Presenters** Chief Financial Officer / Chief Operating Officer	**Purpose** To recommend for Board approval To endorse Updated Plan for submission by 7th May (Apr meeting)	**Outcome /Action taken** Agreed a revised plan that is at balance to be submitted to NHS England. Board Ratification to be sought for endorsed submission
Medium-Term Financial Model			**Apr**	**Presenters** Director of Finance (Strategic)	**Purpose** For information	**Outcome /Action taken** Noted assurance for the process applied and that there is a recognised need to refresh the modelling. To be brought back in Q3.
Electronic Patient Record Update Invitation To Tender (ITT)		**Mar**		**Presenter** Chief Information Officer	**Purpose** For information and to endorse	**Outcome /Action taken** Endorsed the EPR/ITT and recommended to the Board
Investment Decisions & Contract Recommendations Replacement of Monoplane/Hybrid(Feb) Theatre 6 (RSCH,TKT)	**Feb**			**Presenter** Chief Finance Officer/ Division Director of Ops (Specialist)	**Purpose** To Approve	**Outcome /Action taken** Ratified spend approval by the Chief Finance Officer to maintain service. Approved associated costs for services

Investment Decisions & Contract Recommendation SRH Same Day Emergency Care(SDEC)			**Apr**	**Presenter** Chief Finance Officer/ Director of Capital Planning	**Purpose** To Approve	**Outcome /Action taken** Approved extended amount added to this business case (previously anticipated)
Trust Risk Register relating to Finance and Performance			**Apr**	**Presenter** Chief Finance Officer / Company Secretary	**Purpose** For information	**Outcome /Action taken** Noted that the key risks were discussed in Committee and aligned appropriately with the BAF

Actions taken by the Committee within its Terms of Reference	
The Committee considered and **APPROVED** business cases and contract approvals within its authority limits	
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)	
Revised Green Plan to come back as routine item following the NHS England changes to requirement Update on Refocussing of Urgent & Emergency Care Improvement Plans Medium Term Financial Plan with revised scenario modelling (Q3 2025/26)	
Items referred to the Board or another Committee for decision or action	
Item	**Date**
The FPC **RECOMMENDS** that the Board **RATIFY:** • Approval of the refreshed Submission of the Trust Plan for 2025/26 to NHS England	**May 2025**

NHS
University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	15.	**Meeting:**	Trust Board in Public	**Meeting Date:**	8 May 2025
Report Title:	Audit Committee Chair's Report				
Author(s):	David Curley – Audit Committee Chair				
Report previously considered by and date:					
Purpose of the report:					
Information		Yes	Assurance		Yes
Review and Discussion		Yes	Approval / Agreement		N/A
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality			Staff confidentiality		
Patient confidentiality			Other exceptional circumstances		
Link to ICB / Trust Annual Plan					
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes		
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	Yes	The Committee provides oversight of the process supporting each aspect of the BAF			
Sustainability	Yes	The Committee provides oversight of the process supporting each aspect of the BAF			
People	Yes	The Committee provides oversight of the process supporting each aspect of the BAF			
Quality	Yes	The Committee provides oversight of the process supporting each aspect of the BAF			
Systems and Partnerships	Yes	The Committee provides oversight of the process supporting each aspect of the BAF			
Research and Innovation	Yes	The Committee provides oversight of the process supporting each aspect of the BAF			
Link to CQC Domains:					
Safe		Yes	Effective		Yes
Caring		Yes	Responsive		Yes
Well-led		Yes	Use of Resources		Yes
Regulatory / Statutory reporting requirement					
There is a requirement to have a functioning and effective Audit Committee. The Audit Committee is established to support the Board in securing assurance over the Trust's governance, risk management and internal controls systems.					
Communication and Consultation:					
Report:					

The Audit Committee met on the 22 April 2025 and was quorate as it was attended by 4 Non-Executive Directors. In attendance were the Chief Financial Officer, the Trust's Interim Operational Finance Director, Deputy Director of Finance – operational finance, Company Secretary and Deputy Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members. The Chief Operating Officer attended for the relevant internal audit report in respect of UEC Data Quality and the Chief Information Officer and Head of Information Governance and Data Protection Officer attended for the Data Security and Protection Toolkit report.

Risk Management

The Audit Committee considered, reviewed and discussed the Trust's risk management policy compliance report, noting that the quarter 4 BAF had already been presented and considered at the Board within its meeting on 31 March 2025.

The Committee noted the impact the Executive Led Risk Oversight Group has had over the 18 months it has been in existence noting that in the last quarter there had been a slower rate of improvement than in prior quarters. The Committee also noted the work undertaken in delivering the agreed actions recommended by Internal Audit in the report over the divisional risk management processes.

The Committee reflected that as the ROG moves into its meeting cycle for 2025/26 it would be of value for it to consider the thematic nature of some of the risks to drive action that will support the management of multiple separately identified risks and asked that the central risk assurance team consider how they can better group identical risks held on respective divisional risk registers to reduce some of the administrative burden for their update and maintenance.

Internal Audit activity

The Committee noted the work undertaken in the quarter and the process to finalise the remaining work for the 2024/25 work plan, with Internal Audit confirming that they will deliver all their reviews in time to prepare a final Head of Internal Audit Opinion.

The Committee noted the negative assurance opinion on the Trust's UEC Data Quality processes which was identified by executive management as an area of concern and thus the scoping of this work. The Chief Operating Officer provided assurance that the findings are being addressed, and oversight of their delivery would fall to himself. The Committee asked that as part of the 2025/26 internal audit plan a dedicated piece of work be added to retest this area to ensure the actions taken have improved the robustness of the underlying data.

The Committee noted the dip in delivery of the agreed management actions in the last quarter, whilst reflecting that the majority of those outstanding actions fell to one director, assurance was provided by the Chief Financial Officer that he is engaging with others to secure updates to these and improved engagement with the follow up process for the next quarterly report.

Head of Internal Audit Opinion

The Committee received the draft Head of Internal Audit Opinion and noted that it provided a positive opinion on the Trust's overall systems of governance, risk management and internal control. The opinion reflected that whilst a small number of individual negative opinions had been provided within the year, these were in areas that Internal Audit had been asked to support the Trust with their planned improvements work and this was reflected positively by the Head of Internal Audit. The Committee noted that the report provided confirmation of Internal Audit's compliance with the required Public Sector Internal Auditing Standards.

Internal Audit Plan for 2025/26

In respect of the Internal Audit work plan for 2025/26 the Committee discussed the breadth of the reviews and their alignment to the Trust strategic objectives and risks. The Committee also discussed the level of resources being deployed within the plan and considered based on feedback by the Chief Financial Officer these to be reasonable. The Committee approved the plan subject to the inclusion of an additional review in respect of the re audit of UEC Data Quality and the expansion of the planned Estates review to include the capital allocation process for estates work.

Annual Accounts

External audit

The Committee noted that the 2024/25 external audit progress report confirmed that work is progressing well for the 2024/25 year end, with good liaison maintained with the Trust's finance team.

The Committee received the external plan, noting the work planned for each of the identified risks in respect of the production of the accounts and to the items within the accounts. The Committee noted that there were no elevated specific risks over and the routine work of the external auditors.

The Committee considered the non-audit work being undertaken in respect of to a national piece of NHS work on coding and agreed this did not pose a threat to their independence.

In approving the plan, the Committee agreed the fee proposed noting this was in line with the tender value for the work

Going concern

The Committee considered the Trust's going concern assessment which had been reviewed by the Chief Financial Officer. Based on the discussion held with the Chief Financial Officer and Deputy Director of Finance the Committee agreed with this assessment and that the Trust should prepare its accounts on the basis of being a going concern.

Draft Annual Governance Statement

The Committee considered the draft AGS, noting that it would be updated to reflect reports from Internal Audit and Counter Fraud received at today's meeting.

The Committee discussed its content and made a small number of suggestions for areas where the draft text could be enhanced and subject to that feedback agreed the adjusted statement should be incorporated into the Trust's annual report and be provided to External Audit for their formal review.

Preparation of the financial statements

The Committee received an update on the Trust's progress to submit its draft financial statements and considered the management responses provided to External Audit in respect of the Trust processes noting these had been reviewed by the Chief Financial Officer. The Committee agreed there was nothing they were aware of that would invalidate these assertions.

The Committee also noted the update provided by the Executive Team in respect to progress against the prior year external audit VFM recommendations.

Declarations of Interest

The Committee noted the assurance the report provided over the Trust's continual compliance with its declaration of interest, gifts and hospitality policies. The Committee noted that high level of returns at over 90% and, for those expected to make a return that had not done so by the year end, whilst they would continue to be chased none had any budgetary responsibilities.

The Committee noted the review of the declared interests and that none posed any significant issues, and that process had been put in place to manage these interests in the areas of procurement decisions with the sharing of this information and the whole register with the procurement team.

Information Governance

Data Security Protection Toolkit

The Committee received the report confirming that whilst the assessment criteria had changed significantly for this year, 2024/25, the Trust has established a process of seeking, validating and learning from the assurances being obtained against the established standards. The Committee took confidence from the update from the Chief Information Officer and Data Protection Officer that the Trust will be able to make a strong submission by the June deadline.

University Hospitals Sussex NHS Foundation Trust

Data Protection Officer's report

The Committee received an annual report from the Data Protection Officer which provided assurance over the Trust's processes and reflected the work undertaken over the year to strengthen these from those in operation within the legacy Trusts. The Committee noted also that the routine work is reported to the Research, Innovation and Digital Steering Group a reporting group to the Board Committee on Research, Innovation and Digital Strategy and agreed that it would adjust its reporting requirements to receive the annual assurance report in its April meetings going forward.

Key Recommendation(s):

The Board is also asked to **NOTE**

- The overall positive Head of Internal Audit opinion for the year 2024/25.
- That the Audit Committee approved the Internal Audit work plan for 2025/26
- That the Audit Committee confirmed the that the Trust's financial statements should be prepared on a going concern basis
- That the Audit Committee approved the External Audit plan and associated fee for the 2024/25 audit
- That the Audit Committee agreed that the draft Annual Governance Statement should be submitted to external audit for formal review as part of the submission of the Trust's annual report for audit.

University Hospitals Sussex NHS Foundation Trust

COMMITTEE ACTIVITY HIGHLIGHT REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate
Audit Committee	22 April 2025	David Curley	**Yes**

Declarations of Interest Made

There were no declarations of interest made.

Matters received at the Committee meeting

Item	Presenter	Purpose of the paper	Action Taken
Risk Management Policy Compliance report	Deputy Company Secretary	For assurance over Trust's process.	The Committee noted the impact the Executive Led Risk Oversight Group has had over the 18 months it has been in existence noting that in the last quarter there had been a slower rate of improvement than in prior quarters. The Committee noted the work undertaken in delivering the agreed actions recommended by Internal Audit in the report over the divisional risk management processes. The Committee reflected that as the ROG moves into its meeting cycle for 2025/26 it would be of value for it to consider the thematic nature of some of the risks to drive action that will support the management of multiple separately identified risks and asked that the central risk assurance team consider how they can better group identical risks held on respective divisional risk registers to reduce some of the administration of their update and maintenance.
Internal Audit Reports - Activity Progress Report - Recommendation Follow Up Report - Draft Head of Internal Audit Opinion for 24/25 - Annual Internal Audit work plan for 25/26	BDO (Internal Auditors)	For assurance over respective areas of internal control	The Committee noted the work undertaken in the quarter and the process to finalise the remaining work for the 2024/25 work plan, with Internal Audit confirming that they will deliver all their reviews in time to prepare a final Head of Internal Audit Opinion. The Committee noted the negative assurance opinion on the Trust's UEC Data Quality processes which was identified by executive management as an area of concern and thus the scoping of this work.

			The Chief Operating Officer provided assurance that the findings are being address and oversight of their delivery would fall to himself. The Committee asked that as part of the 2025/26 internal audit plan a dedicated piece of work be added to retest this area to ensure the actions taken have improved the robustness of the underlying data. The Committee noted the dip in delivery of the agreed management actions in the last quarter, whilst reflecting that the majority of those outstanding actions fell to one director, assurance was provided by the Chief Financial Officer that he is engaging with others to secure updates to these and improved engagement with the follow up process for the next quarterly report. The Committee received the draft Head of Internal Audit Opinion and noted that the opinion was positive and the report provided confirmation of Internal Audit's compliance with the required Public Sector Internal Auditing Standards. In respect of the Internal Audit plan for 2025/26 the Committee approved the plan subject to the additional review in respect of UEC Data Quality and the expansion of the estates work to include the capital allocation process for estates work.
Counter Fraud Reports - Activity Progress Report - 2024/25 Annual Report	RSM (LCFS)	For assurance over respective areas of internal control and for information on the Trust's fraud profile and links to LCFS work	The Committee noted the work undertaken by the counter fraud team, that there were no elevated fraud risks from the work in the final quarter of the year. The Committee in receiving the annual report noted the work undertaken across the year against each of the assessed fraud risks and were assured by the counter fraud specialist that all the required actions had been taken. The Committee noted the work being undertaken to enhance staff awareness and training which matched the one

			amber rated functional return standards. The Committee in approving the annual report reflected that the types of fraud being reported, detected and investigated remained in the same categories as those in prior years.
External Audit Update - Progress report - 2024/25 Plan	GT (External Audit)	To note status of the External Audit work	The Committee noted that the 2024/25 external audit progress report confirmed that work is progressing well for the 2024/25 year end, with good liaison maintained with the Trust's finance team. The Committee received the external plan, noting the work planned for each of the identified risks in respect of the production of the accounts and to the items within the accounts. The Committee noted that there were no elevated specific risks over and the routine work of the external auditors. The Committee considered the non audit work being undertaken in respect of to a national piece of NHS work om coding and agree this did not pose a threat to their independence. In approving the plan, the Committee agreed the fee proposed noting this was in line with the tender value for the work.
Annual Accounts Preparation update	Deputy Director of Finance - Operational Finance	To review and approve	The Committee received an update on the Trust's progress to submit its draft financial statements and considered the management responses provided to External Audit in respect of the Trust processes noting these had been reviewed by the Chief Financial Officer. The Committee agreed there was noting they were aware of that would invalidate these assertions. The Committee also noted the update provided by the Executive Team in respect to progress against the prior year external audit VFM recommendations.

Going Concern Assessment report	Deputy Director of Finance - Operational Finance	To review and approve	The Committee considered the Trust's going concern assessment which had been reviewed by the Chief Financial Officer. Based on the discussion held with the Chief Financial Officer and Deputy Director of Finance the Committee agreed with this assessment and that the Trust should prepare its accounts on the basis of being a going concern. The Committee discussed how this document could be adjusted slightly to support the disclosure in the Trust annual report and financial statements.
Draft Annual Governance Statement	Company Secretary	To review and recommend to submission to the external auditors.	The Committee considered the draft AGS, noting that it would be updated to reflect reports from Internal Audit and Counter Fraud received at today's meeting. The Committee discussed its content and made a small number of suggestions for areas where the draft text could be enhanced and subject to that feedback agreed the adjusted statement should be incorporated into the Trust's annual report and be provided to External Audit for their formal review.
Losses, Special Payments and Overpayments Register	Deputy Director of Finance - Operational Finance	To note the report and the assurance it provides over the Trust's processes.	The Committee took assurance from the comparably low value of losses and special payments. The Committee also received information in respect of payroll improvement group actions to raise awareness for managers on the correct process to be followed to minimise issues for their staff and the Trust in the future.
Tender Waiver Report	Commercial Director	To note the report and the assurance it provides over the Trust's processes.	The Committee noted the relatively low level of these across the year and in the quarter and through discussion the Committee was assured over the processes being applied to support the review of Waivers.
Data Security and Protection Toolkit 2024/25	Chief Information Officer and	To note the progress made and receive an	The Committee was reminded that the assessment criteria has significantly changed for 2024/25

	Information Governance Manager / Data Protection Officer	update on the Trusts processes	and work is progressing well with the securing of evidence to allow the Trust to make its submission by June 2025. The Committee noted that the Trust is expected to be in a position to declare a compliance rate of 95% by the submission date in June.
Data Protection Officer's Annual Report	Chief Information Officer and Information Governance Manager / Data Protection Officer	To note	The Committee received an annual report from the Data Protection Officer which provided assurance over the Trust's processes and reflected the work undertaken over the year to strengthen these from those in operation within the legacy Trusts. The Committee noted also that the routine work is reported to the Research, Innovation and Digital Steering Group a reporting group to the Board Committee on Research, Innovation and Digital and agreed that it would adjust its reporting requirements to receipt of the annual assurance report in its April meetings going forward.
Health and Safety Committee Chairs Report	Company Secretary	Provision of information on the activity of this Committee and review of the Committee's view of the Trust's Health and Safety risks.	The Committee noted the assurance provided over the continued meeting of the H&S Committee. The Committee noted the correlation of the risks within this update and the work within the Estates Improvement Group.
Annual Declarations of Interest Report	Company Secretary	For assurance	The Committee noted the assurance the report provided over the Trust's continual compliance with its declaration of interest, gifts and hospitality policies. The Committee noted that high level of returns at over 90% and for those expected to make a return that had not done so by the year end, whilst they would continue to be chased none had any budgetary responsibilities. The Committee noted the review of the declared interests and that none posed any significant issues, and that process had been put in place to manage these interests in the areas of procurement decisions with the sharing of this information and the whole register with the procurement team.

Committee schedule of business for 2025/26	Company Secretary	For agreement	The Committee agreed its schedule of business across its four main meetings plus one meeting devoted to the year end subject to the change in the reporting frequency of the report from the Trust's Data Protection Officer.
External Audit retender	Chief Finance Officer	For agreement	The Committee agreed the process being applied to retender for the external audit provider from 2025/26 year onwards

Actions taken by the Committee within its Terms of Reference

The Committee approved the Internal Audit plan subject to the additional review on UEC Data Quality and the extended scope for the estates review.

The Committee approved the External Audit plan and associated fees for the 2024/25 audit.

The Committee agreed the Going Concern assessment and thus that the Trust's financial statements should be prepared on that basis.

The Committee agreed the submission of the draft Annual Governance Statement to the external auditors as part of the draft annual report subject to Company Secretary and Chief Executive considering the suggestions made at the meeting.

The Committee agreed the process for the external audit retender.

The Committee agreed its cycle of business for the forthcoming year (2025/26).

Items to come back to Committee (Items the Committee keeping an eye on outside its routine business cycle)

There were no specific items outside those within the Committee's business plan required to return to the Committee, but the Committee did wish to see improved engagement in the delivery of agreed management actions in respect of internal audit recommendations.

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

Item	Referred to
There were no matters referred to the Board or another Committee for decision.	

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16.	**Meeting:**	Trust Board in Public	**Meeting Date:**	8 May 2025
Report Title:	Strategy and Major Projects Assurance Committee Chair's Report to Board				
Committee Chair:	Paul Layzell – Committee Chair				
Author(s):	Paul Layzell – Committee Chair				
Report previously considered by and date:					

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

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

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

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	The Committee is to provide assurance that major projects support the delivery of the Trust Strategy and this the delivery of its strategic objectives
Sustainability	Yes	The Committee is to provide assurance that major projects support the delivery of the Trust Strategy and this the delivery of its strategic objectives
People	Yes	The Committee is to provide assurance that major projects support the delivery of the Trust Strategy and this the delivery of its strategic objectives
Quality	Yes	The Committee is to provide assurance that major projects support the delivery of the Trust Strategy and this the delivery of its strategic objectives
Systems and Partnerships	Yes	The Committee is to provide assurance that major projects support the delivery of the Trust Strategy and this the delivery of its strategic objectives
Research and Innovation	Yes	The Committee is to provide assurance that major projects support the delivery of the Trust Strategy and this the delivery of its strategic objectives

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Report:

This was the first meeting of the newly established Committee which is dedicated to provide assurance over the governance of major Trust projects. Held on the 1 May, the meeting was quorate, attended by 4 Non-Executives and 7 Executives including the Chief Strategy Officer who is the executive lead for the Committee. In attendance at these meetings were also the Director of Strategy and the Director of Strategic Finance.

University Hospitals Sussex
NHS Foundation Trust

Operation of the Committee

The Committee **discussed** the hallmarks of a process that leads to successful projects, how projects would be screened through the Trust's strategy lens to determine those that would fall within the major projects portfolio and the role of the supporting executive-led steering group in providing assurance to the Committee.

The Committee **discussed** the way it would work, recognsing its role of providing assurance over the delivery of the Trust's 5 strategic ambitions and the supporting major projects portfolio which is complementary to the assurance role of the other Board Committees on improvement outcomes. The committee also **considered** the structure and content of the reports it would receive and it **provided** feedback to the Director of Strategy on both format and content, noting these would likely evolve as the Committee meets during 2025/26.

The Committee **discussed** the relationship it would have with the executive-led steering group and the role the Committee has in providing a depth of assurance to the Board through a process of received fuller reports from the steering group on specific projects on a cyclical basis.

Terms for Reference

The Committee **discussed** a draft of a Terms of Reference and agreed that as the work if Committee developed, it will review these before the year end. In discussing these, the Committee considered its remit and interrelationship with the other Board Committees recognsing that this Committee would provide assurance to the Board on the delivery of the major projects portfolio along with the delivery of the strategic ambitions whilst assurances on improvement outcomes would remain with the other established Board Committees.

The Committee noted that executive members of the Committee would represent the executive team's view as a whole and therefore not all executives were required to be members of the Committee although, as with all committees, meetings were open to all Board members. The Committee **agreed** to recommend to the Board amended Terms of Reference and that these would be subject to review after a couple more meetings, based upon an assessment of the Committee is working with the Executive-led feeder steering group and the developed reporting for both strategy delivery and the major projects portfolio as noted above. The adjusted Terms of Reference are included at appendix 1.

Estates Strategy

The Committee received the Estates Strategy – an important contextual element of the Cancer Centre major project. The Committee noted that this document drew together the work from the Estates Master Planning corporate project and the Trust's six facet survey work, both pieces of work having been undertaken previously, with the Committee taking confidence from the review of that work by the Executives previously.

The Committee **approved** the document and supported its submission to NHS E as part of the cancer centre information requests.

Recommendations

The Board is **recommended to accept** the adjusted Terms of Reference, recommended by the Committee, noting that these will be subject to review before the end of the Committee's first year. These are included in appendix 1.

The Board is asked to **note** that the Committee approved the Estates Strategy.

NHS
University Hospitals Sussex
NHS Foundation Trust

Trust Board in Public

08 May 2025

APPENDICES

Appendix A: SIP Portfolio Delivery Dashboard

MARCH 2025 (reporting APRIL 2025)

UHSx Single Improvement Plan

PORTFOLIO DASHBOARD

MARCH 2025 (reporting APRIL 2025)

NHS University Hospitals Sussex NHS Foundation Trust

	Surgery	Planned Care Inc Cancer	UEC	Specialised Services	Maternity
RAG Trend	Last / Current / Future	Last / Current / Future	Last / Current / Future	Last / Current / Future	Last / Current / Future
Current RAG Criteria (Mar '25)	Plan: Amber; Delivery Resource: Amber; Financial Risk: Amber; Governance: Green; Performance: Amber	Plan: Amber; Delivery Resource: Red; Financial Risk: Green; Governance: Red; Performance: Amber	Plan: Amber; Delivery Resource: Amber; Financial Risk: Amber; Governance: Amber; Performance: Red	Plan: Amber; Delivery Resource: Green; Financial Risk: Red; Governance: Amber; Performance: Amber	Plan: Amber; Delivery Resource: Green; Financial Risk: Green; Governance: Green; Performance: Amber
Key Measure of Success	RCS Recommendations **29 out of 43 actions fully addressed**	RTT >65wks (target 0): **377 March '25**	ED Waits 78% seen within 4hrs: **71.5% March '25** (compared to 70.2% in February '25)	**KPI – Not yet agreed**	Perinatal Mortality **2.81 / 1000 – March'25** (Target 5.0 / 1000)
Commentary	The response submitted to the Royal College in January 2025 has been shared with the review team, who have confirmed their satisfaction with the progress the Trust has made in addressing the recommendations outlined in the report. They have also expressed confidence in the programme of work established to implement the remaining actions moving forward. The outstanding recommendations will be addressed via BAU routes following SIP closure. RTC colorectal move continues to be implemented.	With focused support from GIRFT, recovery plans are in place for each specialty and are monitored. ERF activity delivery has reached 117%, with continued improvements expected through July. Current activity stands at 377, with ENT accounting for 34% of the total.	Trust wide programme to deliver a standardised UTC model delivering compliance with the 32 national UTC recommendations across all sites including SRH in progress. Programme comprises of 5 workstreams aligned with themes within 32 standards: Clinical model inclusion/exclusion criteria; Funding and commissioning; Patient and pathway modelling; workforce recruitment and training and digital and data enablers.	Phase one of service review underway. 37 services under review out of 62. Specialised commissioning bundles of services to develop centres of excellence to be identified. Governance live and on-going.	Midwifery and obstetric leadership roles now fully recruited. Maternity strategy engagement is in ratification process and expected to be completed by the end of Q4

Key: On track (Low) | Off track, delivery not at risk (Medium) | Off track – Delivery at Risk (High)

UHSx Single Improvement Plan

PORTFOLIO DASHBOARD

MARCH 2025 (reporting APRIL 2025)

NHS University Hospitals Sussex NHS Foundation Trust

	Culture	Quality Improvement	CQC	EDI
Programmes				
RAG Trend	Last / Current / Future	Last / Current / Future	Last / Current / Future	Last / Current / Future
Current RAG Criteria (Mar '25)	Plan, Delivery Resource, Financial Risk, Governance, Performance	Plan, Delivery Resource, Financial Risk, Governance, Performance	Plan, Delivery Resource, Financial Risk, Governance, Performance	Plan, Delivery Resource, Financial Risk, Governance, Performance
Key Measure of Success	**Freedom to Speak Up** **21 referrals [Mar'24] [18 in Feb]**	**Complaints** **172 Formal Complaints March '25 [154 in Feb]**	**CQC Must Do, Should Do** - **137 sub-actions – 119 have been delivered/moved to BAU**	**People Promise** **- WRES (1.64 H1 24/25)** **WDES (1.27 H1 24/25)**
Commentary	The Culture Programme continues to make steady progress in line with the priorities set out in the strategic plan. Key workstreams; Management & Leadership, Values & Behaviour, Organisational Development (OD) Interventions, Reward and Recognition, and Safety Culture are actively underway. Each workstream now has established milestones and clearly defined delivery timelines to ensure structured implementation.	Clinical and Corporate document templates have been approved and are live. Mar 2025: 3605 files in Document library, 41.7% are in date Divisional quality governance work is progressing under the DCMO's leadership. There has been an increase in the numbers of complaints received resulting in higher numbers of open complaints. However, there are fewer long-open complaints, and more are being closed through early resolution. The CAF was completed in Spring 2024.	Of the 137 actions, 128 were approved as completed / BAU at the end of Q4 2024/25. Outstanding actions are managed by the CQC Improvement group	The EDI programme has transitioned into BAU, and progress is being reported to People and Culture Committee monthly and ICB quarterly.

Key: On track | Off track, delivery not at risk | Off track – Delivery at Risk

UHSx Single Improvement Plan

PORTFOLIO DASHBOARD

MARCH 2025 (reporting APRIL 2025)

University Hospitals Sussex NHS Foundation Trust

Programmes

Well-Led

RAG Trend

Last	Current	Future

Key: On track | Off track, delivery not at risk | Off track – Delivery at Risk

Current RAG Criteria (Mar '25)

Plan	Delivery Resource	Financial Risk	Governance	Performance

Key Measure of Success

KPIs

Not yet defined

Commentary

The external provider, Niche, continues to work in partnership with the Trust on the Well-Led developmental review and remains on track to complete the review by June 2025.
NICHE have completed their interviews with system stakeholders, the Trust Board and various senior leaders including a number of clinical triumvirates and corporate directors along with a number of focus groups and site visits complementing their observations of a Board meeting and three Committee meetings

Details of work undertaken and planned are reported to the Chair and CEO routinely.

Key to RAG criteria:-

Category	Blue (Completed)	Green (On Track)	Amber (At Risk)	Red (Off Track)
Overall Status	Project/programme is completed.	Project is progressing as planned, with no significant issues.	Minor issues are present but manageable with corrective actions.	Major issues threaten project delivery or objectives.
Plan	All planned tasks and milestones are completed.	Project is on schedule with no delays.	Some tasks are delayed, but overall delivery is still achievable.	Significant delays make delivery unlikely without major intervention.
Resourcing	All resource requirements are fulfilled and stable.	Resourcing is sufficient to meet current project needs.	Resource gaps are present but manageable.	Critical resource shortages are jeopardizing the project.
Budget	Budget utilisation is complete and within limits.	Budget is on track, with no overspend forecasted.	Some overspending is likely but manageable within contingencies.	Overspending or funding gaps threaten project viability.
Performance	All performance objectives have been achieved.	Performance targets are being met as expected.	Some performance targets are at risk, requiring adjustments.	Key performance targets are missed, risking overall goals.
Governance	Governance processes are completed and fully compliant.	Governance is active and functioning effectively.	Some governance elements need attention to ensure effectiveness.	Governance processes are absent or ineffective, posing serious risks.

NHS
University Hospitals Sussex
NHS Foundation Trust

Scorecard

Single Improvement Programme| Key Performance Indicator KPI (cont'd)

March 2025

University Hospitals Sussex NHS Foundation Trust

UHSussex Single improvement plan (SIP)	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Trend
CQC														
▶ %must dos complete				3	3	n/a	3	4	4	10	16	lag	lag	
▶ %should dos complete				1	1	n/a	1	1	1	4	9	lag	lag	
Quality improvement														
▶ FSoC - All falls	256	255	310	238	227	239	229	250	275	255	258	263	lag	
▶ FSoC - Falls resulting in harm	108	97	123	86	79	80	84	98	88	71	90	87	lag	
▶ FSoC - Falls resulting in severe harm or death	5	6	5	1	1	6	5	4	5	1	5	5	lag	
▶ FSoC - Grade 2+ pressure ulcers	129	157	147	149	140	140	132	178	141	163	197	173	lag	
▶ FSoC - Breaches in mixed sex accomodation arrangements	391	622	413	385	431	494	418	447	456	515	575	492	lag	
▶ FSoC - %patients receiving timely observations (NEW2)	65.4%	66.9%	68.3%	68.5%	69.2%	70.2%	72.0%	73.5%	74.7%	73.1%	72.9%	74.3%	75.7%	
▶ FSoC - %patients receiving timely observations (PNEWS2)		68.1%	67.0%	75.9%	71.1%	72.1%	73.3%	61.0%	58.3%	59.4%	63.3%	64.9%	66.0%	
▶ FSoC - %patients with sepsis receiving antibiotic with one hour	66.3%	59.8%	56.6%	65.9%	60.6%	65.7%	61.1%	63.2%	57.9%	60.3%	67.7%	61.8%	lag	
▶ FSoC - VTE Initial Assessment Compliance		91.2%	90.9%	90.6%	91.1%	91.2%	90.7%	90.4%	90.9%	89.7%	89.7%	90.0%	89.7%	
▶ %national audits awaiting divisional action (replaced by following 2 metrics)	81.4%	83.0%	84.0%	93.2%	86.8%	88.5%	85.3%							
▶ %National Audit reports awaiting review by 1 or more divisions (replaced by following 2 metrics)							79.8%	79.8%	80.8%	80.6%				
▶ %National Audits with one or more actions overdue (replaced by following 2 metrics)							85.7%	75.0%	75.0%	55.6%				
▶ %Of published National Audit reports assessments overdue > 90 days											62.5%	94.0%	95.4%	
▶ %Of published NCEPOD reports assessments overdue > 90 days											30.8%	30.8%	30.8%	
▶ %NICE guidance overdue (excl. open in date)						26.3%	24.0%	18.5%	16.6%	12.4%	5.4%	9.5%	2.4%	
▶ %NICE guidance with a named lead	75.1%	75.0%	75.2%	76.1%	75.6%	73.4%	81.8%	100.0%	100.0%	100.0%	93.9%	100.0%	100.0%	
▶ %NICE guidance partially or not compliant (excl. not relevant and withdrawn guidance)						23.6%	23.1%	23.9%	36.4%	34.6%	37.7%	36.1%	42.0%	
▶ FFT - %patient rating care as good or very good	87.5%	88.9%	89.4%	88.8%	89.0%	89.7%	89.8%	89.5%	88.8%	89.3%	90.7%	90.6%	89.7%	
▶ Number of Formal complaints	125	132	125	116	121	126	143	113	106	107	138	154	172	
Culture														
▶ Rate of incident reporting per 1000 bed days	44.32	49.22	52.74	50.58	50.88	52.32	49.49	55.24	53.86	53.55	56.43	54.69	lag	
▶ FTSUG referrals (numbers) (monthly)	29	16	20	29	18	17	12	27	20	26	24	18	21	
▶ Appraisals	80.2%	80.6%	81.8%	82.2%	82.4%	82.4%	84.3%	83.3%	83.9%	84.9%	83.4%	83.8%	83.3%	
▶ STAM	89.8%	90.5%	90.7%	90.6%	90.7%	90.5%	90.5%	90.8%	91.2%	91.3%	91.4%	91.4%	91.2%	
▶ Sickness	4.9%	4.9%	4.9%	4.9%	5.4%	3.8%	5.0%	5.5%	5.4%	5.6%	5.4%	5.0%	lag	
▶ Staff Engagement - If I spoke up about something that concerned me I am confident my organisation would address my concern														
▶ Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	7.28	7.12	7.26	7.09	6.91	6.17	6.29	6.32	6.45	6.32	6.47	6.50	6.42	
Surgery														
▶ SJR backlog - TOTAL (older than 90 days, not allocated or completed)	510	363	260	256	383	378	124	74	47	7				
▶ Mortality (SHMI) data	105.2	104.2	103.1	103.6	104.3	104.1	103.8	103.9	lag	lag	lag	lag	lag	
▶ Number of RCS recommendations fully actioned			5/43											
▶ Medical workforce vacancy factor	4.9%	4.0%	4.9%	4.9%	4.8%	4.6%	0.9%	0.4%	1.9%	2.2%	lag	lag	lag	
▶ CEPOD P1							108	53	lag	lag	lag	lag	lag	
▶ P2							9	0	lag	lag	lag	lag	lag	
▶ Trust currently participates in national audits including neurosurgical audit programme, elective surgery national PROM		45.8%	37.5%	41.7%	45.8%	52.2%	76.0%	80.0%	80.0%	80.0%	lag	lag	lag	

Single Improvement Programme| Key Performance Indicator KPI

March 2025

University Hospitals Sussex NHS Foundation Trust

UHSussex Single improvement plan (SIP)	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Trend
Planned Care & Cancer														
ERF value-weighted activity delivered (% of 19/20 baseline)	1.04	1.20	1.19	2.44	1.15	1.18	1.17	1.18	1.16	1.17	lag	lag	lag	
Cancer 62-day backlog	298	392	468	417	499	540	566	511	355	390	375	288	278	
Cancer 62-day standard: 70% by Mar-25;	60.2%	59.8%	59.3%	58.3%	58.5%	60.0%	55.3%	55.8%	63.6%	64.1%	57.8%	60.8%	lag	
Cancer 28-day faster diagnosis standard: 77% by Mar-25	70.8%	68.9%	67.2%	66.7%	67.4%	65.4%	65.6%	68.3%	71.0%	73.6%	71.3%	81.6%	lag	
Diagnostics (DM01) performance of 8% Mar-25	30.0%	28.0%	26.3%	25.8%	26.9%	29.8%	28.2%	24.0%	21.3%	22.1%	20.4%	14.3%	13.6%	
80% specialties using e-RS – July 24		63.3%	60.0%	50.0%	46.7%	46.7%	50.0%	48.1%	55.6%	51.9%	50.0%	50.0%	50.0%	
Diagnostics – 6 week backlog	6537	6079	5485	5380	5539	6096	5698	4949	4181	4203	3777	2737	2539	
Diagnostics – activity	35847	37447	38734	38514	39993	35994	37680	41084	41716	36488	40444	37541	40740	
Diagnostics – waiting list size	20413	20589	19798	19561	19236	19188	18803	19255	18392	17973	17637	18129	17646	
Elective care activity		1.15	1.16	1.17	1.06	1.07	1.06	1.12	1.10	1.13	1.10	1.13	1.50	
RTT - 52 weeks	15824	16480	16941	16157	15052	14168	10976	9965	9200	8278	7848	7437	6923	
RTT - 65 weeks	3658	4374	5245	5592	5288	4866	2525	2492	2189	2278	1982	1251	377	
RTT - 104 weeks	0	4	4	4	4	2	4	6	6	6	8	5	4	
RTT - Clocks starts	19448	20563	21290	19011	20716	17698	17468	20540	18977	17157	21547	18690	19576	
RTT - Clocks stops	19925	21765	22277	23470	24053	20976	22814	25072	23236	19764	23415	21490	22711	
RTT - Waiting list size	141173	142917	141517	136410	133732	130232	123868	119791	117899	121127	118530	114850	114131	
UEC														
78% of patients in ED seen, treated, admitted or discharged within 4 hours by March 2025	69.1%	69.6%	69.0%	70.3%	71.3%	71.6%	71.6%	71.9%	69.3%	68.1%	69.3%	70.2%	71.5%	
No more than 2% of patients waiting over 12 hours from arrival in ED	3.6%	4.6%	3.9%	3.4%	4.0%	3.7%	4.1%	4.3%	2.9%	2.6%	3.8%	3.3%	2.8%	
10% reduction in number of patients with a Length of Stay of over 7 days	23.8%	23.7%	23.7%	23.9%	24.4%	22.9%	22.3%	22.9%	22.2%	24.0%	24.7%	22.4%	20.4%	
Reduce ambulance handover delays over 60 mins to 0%	6.7%	8.7%	6.8%	4.9%	5.9%	4.6%	6.1%	7.2%	6.0%	6.5%	6.5%	5.0%	2.5%	
EDI														
Ratio interview to appointment for white: minoritised people	1.64		2.45			2.04								
WRES metrics	1.8						1.64							
WDES metrics	1.1						1.27							
Maternity														
Midwifery workforce	16.67%	14.23%	10.96%	10.44%	13.78%	17.69%	15.04%	11.68%	10.30%	7.76%	lag	lag	lag	
MSSP total maternity improvement plan actions [set number] %	30%	38%	44%	46%	48%	50%	53%							
MSSP exit criteria actions %	56%	61%	61%	61%	67%	67%	67%	67%	67%	78%	89%	lag	lag	
Complaints raised in reporting month	6	10	5	10	6	7	5	5	10	7	lag	lag	lag	
FFT	95.89%	94.74%	95.50%	90.38%	95.51%	92.86%	92.92%	95.15%	95.05%	93.90%	lag	lag	lag	
MNSI referrals in reporting month	0	0	1	3	1	0	0	0	1	1	lag	lag	lag	
PSIIs - raised in reporting month (MNSI cases removed)	0	0	0	1	0	0	1	1	0	0	lag	lag	lag	
Mortality rate (perinatal - national benchmark 5.0/1000)	3.24	3.01	3.13	2.91	2.78	2.76	2.77	2.54	2.44	2.69	2.81	2.69	2.81	
Brain injury rate (HIE 2 & 3) (national benchmark 1.3/1000)	0.7	0.69	0.70	0.93	0.81	0.81	0.69	lag	lag	lag	lag	lag	lag	

University Hospitals Sussex
NHS Foundation Trust

Report on progress against the Single Improvement Plan June 2024

April 2025

v3

June 2024: Overarching plan for improvement

Q4 23/24	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 25/26
Creation of the Compliance & Assurance Framework (CAF)	Well-led actions completed	Quality conference– manual launched	90% must and should dos completed	78% UEC patients in 4 hours	Completion of must do/should dos (from 2024 report)
Establishment of Structured Judgement Review (SJR) Reviewer and Mortality Board	CQC steering group established	Divisional CAF improvements initiated	Clinical guidelines at 90% compliant	Length of stay reduced	Single system for governance reporting of Clinical Outcomes & Effectiveness (CO&E) from divisions to Board
New IT platform for guidelines, policies and protocol documentation	Phase 1 Fundamental Standards of Care (FSoC) meets target	OD plan developed and approved	OD plan implementation commences	Improve performance against the 28-day Faster Diagnosis Standard to 77%	Reduction in unwarranted variation in delivery of surgical provision
Approval of Staff Dress Code and Uniform policy	Compliance & Assurance Framework (CAF) completed for all divisions	Develop / implement surgical operating model – 18 month programme	No outstanding SJRs	Increase the percentage of patients that receive a diagnostic test within six weeks to 95%	90% staff completing Level 1 Human Factor training
Gap analysis of Safety Culture learning actions previously collated	Clinical assurance visit programme commences	Rightsizing theatre capacity programme - 18 month programme	Surgical trainees training programme developed		25% staff completing Level 2/3 Human Factor training
Complete self-assessment against CQC 'we' statements for Well-Led	100-day report – culture and organisational development (OD)	80% specialties using e-Referral Service (e-RS)	Waits >65 weeks eliminated		*KEY:*
	Action plan developed from Royal College of Surgeons (RCS) recommendations	Netcall implemented	local teams are able to use Power BI to identify EDI improvements		*Well Led / CQC*
	Surgery cultural diagnostics and engagement	Reconfiguration of clinical site at RSCH for UEC	Review Emergency Department (ED) processes at WGH		*Quality Improvement*
	Operational plans submitted	Optimise SRH Urgent Treatment Centre (UTC) model	Maternity Clinical Operating Model (COM) and recruitment		*Culture (inc Safety Culture)*
	Site based Urgent & Emergency Care (UEC) plans developed	Update Equality, Diversity & Inclusion (EDI) action plan with insights from audit and implementation underway			*Improving Access to Surgery*
	New UEC oversight approach embedded	Maternity strategy engagement			*Planned Care*
	Complete Workforce Race / Workforce Disability Equality Standards (WRES/WDES) reports				*UEC*
	Launch specialised services steering group				*EDI*
	Specialised services contracts and Service Development & Improvement Plan (SDIP) agreed				*Specialist Services*

NOTE: workstream updated to reflect most recent delivery routes

WORKSTREAM: CQC/Well Led

University Hospitals Sussex NHS Foundation Trust

Milestone	Original Target Completion	Completed (Y – date, N – new date)	KPI (if applicable)	Comments
Complete self-assessment against CQC 'we' statements for Well-Led	Q4 23/24	Y-April 2024	n/a	The self-assessment was undertaken and agreed by the Board prior to the commencement of the developmental review
Well-led actions completed	Q1 2024/25	Y – April 2024	n/a	Well Led actions have been completed .An external developmental review of UHSx Well Led commenced in January 2025 and planned to be completed in June 2025. Findings from the review will be provided to the Trust Board.
CQC steering group established	Q1 2024/25	Y- April 2024	n/a	CQC Improvement Group(CQCIG) has been established to drive required improvement
90% must and should dos completed	Q3 2024/25	Y- March 2025	n/a	To date 97% of actions are complete. Of the remaining 4 sub actions these will be addressed through evidence for:
Completion of must do/should dos (from 2024 report)	Q2 25/26 (revised from Q1 25/26)	N- September 2025	n/a	1 – data for out of hours discharges is collated and acted upon; agreement reached on the 'how' awaiting the written plan 2 – Reducing the number of times patients are moved; agreement reached on the 'how' awaiting the written plan 1 – IPC plan to roll out deep dives in development. Evidence to be reviewed.

WORKSTREAM: QUALITY IMPROVEMENT (1 of 2)

University Hospitals Sussex NHS Foundation Trust

Milestone	Original Target Completion	Completed (Y – date, N – new date)	KPI (if applicable)	Comments
Creation of the Compliance & Assurance Framework (CAF)	Q4 23/24	Y - April 2024	N/A	A compliance and assurance framework (CAF) has been designed and completed so the extent to which CQC standards and expectations are met is better understood and improvement priorities are established. The CAF has been completed with the divisions and output disseminated to divisional leaders outlining compliant areas as well as gaps requiring improvements.
Establishment of SJR reviewer and Mortality Board	Q4 23/24	Y - September 2024	N/A	SJR review panel established. SJR Training completed in line with trajectory. Mortality & Morbidity Surveillance Group being established from April 2025.
New IT platform for guidelines, policies and protocol documentation	Q4 23/24	Y - January 2024	N/A	Single Document Library across UHSx is in place.
Phase 1 FSoC meets target	Q1 24/25	Y - June 2024	N/A	Phase one of the Fundamental standards of care (FSOC) includes the addition of key FSOC metrics (Falls, pressure ulcer, Nutrition and hydration, NEWS and PEWS, Sepsis, IPC etc) to Clinical Assurance Dashboard to allow clinical staff complete audits and monitor compliance.
CAF completed for all divisions	Q1 24/25	Y - April 2024	N/A	Compliance Assurance Framework assessment has been completed for all divisions.
Clinical assurance visit programme commences	Q1 24/25	Y - June 2024	N/A	Clinical Assurance Visits led by the Deputy Chief Medical Officer and Hospital Director of Nursing have commenced and are ongoing.
Quality Governance– manual launched	Q2 24/25	Y - August 2024	N/A	UHSx Quality Governance Manual was signed off and launched in August 2024.

WORKSTREAM: QUALITY IMPROVEMENT (2 of 2)

University Hospitals Sussex NHS Foundation Trust

Milestone	Original Target Completion	Completed (Y – date, N – new date)	KPI (if applicable)	Comments
Divisional CAF improvements initiated	Q2 24/25	Y- October 2024	N/A	Improvement plan are being implemented for key areas of the CAF including but not limited to Medical Devices, Medicines Management, ligature risks etc.
Clinical guidelines at 90% compliant	Q3 24/25	N - March 26	March 2025: 3605 files in Document library /41.7% are in date	Policy for Control and Management of Trust Documents is out for consultation and will be ratified at Trust Management Committee during Q1 25/26. Clinical and Corporate document templates have been approved and are live. April 2024: 3009 files in Document Library/ 41.7% are in date Sept 2024: 3235 files in Document Library/ 42.7% are in date. Feb 2025: 3463 files in Document Library / 44.3% in date Mar 2025: 3605 files in Document library /41.7% are in date
No outstanding SJRs	Q3 24/25	Y – December 2025	0% of SJRs open more than 60 days	SJR Backlog is closed, and the Trust is moving into BAU management of SJR processes to within 90 days with monitoring and escalation of those over 60 days.
Single system for governance reporting of CO&E from divisions to Board	Q1 25/26	Y – January 2025		COEG Scorecard is in development through MS Lists, Power Automate and Power BI to digitise the management of COE processes such as NICE and National; Audit reports; with a go live date of July 2025 expected. Local Quality Requirements (KPIs) have been agreed by COEG in Jan 25. As of Dec 24 NICE is now being managed through MS Lists, and the NICE element of the scorecard report are in late-stage development ready for testing in Mar/April. This report will flow from divisions to COEG, through QGSG and PQC and enable streamlined monthly reporting, with quarterly deep dive reports.

WORKSTREAM: SURGERY

NHS
University Hospitals Sussex
NHS Foundation Trust

Milestone	Original Target Completion	Completed (Y – date, N – new date)	KPI (if applicable)	Comments
Action plan developed from RCS recommendations	Q1 2024/25	Y - April 2024	N/A	A workstream and robust plan was created to address the recommendations from the Royal College of Surgeon in 2024. Progress on the plans have been shared with the college and NHSE in Jan and Feb 25 respectively.
Develop/ implement surgical operating model – 18-month programme	Q2 2024/25	N - April 2026	N/A	A surgical Operating model has been developed and proposed to the Trust Executives. Implementation of the SOM will now be completed as part of the Trust wide Target Operating Model (TOM), a new piece of work commencing Q1 25/26 that will incorporate a wider scope across more specialities in the Trust, including clinical and corporate areas.
Rightsizing theatre capacity programme – 18-month programme	Q2 2024/25	N - July 2025	N/A	•Colorectal Business Case approved by BCSP •Colorectal implementation governance agreed and set up and steering group commenced in Oct 24. •Surgeon consultation concluded in Feb 25. Single MDT launched early Feb 25. Full implementation of Brighton patients to Worthing move to be completed by July 25 •Agreed option to move Gynae Onc to PRH robot. •Business case to move 6 sessions of Ophthalmology from SRH to STH is WIP •Business case to build 2 new day case theatres supported by national GIRFT team is WIP •Southlands theatres is a newly identified opportunity
Surgical trainees training programme developed	Q3 2024/25	Y – October 2024	N/A	A training programme was developed for the surgical trainees prior to their return in Oct 24.
Reduction in unwarranted variation in delivery of surgical provision	Q1 25/26	N - March 26	P1 & P2 metrics	There are plans in place to merge Patient Tracking List (PTL) and to standardise divisional processes within surgery. Priority surgical areas have been identified- ENT, Colorectal, Pain management, Audiology, Ophthalmology, Trauma and Orthopaedics and Urology. ENT single PTL has been completed. Colorectal PTL work has commenced and will form part of the colorectal move to Worthing Hospital. This programme is ongoing and part of the new Trust strategy.

WORKSTREAM: PLANNED CARE

University Hospitals Sussex NHS Foundation Trust

Milestone	Original Target Completion	Completed (Y – date, N – new date)	KPI (if applicable)	Comments
Operational plans submitted	Q1 2024/25	Y, as per BAU contracting processes.	N/A	N/A
80% specialties using e-RS	Q2 2024/25	Y - February 2025	Increase the number of referrals triaged within ERS to 90% for eligible services	Expected total project completion April 2025 for all specialities. Plans in place for outstanding specialities with the support of GIRFT & CLEAR.
Netcall implemented	Q2 2024/25	Y - October 2024	RAIDR Compliance – 12 Week Validation and DNA Rates	2.39m messages sent, a reduction of DNA's in areas with Netcall implemented by 5.52%. Nominated for a HSJ awards. Significant improvements in waiting list validation noted.
Waits >65 weeks eliminated	Q1 2025/6 (previously Q3 2024/25)	N - June 2025	65 week wait position	Under focused support from GIRFT, recovery plans in place for each speciality. Under tier 1 reporting. Delivered 117% of ERF activity. Expected delivery July, continued improvements made. 377 patients currently driven by ENT 34%.
Improve performance against the 28-day Faster Diagnosis Standard to 77%	Q4 2024/25	Y- March 2025	28 day faster diagnosis performance	Current confirmed position 81.6% in March 2025 Trust currently under Tier 1 reporting with support from the cancer alliance.
Increase the percentage of patients that receive a diagnostic test within six weeks to 95%	Revised target April 2025 (previously Q4 2024/25)	N- April 2025	DMO1 breaches %	Diagnostic board launched, recovery plans in place and currently under NHSE tier 1 reporting. DM01 Best performance in 5 years in March 2025 of 14.3%, improved from 30% in April 24.

WORKSTREAM: UEC (1 of 2)

University Hospitals Sussex NHS Foundation Trust

Milestone	Original Target Completion	Completed (Y – date, N – new date)	KPI (if applicable)	Comments
Site based UEC plans developed	Q1 2024/25	Y	N/A	- Site level improvement portfolios developed for each main site (RSCH/RACH/PRH/WH/SRH) with associated performance trajectories. - 9 Trust wide workstreams additionally developed to address cross cutting improvement themes i.e. Frailty, UTC, SDEC. - Mapping and alignment of UEC GIRFT recommendations to improvement portfolio to ensure delivery and integration of national best practice.
New UEC oversight approach embedded	Q1 2024/25	Y	N/A	- Structure of governance in place to deliver UEC Improvement Programme from project level groups through to Exec Oversight and NED Committee.
Reconfiguration of clinical site at RSCH for UEC	Q2 2024/25	N – *Q2/3 25/26*	78% patients seen and treated within 4 hours Number of patients waiting over 12 hours from arrival in ED Current performance: 4-hour performance 66.9% (Mar 25). 12-hour breaches 2, 606 (Mar 25), 7.9% of attendances.	- Signpost to Acute Floor Re-design and stage 1 benefit realisation following LMB build. - Trust wide project initiated to address Corridor care safety and elimination as a pre-requisite to commencing capital works. - Opening of SAU
Optimise SRH UTC model	Q2 2024/25	N – July 2025	78% patients seen and treated within 4 hours Not admitted and not referred (NANR) 4hr performance Total time in department for walk-in patients Overall UTC activity throughput & referrals back to ED Time to clinician UTC/ majors	- Trust wide programme to deliver a standardised UTC model delivering compliance with the 32 national UTC recommendations across all sites including SRH in progress. - Programme comprises of 5 workstreams aligned with themes within 32 standards: Clinical model inclusion/exclusion criteria; Funding and commissioning; Patient and pathway modelling; workforce recruitment and training and digital and data enablers. - UHSx UTC exclusion criteria agreed with Clinical approval - 2x UHSX Stakeholder engagement workshops completed. - HR team progressing staffing/recruitment conversations with ABC/HERE re TUPE for HERE/ABC. - UHSX Comms plan developed. Exec COO message sent. - I.T System technical requirements sessions held with key stakeholders. - Benefit Realisation plan progressing.

WORKSTREAM: UEC (2 of 2)

University Hospitals Sussex NHS Foundation Trust

Milestone	Original Target Completion	Completed (Y – date, N – new date)	KPI (if applicable)	Comments
78% UEC patients in 4 hours	Q4 2024/25	N – *new date Q4 2025/26*	% patients seen and treated within 4 hours. Current performance: 66.95% (exc. Sussex Eye Hospital and MIU's) Mar-25.	- 20 site based projects with 4 hour performance as the primary objective. These are being reviewed to establish what is being used to business as usual and for operational grip - 9 Trust wide programmes targeting 4 hour performance through direct changes to ED processes or indirect improvements to flow through the department and time spent in ED including: Optimising SDEC; Frailty Pathway Optimisation; Implementation of Interprofessional Standards; Implementation of Continuous Flow Model; Optimisation of the UHSx UTC Service. ECIST involved in development of the Frailty work - UEC Data Integrity project to ensure accuracy and standardisation of process and coding to ensure integrity of performance reporting and to support operational and clinical decision making. - Integration of 4 hour performance focussed GIRFT recommendations into improvement plan.
Length of stay reduced	Q4 2024/25	N – *new date Q4 2025/26*	Average LoS exc. day 0 by Trust/Site/Division/Ward Variance to 10% target by Trust/Site/Division/Ward 21 day cohort and % change by Trust and Site % Bed Occupancy by Trust and Site DRD patients by Trust and Site Current performance: Relatively static position of 10.4 days (March-25) compared to previous in-month's average of 10.2 days. 24/25 target-9.0 days.	- Completion of Discharge Planning Standards maturity matrix by all in scope divisions to ascertain level of discharge planning process best practice embedded at ward level. - Divisional plans in place aiming to deliver 10% reduction target. - Focus on 3 priority Trust level workstreams in 25/26: Discharge Planning and Training; Reducing De-conditioning and Optimising Therapies. - Divisional plans developed and progressing against 10% LoS reduction targets. - Unified ref form in development to support OT/PT front door services and Frailty Wards. - Deconditioning training offer implemented. - Reducing Deconditioning 'Activity Week' designed for 2/6. - Continue flow models implemented at sites. - Developed c. 50% of discharge planning online training aimed at supporting roll out of discharge planning training. Above bed-board pilot launched.

WORKSTREAM: EDI

NHS
University Hospitals Sussex
NHS Foundation Trust

Milestone	Original Target Completion	Completed (Y – date, N – new date)	KPI (if applicable)	Comments
Complete WRES/WDES reports	Q1 2024/25	Y- Q1 2024/25	WDES and WDES are reported on and used as ongoing measures with reporting every 3 months.	Latest Trust WRES and WDES reports were published in November 2024. Preparation for publication of the Trust's 2024/25 Annual Equality Report is now underway (due in Q1 2025/26)
Update EDI action plan with insights from audit and implementation underway	Q2 2024/25	Y- Q2 2024/25	Confirmation post People & Culture Committee approval	For the EDI Action Plan with insights from (BDO EDI Maturity Assessment) Audit the BDO recommendations have been integrated into the Three-Year EDI/Workforce Inclusion Plan Strategy (2022-2025). The Year 3 refresh is due to go to People & Culture Committee for approval in March 2025.
local teams are able to use power BI to identify EDI improvements	Q3 2024/25	Y- Q3 2024/25	N/A	The EDI Dashboard has been developed and implemented.

WORKSTREAM: MATERNITY

University Hospitals Sussex NHS Foundation Trust

Milestone	Original Target Completion	Completed (Y – date, N – new date)	KPI (if applicable)	Comments
Maternity strategy engagement	Q2 2024/25	Y but delayed to Q4 2025/26	n/a	Draft completed and out for comment, once reviewed, will follow usual ratification process.
Maternity COM and recruitment	Q3 2024/25	>80% complete	Vacancies	Midwifery and obstetric leadership roles now fully recruited

WORKSTREAM: SPECIALISED SERVICES

University Hospitals Sussex NHS Foundation Trust

Milestone	Original Target Completion	Completed (Y – date, N – new date)	KPI (if applicable)	Comments
Launch specialised services steering group	Q1 2024/25	Y- Sept 2024	N/A	Service review process underway with all spec com services. UHSx & spec com now working closer together to support recovery. Divisions and services now engaged on spec com strategy.
Specialised services contracts and SDIPs agreed	Q1 2024/25	Y- Jan 2024	N/A	SDIP's now completed and being monitored through NHS E CRM and overarching trust governance where appropriate.

WORKSTREAM: CULTURE

University Hospitals Sussex NHS Foundation Trust

Milestone	Original Target Completion	Completed (Y – date, N – new date)	KPI (if applicable)	Comments
100-day report – culture and OD	Q1 2024/25	Y- Q1 2024/25	N/A	Full report with key recommendations shared with the Trust. These recommendations formed the basis for the OD and Culture plan.
OD plan developed and approved	Q2 2024/25	Y- Q2 2024/25	N/A	An initial plan for the OD and culture work has been developed and approved to outline the year 1 activities aligned to Trust strategy, there is further work on addressing trust-wide culture issues which will form plans for subsequent years of work.
OD plan implementation commences	Q3 2024/25	Y- Q3 2024/25	Staff survey and pulse survey scores : i.) Overall staff engagement ii) Advocacy domain scores	The implementation of work within the OD and Culture programme has commenced and is currently in delivery . This is being organised through a structure initially of six key workstreams as part of the culture programme and these cover the priorities as outlined

WORKSTREAM: AREAS OF JOINT DELIVERY

NHS University Hospitals Sussex NHS Foundation Trust

Milestone	Original Target Completion	Completed (Y – date, N – new date)	KPI (if applicable)	Comments
Surgery cultural diagnostics and engagement	Q1 2024/25	Y- Q4 2024/25	N/A	Bespoke educational resources and executive led training have been provided to the department to improve behaviour and relationships. These include Freedom to Speak Up, 'Civility Saves Lives', 'Active Bystander' - November 24 and Human Factors training – January 25. Identification of hotspots within clinical areas will direct the training rollout. This is an area of joint working across a number of workstreams and BAU activity
Approval of Staff Dress Code and Uniform policy	Q4 23/24	Y- Jan 2024	N/A	Dress Code Uniform Standards policy was ratified at the Trust Management in January 2024. Policy developed and implemented to drive change across the Trust.
90% staff completing Level 1 Human Factor training	Q1 25/26	N – 2028	Numbers of attendees 8090	Clarification: target relates to 90% of staff to complete Level 1 training "Essentials of Patient Safety" by 2028. The course is a combination of introduction to Human Factors Level 1 and deteriorating patients . The training was implemented in April 2024 and as of March 2025, 51% (8090/15593)) of staff have completed this training.
25% staff completing Level 2/3 Human Factor training (surgery)	Q1 25/26	N - 2028	Numbers of attendees: Level 2 (half day) - 61 Level 3 (full day) - 1603	As of March 2025, 1603, staff members have completed Human Factors Training Level 2 (half day) and 3 (full day) which have been combined to maximise attendance opportunities. This training programme is initiated with monthly training sessions for all staff. Bespoke Human Factors trainings are also delivered to specific staff cohort and departments on request. This is embedded within existing training offer to all staff is currently not mandatory. Ongoing oversight of training sits with the Medical Education team and full programme is place for the next 12 months

University Hospitals Sussex
NHS Foundation Trust

Perinatal Quality Surveillance – Trust wide summary report – February 2025 data

Purpose

There are five principles for improving oversight for effective perinatal[1] clinical quality[2] to ensure positive experience for women and their families. They integrate perinatal clinical quality into developing integrated care system (ICS) structures and provide clear lines for responsibility and accountability for addressing quality concerns at each level of the system.

Background

In response to the need to proactively identify trusts that require support before serious issues arise, a new quality surveillance model seeks to provide for consistent and methodical oversight of all services, specifically including maternity services. The model has been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services.

The provider trust and its board, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, remain responsible for the quality of the services provided and for ongoing improvement to these.

Introduction

The Ockenden enquiry concluded that there needs to be more direct Board oversight of Maternity. A suggested dashboard was produced by NHSE/1 which we have adapted for use at University Hospitals Sussex Trust and tested via Quality Board.

[1] In recognition that neonatal services are inextricably interdependent with maternity services, we refer to maternity and neonatal quality in terms of 'perinatal clinical quality' throughout this document.
[2] High quality care is understood, as per National Quality Board (NQB) definitions, to be care that is safe, clinically effective and which provides a positive experience for women. Additionally, in maternity, it is recognised that safe care can only be achieved when care is personalised

This single page data dashboard together with an exception report relating to the metrics is submitted each month to Board for presentation by Emma Chambers, Director of Midwifery, sponsored by Maggie Davies as Maternity Champion at Board level. The surveillance dashboard/exception report will flow through the Monthly maternity Quality and Safety meetings.

Risk Register

The following risks were added during February with a score of 16 and above.

ID	Title	Risk Register	Type	Current Risk Grading	Last risk updated date
2411	Lack of administration support across obstetric service-ante natal.	Women & Children	Service Delivery	16	17/03/2025 16:06

There were no risks closed during February with a score of 16 and above.

Escalations for April meeting

- Continued sonography gaps meaning that not all women are receiving scans in line with Saving babies Lives v3 recommendations. There is a National and local sonographer shortage, escalations to NHSE have not resulted in any action.

Celebrations for April meeting

- The Trust has met the national NHSE ambition set in 2017 by the Secretary of State for Health, to reduce the stillbirth rate by 50% by 2025. The aspiration was a rate 2.5/1000 births. The service has in fact significantly exceeded this ambition with the rate currently being 1.05/1000 births.

Domains

1. *Deaths and Harm*

Feb-25	Latest MBRRACE National Figure (June 2023)	Southeast Benchmark (June 2023)	Trust Rates	Princess Royal, Haywards Heath	Royal Sussex County Hospital, Brighton	St Richards Hospital, Chichester	Worthing Hospital, Worthing
Deaths and Harm							
12 Month Rolling Neonatal Death (NND) Rate per 1000 births	1.67 (2.33 for Level 3 NNICU sites including RSCH)	1.4	1.64	0 NNDs 12 month rolling rate is 2.26/1000	0 NNDs 12 Month rolling rate is 2.66/1000	0 NND. 12 month rolling rate is 1.39/1000	0 NNDs. 12 month rolling rate is 0/1000
12 Month Rolling Stillbirth Rate per 1000 births	3.33	3.3	1.05	0 Stillbirths 12 month rolling rate is 1.36/1000	1 Stillbirth 12 month rolling rate is 1.33/1000	0 Stillbirths 12 month rolling rate is 0.92/1000	0 Stillbirths 12 month rolling rate is 0.52/1000
12 Month Rolling Perinatal Mortality Rate per 1000 births	5 (5.66 for Level 3 NNICU sites including RSCH)	4.7	2.69	3.62	3.99	2.31	0.52
MNSI Referrals	n/a	n/a	2 x MNSI	1 x MNSI	0 x MNSI	1 x MNSI	0 x MNSI
Serious Incidents (SI)/PSII	n/a	n/a	2 x SI	1 x SI	0 x SI	1 x SI	0 x SI

Maternity and Neonatal Safety Investigation (MNSI) Referrals:

PRH: Cooling case

SRH: Cooling case

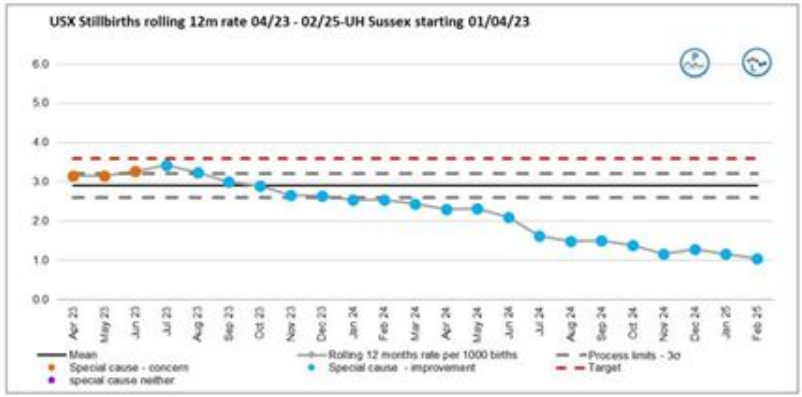
Analysis:

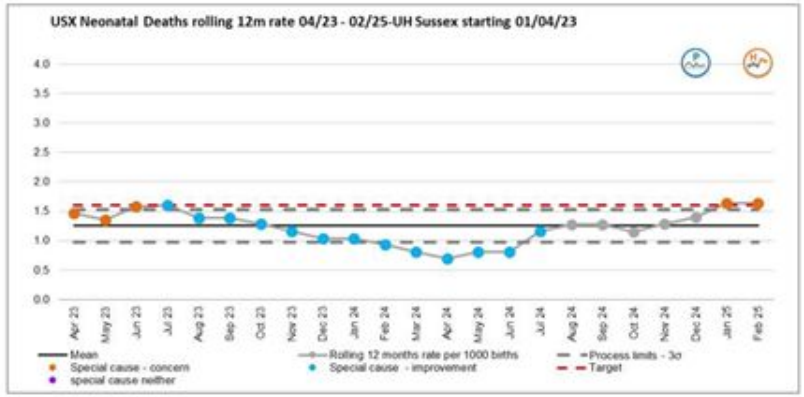
Overall, the service continues to demonstrate special cause improvement in stillbirth and overall perinatal mortality rates as well as Hypoxic Ischemic Encephalopathy (HIE or brain injury) grades 2&3. Special Cause Concerning Variation had been noted for neonatal deaths; a thematic review MDT panel attended by external representation, examined the cases in March, no themes were identified. The report can be viewed here: NND review PRH-SRH 2024.pptx

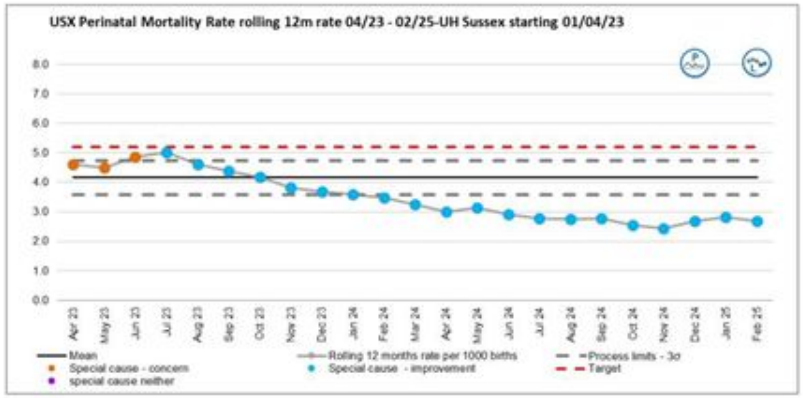
The Trust has met the national NHSE ambition set in 2017 by the Secretary of State for Health, to reduce the stillbirth rate by 50% by 2025. The aspiration was a rate 2.5/1000 births. The service has in fact significantly exceeded this ambition with the rate currently being 1.05/1000 births. The service continues to progress quality improvement actions previously outlined, which are focused on reducing poor outcomes further. These include workforce improvements, training, culture, documentation, and fetal monitoring.

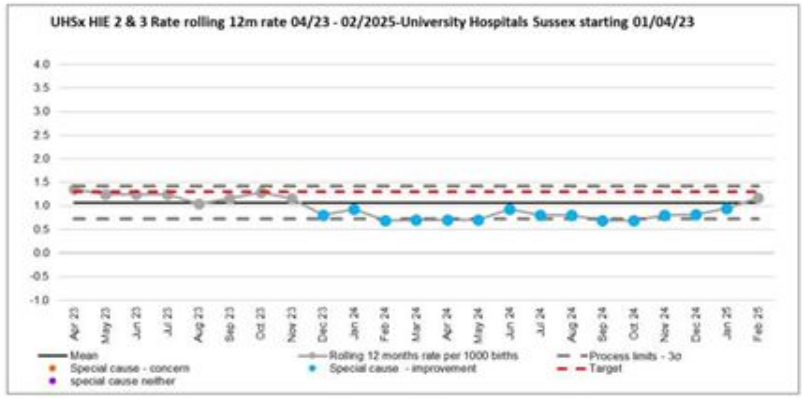
Perinatal Mortality Statistical Process Control (SPC) charts, (using the NHS England SPC tool[3]) (next page)

[3] Statistical-Process-Control-Tool.xlsm (live.com)









Health Inequalities – data not available from LMNS – to report in May paper

Maternity Safety Support Programme (MSSP) and Maternity Improvement Plan (MIP):

The service continues to make progress towards achieving the required exit criteria. This was recognised during a review meeting in November. A further review meeting is scheduled for May, with a view to moving into the sustainability phase of the programme, with the aim for exit late 2025. One 'exit criteria' action remains, to provide access to a separate theatre for planned caesarean sections. Agreement has been reached with the executive team regarding which option will be pursued, and the planning is progressing, with the aspiration that lists will be running before the MSSP review meeting in May.

2. *Leadership and training*

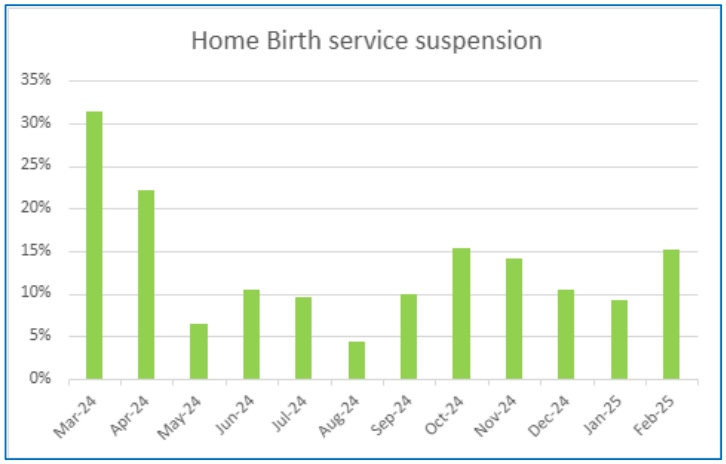
Feb-25	PRH		PRH		RSCH		RSCH		SRH		SRH		WH		WH	
	12 months rolling		In month		12 months rolling		In month		12 months rolling		In month		12 months rolling		In month	
Fetal Monitoring - Midwives	84.44%	↓	81.65%	↓	78.97%	↓	78.49%	↓	94.86%	↑	96.09%	↑	89.71%	↓	88.80%	↓
Fetal Monitoring - Medical	66.09%	↑	72.73%	↓	54.04%	↓	52.17%	↑	92.88%	↔	92.31%	↑	78.52%	↑	96.00%	↑
Multi-Disciplinary Skills Drills	92.19%	↓	88.86%	↑	87.52%	↑	89.59%	↑	86.43%	↑	90.69%	↓	85.10%	↑	93.75%	↑

Poor training compliance in PRH and RSCH medical teams escalated to the clinical director and site clinical lead consultants.

3. <u>Voice of the User</u>

Voice of the user	Princess Royal, Haywards Heath	Royal Sussex County Hospital, Brighton	St Richards Hospital, Chichester	Worthing Hospital, Worthing
Friend and Family Test	92.86%	94.1%	96.88%	92.00%
Complaints	1	3	2	1
Legal Claims	0	1	0	0
MNVP concerns	0	0	0	1

Home Birth Suspensions:



Sickness within the home birth and wider midwifery teams has impacted home birth service delivery, the current model of home birth provision at PRH and RSCH is impacting the wellbeing of the team, a review of this model is underway. The reducing overall midwifery vacancy will positively impact this service over the coming months.

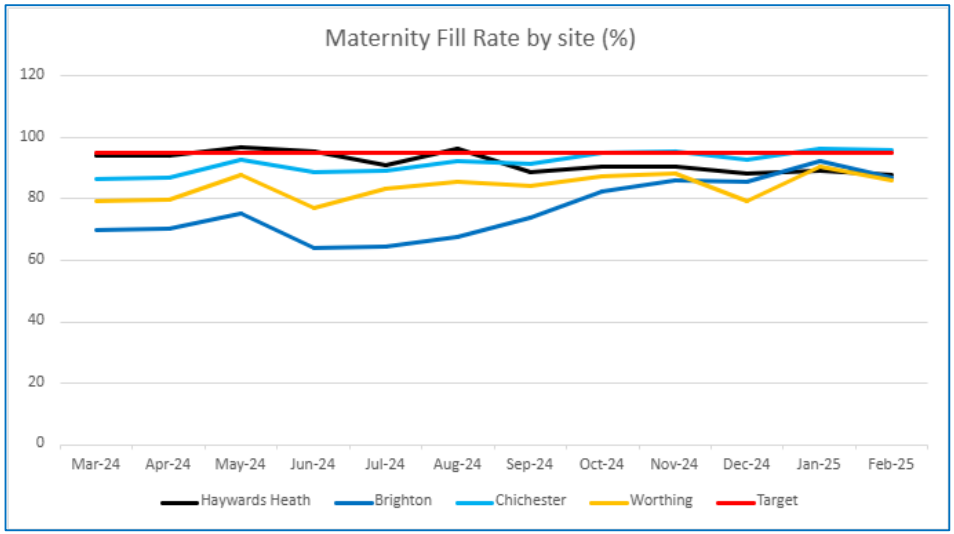
4. Team feedback

Perinatal Workforce

A maternity Safety Forum was chaired by Lucy Bloem, Maternity Safety Champion NED, and Maggie Davies, executive Maternity safety Champion, on 1st April 2025 Discussions focused on the Staff Survey results, CQC high-level feedback and smoking cessation. The quadrumvirate and maternity safety champions (exec and non-exec), met on 7th April, planned caesarean lists and CQC high-level feedback actions were discussed.

Midwifery workforce:

Workforce	Princess Royal, Haywards Heath		Royal Sussex County Hospital, Brighton		St Richards Hospital, Chichester		Worthing Hospital, Worthing	
Midwifery B5/6/7 core vacancy	-0.89%	↑	7%	↓	0.00%	↔	0.00%	↔
Midwifery sickness	8.10%	↓	6.10%	↓	4.70%	↓	8.90%	↑
Actual vs planned staffing	88.00%	↓	87.13%	↓	95.73%	↓	86.09%	↓



A reduction in midwifery vacancy rates has resulted in increased fill rates, especially in Brighton. Sickness rates remain high on some sites, targeted action supported by HR, is taking place in these specific cost codes.

Neonatal nursing

	Princess Royal Haywards		Royal Sussex County Hospital.		Worthing		St Richards	
Nursing vacancy rate	8.7%	↓	22.2	↑	13.4%	↓	20.7%	↑
Nursing sickness rate	2.9%	↓	8.3%	↑	11.0%	↑	5.3%	↓
Parenting leave	3.1%		4.0%		0%		4.0%	

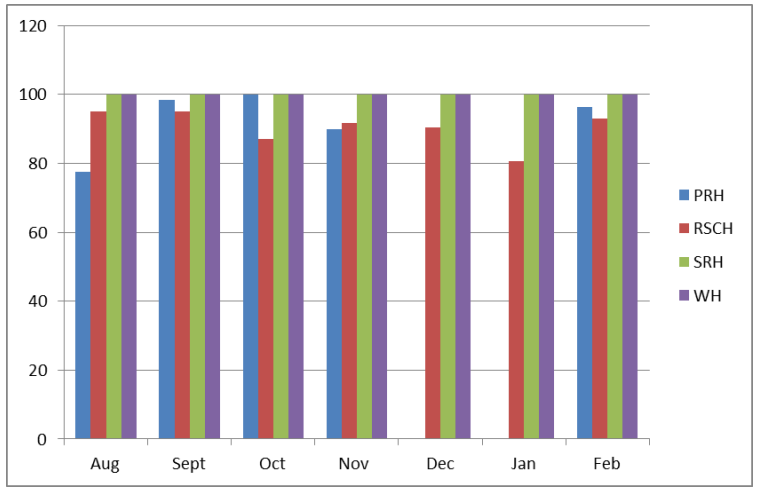
Active recruitment continues all sites for neonatal nursing. At our NICU in Brighton a workforce plan to increase nurse staffing numbers incrementally over 3 years is on track, with a forecast of a reduction to 15% by April. The plan includes an education strategy to improve numbers of QIS trained nurses and to reach the 70% standard for QIS nurses on shift. Nursing numbers in our level 1 SCU's remain fragile although improving due to small teams however this is supported by additional bank work carried out by regular temporary staff and additional hours by substantive employees. Work continues to recruit and retain experienced neonatal nurses. Sickness rates remain high, with work ongoing to support the team's well-being and to appropriately manage sickness absence.

Obstetric medical

O&G WH/SRH	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	32.01	26.61	5.40
Medical - SAS Doctor	1.53	1.20	0.33
Medical - Resident Doctors	44.87	40.62	4.25
O&G PRH/RSCH	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	24.46	23.24	1.22
Medical - SAS Doctor	2.01	0.00	2.01
Medical - Resident Doctors	35.80	38.03	(2.23)

- All site lead consultants have been appointed and are now in post
- Consultant vacancy quoted higher than expected on WH/SRH site and all job plans being reviewed
- Three fixed term consultants at PRH/RSCH will have job plans reviewed with plan to substantiate later this year
- 12 month fixed term locum consultant at SRH to be appointed April/May
- Resident doctor recruitment ongoing

Twice daily consultant ward round compliance:



A requirement from the first Ockenden report (2020) was to provide 'consultant present' ward round twice daily. This has been very challenging to achieve at PRH due to vacancy and job planning restrictions, meaning that the consultant attended remotely. A resolution was found in the summer 2024, and the process is embedding with improving attendance.

Data capture errors impacted evidencing this in December and January, however, anecdotal evidence suggested attendance. The expectation is that 100% compliance will be achieved, this is being closely monitored by the obstetric clinical director.

Neonatal medical

Paediatrics WH/SRH	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	29.37	29.66	(0.29)
Medical - SAS Doctor	4.22	4.52	(0.30)
Medical - Resident Doctors	40.21	25.53	14.68

The medical teams cover general paediatric and neonatal services at WH/SRH. Consultant numbers include ROCC posts who Contribute to the middle grade rotas on both sites

TMBU	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	12.30	14.64	(2.34)
Medical - SAS Doctor	0.00	2.00	(2.00)
Medical - Resident Doctors	18.70	18.06	0.64

The TMBU and PRH neonatal tier 1 and 2 rotas overlap with ANNP's deployed to medical rotas on both sites and tier 2 medical staff supporting PRH alongside ANNP's.

Advanced Neonatal Nurse Practitioners (ANNP) workforce RSCH/PRH

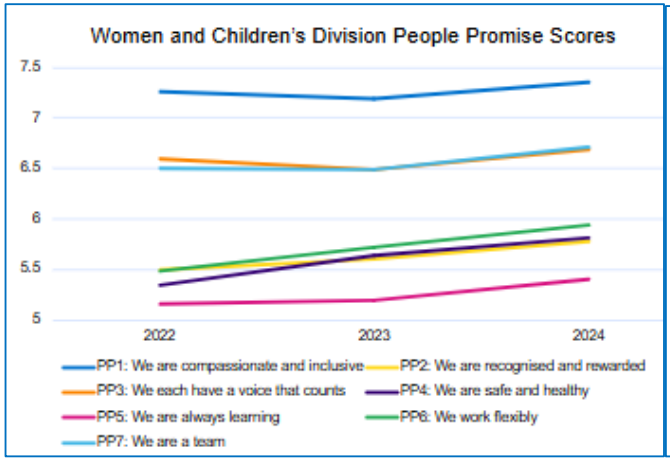
ANNPs	Budget WTE	Contracted WTE	Vacancies
Nursing & Midwifery - Registered	16.00	15.85	0.15

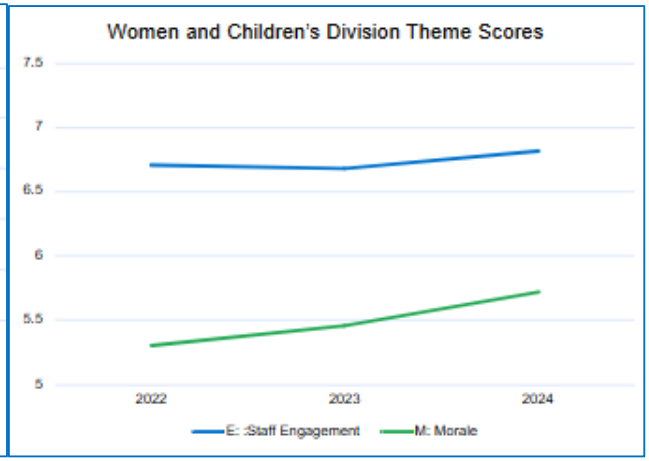
Workforce pressures affecting the neonatal rota at PRH have eased with the recent successful recruitment of ANNP's. However, there is ongoing support from the tier 2 medical staff from PRH.

In September a Prevention of Future Deaths (PFD) notice was received from the coroner following an inquest for a baby who died following birth at PRH. The PFD raises concerns around the fact that out of hours consultant neonatology cover is for both PRH and RSCH at the same time. Although this did not contribute to the death in this case, the coroner raised concerns regarding the risk of future death. A response is being prepared.

Staff Engagement:

As a division, a positive shift was seen in all People Promise domains in the 2024 Staff Survey:

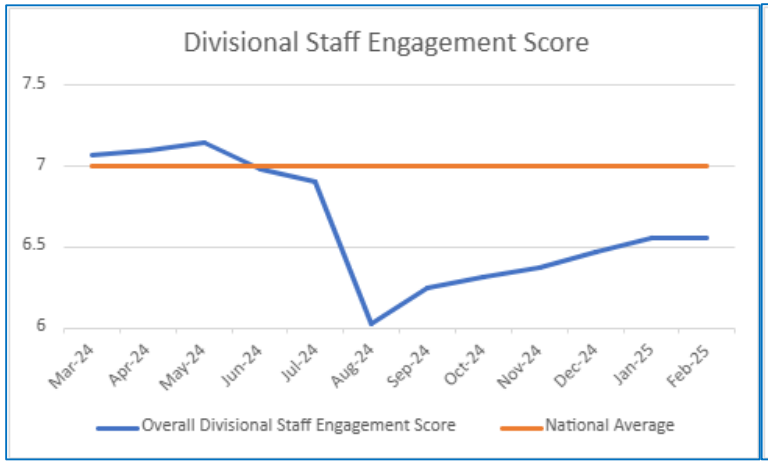


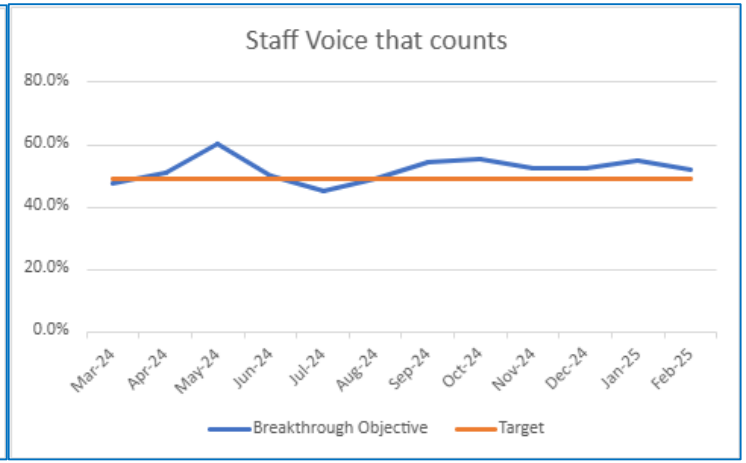


At question level all staff groups in Maternity Services in RSCH/PRH improved by 82%, and at SRH/WH they improved by 70% for non-medical staff and 58% for medical staff from 2023 scores for the comparable questions. Some questions have demonstrated deteriorating scores however, these include staff experience of discrimination and are being explored on a cost code basis by service leads.

The Staff Voice that Counts Score for the Division remains above the Trust target, the Staff Engagement Score is recovering following a significant drop in the summer. Staff engagement work continues, including Listening Events across the services, video messaging and service specific and Division wide newsletters. The Quadrumvirate has introduced 'Town Hall' face to face sessions on each site each month. We now also have a team of clinical Maternity Safety Champions, who will directly communicate with the clinical teams, leadership, executive and non-executive Safety Champions and share information with the clinical teams.

The Divisional Clinical Operating Model is nearly recruited, meaning that visible, site-specific leadership, as well as service wide leadership will be available to the teams.





ImproveWell

The ImproveWell app is a tool to improve staff engagement and wellbeing. 241 members of the team are now using the app, with 77 ideas having been submitted to date. These include cost saving ideas, environmental improvements, and support for families whose first language is not English.

Conclusion and Recommendations:

The perinatal service has seen positive progress in several areas; continued reductions in perinatal mortality and morbidity, continued positive service user feedback rates, improved Staff Survey responses, CNST MIS year 6 submission and positive high-level feedback following the CQC inspection. Progress within the vast Maternity Improvement Plan, improved vacancy position within the clinical teams and increased capacity of leadership teams has been pivotal in this progress. There is much to still achieve, however, momentum and trajectory are very encouraging.

Report prepared by: Sally Harborow, Maternity Clinical Effectiveness Manager, Raili Frost, Maternity Improvement Programme Manager, Beckie Elms, Interim Head of Midwifery for RSCH & PRH, Gail Addison, Head of Midwifery for SRH & WH, Claire Hunt, Divisional Director of Nursing, Emma Chambers: Director of Midwifery

Date: 9th April 2025

University Hospitals Sussex
NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust
Saving Babies Lives Quarterly report – Quarter 3 24/25

Introduction

An audit plan has been developed to continually monitor and identify areas to improve the service and outcomes relating to the care bundle. Saving Babies Lives (SBL) audits for quarter 3 2024/25 have been completed. The aim is to provide assurance to our Trust and the Local Maternity and Neonatal System that all six elements have been implemented. Furthermore, that where quality improvement areas are identified there is a robust plan to assess and review and changes to practice.

The NHS Long Term Plan reiterates the NHS's commitment to a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury and a reduction in preterm birth rate, from 8% to 6%, by 2025. Implementation of the care bundle has been included in NHS contracts and is a requirement of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. The initiative brings together 6 elements of care that is recognised as evidence-based and/or best practice, these include:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth
3. Raising awareness of reduced fetal movements
4. Effective fetal monitoring in labour
5. Reducing preterm birth.
6. Management of pre-existing diabetes in pregnancy

This report captures compliance at all 4 sites. Worthing, St Richards, Royal Sussex County and Princess Royal Hospitals. All process and outcome indicators are now in line with Saving Babies Lives Care Bundle version 3 (SBLCBv3). UHSussex rapidly increased compliance on all areas since the implementation tool was introduced. The trust is currently 100% compliant for the quarterly Saving Babies Lives assurance meetings with the LMNS. These meetings are used to review the quality of the data used to provide assurance relating to compliance with the care bundle. The team continues to embed the regional preterm optimisation QI initiative, Prem 7+ and the British Association of Perinatal Medicine (BAPM) guidance to increase element 5 compliance.

The next assurance meeting with the LMNS is planned for March and as UHSussex is now 100% compliant with the implementation tool focus will change to identify meaningful QI projects with leads from the relevant elements to improve care for our women and their families which in turn will assist in reducing the still birth and neonatal death rates.

This report is to be presented at the Maternity Safety and Quality meeting.

1.REDUCING SMOKING IN PREGNANCY

UHSussex has an in-house Smoke Free Pregnancy Team (SFPT) as per Saving Babies Lives (SBL) recommendation. The team is well established and the results and outcomes positive. The team provide a thorough in-depth quarterly report due to the complexity of this element the summary of performance is reported here.

Smoking at time of booking: 6.49%
Smoking at time of delivery: 4.76%

Process indicators and Outcomes		Ambition	Stretch ambition	Quarter progress
CO@ booking 1 a.i	91.3%	90%	95%	-3.6%
CO@36/40 1 a.ii	87.5%	80%	95%	-1.1%
Asked about smoking at booking 1 a.iii	100%	80%	95%	-0.1%
Asked about smoking at 36/40 1 a.iv	63.3%	80%	95%	-1.4%
% of tobacco smokers referred to opt out service 1.b	94.4%	90%	95%	-2.1%
% of tobacco smokers in Q1 who set a quit date 1 c	59.9%	50%	60%	-8.4%
% of tobacco smokers at booking that are CO verified non smokers at 36 weeks 1 d	31.7%	25%	NA	-5%
% of tobacco smokers who set a quit date and have a non-smoking CO verified reading at 4 weeks 1 e – new process of data capture	22.8%	50%	60%	+4.5%
% of tobacco smokers where CO is recorded at all antenatal appointments 1.2	64.3%	Maintain	NA	-10.6%
% of tobacco smokers where smoking status is recorded at all antenatal appointments 1.3	77.8%	Maintain	NA	-4.2%

1.7 – Feedback for named maternity health care professional is well established. Communication emails are direct from SFPT to named midwife including celebrations of successful quit attempts as well as relapse.

1.8 – All staff using CO machines have had training and new members of staff are captured within the recruitment processes. This is a one-off training with the SFPT and although the SFPT deliver education the machines have not changed and repeat training on devices and interpreting the results is not required annually.

1.9 – The SFPT have a 30 min slot on mandatory training which included processes, opt out referrals, feedback and data collection. The verbal update supported by SBL eLearning for Health package. Training for Q4 will be different as we approach a new education year.

In Q3 265/286 members of staff attended their mandatory SFP update. This is 92% of staff expected to attend this day.

1.10 – All staff delivering TDT have been trained in the delivery of this. There are no new members of staff in the team in Q3.

2. RISK ASSESSMENT, PREVENTION AND SURVEILLANCE OF PREGNANCIES AT RISK OF FETAL GROWTH RESTRICTION (FGR)

INTERVENTIONS: Reducing the risk of FGR

Assessing women at booking to determine if a prescription of aspirin is appropriate.

All women/people are risk assessed at booking for FGR and hypertensive disorders. The guidance from SBL Appendix C is incorporated in local clinical guidance and midwives can refer to the GP to prescribe aspirin for at risk pregnancies for timely commencement by 16 weeks.

Additional Measure		Ambition	Stretch ambition	Quarter progress
Percentage of women booked who had a risk assessment for aspirin	99.1%	80%	90%	+0.%

The latest quarterly audit of 10 exceptions demonstrated there is work to be done in improving risk assessments and is captured in the Element two leads meeting. A working party has already been formed to support improvement efforts with the community teams, work has not progressed due to redeployment of specialist staff to work in the acute setting.

Recommending vitamin D to all pregnant women.

Recommendation of vitamin D for all is within local guidance relating to antenatal care. Furthermore, it is included on every BadgerNet (digital maternity notes system) management plan.

Additional measure		Ambition	Stretch ambition	Quarter progress
Vitamin D recommended at booking as per BN report	44%	80%	90%	N/A
Vitamin D recorded as being taken	92%			-6%
Audit of all SGA babies	93%			+1%

A review of cases noted that where the data is missing vitamin D is often noted as free text rather than selecting the picklist options, meaning compliance is higher than BadgerNet reports. Also, most patients are taking it and thus a recommendation is not needed, midwives view ticking the box on BadgerNet as unnecessary.

INTERVENTIONS: Monitor and review risk of FGR throughout pregnancy

Perform a risk assessment pathway (for example, Appendix D) which triages women at increased risk of FGR into an appropriate clinical pathway to provide surveillance for FGR.

People are stratified into low, moderate and high-risk pathways to increase surveillance. Multiple pregnancies follow surveillance as per NICE guidance.

Outcome Indicator 2a		Ambition	Stretch ambition
Numerator: Number of pregnancies where a risk assessment is completed by 14 weeks	2104	80%	90%
Denominator: Total number of pregnancies submitted to MSDS	2106		
FGR assessment complete	99.9%		

Risk assessments are taking place in all bookings that occur before 14 weeks.

Quality of risk assessments has been a theme when auditing. Opportunity for QI has been identified in the following areas:

1. Education and support for community staff undertaking the assessments.
2. The double-checking process for the antenatal clinic leads once referral received.
3. The reassessment of risk following combined screening and the results

This had commenced and all parties were engaged well until the start of Q2. Since then, this work has not progressed due to redeployment of specialist staff to work in the acute setting, this redeployment ended at the end of Q3.

2.7 - Women who are high risk for FGR (Appendix D) should undergo Uterine Artery Doppler (UAD) assessment between 18+0 to 23+6 weeks.

Scan results are not recorded on BadgerNet, meaning a full audit of uterine artery dopplers for high-risk people identified at booking is not possible. Out of 40 high risk people 31 77.5% had correctly had their UAD performed at their 20-week scan. The processes and follow up have been identified as a QI project within the leads meeting and is part of a bigger piece of work surrounding capacity. UHSussex have scanning capacity issues at Royal Sussex County and Princess Royal Hospitals. This features on the divisional risk register as aligns to the same risk on the Clinical Support Services risk register, with a score of 20 on both. A gap analysis has been undertaken supported by the LMNS and shared with NHSE.

2.10 - Women who are at low risk of FGR following risk assessment should have surveillance using antenatal fundal height (FH) measurement before 28+6 weeks gestation. Measurements should be plotted or recorded on charts by clinicians trained in their use.

Measuring FH is well embedded within midwifery skills and performed well on low-risk women. The fetal wellbeing team supplies training. There were 3 cases in Q3 that were mismanaged with low-risk surveillance which resulted in an SGA baby. One case at Worthing did not see a community midwife for 6 weeks and SFH was not measured by the obstetrician in antenatal clinic during that time. One case was a smoker who didn't have growth scans due to scanning capacity at RSCH and the final case was at PRH which saw a big drop in SFH at 29 weeks and was not referred for a growth scan until 36 weeks. All three cases have been Datix and followed up with feedback to the staff concerned. This equates to 93.5% compliance.

2.11 - Training of fundal height measurement, both technique and referral are covered in education on an MDT Fetal Wellbeing Day and will remain within maternity education annually to meet all requirements of the Core Competency Framework.

Training of fundal height measurement, both technique and referral is covered in our multidisciplinary MDT Fetal Wellbeing Day and will maintain an annual training obligation within maternity education to meet all requirements of the Core Competency Framework. 82.7% of midwifery and obstetric staff attended training in Q3

Management of the small for gestational age (SGA) and growth restricted fetus (FGR).

Commonly, the definition of SGA refers to a fetus with a predicted weight or an abdominal circumference (AC) measurement less than the 10th centile. SGA at birth is commonly diagnosed based on a birthweight below the 10th centile and often birthweight charts are adjusted for the sex of the baby.

Fetal growth restriction (FGR) implies a pathological restriction of the genetic growth potential. Some, but not all, growth restricted fetuses/infants are SGA. The likelihood of FGR is higher in fetuses that are smaller. Growth restricted fetuses may manifest evidence of fetal compromise (abnormal Doppler studies, reduced liquor volume). Defining FGR and thus diagnosing it in a current pregnancy is challenging because of the need to determine growth potential. Similarly, risk assessing whether FGR existed in a previous pregnancy presents a different challenge. There is a need to focus on those fetuses at risk of adverse outcome and thus those that are FGR rather than SGA using varying parameters such as sequential ultrasound measurements, Doppler assessments, and biomarkers.

All FGR cases both detected and undetected are reviewed by the fetal wellbeing team (SBL requires 20 undetected per year). Staff are requested to Datix unexpected cases to ensure there is a review of these potentially missed cases. Reporting on BadgerNet is limited due to the centiles used which are 0-0.4, 0.4-2.0 and >2-9.0, moreover it relies on staff entering the right information in the places for the report to be accurate. This means a manual audit is needed for thoroughness.

Outcome Indicator 2b		Ambition
Numerator: Number of pregnancies where an SGA fetus is detected during the antenatal period	111	N/A
Denominator: Total number of pregnancies submitted to MSDS	2098	
% of pregnancies where an SGA fetus is antenatally detected	5.3%	
Outcome Indicator 2d		Ambition
Numerator: Number of babies <3rd centile >37+6	16	Maintain Current compliance
Denominator: Babies born under the 3rd centile	28	
% of babies born under the 3rd centile >37+6	57.1%	

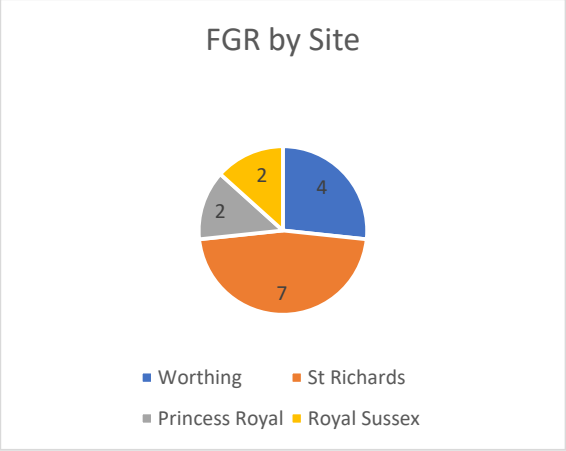
These outcome indicators are said to be a measure of effective detection and management of FGR.

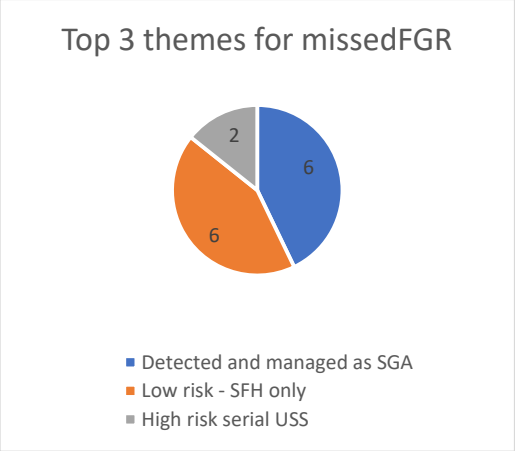
12 babies born within guidance = **42.9% (-4.5%) detection rate** for births < 3rd centile and born under 38 weeks.

16 babies were undetected for FGR. On review of the 16 born < 3rd >37+6:

- 6 women were risk assessed appropriately and followed SBL USS growth pathway but were detected and managed as SGA not FGR.
- 2 women were on a high-risk scanning pathway and not detected as SGA/FGR.
- 1 woman smoked tobacco and had serial scans as per SBL and was not detected as SGA/FGR.
- 1 with a high BMI and had serial scans as per SBL and was not detected as SGA/FGR.
- 6 women were on a low-risk pathway and did not have serial scans with no detection of SGA through symphysis fundal height measurements.

1 Woman chose to decline IOL for FGR following informed consent.





This data is produced in addition to SBL requirements to ensure consistency across the LMNS reporting	
Numerator: Number of pregnancies where an SGA fetus is detected during the antenatal period and born <10th centile	48
Denominator: Total number of pregnancies where a baby is born <10th centile	131
% of pregnancies where an SGA fetus is antenatally detected	36.6% (-5.9%)

UHSussex had 131 babies born under the 10th centile at any gestation (10 less than the previous quarter). Of these babies 48 were detected antenatally.

Babies born over 3rd and under 10th centile:

All babies born between 3rd and 10th centile and over 39+6 weeks gestation were reviewed, there were 30 babies born that fell into this category, 3 of which received antenatal care outside of UHSussex and one that declined monitoring of growth and therefore were excluded from analysis.

The following themes were identified with the 26 babies:

9 had SFH measurements which were not performed as per guideline and/or escalated appropriately. 8 of these were at the RSCH and PRH sites where scanning capacity is a known issue and not all risk factors are captured with serial scans as per SBL guidance. There is agreement that the clinical support services would not align guidance to SBLCBv3 until the capacity and demand issues are resolved.

Outcome Indicator 2e		Ambition	Quarter progress
Numerator: Number of babies >3rd centile <39+0 and IOL/LSCS for Suspected SGA	3	0%	+2 babies
Denominator: Babies born over 3rd centile	2069		
% of babies born above the 3rd centile <39+0 and IOL/LSCS for Suspected SGA	0.4%		

The aim of this indicator is to pick up babies who are identified as being small but are not small and have been induced/delivered unnecessarily. There were 3 unnecessary deliveries at UHSussex in Q3.

Process Indicator 2d. Annual data presented. Avoidable death report due in Q3. Findings will be shared in Q4.

3. RAISING AWARENESS OF REDUCED FETAL MOVEMENT (RFM)

INTERVENTIONS

Use Reduced Fetal Movements checklist to manage care of pregnant women who report RFM, in line with national evidence-based guidance.

The recommended reduced fetal movements checklist incorporated BadgerNet is used in addition to computerised Cardiotocograph (cCTG) analysis available on all sites. Audit in Q3: There were 1786 attendances at 28 weeks and above and the results were as follows:

Process indicator 3a		Ambition	Quarter progress
Numerator: Number of women with RFM that have cCTG	1531	Maintain	-2.1%
Denominator: Number of care contacts with RFM	1765		
% of women who attend with RFM and have a cCTG	86.7%		
Process indicator 3b		Ambition	
Numerator: Number of women with USS performed	46	65% (New)	-14%
Denominator: Number of care contacts with recurrent RFM	467		
Proportion of women who attend with recurrent RFM who had an ultrasound the next working day	46/467		
Manual Audit 5% of RFM attendances	13/24 54.1%		

BadgerNet displays the case as non-compliant even if the person was in labour and had a baby the next day, therefore a manual audit is needed. The audit of 5% of recurrent RFM 54% had a USS the next working day (MON-FRI) this is a reduction from 68% from the previous quarter. Sonography continues to be a challenged area in maternity as discussed in element 2. Of note, over 80% of the cases without a scan the next working day were at RSCH/PRH venues.

Outcome indicator 3d		Ambition	Quarter Progress
Numerator: Number inductions before 39 weeks where the only indication is RFM	10	<5%	+0.1%
Denominator: Number of inductions before 39 weeks	203		
Rate of induction when RFM is the only indication before 39 weeks	4.9%		

There is minimal change in this data. 5 cases are from PRH and the other 5 spread over the other 4 sites. No themes identified in relation to a particular member of staff offering IOL. Care is personalised and of note, there is a rise in listening to women's concerns and offering IOL following informed and individualised discussions.

Outcome Indicator 3c. Annual data presented. Avoidable death report due in Q3. Findings will be shared in Q4.

4. EFFECTIVE FETAL MONITORING DURING LABOUR

Process and outcome indicators:

- Percentage of staff who have received training on CTG interpretation and auscultation, human factors, and situational awareness.
- Percentage of staff who have successfully completed mandatory annual competency assessment.
- The percentage of intrapartum stillbirths, early neonatal deaths, and severe brain injury where failures in intrapartum monitoring are identified as a contributory factor.

INTERVENTIONS

All staff who care for women in labour are required to undertake annual training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation. Training should be multidisciplinary and include training in situational awareness and human factors.

The wellbeing team deliver a mandatory fetal wellbeing education day attended by the MDT. The day is inclusive of a competency assessment and a failsafe pathway is followed to ensure staff do not work unsupported and alone on labour ward unless they are in date with annual training and have met the minimum 85% pass mark set by the 2023 core competency framework. The competency assessment was produced in collaboration with the LMNS.

New data collection has been agreed for ease of reporting on the training compliance within the perinatal quality surveillance dashboard. The data is reported as rolling compliance and compliance is only reported if both attendance on the day and the assessment has been completed successfully.

Process indicator 4a		Ambition	Stretch ambition
% of staff who have received training on CTG interpretation and intermittent auscultation, human factors and situational awareness	88.1%	80%	90%

Process indicator 4b		Ambition	Stretch ambition
% of staff who have successfully completed mandatory annual competency assessment	100%	85% (of the 80% in 4a)	90%

UHSussex has adopted an intrapartum risk assessment based on national NICE guidance in place and use a 'fresh eyes' system in the form of CTG peer reviews.

Additional Measures		Ambition	Quarter progress
Risk assessment at the onset of labour	86%	80%	-4.8%
Number of audited records that had hourly documented review of maternal and fetal wellbeing	76% (within 15min)	80%	
Documented fresh eyes review of fetal heat rate or categorisation of CTG and risk factors and escalation	76%	80%	

There is continued variation regionally and nationally in auditing and reporting fetal monitoring compliance in labour, including allowances of up to 10-30% in time for compliance of reviews for CTGs. The SBL forum chaired regionally has highlighted this and there is no technical definition to support data capture to ensure consistency.

UHSussex agreed with the LMNS to perform a deep dive into fetal monitoring in labour in Q2 to get a deeper understanding of any issues. As a result of the findings an action plan was developed to support staff with documentation and standards.

The following was agreed at the LMNS assurance meeting from Q3:

- Reduce time consuming manual audit
- UHSussex will utilise the reporting tools within BadgerNet from Q1 25/26
- The fetal wellbeing team will spend more time within the acute setting supporting staff with fetal monitoring in real time
- This should support improved documentation and long term improve data reported via BadgerNet
- Themes would be presented in this report from reviews and Datix

The deep dive will be repeated 12 months on from the initial audit to track progress.

Outcome indicator 4d. Annual data presented. Avoidable death report due in Q3. Findings will be shared in Q4.

5. REDUCING PRETERM BIRTHS

INTERVENTIONS

Assess all women at booking for the risk of preterm birth and stratify to low, intermediate and high-risk pathways using the criteria in Appendix F SBLV3

Outcome indicator 5l.a		Ambition	Quarter progress
Numerator: Number of women who give birth to a singleton between 16+0 and 23+6	1	Maintain	-0.6%
Denominator: Total number of singleton births	2056		
% of births with a singleton baby giving birth between 16 and 23+6	0.1%		
Numerator: Number of women who give birth to a singleton between 24+0 and 36+6	140	Maintain	+1.8%
Denominator: Total number of singleton births	2052		
% of births with a singleton baby giving birth between 24 and 36+6	6.8%		

5.20i – Mortality to discharge in the very preterm babies. During Q3 there were 20 babies that were discharged from neonatal units who were born in the previous months under 31+6. There was 1 baby born June who sadly passed away in July respectively. This gives a rate of 5% (-11%).

5.21j – 0%

5.3 Additional Measure: Number of women at booking who had a completed risk assessment for preterm		Ambition	Stretch ambition	Quarter progress
Numerator: Number of women with a completed risk assessment	2459	80%	90%	=
Denominator: Number of women booked	2461			
% of women at booking who had a completed risk assessment for preterm	99.9 %			

5.9 – There has been a national decision to no longer procure quantitative fetal fibronectin cassettes. This has hindered use of the QUiPP app as the other figure to input is a cervical length taken within the last 24 hours which is often not available. UHSussex acknowledge this will likely hinder optimisation as not all obstetricians can perform a bedside trans vaginal scan to assess cervical length.

5.11 – Completing and following up an MSU for intermediate and high-risk people has always been well embedded and Q3 showed 92% had an MSU within 7 days of booking.

5.16 – UHSx have good processes embedded for involving neonatal in the discussions with parents regarding preterm birth. All preterm births are audited and will be reported as exceptions. There were no exceptions in Q3.

Optimise place of birth – women at imminent risk of preterm birth should be offered transfer to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN)

Process indicator 5a		Ambition	Stretch ambition	Quarter progress
Numerator: 1st birth <27weeks (singleton) <28 weeks (multiple) and <800g born in the same site a NICU	6	70%	85%	+2.7%
Denominator: Total number of 1st baby born <27 weeks<28 (multiples) and under 800g	7			

% of singleton infants less than 27 weeks, or 28 if multiples with an EFW of under 800g born in maternity services with NICU	87.5 %			

PRH – 1 born following admission and placental abruption

Antenatal corticosteroids to be offered to women between 22+0 and 33+6 weeks, optimally at 48 hours before a planned birth. A steroid-to-birth interval of greater than seven days should be avoided if possible.

Process indicator 5b		Ambition	Stretch ambition	Quarter progress
Numerator: Number of live births ,34+0 who receive a full course of antenatal corticosteroids within 7 days of birth	21	40%	55%	=%
Denominator: Total number of live births before 34+0	40			
% of babies <34 weeks receiving a full dose of antenatal corticosteroids within 1 week before birth	53.7%			
% of babies where birth is more than 7 days after receiving their first course of antenatal corticosteriods	12%	NA		

The remaining 16.2% only received one dose was two births, one was born in an ambulance and one was fully dilated and had a rapid vaginal birth

Magnesium sulphate to be offered to women between 22+0 and 29+6 weeks of pregnancy and considered for women between 30+0 and 33+6 weeks of pregnancy, who are in established labour or are having a planned preterm birth within 24 hours.

Process indicator 5c		Ambition	Stretch ambition	Quarter progress
Numerator: number of babies born <30 weeks who receive magnesium sulphate within 24 hours prior to birth	9	80%	90%	+1%
Denominator: Total number of live births before 30+0	11			
% of babies born <30 weeks who receive magnesium sulphate within 24 hours prior to birth	81%			

			Ambition	Quarter progress
5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection.	Num: 11 Denom: 14	77.8%	Maintain	-12.2%
5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth.	Num: 40 Denom: 50	80%	50%	+2.2%
5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth.	Num: 40 Denom: 40	80%	65%	+2.2%
5g. Percentage of babies born below 34 weeks of gestation who receive their own mothers milk within 24 hours of birth.	Num: 14 Denom: 36	63.8%	Maintain	+24.9%
Volume-Targeted Ventilation for babies born below 34 weeks' gestation who need invasive ventilation	Num: 8 Denom: 8	100%	>95%	
Caffeine For babies born below 30 weeks' gestation	Num: 8 Denom: 8	100%	>95%	
5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (1 to 9 above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation).	156/219 eligible interventions were received: 69.4%		Review Maintain	+2.9%

Q3 has seen an increase in babies receiving maternal breast milk. This could have been due to the transformational lead completing the audits and cross referencing Metavision (the system where the Neonatal team document clinical care) for thoroughness. There were

occasions where the data was found which had not been entered into BadgerNet Neonatal causing a skew. This will be fed back to the Neonatal teams.

The QI identified for this element alongside PREM7+ is optimal cord clamping to support thermal regulation too. Collaboration is ongoing with the Kent Surrey Sussex Operational Delivery Network to deliver a simulation-based training package to support the perinatal teams. Discussions are ongoing in efforts to involve all stakeholders in the perinatal team needed for this. The first planning meeting is to be held in January.

Outcome indicator 5k. Annual data presented. Avoidable death report due in Q3. Findings will be shared in Q4.

6. Management of Diabetes in Pregnancy

INTERVENTIONS

Women with a pre-existing diagnosis of diabetes in pregnancy should be referred to a one stop clinic, providing care to pre-existing diabetes only, which routinely offers multidisciplinary review and has the resource and skill to address all antenatal care.

UHSussex has a good diabetes service on all four sites that is well established. Each site has a dedicated multidisciplinary clinic consisting of a midwife, specialist diabetes nurse and an obstetrician. All women with type 1 diabetes have continuous glucose real time monitoring. Staff are trained in the support of these devices. Those with type 2 diabetes have capillary glucose monitoring, the results of which are entered into a digital app Libreview.

Outcome indicator 6g		Ambition	Stretch ambition	Quarter progress
Numerator: number of pregnant women with type 1 and type 2 diabetes that have HbA1c measured between 24+0 and 30+0 weeks.	12	80%	>95%	-2%
Denominator: Number of women with type 1 and type 2 diabetes	15			
% of women with type 1 or type 2 diabetes that have their HbA1c measured at the start of the 3rd trimester	80%			

Compliance has improved greatly in the past year. The need to test the HbA1c is slowly becoming better embedded, one missed at Worthing and two missed at St Richards, feedback has gone to the leads for these areas.

CONCLUSION

UHSussex are 100% compliant with the implementation tool for SBLCBv3. CNST compliance was met for 2023. UHSussex engaged with LMNS quarterly assurance meetings as per CNST requirement. Internal quarterly meetings are in place for the leads involved in all 6 elements. Reports from audits are sent the month following the previous quarter. Leads for each element have a responsibility to present their audits, findings, and action plans at least once per year to the departmental safety and quality meetings**.**

Quality improvement projects are ongoing and ever evolving to meet the required outcomes of the care bundle. Saving babies' lives is everyone's responsibility and to make meaningful change all stakeholders need to be engaged. There are some issues around job planning for obstetricians which makes engagement challenging and these are being addressed by the trust, with a new clinical operating model as been agreed and is being recruited into. Scanning capacity at two of the sites remains a challenge to implementing the care bundle fully.

During quarter 3 redeployment of all staff from specialist roles into working clinically to support the acute services has fundamentally stalled quality improvement plans. This decision was not taken lightly and was only actioned after all other opportunities to improve staffing were exhausted. The impact has been felt within the individual element meetings but quality of delivering the care bundle has not been affected.

Below is a local action plan relating to the quality improvement for each element which is developed with the element leads and the action plan from the local maternity and neonatal system (LMNS) during the quarterly assurance meetings.

University Hospitals Sussex
NHS Foundation Trust

UHSussex ACTION PLAN

Element	Element description	Intervention reference	Action	Lead	Timeline	RAG
2	Fetal growth restriction	2.7	Uterine Artery Doppler audit required from obstetrics lead at WH/SRH	Fetal Wellbeing Consultant Obstetrician Lead	Q4 24/25	Stalled due to escalation
		Outcome indicator 2a	Risk assessment Quality	Community Leads / ANC leads / Digital leads	Q4 24/25	Stalled due to escalation
		Digital BP	Further planning needed to embed digital BP recording	HoM/Transformation	New education year	Stalled due to escalation
		2.14	Low Papp-A process variation across the two legacies	New 8a Screening lead	Q1 25/26	Not started
3	Reduced Fetal Movements	3.2	MAU/ANC to document when an ultrasound is performed following RFM to support reporting	Transformation Lead MAU/Triage leads/ANC	Q4 24/25	Stalled due to escalation
		3.2	cCTC documentation – needs greater awareness	MAU/Trage	Q4 24/25	New action
4	Fetal monitoring in Labour	4.3	Agree content and create a visual aid to have attached to CTG machine to support holistic review documentation	FWB MW	Q4 24/25	New action
		4.3	Add column to hand overboard to say when CTG fresh eyes due to support timely review at PRH and RSCH	FWB MW	Q4 24/25	New action
		4.3	Message of the Week relating to epidural and FM during siting. Variance identified - WH and SRH will do a pre-epidural CTG RSCH and PRH do not	FWB MW	Q4 24/25	New action
5	Pre-term birth	5e 5f	Optimal cord management	Transformation Lead, I/P matrons, Neonatal cons	Q4 24/25	Ongoing

Action Plan from LMNS assurance meeting

Action No.	Date of Meeting	Action detail	Description	Action owner	Due Date	Update	Action status - RAG rating	Date Complete	Admin Notes
12	22/03/2024	East extra diabetes clinic	BE to update around the progress of the business case in the East for an extra diabetes clinic.	BE	14/03/2025	2024.06.21: BE-Business case is in development, report in Q2 2024/25 2024.09.30: BE is organising for the MDT Panel and developing business case for increasing demand	Progressing		
33	30/09/2024	Low PAPP-A variation workstream obstetric support	LJ and BE to link around LMNS obstetric lead support for the low PAPP-A variation workstream.	LJ/BE	14/03/2025	**12.12.24: No current update due to different processes at legacy Trusts - will go to next MIG**	Progressing		
37	30/09/2024	Fetal Monitoring policy	LS to update at the December 2024 meeting around the Medicines Committee considering the Fetal Monitoring policy in the Trust's improvement presentation.	LS	14/03/2025	**12.12.24 FM guideline still being worked on - not ready for JOGG**	Progressing		
39	30/09/2024	steroid administration data triangulation	LJ to link with LS around steroid administration triangulated with ATAIN figures.	LJ/LS	14/03/2025	**12.12.24 - No progress. SRH/WH to share methodology with colleagues at RSCH/PRH**	Progressing		
41	12/12/2024	Readiness Assessment Tool	This is subject to governance information sharing - currently awaiting sign off - LS to chase and escalate if appropriate	LS	14/03/2025	**March 25:**	Progressing		
42	12/12/2024	CTG Interpretation Conversations	To review WEF agenda for Jan/Feb 25 to enable discussions to be scheduled in	LJ	14/03/2025	**March 25:**	Progressing		
43	12/12/2024	Meet the Neighbours'	LJ to discuss with inpatient Matrons	LJ	14/03/2025	**March 25:**	Progressing		
44	12/12/2024	WEF Invites	LJ to think about suggestions to invite universities to WEF	LJ	14/03/2025	**March 25:**	Progressing		
45	12/12/2024	Pre term birth leads	LS to link with RF and ensure preterm leads are included in MIG action plan	LS/RF	14/03/2025	**March 25:**	Progressing		
46	12/12/2024	Pre term birth network group	LJ to update on progress with the system wide pre term group at March assurance	LJ	14/03/2025	**March 25:**	Progressing		
47	12/12/2024	Postnatal continuity for preterm births	To explore the improvement of postnatal continuity	LS	14/03/2025	**March 25:**	Progressing		
48	12/12/2024	SOP for diabetic clinic	To look at developing SOP or something similar so agreed processes are in place as business continuity	LS	14/03/2025	**March 25:**	Progressing		
49	12/12/2024	Business Case at RSCH	Update of progress with the business case will be given at March assurance meeting	BE	14/03/2025	**March 25:**	Progressing		
50	12/12/2024	LJ to link in with the sonography task and finish to ascertain the full impact including the total numbers	LJ to explore further	LJ	14/03/2025	**March 25:**	Progressing		

Background

University Hospitals Sussex
NHS Foundation Trust

The purpose of this paper is to provide a bi-annual report for the Trust Board regarding the Perinatal workforce in response to the First Ockenden report and Clinical Negligence Scheme for Trusts, Maternity Incentive Scheme requirements.

This report encompasses all specialities within the Women and Children's Division that contribute to perinatal services – namely midwifery, obstetric, neonatal nursing, and medical workforce.

The Maternity Incentive Scheme Year 6 declaration evidenced workforce planning to the required standard. A BirthRate Plus assessment was completed in 2023, assessing the midwifery and maternity support worker workforce. The Trust Board accepted the recommendations, and the service is funded to the recommended establishment.

NHS
University Hospitals Sussex
NHS Foundation Trust

Perinatal Workforce Report
April 2025

Maternity

In September 2024 two WTE 8a Recruitment and Retention Matrons started in post for UHSx maternity services on a 12-month fixed term contract, working within the central Nursing & Midwifery Workforce team. Their focus has been on understanding the vacancy picture at each site for midwives and support workers and developing both short and long-term solutions to tackle it.

One strategy (where possible) is to offer joined up, cross site recruitment events to fill multiple vacancies with one advert. Where the number of appointable candidates exceeds the current vacancy, a 3-month holding system is used so that candidates can be allocated to new vacancy as it becomes available. This reduces time spent repeating the recruitment process and minimising the length of vacancies. The administrative burden of recruitment for clinical leaders is also markedly reduced. This has proved particularly successful with B3 Maternity Support Workers with an annual recruitment cycle with quarterly events planned.

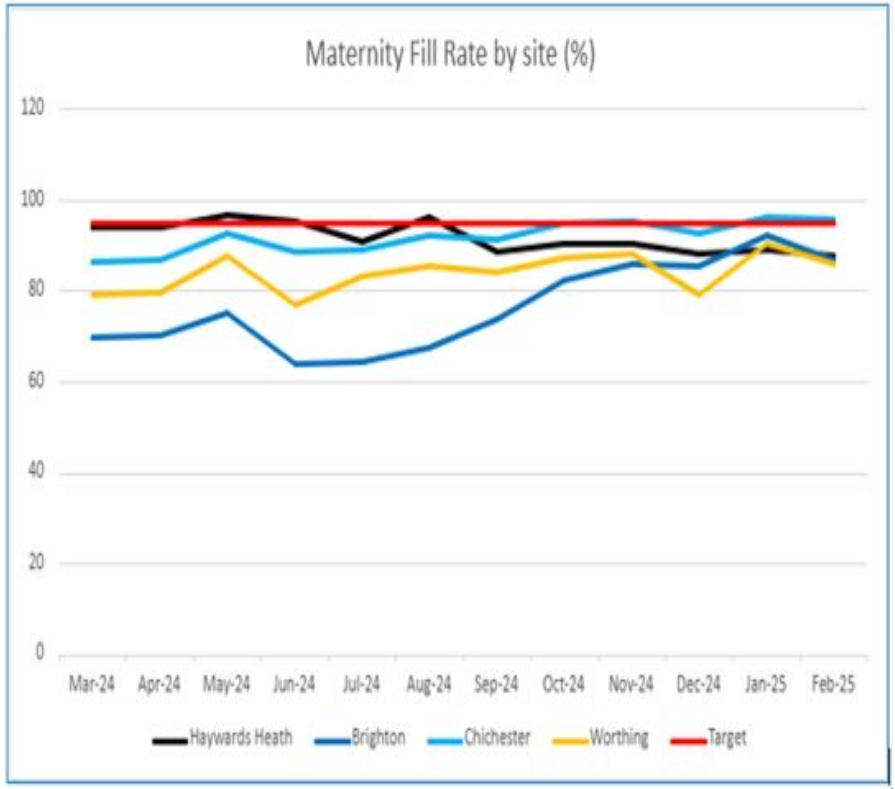
Matrons from each area meet with the R&R leads bi-monthly to report any new vacancies or parental leave, allowing a responsive rather than reactive recruitment process, reducing the length of time posts may be vacant for. R&R Leads have implemented T-Level student placements for the first time in maternity, a key celebration as there is a high correlation to these students' pursuing careers in the health sector.

A new Birthrate Plus review is planned in September 25 to ensure the recommended templates and establishments are representative of the workload acuity at all sites.

In previous reports, maternity data has been presented for each legacy Trust configuration, this is now shown for each of the individual hospital services to capture the individual challenges faced at each site.

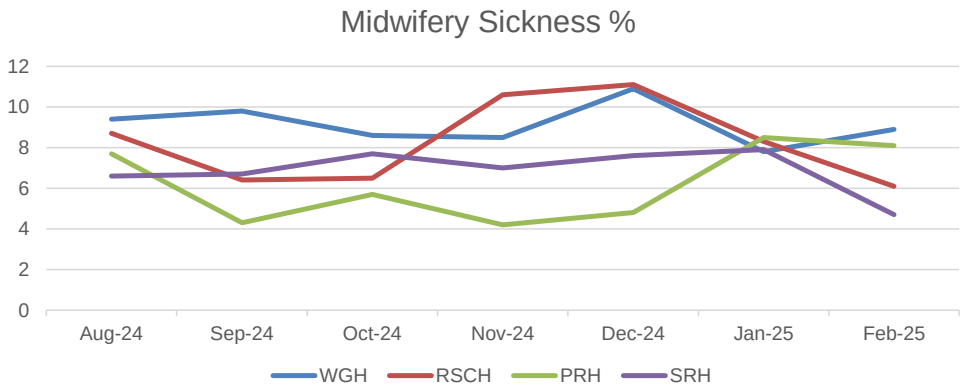
Current position - midwifery

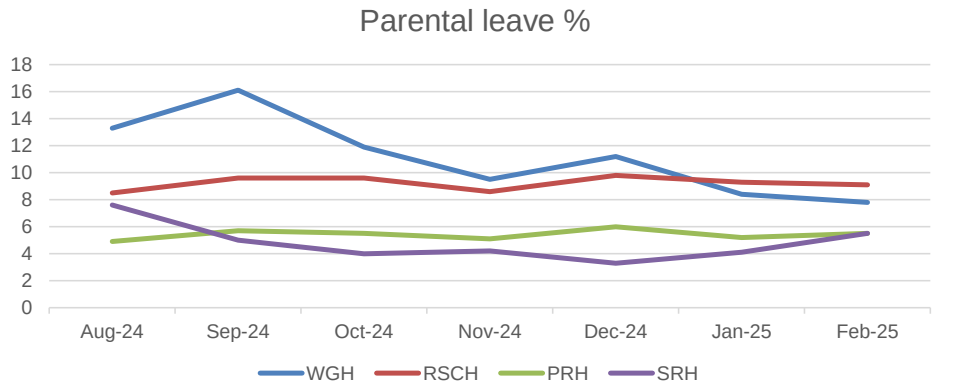
NHS
University Hospitals Sussex
NHS Foundation Trust



- Actual verses planned staffing (fill rates) at RSCH have seen steady improvement since June 24 and are anticipated to continue on this positive trajectory with new Band 6 midwives joining the team in spring/summer. Despite a slight reduction in Dec, WH also has a positive upward trajectory. SRH fill rates have improved in the last 12 months with target rates maintained since Oct. PRH have seen some fluctuation in fill rate since June 24 due to unfilled vacancy, sickness and higher parental leave and are now lower than required.
- The predicted workforce gaps in maternity over the summer months are significantly improved from the shortfalls experienced last summer but remain a risk, particularly at RSCH. Redeployment of specialist midwives and managers for a proportion of their working hours is being considered over the summer months to mitigate this risk, but must be balanced against the risk to their substantive roles.
- Agency use has ceased at WH, however continues at RSCH. This is anticipated to end at RSCH from May when midwives return from parental leave and new midwives join the team.
- The midwifery shift leaders are well versed in the use of the maternity escalation policy. Short term support is often available but is not captured in the fill rate data.
- **One to one care in established labour is maintained 100% of the time**, however, this can sometimes only be achieved by redeploying midwives from other parts of the service, for example the postnatal ward or home birth service.

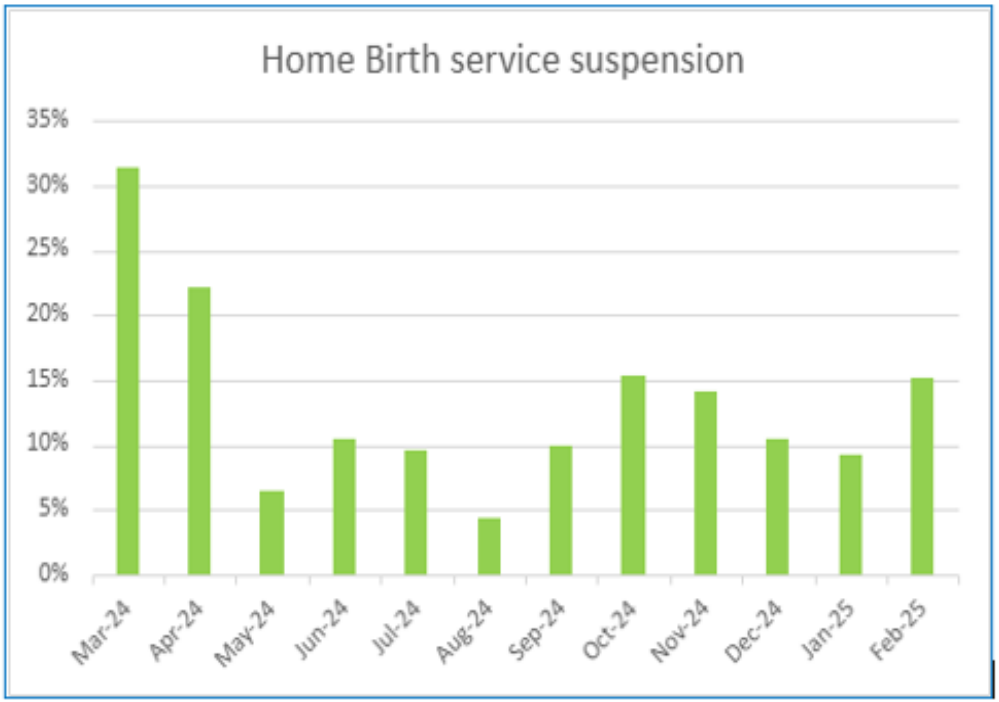
Midwifery sickness and parental leave





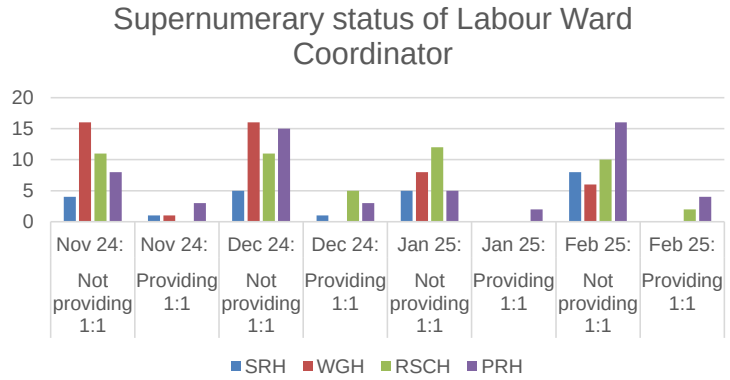
- Sickness level continue to trend above Trust targets on all sites.
- Exploration into reasons for sickness has been conducted via an A3 supported by the Divisional HR business partner, focused work has resulted in reduced sickness rates in some cost codes.
- Maternity leaders who line manage staff are to complete the Trust Management Skills Training: Health, Wellbeing and Absence to ensure Management of sickness is robust and in line with policy, supported by the HR team.
- Various support and wellbeing offers are in place across the Division, including Listening Events, regular updates via newsletters and video messages, and increased visibility of leaders.
- Parental leave at all sites remains high and represents a unique challenge in a service with an almost exclusively female workforce. The removal of the bursary for student midwives has resulted in a younger newly qualified midwifery workforce and higher maternity leave rates as a result.
- The Trust initiative to automatically on-board nursing & midwifery students to employment will have a positive impact on filling both parental and sickness absence (more detail slides 10-13).

Home Birth Service



- The model of care for home births at PRH & RSCH changed in May 2024. This initially led to significant reduction in suspensions of the service, however, rates have again increased since October.
- The model is currently under review by the senior leadership team with burnout cited as a significant factor in short term sickness.
- All new starters to community teams in PRH/RSCH will now be required to complete one on call a month to support the homebirth service. This aligns with practice at Chichester/Worthing where suspension is infrequent.
- As vacancy and fill rates continue to improve there is also greater scope for hospital based midwives to support as a second midwife at homebirths on a case by case basis.

Acuity



University Hospitals Sussex NHS Foundation Trust

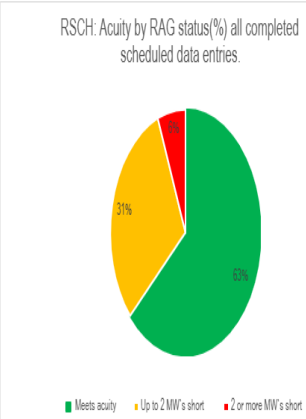
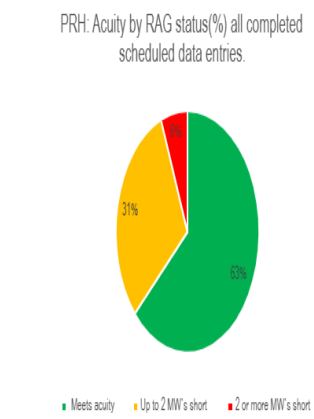
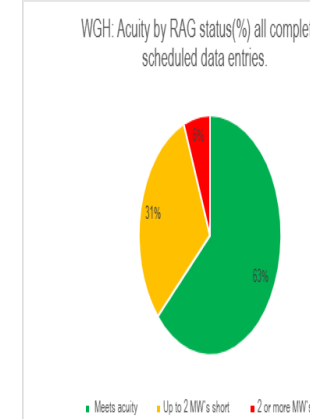
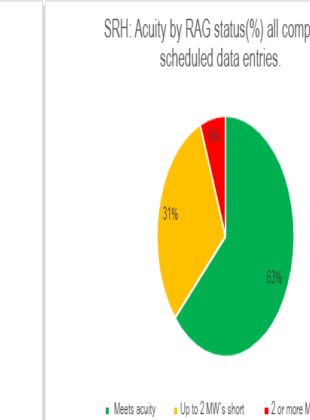
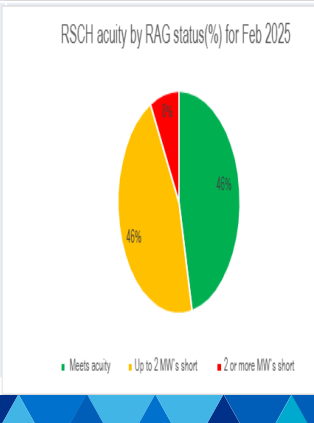
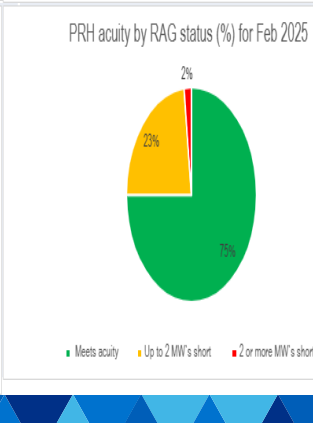
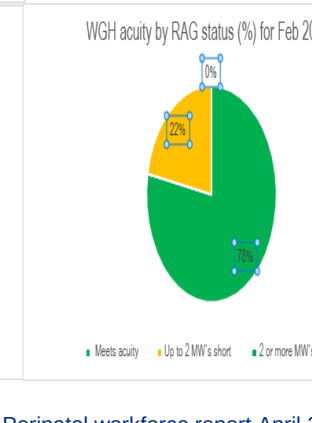
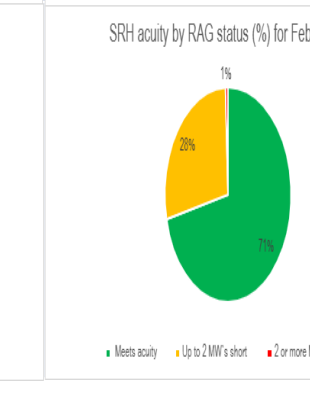
- There is a requirement for the labour ward coordinator (LWC) to be supernumerary, these staff should not be providing 1:1 care to women and people in established labour. 'Red Flag' incidents relating to supernumerary status of the Labour Ward Coordinator are captured as part of acuity reporting. The service met the requirements as defined by the CNST Maternity Incentive Scheme year 6 and are on track to meet this requirement for year 7. 22 episodes of 1:1 care provision by LWC occurred in a 4 month period (Nov 24-Feb 25) The LWC does on occasion provide care to postnatal women and people on labour ward or those requiring triage (156 episodes in reporting period). This is not classed as 1:1 care but is avoided as much as possible. This requirement has reduced in Worthing since workforce mitigations were implemented.
- A quality improvement project commenced in Q1 2024 to improve the reporting of further red flags such as induction of labour delays in line with Safe midwifery staffing for maternity settings (nice.org.uk). This project stalled due to the redeployment of specialist midwives and managers for some of their hours over the summer period of 2024, however, this is now be prioritised and a working party has been formed. Red flag data forms a part of a monthly report shared within Divisional governance meetings and monthly Maternity Safety Champion meetings.
- The is no recognised national midwife to birth ratio to benchmark against. UHSx maternity staffing requirements have been calculated by the BirthRate Plus workforce assessment published in 2023. The current is midwife to birth ratio is 1:22 which is a deterioration from the ration of 1:21 in the last report (April 2024).
- Acuity is measured on a four hourly basis using a specific workforce tool app (see next slide). The complexity of the cases on labour ward at the time, and the available staffing are entered to calculate acuity.
- Activity within maternity can be inconsistent, with peaks and troughs. The escalation policy is enacted to support the service at times when the staffing does not meet acuity.

Quarterly acuity (midwife : activity)

NHS University Hospitals Sussex NHS Foundation Trust

Meets acuity
Up to 2 midwives short
More than 2 midwives short

This data does not include midwives redeployed from other areas for periods of time to mitigate.

	Brighton	Haywards Heath	Worthing	Chichester
Q3				
FEB 25				

Projected vacancy position - midwifery

University Hospitals Sussex NHS Foundation Trust

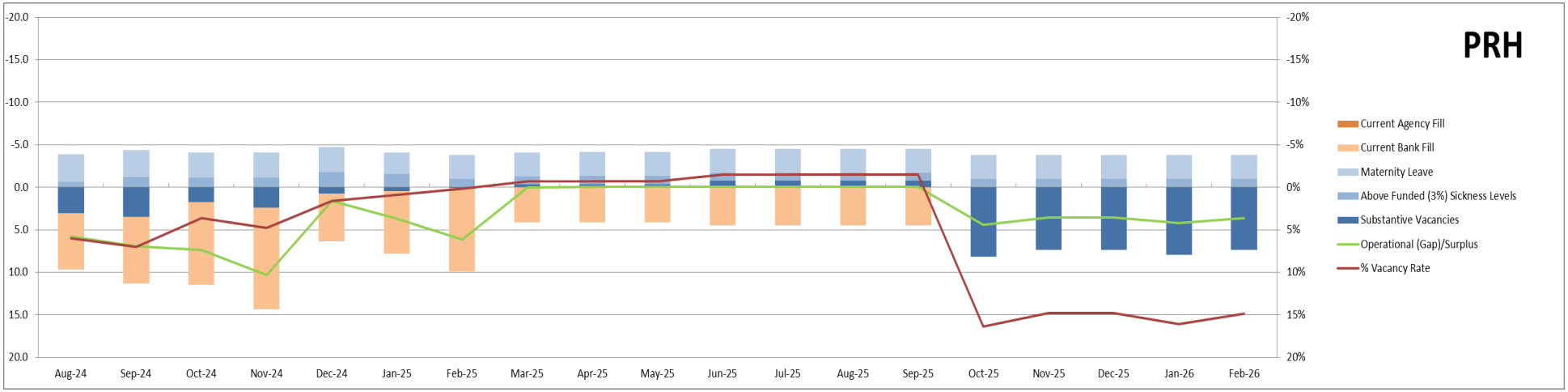
- The midwifery vacancy continues to significantly reduce.
- In 2024 and 2025, the Trust supported automatic job offers for student nurses and midwives training at UHSx.
- The national pathway for newly qualified midwives (NQM) is to automatically progress to B6 on completion of a Preceptorship programme (typically 12 months, no longer than 24 months). Therefore, when the 2024 cohort of NQMs achieve their B6 uplift, this initiative will result in an over recruitment to the B6 line in 2025 and again in 2026.
- This will mitigate the workforce challenges experienced with consistently high rates of maternity leave at all sites, significantly reduce bank use and support the termination of agency use. The anticipated impact is shown at each site on slides 10-13.

UHSx Maternity Total Bank & Agency 2024/25	Aug	Sept	Oct	Nov	Dec	Jan	Feb
WTE Total	25.5	28.5	31	36.3	23.8	29.8	32.6

- As fill rates improve, attrition of staff should also decrease. Low morale and burnout due to poor staffing have historically been cited as reasons for leaving in exit interviews.
- The operational gap/surplus (demonstrated by the green line) in the following slides takes in to account external turnover, however, does not account for staff who move to a different cost code within the department e.g. hospital to community

Operational Gap/Surplus PRH Hospital Midwives (B5, B6, B7)

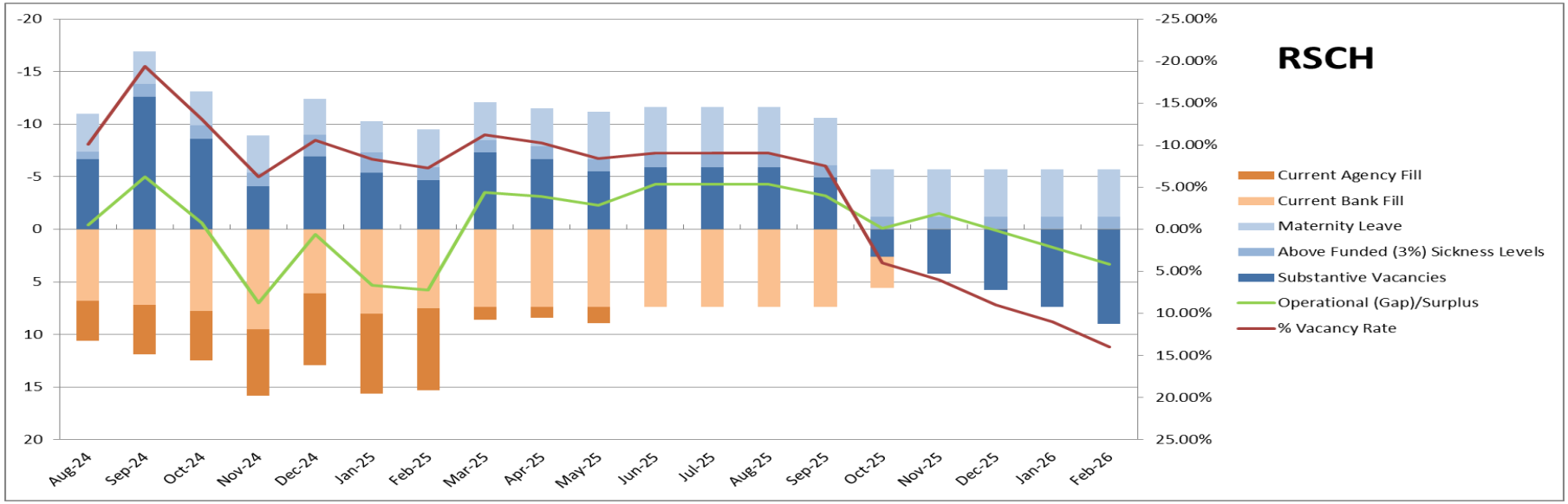
University Hospitals Sussex
NHS Foundation Trust



- Due to a reduction in the PRH B6 budget in April 24 an over recruitment was seen until January 25. This is now neutral as staff have left the service or moved to different cost codes.
- Parental leave has remained high, in addition to sick leave with fill rates supported by bank use. Fixed term contracts to cover maternity leave have proved difficult to recruit to.
- The operational surplus in November 24 is likely due to newly qualified starters still being in their supernumerary orientation period, with staffing supported by bank use.
- Fill rates over the summer months are anticipated to be stable supported by a reduced bank use (equivalent 4 WTE).
- When NQM start in Oct 25 and current preceptee's are anticipated to progress to B6 the operational surplus is expected to be around 4% without bank use. *Note – bank will likely continue until December and the completion of new starter supernumerary induction.

Operational Gap/Surplus RSCH Hospital Midwives (B5, B6, B7)

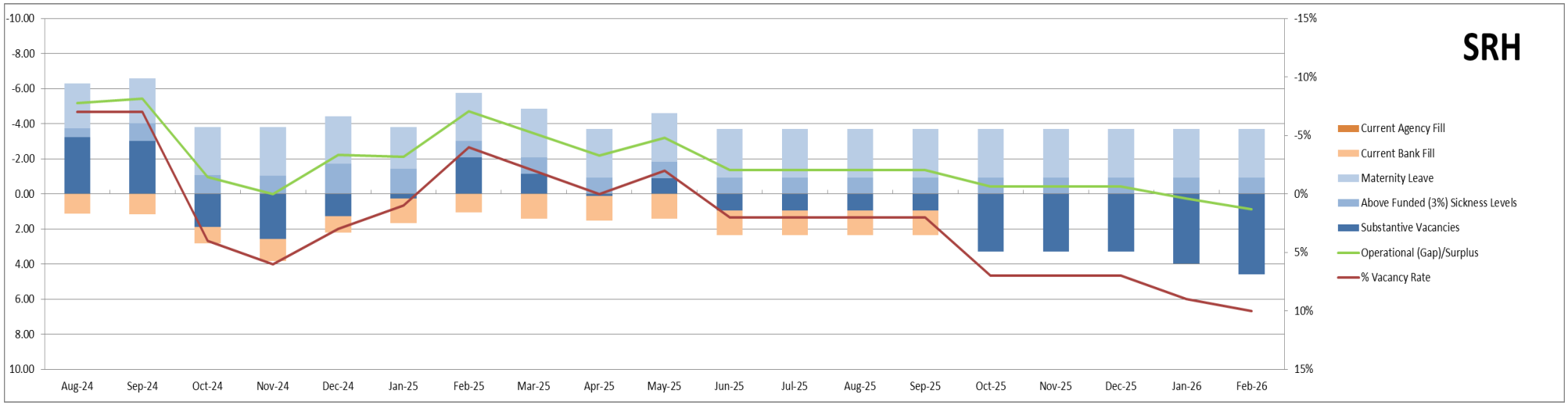
University Hospitals Sussex NHS Foundation Trust



- Substantive vacancy has significantly improved at RSCH from a peak of 16% in Aug to 7% in Feb. However, coupled with absence from sick and parental leave the picture remains challenging and is projected to continue over the summer months. Redeployment of specialist/management staff for some of their hours could mitigate this risk but needs to be balanced in terms of the subsequent risks to those services and staff morale.
- Parental leave is particularly high at RSCH in addition to sick leave with fill rates supported by bank and agency use. A reduction of agency use is planned for March and April and will cease in May as new Band 6 midwives join the team over the summer.
- When NQM start in Oct 25 and current preceptee's are anticipated to progress to B6 the operational surplus is expected to be neutral with a significant reduction in bank use. *Note – bank will likely continue until December and the completion of new starter supernumerary induction.

Operational Gap/Surplus SRH Hospital Midwives (B5, B6, B7)

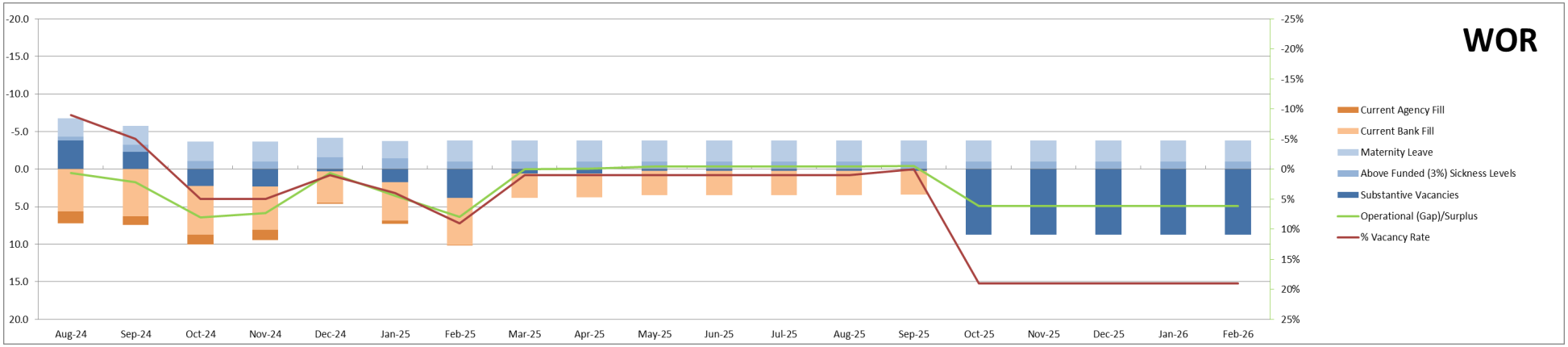
University Hospitals Sussex
NHS Foundation Trust



- The vacancy at SRH is broadly stable, however parental leave represents a significant challenge and despite a small over recruitment coupled with sick leave a small operational gap remains supported by bank use (1.4 WTE).
- When NQM start in Oct 25 and current preceptee's are anticipated to progress to B6 the operational surplus is expected to be neutral without bank use. *Note – bank will likely continue until December and the completion of new starter supernumerary induction.

Operational Gap/Surplus WH Hospital Midwives (B5, B6, B7)

University Hospitals Sussex
NHS Foundation Trust



- Vacancy had improved at WH from 4% in August to a slight over recruitment of around 2% since October 24. Alongside bank and some agency use between August and January this has meant there has been an operational surplus at WH during the autumn.
- From March, the vacancy is expected to be 0% with bank use supporting parental leave and sickness over the summer months.
- In Oct 24, WH recruited a significantly larger cohort of NQM as part of the Trust on-boarding initiative. When this cohort progresses to B6 following completion of preceptorship, WH will have a significant over recruitment of midwives and an operational surplus without bank use. The Birthrate Plus review planned for September 25 will help to establish if this site has the correct template for its workload and acuity.
- The over recruitment will enable opportunity for development of practice rotation e.g. to the community service and a requirement in new contracts for cross site redeployment to meet the service need, following HR consultation.

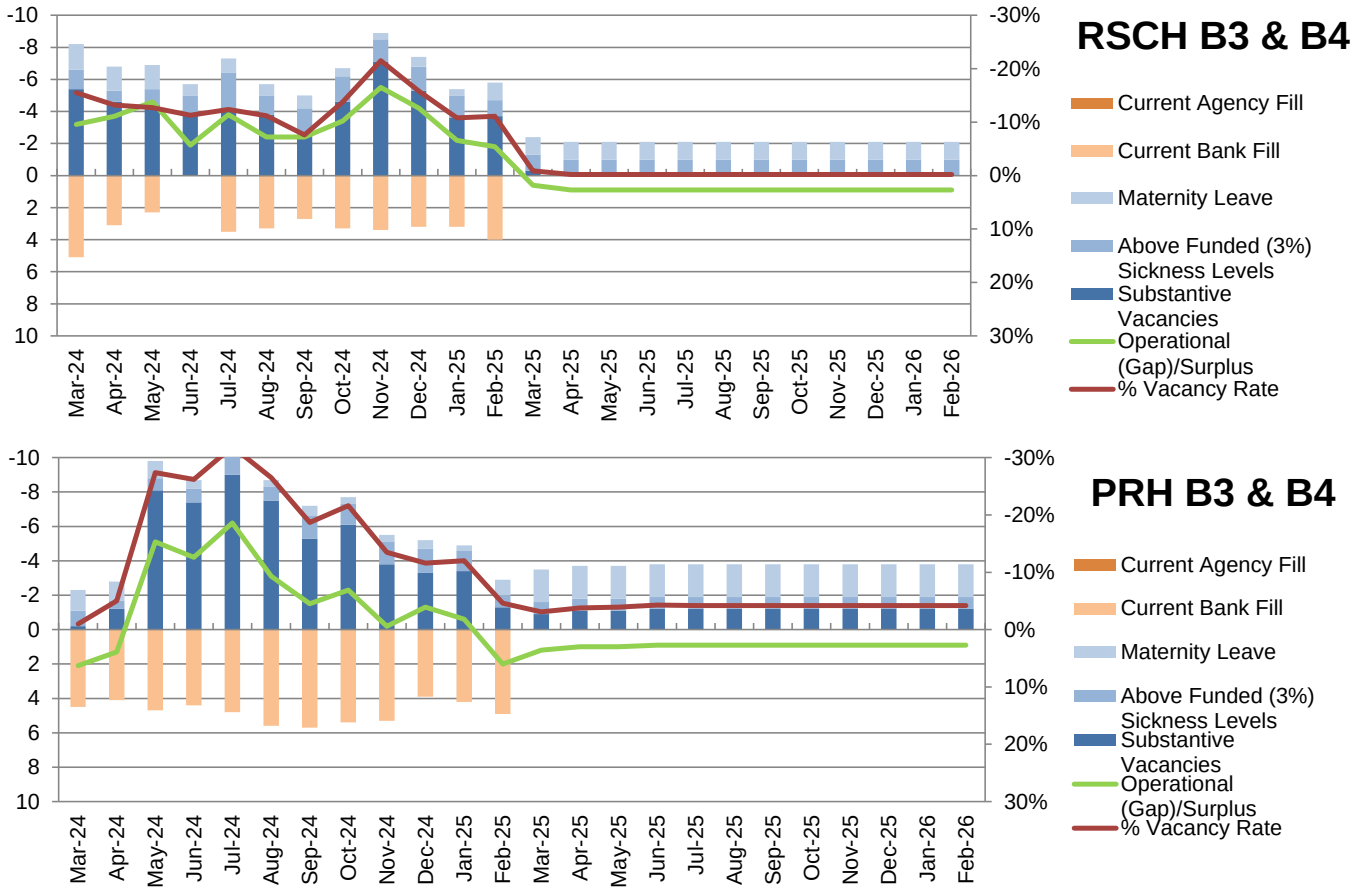
Maternity Support Workers and Nursery Nurses

University Hospitals Sussex NHS Foundation Trust

- The maternity support worker (MSW) and nursery nurse (NN) team are an essential part of the service, providing clinical care to service users and support to the midwifery team.
- Retention of these colleagues can be challenging due to competing opportunities with similar remuneration, but with less responsibility and unsocial hours. Turnover is consistently higher than midwifery.
- Positively, often MSWs and NNs are leaving to commence their midwifery training; these roles are a recognised pathway into midwifery.
- The R&R Matrons have implemented quarterly cross site recruitment events to fill existing vacancies and in anticipation of when there is known attrition (e.g. September with leavers starting university courses). Appointable candidates who are not offered a vacancy following initial interview are offered the opportunity of a holding list for up to 3 months when they will be allocated to new vacancy as it becomes available.
- Recent MSW vacancies have received significant interest from international candidates, living in the UK many of whom are internationally educated midwives (IEM), pursuing completion of NMC pin the UK.
- The R&R Matrons are working alongside the International Recruitment team to develop an IEM pathway, providing an additional recruitment pipeline and increasing diversity of maternity staff.
- We are keen to pursue Midwifery Apprenticeships, however, continue to await Government decision regarding funding for backfill to these posts which remains a prohibitive factor.

Operational Gap/Surplus PRH & RSCH Hospital Support Workers (B3 & B4)

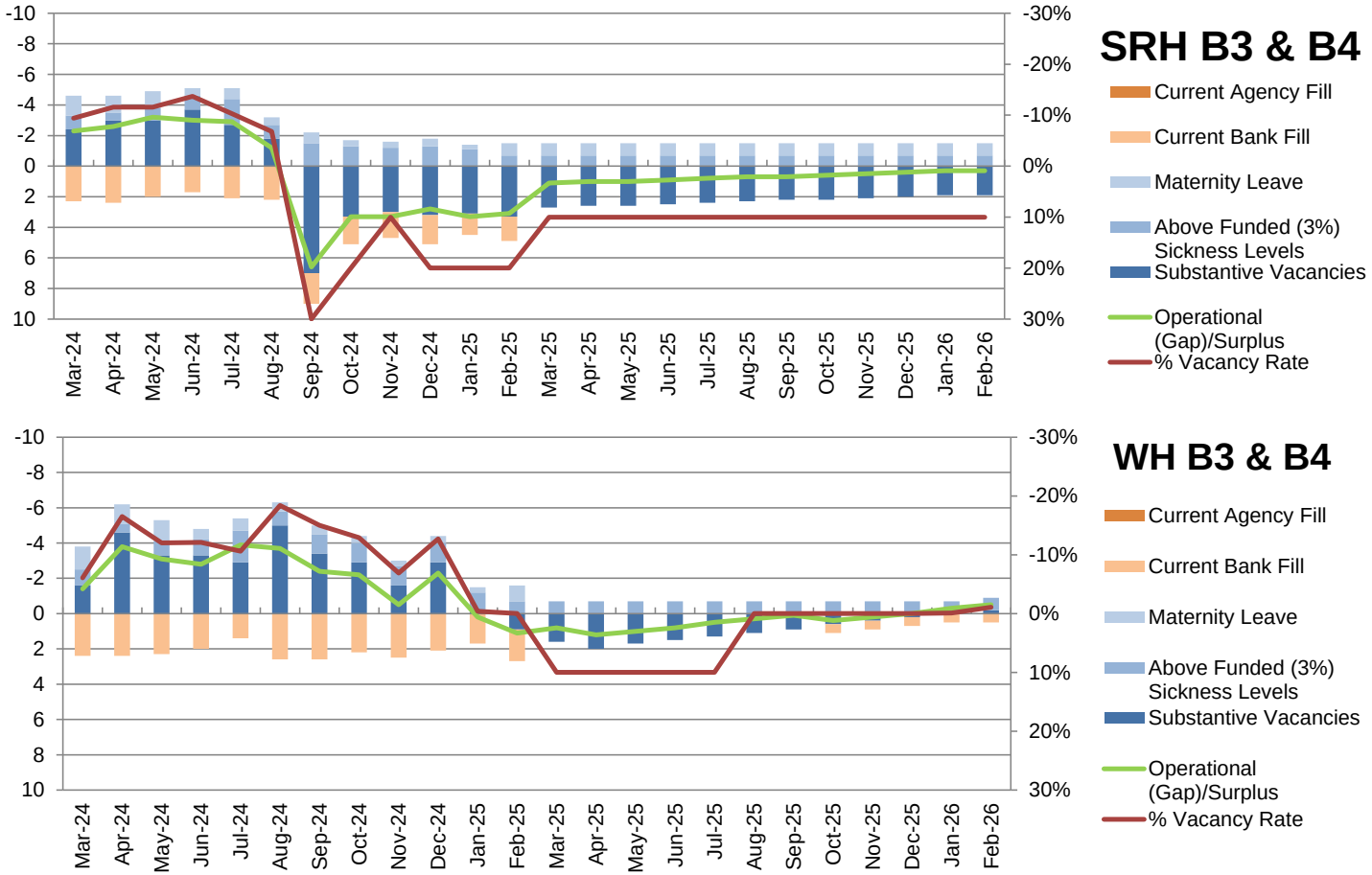
University Hospitals Sussex NHS Foundation Trust



The new recruitment process has been effective in significantly reducing vacancy for support workers. The vacancy at PRH represent 0.8WTE B3 – in the most recent recruitment, the majority of candidates were looking for full time contracts to meet visa requirements. This vacancy is anticipated to be filled at the next event.

Operational Gap/Surplus SRH & WH Hospital Support Workers (B3 & B4)

University Hospitals Sussex NHS Foundation Trust

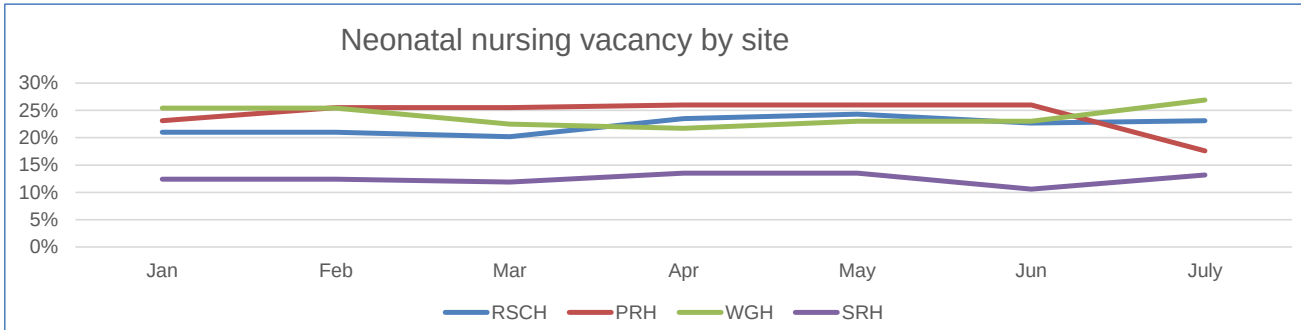


At SRH the funded establishment reduced from 21.1 to 16.5 WTE in Sept 24 resulting in an initial over recruitment of 20% now reduced to 10%. Which, without bank should now represent target fill rates.

At WH the funded establishment reduced from 27.5 to 22.8, resulting in an over recruitment. This is anticipated to reach a neutral fill rate by summer 25.

Neonatal nursing – trajectory

University Hospitals Sussex NHS Foundation Trust



Pipeline recruitment	WTE
RSCH	12.45
PRH	1.0
WGH	4.22
SRH	4.0

- Active recruitment continues on all sites for neonatal nursing. At our NICU in Brighton a workforce plan to increase nurse staffing numbers incrementally over 3 years is on track, with a forecast of a reduction to 15% by April.
- The plan includes an education strategy to improve numbers of QIS trained nurses and to reach the 70% standard for QIS nurses on shift. Nursing numbers in our level 1 SCU's remain fragile although improving due to small teams however this is supported by additional bank work carried out by regular temporary staff and additional hours by substantive employees.
- Work continues to recruit and retain experienced neonatal nurses. Sickness rates remain high, with work ongoing to support the team's well-being and to appropriately manage sickness absence.
- The recruitment and retention midwifery matrons will be supporting the neonatal nursing leadership team to develop reporting of workforce position in line with midwifery services. This improved reporting will be available in the next bi-annual report.

Neonatal nursing – current position

University Hospitals Sussex NHS Foundation Trust

	Princess Royal, Haywards Heath		Royal Sussex County Hospital, Brighton		Worthing Hospital, Worthing		St Richards Hospital, Chichester	
Nursing vacancy rate	8.7%	↓	22.2	↑	13.4%	↓	20.7%	↑
Nursing sickness rate	2.9%	↓	8.3%	↑	11.0%	↑	5.3%	↓
Parenting leave	3.1%		4.0%		0%		4.6%	

Neonatal Medical workforce

University Hospitals Sussex NHS Foundation Trust

Paediatrics WH/SRH	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	29.37	29.66	(0.29)
Medical - SAS Doctor	4.22	4.52	(0.30)
Medical - Resident Doctors	40.21	25.53	14.68

The medical teams cover general paediatric and neonatal services at WH/SRH. Consultant numbers include ROCC posts who Contribute to the middle grade rotas on both sites

TMBU	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	12.30	14.64	(2.34)
Medical - SAS Doctor	0.00	2.00	(2.00)
Medical - Resident Doctors	18.70	18.06	0.64

The TMBU and PRH neonatal tier 1 and 2 rotas overlap with ANNP's deployed to medical rotas on both sites and tier 2 medical staff supporting PRH alongside ANNP's.

Advanced Neonatal Nurse Practitioners (ANNP) workforce RSCH/PRH

ANNPs	Budget WTE	Contracted WTE	Vacancies
Nursing & Midwifery - Registered	16.00	15.85	0.15

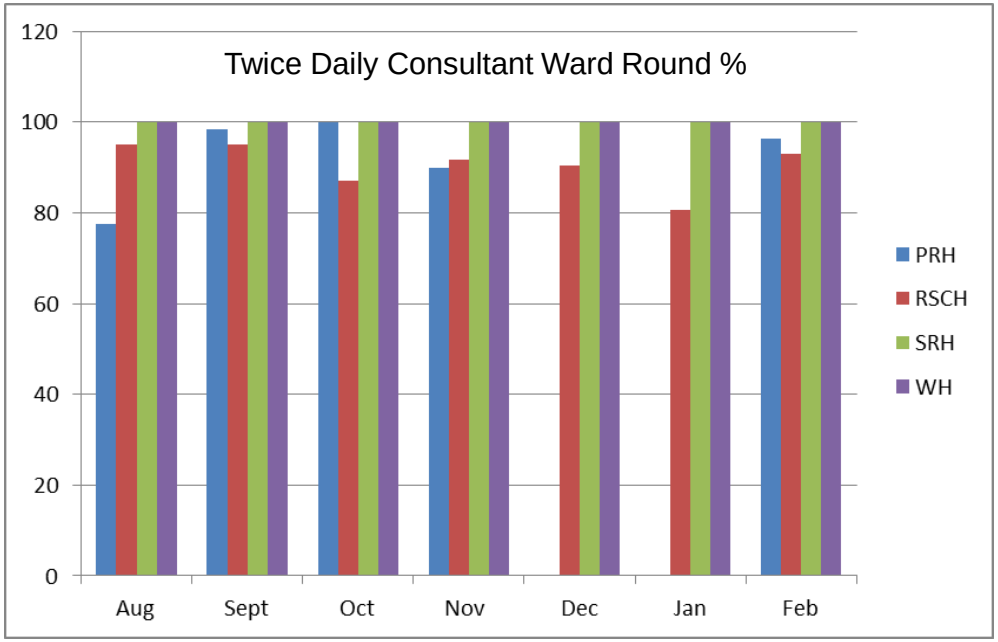
Workforce pressures affecting the neonatal rota at PRH have eased with the recent successful recruitment of ANNP's. However, there is ongoing support from the tier 2 medical staff from PRH.
In September a Prevention of Future Deaths (PFD) notice was received from the coroner following an inquest for a baby who died following birth at PRH. The PFD raises concerns around the fact that out of hours consultant neonatology cover is for both PRH and RSCH at the same time. Although this did not contribute to the death in this case, the coroner raised concerns regarding the risk of future death. A response is being prepared.

Obstetric medical workforce

O&G WH/SRH	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	32.01	26.61	5.40
Medical - SAS Doctor	1.53	1.20	0.33
Medical - Resident Doctors	44.87	40.62	4.25
O&G PRH/RSCH	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	24.46	23.24	1.22
Medical - SAS Doctor	2.01	0.00	2.01
Medical - Resident Doctors	35.80	38.03	(2.23)

- Obstetric and gynaecology medical leadership arrangements will strengthen over Q3 and Q4 with the implementation of the new divisional Clinical Operating Model which includes overarching cross site Clinical Director roles for both specialities alongside dedicated site-specific medical leadership.
- All site lead consultants have been appointed and are now in post
- Consultant vacancy quoted higher than expected on WH/SRH site and all job plans being reviewed
- Three fixed term consultants at PRH/RSCH will have job plans reviewed with plan to substantiate later this year
- 12-month fixed term locum consultant at SRH to be appointed April/May
- Resident doctor recruitment ongoing

Twice Daily Consultant Ward Round Compliance



A requirement from the first Ockenden report (2020) was to provide 'consultant present' ward round twice daily. This has been very challenging to achieve at PRH due to vacancy and job planning restrictions, meaning that the consultant attended remotely. A resolution was found in the summer 2024, and the process is embedding with improving attendance.

Data capture errors impacted evidencing this in December and January, however, anecdotal evidence suggested attendance. The expectation is that 100% compliance will be achieved, this is being closely monitored by the obstetric clinical director.

Divisional staff engagement scores

The Staff Voice that Counts Score for the Division remains above the Trust target, the Staff Engagement Score is recovering following a significant drop in the summer. Staff engagement work continues, including Listening Events across the services, video messaging and service specific and Division wide newsletters. The Quadrumvirate has introduced 'Town Hall' face to face sessions on each site each month.

We now also have a team of clinical Maternity Safety Champions, who will directly communicate with the clinical teams, leadership, executive and non-executive Safety Champions and share information with the clinical teams.
The Divisional Clinical Operating Model is almost fully recruited, meaning that visible, site-specific leadership, as well as service wide leadership will be available to the teams.

Analysis

University Hospitals Sussex NHS Foundation Trust

- Comments have been received regarding staffing and delays within our FFT responses and via the Maternity and Neonatal Voices partnership (MNVP), and formal complaints have been received regarding the quality of postnatal care, as previously mentioned, this is often impacted by staff being redeployed to labour wards.
- Neonatal services are not meeting the British Association of Perinatal Medicine (BAPM) standards of staffing levels, resulting in the inability to accept babies on occasions. There are workforce plans in progress.
- Moral injury to our clinical teams is a risk when working on shifts with poor staffing. The following actions are in place to support the clinical teams:
  - Daily safety huddles involving senior leads from maternity and neonates, to identify and plan the management of staffing gaps. Introduction of an acuity tool for the antenatal and postnatal wards.
  - Increased visibility of the clinical and Divisional leadership team, completing clinical shifts.
  - Joint obstetric consultant meetings to share learning and support.
  - Team of TRiM practitioners to debrief and support staff during After Action Reviews.
  - Increased and permanently funded preceptorship capacity to support newly qualified midwives. All students offered Band 5 roles without interview.
  - Listening events bi-monthly plus bespoke events for teams under pressure.
  - Non-executive Maternity Safety Champion visits to clinical areas within maternity and neonates to listen to staff and offer support.
  - Recruitment and Retention lead midwives in post (NHSE funded).
  - Significant communications offer to keep teams updated.

Conclusion

University Hospitals Sussex NHS Foundation Trust

- Perinatal workforce requirements are complex and can change rapidly. National recommendations have placed further pressure on services, by mandating various roles and requirements that are unfunded (specialist midwifery roles, increased scanning requirements etc.)
- The approved Clinical Operating Model is now almost fully recruited to, meaning an improved and more visible, permanent leadership structure for perinatal services.
- Improvements have been seen in the overall staffing position in all Perinatal services. The focused work of the Recruitment and Retention matrons has expedited this progress.
- There remain teams with low morale as demonstrated by the Staff Survey, targeted work will be completed to understand the issues within these teams.
- Due to the improvements being made at every level as a result of the Maternity Improvement Plan and our commitment to the delivery of national drivers known to impact on patient safety, such as the Saving Babies Lives Care Bundle and the CNST Maternity Incentive Scheme, safety continues to improve as evidenced by our outcome data.
- Positive service user experience Friends and Family feedback data continues to trend above national rates.
- Finally, this paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance. With a clear and robust escalation policy in place and twice daily oversight of the maternity and neonatal units, acuity verses staffing being monitored, early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety remains the priority for the service.

University Hospitals Sussex
NHS Foundation Trust

Safeguarding Quarter 4 Report 2024/2025

NHS
University Hospitals Sussex
NHS Foundation Trust

Safeguarding Adult's Quarter 4 Report April 2025

Introduction and Assurance

NHS
University Hospitals Sussex
NHS Foundation Trust

- The report describes the activities related to safeguarding adults across UHSussex during Q4 2024/25. This quarterly report highlights the efforts undertaken by the adult safeguarding team in relation to its commitment and responsibilities to maintain the safety and protection of adults who are at risk of abuse and neglect.
- The report also outlines key initiatives implemented during this period, including training sessions for staff and collaborative efforts with clinical areas and local agencies aimed at enhancing support systems. Additionally, it provides an analysis of reported cases, identifying trends and highlighting areas for improvement to better address the needs of vulnerable adults.
- This report spans the period from January 2025 to March 2025 and provides assurance that robust systems are in place to ensure that patients using Trust services are effectively protected and that staff are adequately supported to respond appropriately when safeguarding concerns arise.

1. Safeguarding Adults Training

NHS
University Hospitals Sussex
NHS Foundation Trust

Key Performance Headlines

- The adult safeguarding Level 3 training remains below the 85% compliance rate. However, the compliance has increased to 81.6%, which is a 5.6% increase over the last quarter.
- Over the past three months, the safeguarding team has provided 12 training sessions (both virtually and face-to-face), which could accommodate up to 2400 staff. However, of the 205 individuals who registered for the training, only 165 attended. This data indicates that 40 staff members, representing 19.50% of those who booked onto the course, did not attend the training after making a reservation.
- To achieve 85% compliance by the end of April 2025, the safeguarding team will need to train 63 staff members. The team has shared the safeguarding training report with all directors of nursing, outlining the number of staff required to attend the training to meet the compliance target.
- The safeguarding adults teams continue to offer and provide ad-hoc training to staff on the condition that there are at least 10 staff members requiring the training.

1. Training

NHS
University Hospitals Sussex
NHS Foundation Trust

Count of Employee Number		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Training Level	In Date/Out of Date												
Level 1	In Date	5266	5256	5249	5338	5385	5452	5550	5554	5550	5551	5482	5476
	Out of Date	292	280	315	324	331	316	253	220	209	202	211	250
Level 1 Total		5558	5536	5564	5662	5716	5768	5803	5774	5759	5753	5693	5726
Level 2	In Date	9200	8774	8606	8553	8650	8736	8867	8937	8962	9011	9077	9137
	Out of Date	850	677	787	818	748	869	793	754	801	794	824	857
Level 2 Total		10050	9451	9393	9371	9398	9605	9660	9691	9763	9805	9901	9994
Level 3	In Date	579	713	708	1539	777	801	887	1002	1071	1149	1171	1193
	Out of Date	282	816	819	7	787	790	730	629	443	330	285	269
Level 3 Total		861	1529	1527	1546	1564	1591	1617	1631	1514	1479	1456	1462

Average Weekly Additional Staff Required to be in Date to Meet 85% Target by End of April 2025	16

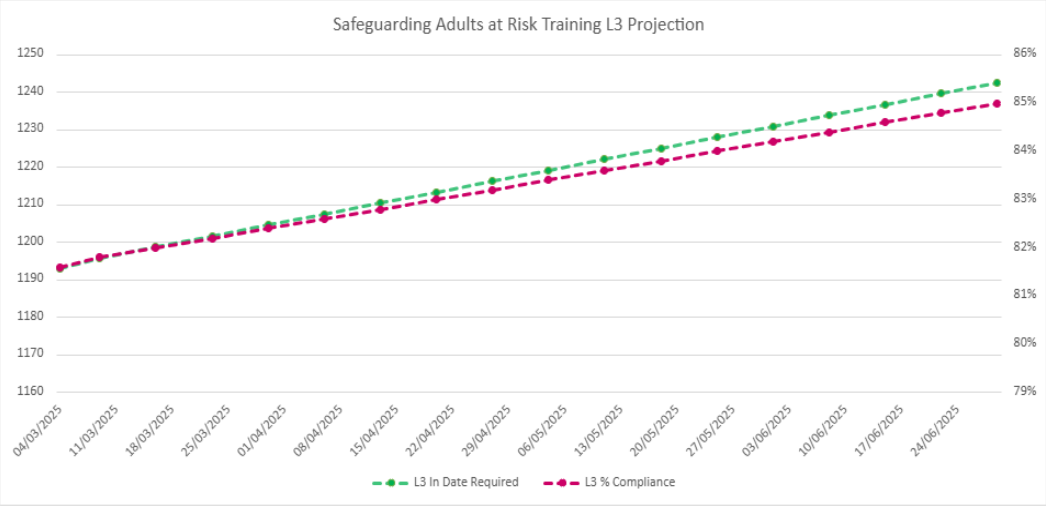
Total Staff Required to be Trained to Meet 85% Target by End of April 2025	63

Safeguarding Adult Training

NHS
University Hospitals Sussex
NHS Foundation Trust

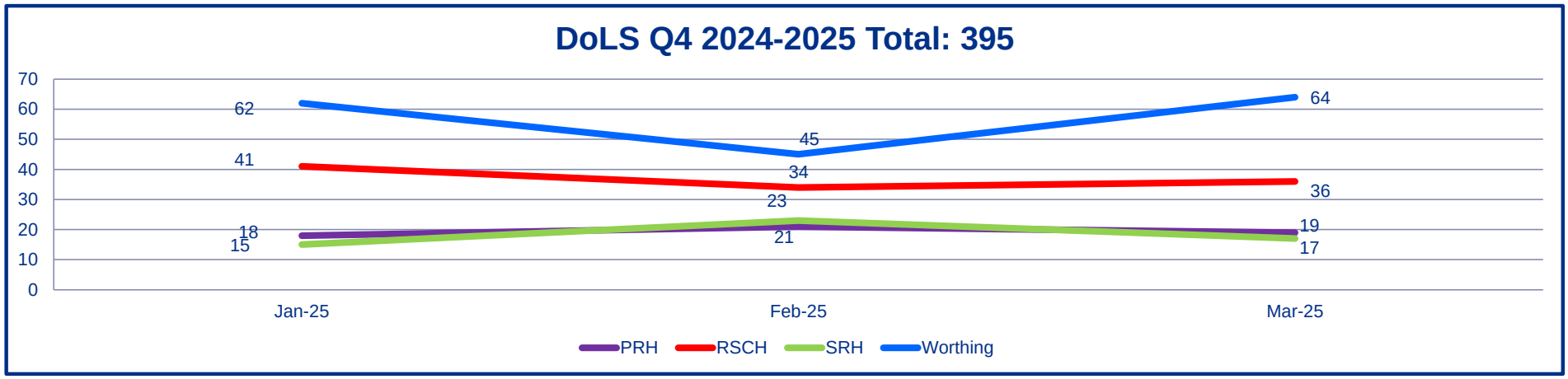
Training Compliance for Safeguarding Adults

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Level 1	94.70%	94.90%	94.30%	94.30%	94.20%	94.50%	95.60%	96.20%	96.40%	96.50%	96.30%	95.60%
Level 2	91.50%	92.80%	91.60%	91.30%	92.00%	91.00%	91.80%	92.20%	91.80%	91.90%	91.70%	91.40%
Level 3	67.20%	46.60%	46.40%	99.50%	49.70%	50.30%	54.90%	61.40%	70.70%	77.70%	80.40%	81.60%



Average Weekly Additional Staff Required to be in Date to Meet 85% Target by End of April 2025	16	Total Staff Required to be Trained to Meet 85% Target by End of April 2025	63

2. MCA & DoLS

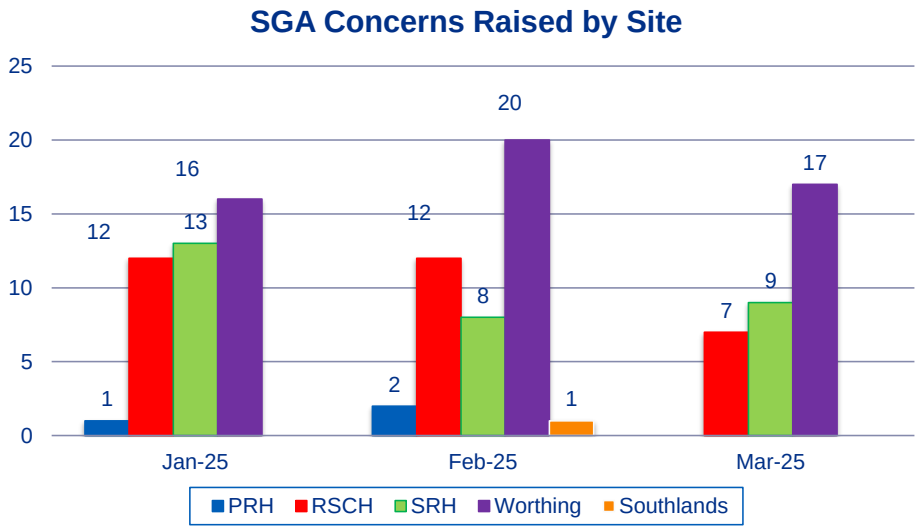


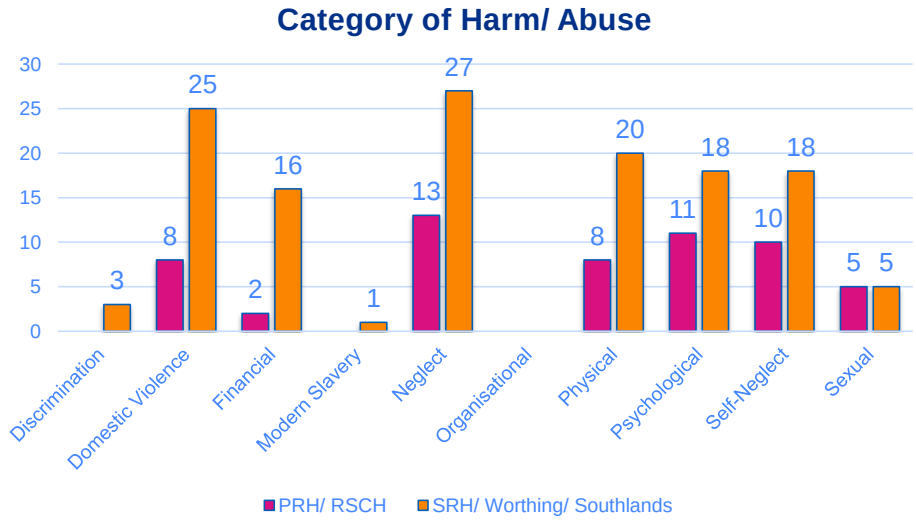
Data Analysis

- Worthing and St Richards have seen comparative data to the previous Quarter 3 for 2022-2023, with figures from both hospitals remaining stable, with total figures for 2023-2024 Q4 of 199 and 2024-2025 Q4 of 226.
- There continue to be significant differences in the number of deprivation of liberty applications between the legacy West of Trust hospitals, with Worthing requesting nearly three times the number of DoLS compared to St Richards. However, overall, both sites have experienced a slight increase in the number of DoLS applications compared to Q4 in 2023-2024.
- Previous reports have acknowledged that, although Worthing has 30% more beds than St Richards, and there is no obvious difference in the relative demographics of patients to explain this disparity, substantial differences remain in the application of the DoLS process. We continue to address this issue through training.
- Royal Sussex County and Princess Royal have experienced a substantial increase of 51% in the total number of applications compared to Q4 data for 2023-2024.However the total number of applications made this quarter is in line previous totals for 2024 – 2025.

Safeguarding Concerns raised by UHSussex

NHS
University Hospitals Sussex
NHS Foundation Trust

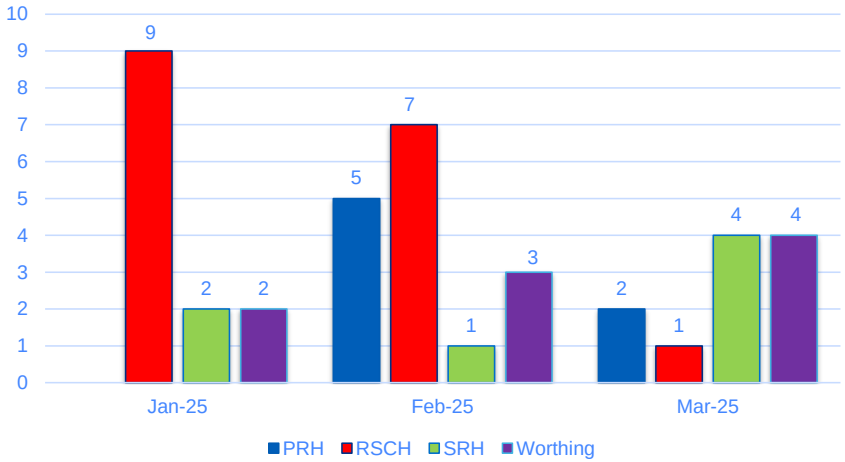


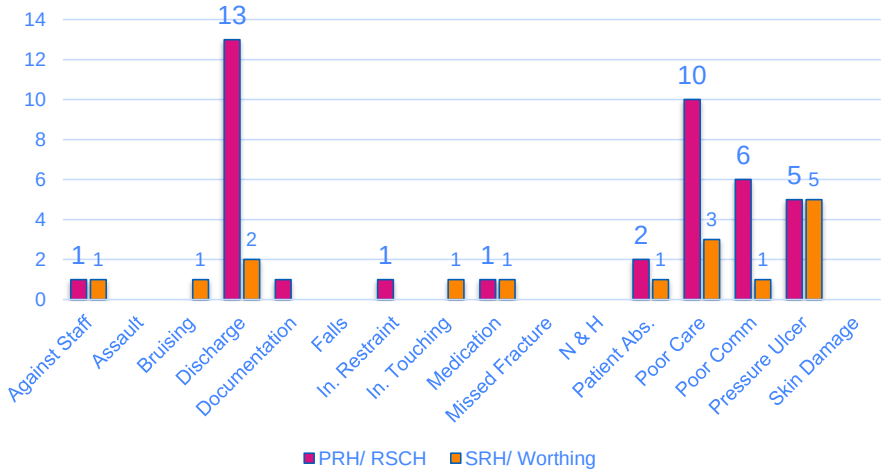


- The UHSussex made a total of 118 safeguarding referrals to the local authority in this quarter. This volume represents a drop of 12% compared to the same period in the previous year. The decline in the number of referrals may be attributed to changes implemented by the local authorities regarding the referral form, which has resulted in UHSussex no longer receiving automatic notifications when a staff member raises a concern with the relevant local authority.
- Neglect, domestic abuse, physical abuse, psychological abuse, self-neglect, and financial abuse were the predominant categories of referrals made by UHSussex.

Section 42 enquiries received

Enquires received regarding the care provided by UHSussex





Section 42 of the Care Act 2014 outlines the duty of local authorities to undertake safeguarding enquiries when they have reasonable suspicion that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect and is unable to protect themselves. During Q4, we received a total of 40 Section 42 enquiries, compared to 32 during the same period in 2023/2024. The majority of concerns raised relate to discharge issues and poor care.

To address these matters, the safeguarding adults team continues to collaborate with the harm-free care team to enhance triangulation and improve patient safety and care quality. Additionally, the team will be reviewing the current discharge checklist across the trust, aiming to establish a standardised checklist throughout the trust.

SGA Reviews

NHS
University Hospitals Sussex
NHS Foundation Trust

	Partnership	Safeguarding Adult Reviews	Date of Review	UHSx Actions	Status
1.	Brighton & Hove	SAR Tommy	2023	Review ongoing	
•	Brighton & Hove	SAR Frank & Paul	2023	Multi-agency Learning event to be held July 24. Draft report to be completed following this	
•	Brighton & Hove	SAR Hassan	2025	Review Ongoing	
	Brighton & Hove	SAR CT	2025	Review ongoing	
	East Sussex	SAR Jack	2023	Review ongoing	
	Partnership	**Domestic Homicide Review**	**Date of Review**	**UHSx Actions**	
1.	West sussex	Operation Albany	2024	Review in progress	
1.	West Sussex	KR/KL	2024	SOI submitted – review ongoing	
1.	Brighton & Hove	Adult U	2024	Review ongoing	
	West Sussex	CV	2024	Review ongoing	

Risk Register Safeguarding Adults
(The risks will be reviewed in May 2025)

NHS
University Hospitals Sussex
NHS Foundation Trust

Datix No	Date opened/ review date	Risk	Current Grading
991	Date opened: 30.09.24.	There is a risk of complaints from a patient or their representative due to a delay in DoLs. This means that a patient does not have the right of appeal against being unlawfully detained.	9
1436	Date opened:29.06.2023	Patients in the Emergency Dept when assessed as requiring a Mental Health bed do not have a legal framework for detention.	12
2064	Date opened: 30/08/24	Risk of missing safeguarding adults referrals which could result to harm to vulnerable patients due to lack of safeguarding plans.	9

Quarter 4 Safeguarding Escalations

NHS
University Hospitals Sussex
NHS Foundation Trust

Changes to the Safeguarding process across Sussex means that the safeguarding team are no longer receiving automated safeguarding alerts that UHsussex staff have raised a safeguarding with the potential risk that the Safeguarding team will not be able to provide support in a more timely manner.

Level 3 safeguarding adults training compliance currently stands at 80%, which is below the target of 85%. This figure remains low despite the safeguarding team's transition from face-to-face delivery to virtual sessions, which provide 200 spaces per session. Additionally, the team continues to offer ad hoc training as needed. They also regularly update all divisions on safeguarding training compliance, assisting them in identifying staff who are not compliant.

Long waiting times for a mental health bed for patients at emergency departments which may have implications in relation to the legal detention of patients wishing to leave the hospital. Work is on-going with the Mental Health Trust and Trust legal department to identify and mitigate risk.

NHS
University Hospitals Sussex
NHS Foundation Trust

Children's Safeguarding Quarter 4 Report 2025

Date: April 2025

Author: Cathy Coppard (Head of Nursing for Children's Safeguarding).

NHS
University Hospitals Sussex
NHS Foundation Trust

Introduction and Assurance

Introduction
This quarterly report is for the period covering the 1st of January – 31st March 2025.

The safeguarding children team has experienced significant staffing changes & challenges at a senior leadership and operational level during Q4 which has had an impact on the team and service delivery. Challenges have been due to vacancy and staff absence and Jury service. Worthing/SRH site have experienced absence of 50% and been in business continuity since the beginning of February. Staff where possible have worked extra paid hours to support the service core functions. Staffing levels have started to improve on the Brighton site and the situation should start to improve mid April for Worthing and Chichester. We now also have a newly appointed Associate Director of Safeguarding.

The staffing challenges have highlighted a renewed need to review the team's functions and resources and consider opportunities for greater collaborative working across the trust as ‘One team’. The Head of nursing for Safeguarding Children along with our new Associate director of safeguarding will support the Named Nurses and teams to ensure the most effective use of resources to support the trusts statutory safeguarding responsibilities. Opportunities will be explored in consultation with the team in order to support a more sustainable and effective way of working.

Standardised processes are being developed by the team; however, challenges continue to remain due to the various IT systems across the sites. Furthermore, the lack of electronic patient records on the Brighton and Princess Royal sites adds additional challenges. The team are working with the Trust IT project managers to find safe workable solutions.

Assurance and purpose;

The purpose of the report is to provide assurance that UH Sussex is meeting its statutory safeguarding responsibilities for children & young people.

Education and Training

Key Performance Headlines

- Q4 performance for Children is **78.2%.** This is a **1.9%** increase from Q3 performance **(76.7%)**. Performance shows an upward trajectory towards our compliance target of 85%

- The model of delivery for level 3 safeguarding is a blended/hybrid approach which combines e-learning via Iris then f2f/virtual session to explore case studies. Both sections need to be completed to be compliant.

- Compliance across Q1-Q4 has ranged between 73 - 78% of an overall number of 2521 staff at UHSussex who require training at Level 3. The number of staff who are now appropriately trained in level 3 safeguarding for children as required for their roles has increased, reducing the risk of children and young people who require safeguarding and protection being missed.

- Over **100 sessions** of hybrid training have been delivered between **April 24 – March 2025**. Analysis of bookings shows staff prefer virtual training sessions. This insight has resulted in the team converting some of the face-to-face sessions to virtual sessions to create more capacity.

- **Medical & Dental Staff** compliance with level 3 **is 65.5%. The safeguarding team is developing a focused plan to engage this group of professionals to** increase compliance.

Education & Training children

2024	Level 3		
	Heads	Total no In date	% In date
Q1 June	2310	1686	73%
Q2 Sept	2386	1866	78.2%
Q3 Dec	2524	1935	76.7%
Q4 March	2521	1971	78.2%

Q4 – 1st Jan – 31st March 2025

Number of people booked	346
Number of people attended	292
% No Shows	16%
Number of sessions run	19
Number of training hours delivered	584

NHS University Hospitals Sussex NHS Foundation Trust

RAG Rating: 85%+ / 80+% / <80%

Extract Date: 18/03/2025

Child Protection Training by Division

Division	Level 1 Heads	Level 1 Total Up To Date	Level 1 % Up To Date	Level 2 Heads	Level 2 Total Up To Date	Level 2 % Up To Date	Level 3 Heads	Level 3 Total Up To Date	Level 3 % Up To Date
Cancer Division	267	255	95.5%	559	521	93.2%	0	0	-
Chief Strategy Officer	425	419	98.6%	5	5	100.0%	0	0	-
Chief Executive	14	12	85.7%	2	2	100.0%	0	0	-
Chief Financial Officer	232	230	99.1%	1	1	100.0%	0	0	-
Chief Medical Officer	79	77	97.5%	98	90	91.8%	20	19	95.0%
Chief Nurse	78	73	93.6%	53	47	88.7%	17	15	88.2%
Chief Operating Officer	572	557	97.4%	215	209	97.2%	0	0	-
Chief People Officer	334	326	97.6%	259	237	91.5%	13	10	76.9%
CSS Division	1088	1045	96.0%	1050	1018	97.0%	60	54	90.0%
Facilities and Estates	1443	1397	96.8%	0	0	-	0	0	-
Medicine (RSCH & PRH) Division	142	136	95.8%	1046	978	93.5%	382	266	69.6%
Medicine (WOR & SRH) Division	216	203	94.0%	1319	1223	92.7%	313	224	71.6%
Specialist Division	203	185	91.1%	1350	1239	91.8%	1	0	0.0%
Surgery (RSCH & PRH) Division	300	277	92.3%	1661	1520	91.5%	33	18	54.5%
Surgery (WOR & SRH) Division	293	285	97.3%	1189	1106	93.0%	1	0	0.0%
Womens & Childrens Division	169	168	99.4%	14	11	78.6%	1695	1372	80.9%
Chief Governance Officer	99	98	99.0%	0	0	-	0	0	-
Total	5954	5743	96.5%	8821	8207	93.0%	2535	1978	78.0%

Child Protection Training by Staff Group

Staff Group	Level 1 Heads	Level 1 Total Up To Date	Level 1 % Up To Date	Level 2 Heads	Level 2 Total Up To Date	Level 2 % Up To Date	Level 3 Heads	Level 3 Total Up To Date	Level 3 % Up To Date
Add Prof Scientific and Technic	276	262	94.9%	78	72	92.3%	10	9	90.0%
Additional Clinical Services	492	460	93.5%	2144	2072	96.6%	436	343	78.7%
Administrative and Clerical	3321	3241	97.6%	14	13	92.9%	8	7	87.5%
Allied Health Professionals	35	26	74.3%	883	853	96.6%	57	53	93.0%
Estates and Ancillary	1374	1325	96.4%	0	0	-	0	0	-
Healthcare Scientists	349	328	94.0%	100	93	93.0%	2	2	100.0%
Medical and Dental	93	89	95.7%	1827	1551	84.9%	603	395	65.5%
Nursing and Midwifery Registered	12	10	83.3%	3711	3490	94.0%	1418	1168	82.4%
Students	2	2	100.0%	64	63	98.4%	1	1	100.0%
Total	5954	5743	96.5%	8821	8207	93.0%	2535	1978	78.0%

Children's delayed discharges & Court authorised DOL

University Hospitals Sussex NHS Foundation Trust

Delayed Discharges for Children & Young people <18 years from when medically fit						
Excess bed days Site/Qu	**Total 2023/24**	**Q1 ≥ from Day 5**	**Q2 ≥ from day 0**	**Q3 ≥ from day 0**	**Q4 ≥ from day 0**	**Total 2024/25**
WH	567	142	15	67	83	**307**
SRH	504	110	44	43	80	**277**
RACH	308	114	261	289	323	**987**
RSCH	40	0	0	31	71	**102**
Total	1,419	366	320	430	557	**1673**

- The safeguarding risks and possible breach of deprivation of liberty (DOL) associated with delayed discharge for children & young people awaiting a suitable placement for discharge from the acute hospital remains a significant ongoing concern.
- During Qu 4 RACH- had 6 young people waiting for either a suitable residential placement, community package or a Tier 4 Mental health bed.
- We have seen a reduction in delayed discharges on the Worthing and SRH sites where we have a paediatric lead for mental health
- Safeguarding team continue to work collaboratively with partner agencies and in supporting the wards. This is an increasing part of our daily safeguarding activity.

Increasing numbers on the RACH site, of children and young people presenting with poor emotional and mental health are remaining for long periods in hospital waiting for either, a local authority residential placement, community package or occasionally Tier 4 mental health bed.
These delays are detrimental to their health & wellbeing and a safeguarding risk.
Risks- 120-graded 25 and 121 graded 5

Risk Register Safeguarding children (part 1)

NHS
University Hospitals Sussex
NHS Foundation Trust

Risk ID	Date Opened	Risk	Current Grading
120	19.06.2018	Risk of physical and psychological deterioration for vulnerable young people on inpatient wards awaiting specialist mental health/FEDS/social care placement	25
157	03.10.23	Risk of delayed diagnosis and patient harm due to lack of paediatric radiology services *which can impact on child protection medicals for skeletal services*	12
1742	05.02.24	No formal rota for child protection medicals in the Chichester area (NAI) A child requiring a protection medical may not be seen in a timely way.	12
1940	04.07.2024	There is currently no funded specialist provision to support Autistic or Neuro diverse , children, young people or adults within Uhsussex, leading to harm	16
1151	07.12.2017	Impact on St Richards Paediatric department acute service and child protection medical provision due to inadequate Chichester CDC	15
2220	06.11.2024	A risk of harm to vulnerable patients not being appropriately flagged on our Centralised IT patient administration systems due to insufficient admin service within all the services that sit under safeguarding	12
1890	25.04.24	There is a significant risk that essential safeguarding processes may not be completed or effectively managed due to staff absence.	12
1896	30.05.24	Due to the various IT systems, versions of systems and access permissions and paper health records, there is no one true source of information to inform clinical and safeguarding decision making. (Brighton and Princess Royal Hospital sites)	12

Risk Register Safeguarding children (part 2)

University Hospitals Sussex NHS Foundation Trust

1909	12.06.24	Domestic abuse victims who are at risk of abuse will not be protected through Multi agency Risk assessment conference (MARAC) because safeguarding team do not have the capacity to meet the demands from increases cases to report on	12
2297	05.12.2024	A lack of understanding a reporting of incidents of restraints has the risk of leading to potential harm to patients	12
2484	20.03.2024	There is no strategy to support Transitional Safeguarding at UHSussex	9
1557	03.10.2023	Risk of missing referrals due to changes made by West Sussex social care to their referral process and risks in delay to sharing of relevant safeguarding information with the wider health network for the child	9
1368	20.04.23	Risks to safeguarding due to poor compliance in completion of safeguarding children training	8
980	05.07.2019	UHSussex - does not have a clinical photography service to support child protection medicals at Worthing & Chichester hospitals. This is a concern in the recording of injuries in children where there is a concern about non-accidental injury. The quality of images is poor and can be a particular problem when images are required as part of court proceedings.	5

Children's Safeguarding practice reviews

NHS
University Hospitals Sussex
NHS Foundation Trust

Child Safeguarding Practice Reviews

West Sussex

	Child	Brief overview	Date of review	Update	UHSx actions	Status
2	**LCSPR Serin EFD**	16yr old who was sectioned under MHA, completed suicide whilst an inpatient in an acute Trust awaiting a Tier 4 bed	Jul-22	**Jan 23** - UHSx external review commissioned by Niche. Nov 2023- SI report released. **Jan 24** - ongoing multi agency work. Inquest posponed until to later in year - 2024 **March 24** - Improvement work is being monitored through CYPMH Project Working Group **Jan 2025** - Publication of the review delayed. Await inquest further delayed to later 2025 . **April 2025-** CYPMH project group leading on this- see action plan evidence	Discussed at CYPMH Project Working Group Care of detained children in hospital reviewed and improved data collection Observation policy and Review in progress HON- Mental Health -appointed and leading on mental health and enhanced oberservations work at UHSx	

Brighton & Hove

	Child	Brief overview	Date of review	Stage	UHSx actions	Status
3	**CSPR Zeta (MM / AMS)**	01/10/2023 YP known to AVRM for explotation, had attendances to RACH for injuries. Died age 17 as a result of a stab wound to the abdomen.	2023 Related to exploitation	Rapid review submitted Oct 2023 and additional information shared May 2024 Oct 24 Practitioner event held Sept 24 and await draft report for review Escalated to the ICB and W&C and Medicine divisions need for provision of youth work service to support 11-25 year olds at UHSussex	Review Delayed information sharing, professional curiosity, adultification, exploitation, youth violence, unconcious bias, contextual safeguarding Review Youth worker service to ensure support is available for all ED's where children are seen and for 11-25 years olds across UHSussex	

WSSCP Statutory Rapid Reviews

University Hospitals Sussex NHS Foundation Trust

Rapid Reviews West Sussex						
Date requested	Child	Brief overview	Date/outcome of review decision	UHSx actions	Update	Status
May-23	CB	County Lines. Perpetrator of knife crime to another minor	2023- decision not for statutory Practice review	Closed see Zeta for wider UHSussex actions and learning	**Feb 2024** Named Nurse and Youth worker attended Practitioner event to discuss west sussex approach to tackling exploitation. UHSussex Inputting into Violence reduction partnership (VRP) and request made for additional youth worker support for emergency departments in West sussex **June 2024** Actions can be part of wider actions in case review Zeta for exploitation	
May-24	JS	Unexplained community child death of a 18/12	across the multi-agency partnership were: Parental behaviours obscuring child's lived experience Domestic abuse and use of the Domestic Violence Disclosure Scheme (commonly known as 'Claire's Law') Assessment and understanding of risk Sharing and triangulating information Parental mental health and substance misuse Engagement of fathers and male carers (links to The Myth of Invisible Men and Safeguarding children at	UHSussex should be invited to strategy meeting held by social care out of hours Ensure ICON message shared with all under 6 month attending urgent treatment settings Stengthen Safeguarding arrangements in ED with Champion role and regular supervision	**Oct 24** Ongoing work with ED's across the trust to strengthen safeguarding. And develop safeguarding champion role. Case of the month set up and networking and regular supervision arrangements **March 2025** SGC team need to review actions at next working group to gain assurance before closing. ? If Action Plan developed	
Jul-24	HS	Unexpected community child death of an infant aged 6/12. Parents had declined FNP offer of support	Await outcome from CRG	Maternity- Needs of the unborn baby were considered- relevant referrals made for support appropriately. Safety risk assessments were made in pregnancy & safe sleeping message shared		
Oct-24	CF	Radicalisation and concerning behaviour of a young adult now aged 18	Await outcome from CRG	Limited involvement following ED attendances at RACH. Will share wider learning from review when made available by WSSCP		
Nov-24	HW	Unexpected community child death of a 6/12 infant	Await outcome from CRG	Maternity to input and RACH	**25/2/25** Maternity Action plan provided by SB	
Nov-24	SC	Unexpected child death 10 1/2 year old child with disabilities CIN	Await outcome from CRG	Perplexing case and actions to be considered including supervision arrangements for AHP's (dieticians) as a group	**06/03/2025** Action plan developed by VW	
Jan-25	AA	Neglect & CSA of a young person		Return submitted - Limited involvement UHSussex. Will share wider learning from review when made available by WSSCP		
Feb-25	JC	Neglect of 2 young people Crawley area		cp MEDICAL & ED attendances. Return submitted - Will share wider learning from review when made available by WSSCP	Case reviewed UHSussex actions appropriate.	

BHSCP and ESSCP Rapid Reviews

University Hospitals Sussex NHS Foundation Trust

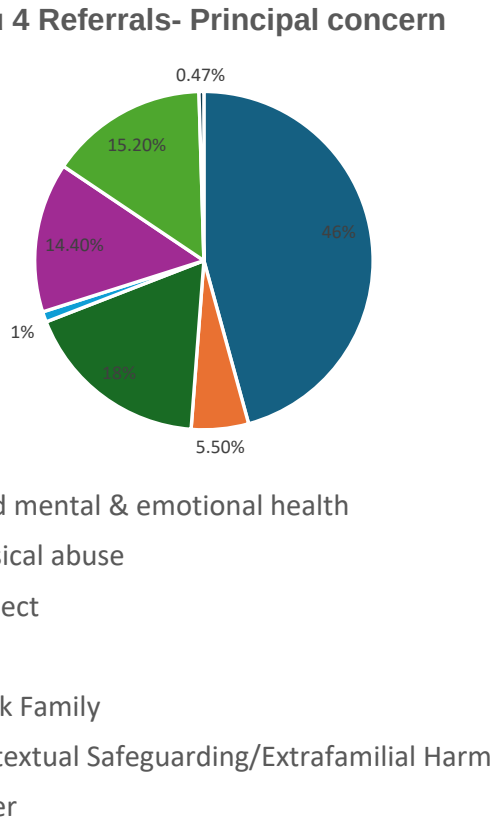
Brighton & Hove						
	Child	Brief overview	Date of review decision	Update	UHSx actions	
26.02.2025	L-J C	Significant Physical abuse and neglect of a 15-19 month. RR focus from birth to June 2024	Await outcome from CRG	Return submitted - Will share wider learning from review when made available by BHSCP		
East Sussex						
	Child	Brief overview	Date of review decision	Update	UHSx actions	
Jul-24	JM	Child sexual exploitation of a 16 year old looked after child	Await outcome from CRG	Some involvement of RACH CED	April 2025 CRG to provide update	

Safeguarding Children Referrals to local authority Integrated front doors (social care/early help)

University Hospitals Sussex NHS Foundation Trust

	Total 2023/24	Q1	Q2	Q3	Q4	Total 2024/25
WH (includes CDC)	1,190	221	258	269	204	**959**
SRH	732	148	175	192	176	**692**
Crawley	29	0	2	17	0	**16**
Brighton	437	110	319	249	235	**913**
PRH	67	9	17	37	24	**87**
Total	2,455	488	771	769	639	**2667**

Note this data only includes referrals the hospital safeguarding team are made aware. Some referrals made the trust has no record of which can create problems as no evidence referral made and no copy in the patient health records. This is on the risk register.



Children's Examples of Good Practice

NHS
University Hospitals Sussex
NHS Foundation Trust

- **The safeguarding team including named Doctors, pulling together to maintain and deliver a core safeguarding service during a very difficult and challenging quarter 4**
- **Children's Safeguarding Supervision-** New Policy and more safeguarding staff are trained in delivering supervision to safeguard. Safeguarding Supervision arrangements are being strengthened out for emergency departments and allied health professionals.
- **Restorative Reflective Supervision-** provided to support the safeguarding team started February 2025
- **Integrated working to safeguarding children**
- **Safeguarding Newsletter**

Microsoft
werPoint Presentat

Children's – Issues for escalation

NHS
University Hospitals Sussex
NHS Foundation Trust

- **Team in business continuity due to staffing challenges and senior leadership changes -**Worthing and Chichester particularly challenged due to long term staff sickness absence, leave and jury service and added pressure due to complexity of patients requiring safeguarding support particularly at RACH
- **Safeguarding Children presenting to hospital with poor mental and emotional health and ensuring they are not being deprived of their liberty** whilst waiting for long periods of time in hospital for a suitable placement remains a significant challenge particularly currently on the Brighton sites.
- **Capacity for partnership and quality improvement work has been limited** this quarter due to business continuity
- **Youth worker provision limited across the trust with no clear sustainable funding model**
- **New provider of Children's Sexual Abuse Referral Centre (SARC) service from April 2025 - Mountain Health care**. This is a national issue and Local NHS services will need to develop new relationships with this private provider to support this important area of work.
- **UHSussex IT systems** - the various 'silo' systems make safeguarding work and information sharing more challenging. This is a risk which has been shared and discussions held with the CIO

NHS
University Hospitals Sussex
NHS Foundation Trust

Maternity Safeguarding Quarter 4 Report.

Date: January 2025-March 2025.

Author: Sarah Barwick

Introduction

University Hospitals Sussex NHS Foundation Trust

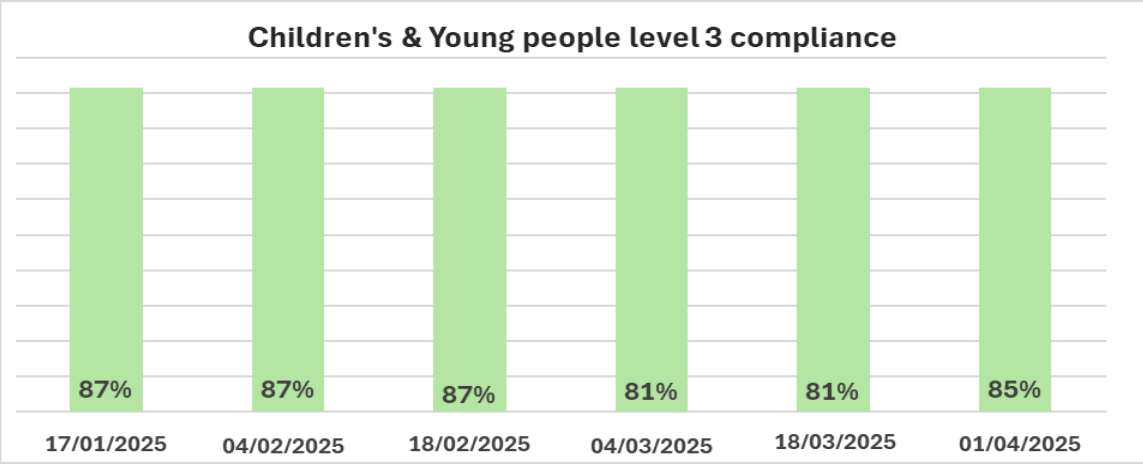
- The safeguarding midwives are an established team working together across all four sites with an aim to support staff to identify potential safeguarding concerns within pregnancy and initial postnatal period and feel confident to make appropriate referrals for support to reduce risk for unborn baby.
- The safeguarding midwives work in collaboration with wider multiagency services within the community to improve communication, planning and outcomes to promote safety of babies and provide support for families.
- The Maternity safeguarding report aims to provide assurance around staff training and supervision, alongside updates regarding relevant guidance and areas of improvement work.
- Safeguarding activity is reported across the sites identifying activity, trends, risks and highlighting themes and areas for further development. Mandatory data collection within Maternity is included within the report, however the Maternity system cannot extract the specific data required for certain fields detailed in the report.

Assurance

NHS
University Hospitals Sussex
NHS Foundation Trust

Training

- The Maternity Safeguarding team are responsible for providing Level 3 Children's & Young People safeguarding training to all staff working within Maternity on a yearly basis. For 2025 this will be delivered face to face for 2 hours.
- The focus of the training is Think Family with a particular focus on Neglect and learning from case reviews including the West Sussex Neglect matrix & 'Day in the life' tool used to identify neglect.
- Specific compliance for level 3 Children & Young person's training for staff working within Maternity continues to be recorded & reported within the Maternity Safeguarding quarterly report. Last year the Safeguarding midwives provided a bespoke session for doctors within the division within a governance day to promote compliance, we plan to repeat again this year.



Supervision

- Safeguarding supervision sessions are now established for Community midwives across all 4 sites. The Community team managers have supported the safeguarding midwives to facilitate these structured sessions by providing Community midwives protected time of one hour every 3 months. These sessions run in groups both virtually and face to face and one to one sessions can be facilitated if requested. Sessions aim to encourage practitioners to reflect on current or previous involvement with families with safeguarding issues within a safe environment, feedback remains positive with an encouraging uptake of sessions. A record is kept of each supervision session when held whether a group or individual to enable more efficient reporting.

- Alongside this, regular supervision takes place within the monthly maternity multi-agency safeguarding meeting. Internal staff leads are invited to attend from core areas such as Delivery suite, antenatal /postnatal and Neonatal units. These meetings include representatives from the West and East Sussex Children's Social Care, Perinatal Mental Health, Health Visitors, Change, Grow, Live, Family Nurse Partnership Programme, and specialist teams alongside maternity and paediatrics team leaders from University Hospitals Sussex (UH Sussex) clinical teams. Individual midwives working with complex families being discussed are encouraged to update & attend where possible.

- Core staff are offered safeguarding supervision following any particularly distressing safeguarding incident or case on wards such as a mother and baby being separated after birth. Safeguarding midwives aim to meet with any staff member affected or involved to provide support and time for reflection.

Policies

Separation at birth

- The Maternity safeguarding team, Local Authorities and wider multiagency services working with vulnerable and complex families continue to work collaboratively to improve the care of mother and baby within care proceedings and separation at birth based on the principles from the Born into Care guidance .The birthing arrangement form has now been implemented and ratified by West Sussex Local Authority alongside the standard Safeguarding Birth & Discharge plan when there is a plan for separation of baby from the mother after birth alongside the safeguarding birth and discharge plan ,with an aim to achieve an improved planning process with the family enabling control, choice and optimal support for families.

- An emphasis from the safeguarding midwives remains on continued focus and drive to ensure timely safeguarding birth and discharge plans are provided to both families and the safeguarding maternity team by 32- 34 weeks of pregnancy. This requirement communicates identified and potential risk factors to clinical staff, ensuring a robust safety plan and preventing unnecessary delays in hospital stays due to social issues.

- Following the completion of Standing Operation Procedure for the HOPE boxes- (Hold on Pain Eases) the Trust have agreed funding therefore all mothers who are within legal proceedings with a plan of separation at birth from their baby antenatally will be offered a HOPE box. The Maternity safeguarding team have provided training sessions with the neonatal units within the Trust so staff are able to support when babies are under their care. This intervention involves long term multiagency collaboration with a steering group including professionals from local authority Children's Services, fostering, and contact service. The Maternity safeguarding team have provided a face-to-face training session for Brighton and Hove Children's social care managers to help embed the innovation within their service. This exciting innovation continues to develop with champions being identified within clinical areas to lead alongside the safeguarding midwives within Maternity.

Baby Abduction Guideline

NHS
University Hospitals Sussex
NHS Foundation Trust

- The new Baby Abduction guideline has now been ratified in JOGG & will be going live across all sites on 23/04/2025.All clinical areas will be given a flowchart to display for use in case of suspected abduction to highlight actions required. The flowchart was created from staff feedback from previous abduction skill drill. Feedback from the skill drill in 2024 at PRH reported the issues with the previous guidance due to requirement of multiple bleeps to activate the required actions. A task and finish group has run over the last quarter to agree the new guidance, including Maternity Lockdown going live across all 4 sites involving Safeguarding lead, Matrons, ward leads, security management and PDT.
- Baby abduction skills drills are a CQC requirement to take place yearly on each site. The first Baby abduction simulation took place at SRH in March 2025 following the new guidance. The drill tested the process of Maternity Lockdown for Maternity, but also switch, security & porters. Feedback was provided following the drill by debrief to all staff actively involved within the simulation but also a summary of events also sent out to all areas who participated within the planning for learning.
- The ongoing plan will be to carry out a planned simulation on each site to identify site specific risks. There is a date planned in May 2025 for a simulation at Worthing, the Trust simulation lead remains involved with the planning and learning .Once every site has ran a simulation, a best practice video will be created incorporating the key learning points which can be used for all staff training on the IRIS platform.
- Whilst there has been a delay in carrying out skills drills, it is paramount the same guidance is consistent throughout the Trust.

Dependency Clinic

NHS
University Hospitals Sussex
NHS Foundation Trust

- The dependency clinic One Stop West on the Worthing and St. Richard hospitals antenatal clinics has now become established running fortnightly on each site. Through professionals completing a robust risk assessment at booking or within the antenatal period ,women with any dependency in pregnancy such as alcohol or substance use can be identified and invited to a supportive multiagency clinic where they are able to access a wide spectrum of professionals at one appointment for individualised support and to plan their antenatal, intrapartum, and postnatal care. The concept follows the well-established 'One Stop' service for pregnant women at Royal Sussex County and Princess Royal hospitals but cannot offer the same level of continuity or individualised care as no funding provided and therefore run by safeguarding midwives rather than specialist midwives. Within the clinics there will be an Obstetrician, safeguarding midwife, smoking cessation, CGL (Change, Grow, Live) practitioner and a paediatrician available.
- It is hoped these joint working clinics will improve care experiences and outcomes for mothers and babies, reducing the need for multiple appointments with professionals in pregnancy, alongside providing a detailed, holistic, individualised plan of care to identify needs and risks for mother and baby prior to birth. Local Rapid Reviews have identified cannabis and alcohol use both in pregnancy and within the family home presents a risk to a newborn baby. Learning from a recent review around mothers who disclose pre pregnancy alcohol use, recommends further exploration from midwives about what this looked like, to discuss the risks of FASD and to offer referral for specialist support to promote sustained abstinence. Alcohol/ cannabis use should be revisited by the multi disciplinary team through the pregnancy and after birth. Alongside the specialist clinic, the woman's alcohol/ drug use needs initial risk assessment for impact on unborn baby and consideration for referral to children's social care and follow up within pregnancy.
- A referral pathway and Maternal and Neonatal care plan have been developed and agreed within the professionals involved in the clinic. One Stop WH Maternal and Neonatal Birth Plan.docx Referral Pathway.pdf
- The Maternity Mandatory training days for 2025 have a One Stop session for 45 minutes to inform all staff in Maternity about the new service, how to refer and to consider scenarios from practice for learning.
- From April data will be captured from the One Stop clinics around activity and outcomes.

Audit

University Hospitals Sussex NHS Foundation Trust

Domestic Abuse Enquiry

- Following on from the findings of the Pan Sussex Maternity safeguarding forum audit, recommendations were made around University Hospitals Trust to provide assurance over the routine domestic abuse enquiry being embedded in practice.
- The Maternity System currently is unable to produce reliable data to demonstrate the routine domestic abuse question is being asked to women during their pregnancy, therefore cannot be reported. The risk has been escalated to the Maternity Clinical Effectiveness Manager who is consulting a data analysist with a hope accurate recording can be achieved.
- Domestic abuse is always covered within mandatory training for all staff focusing on routine enquiry and the impact on children with a Think Family approach. Updates are provided regarding local support services. The Health IDVA's have provided a video which is incorporated within the Maternity level 3 safeguarding training for 2025.
- The Health Independent Domestic Violence Advocates (IDVA) remain visible and are actively involved with Maternity on each site, readily available for advice and support for both women and staff. The service is well advertised for accessibility on all sites. The Health IDVA's attend the Maternity multiagency Safeguarding meetings on each site.
- Safeguarding midwives attend all local MARAC meetings covering all sites and will provide information if pregnant women and their families are being discussed.
- The process of Maternity safeguarding receiving SCARF reports (Single Combined Assessment of Risk) has been very successful with a working group developing and implementing an agreed Standing Operational Procedure for Maternity Pan Sussex for a clear process. This collaborative approach encourages information sharing to reduce risks for both pregnant women, unborn babies and the staff providing care.
- Safeguarding midwives are contributing information and data for the Worth and Health IDVA JTAI audit- to establish actions within Maternity and any gaps in practice.

ICON and Safe Sleep.

University Hospitals Sussex NHS Foundation Trust

- Communication with digital midwives continues with an aim to provide assurance these messages have been delivered in pregnancy and prior to discharge from hospital with baby.
- ICON-Currently can identify the information has been sent electronically antenatally but cannot evidence it has been read or discussed with a health care professional. These messages are part of the information given to parents at the time of discharge from hospital but not recorded in isolation. No ability to run a report specifically around ICON.
- Safe Sleeping- recording the discussion around safe sleeping at the point of discharge is a mandatory field on the Maternity Information system. The mother and baby cannot be discharged unless this is completed.
- The Pan Sussex Maternity Safeguarding Forum continue to meet with an aim to progress this work and consider if a different method is required. The digital midwives have raised the issue of reporting within the National forum.

FGM

- The data below evidences the episodes of disclosed Female Genital Mutilation at each site for women who birthed in the time frame. The Female Genital Mutilation Information system is completed if the baby is female by the safeguarding midwives

FGM disclosed per site	Jan-March 2025
PRH	0
RSCH	6
SRH	4
WGH	0

FGM is completed if an Infant	Jan- March 2025
PRH	0
RSCH	0
SRH	0
WGH	0

FGM is discussed at yearly Mandatory training. Each woman will have an individual holistic assessment to identify potential risks both physically, emotionally and socially. A safeguarding referral will be sent to children's services for unborn baby if a risk is identified antenatally.

UHSussex is participating within the FGM audit within the Pan Sussex Safeguarding Forum. The purpose of the audit is to ensure recommended processes are being followed and risk assessments being completed.

Safeguarding Maternity risks

NHS
University Hospitals Sussex
NHS Foundation Trust

Risks	Actions
Risk- ID 1557	
Change of referral process to the Integrated Front Door at West Sussex local authority risks delay to safeguarding information sharing with the wider health network for the child. If the referrer does not create a copy of the referral and send to the safeguarding midwives, the referral will not be seen and therefore not embedded within Maternity records. The safeguarding midwives will not be aware of the potential risk factor for unborn baby. Remains on risk register for Safeguarding.	• Safeguarding midwives monitor the receipt received to indicate a referral has been made and if a copy of the referral sent by the referrer for safeguarding records. The process mitigates risk team contact the referrer directly for further information. • The Head of Safeguarding for children is liaising with Trust IT leads to implement improved technology.
Risk ID 2357	
Provisions for Perinatal Mental Health midwifery service are inadequate. Doctors training in perinatal mental health is inadequate and require support from specialist midwives. Following several incidents where postnatal women have developed postpartum psychosis and current guidance not followed. Women and babies have been placed at significant risk and in one case the woman suffered harm.	• Case discussed at PSIRG and for a Thematic review and risk added to risk register. • Safeguarding midwives are supporting the development of an agreed process for Postnatal Psychosis Management within a Standard Operating Procedure outlining responsibilities for Maternity and wider multi disciplinary team.
Risk ID 2482	
Insufficient administration support within Maternity safeguarding service may result in women, children and babies experiencing harm and neglect due to key information sharing and communication being missed. On risk register.	• Head of Midwifery has authorised 0.4 hours can be advertised for safeguarding administrator, which would provide cover for 5 days a week.

Learning from incidents

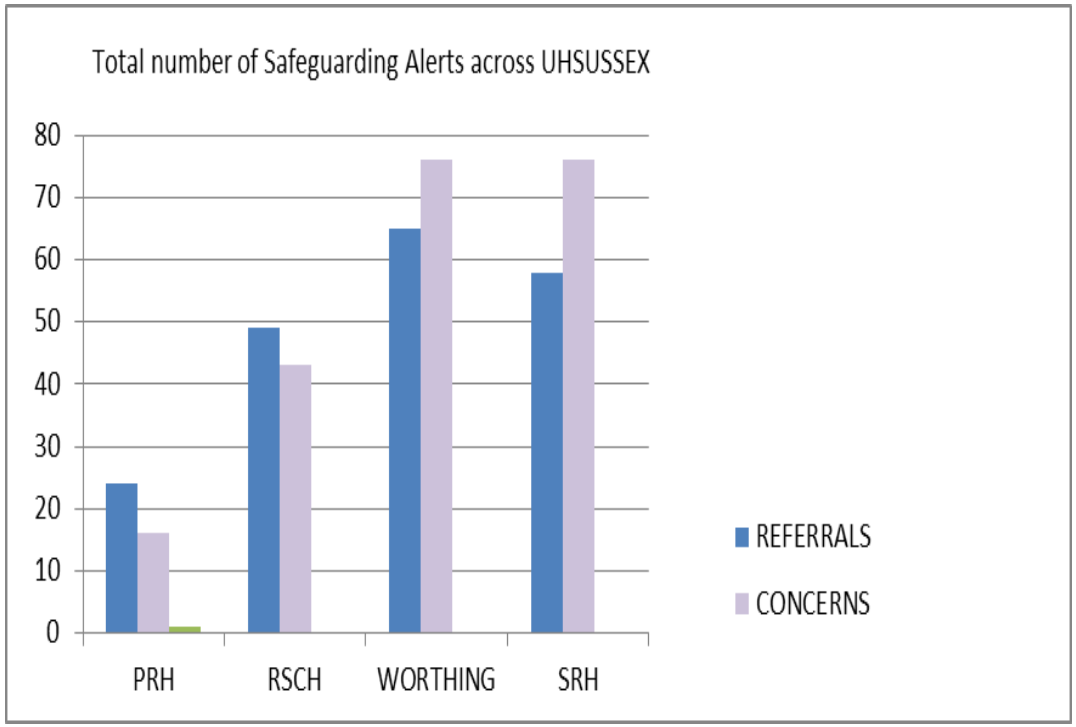
- Documentation of bruises and marks on a baby to prevent unnecessary readmissions and child protection procedures. Further communication within Maternity to promote the use of body map illustrations when a bruise or mark is observed. Message of the Week to all midwives to remind use of body illustrations within the transfer of care forms when a baby is discharged from the hospital and again when discharged from Maternity care to Health visitor. Any new marks observed within the postnatal period should be directly communicated from midwife to Health visitor. As Health Visitors currently cannot access Maternity system, provided with safeguarding midwives contact details should confirmation of documentation be required within a home visit to clarify if escalation is required.

- Safeguarding named midwife and core/ community leads have met with Health visitor leads to discuss how communication between midwives and health visitors can be improved, particularly around documentation of marks or bruises. Following UH Sussex Maternity transferring to digital records, the percentage of red books completed at point of transfer of care is under 30%. Health visitors aware the Trust are encouraging thorough completion of Transfer of Care forms which are emailed to Health Visitor at point of discharge to improve communication/ documentation. Will be a further follow up meeting to review and monitor if process has improved within 3 months.

- Following a recent Rapid Review, UHSussex have implemented actions and will share the Learning briefing across Maternity. Actions recommend midwives actively engage with the social worker and wider professional network of unborn baby/ newborn baby. The actions include ensuring communication is shared about any missed/ rearranged appointments, any concerns around lifestyle which may have health implications for baby and raising concerns or escalating when actions do not effectively safeguard the child. The case study is being used within the level 3 Maternity safeguarding training .

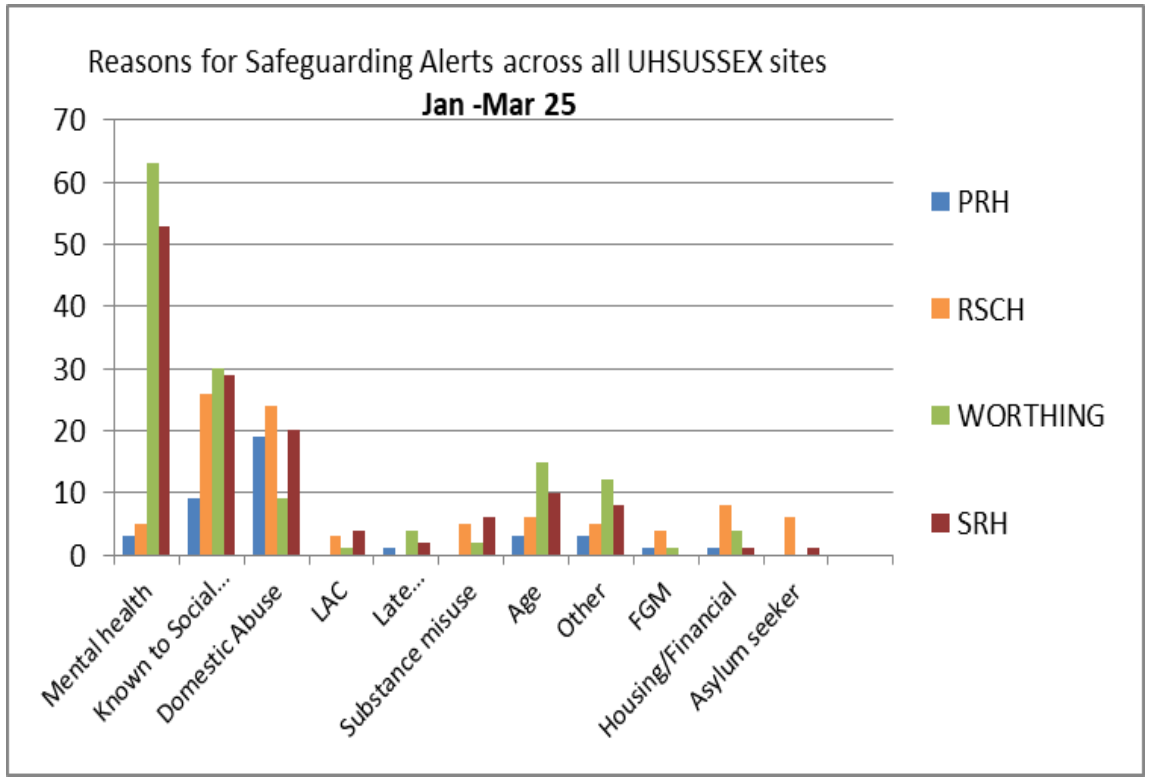
Activity

NHS
University Hospitals Sussex
NHS Foundation Trust



	PRH	RSCH	WTH	SRH
Referrals	24	49	65	58
Concerns	16	43	76	76

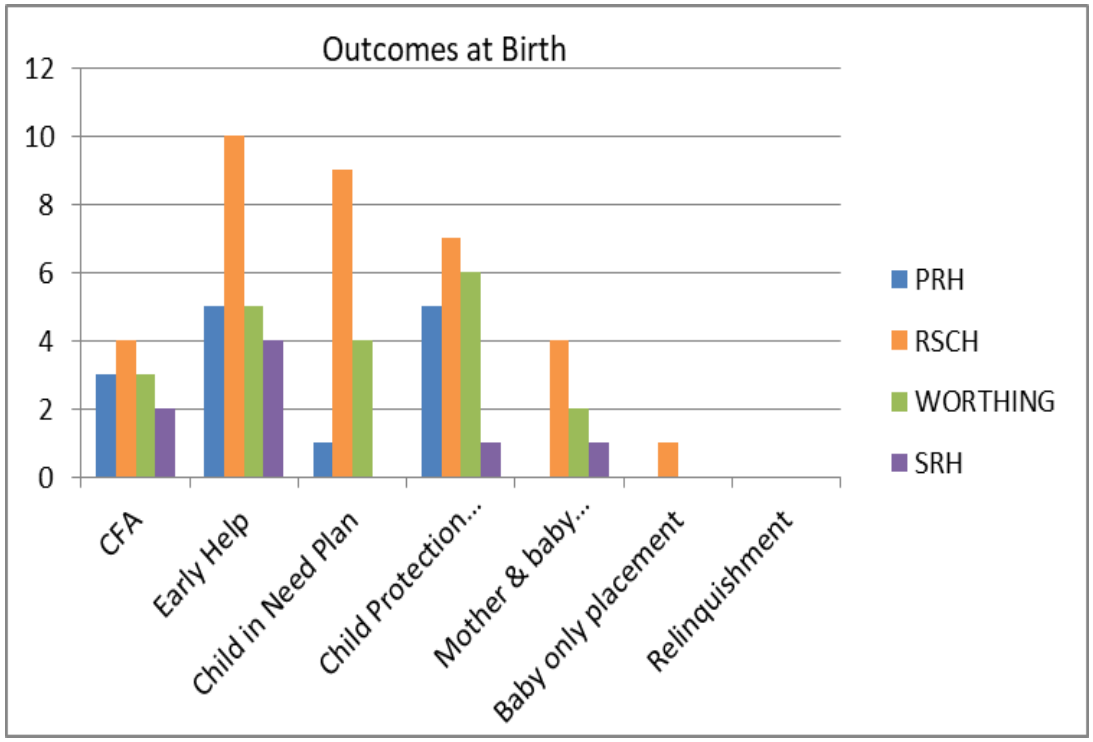
Safeguarding Alerts



Reason for Safeguarding Alert	PRH	RSCH	WTH	SRH
Mental Health	3	5	63	53
Known to Social Care	9	26	30	29
Domestic Abuse	19	24	9	20
LAC	0	3	1	4
Late bookings / Concealed pregnancy	1	0	4	2
Substance misuse	0	5	2	6
Age	3	6	15	10
Other	3	5	12	8
FGM	1	4	1	0
Housing/Financial	1	8	4	1
Asylum Seeker	0	6	0	1

Safeguarding outcomes at time of birth

NHS
University Hospitals Sussex
NHS Foundation Trust



Outcome at birth	PRH	RSCH	SRH	WTH
CFA current	3	4	2	3
Early Help	5	10	4	5
Child In Need plan	1	9	0	4
Child Protection plan	5	7	1	6
Mother & baby placement	0	4	1	2
Baby only placement	0	1	0	0
Relinquishment	0	0	0	0

Data and activity

- Through robust data collection activity levels within safeguarding can be measured. Within Quarter 4 the percentage of all women who birthed with safeguarding concerns identified within the pregnancy per site - PRH- 8%, SRH 25%, RSCH 16% & WH 31%. Outcomes at the time of delivery have been classified in more detail to encompass information about the high-risk cases in child protection and legal proceedings to reflect the time and planning involved.

- Significantly by the time of birth, the percentage of women with an initial safeguarding alert continuing to have children's social care involvement per site- PRH 28%, SRH 4%, RSCH 37% & WH 12%.

- In Quarter 4 of those babies with current social care involvement at birth- 24 were subject to Early help, 14 to Child In Need plans, 19 to Child Protection plans and 7 mothers & babies were discharged directly to placements and 1 baby separated from their mother after birth, prior to discharge to baby only placement. This highlights the level of risk, need for timely pre-birth risk assessments, importance of communication and planning with the relevant Local Authority and other agencies involved. All these babies require robust safeguarding birth and discharge plans and discharge planning meetings.

NHS
University Hospitals Sussex
NHS Foundation Trust

Data and activity continued

- The 3 main reasons for raising a safeguarding alert remain Mental health, current or previous social care involvement with the family and Domestic Abuse.

- The Maternity multiagency safeguarding meetings promote collaborative working, communication and planning for women and families with identified safeguarding needs and vulnerabilities. These meetings ensure all professionals, agencies and internal staff leads involved with woman and family have improved communication and understanding of the family's needs and support to enable improved comprehensive, individualised and timely plans for birth and the postnatal period to increase safety for babies and improve outcomes.

- There are increased numbers of families with extensive complexities and vulnerabilities accessing care and the need for effective communication and planning is essential to ensure baby's needs are identified and thoroughly risk assessed. This quarter Asylum seekers have been added as a reason for needing a safeguarding alert.

University Hospitals Sussex NHS Foundation Trust

Items for Escalation.

Concerns

- Further communication and collaborative working with Local Authorities to ensure timely and robust safeguarding birth plans are in place prior to birth to prevent risk to baby at birth and delay in a safe discharge. Pre birth social workers to attend all Maternity multiagency safeguarding meetings for each site to ensure robust plans in place prior to birth.

- Unable to extract Domestic Abuse routine enquiry data from Maternity system.

- The volume of administration remains very high in terms of routine enquiries and increasing demands to document and record all communication to aim to reduce risk. The administration requires a full time equivalent to be able to meet the demands across the sites to allow the safeguarding midwives to fulfil their specialist role.

NHS
University Hospitals Sussex
NHS Foundation Trust

Items for Escalation.

Examples of Good Practice

- Learning from incidents – implementing actions from local Rapid Reviews to improve outcomes and reduce risks for children. Continue to improve communication between Maternity and children's social care and wider multi-agencies. Learning being shared though training. Increased communication with Health Visitors to improve communication during transfer of care from Maternity around documentation of marks and bruises.

- Continued partnership working, and development of HOPE boxes and Birthing arrangement forms with support from the Trust by agreeing initial funding. West Sussex children's services have incorporated the Birthing arrangements form into their pre-birth guidance for use within the safeguarding birth plan process when separation at birth is planned.

- Increased visibility and collaborative working with partner agencies within the community through the Maternity multiagency safeguarding meetings to improve communication, planning and outcomes for women, babies, and their families.

- Baby Abduction guideline now ratified and Maternity Lockdown agreed to be live across 4 sites by May 2025.Simulation and learning shared on 1 site, next planned for May 2025.

NHS
University Hospitals Sussex
NHS Foundation Trust

Dementia and Delirium Quarter 4 Report 2024

Date: April 2025

Author: Andy Nuttall (Head of Nursing for Dementia & Delirium).

NHS
University Hospitals Sussex
NHS Foundation Trust

Introduction and Assurance

This quarterly report is for the period covering the 1st January 25 – 31st March 2025 and gathers data on key metrics relating to patient care around dementia and delirium. Narrative to analyse key priorities, risks and assurance, provides a focused approach to improve patient experience, quality, and safety outcomes underpinning this report.

Assurances

The purpose of the report is to provide assurance that UH Sussex is providing safe effective person-centred care for people living with dementia. There is a workforce equipped with the appropriate level of knowledge to be able to support not only the patient but family friends and carers through the acute hospital admission.

Education and Training

- Communication & interactive training (CAIT) remains the main source of dementia training offered within UHSussex
- The CAIT trainers remain in post until the 1st Oct 25. The CAIT trainers funding is under review.
- There are multiple sessions available on all sites up until the end of June 25.
- With the loss of the trainers in October there will be a reduction in how many sessions can be offered by the dementia team due to the day to day demands of their role.
- To help to mitigate the risk there has been a targeted approach to ensure staff who are in clinical areas and see a higher number of patients with dementia and delirium have gone through the training.
- We know that with an educated confident workforce with the knowledge and skills to manage behaviours that challenge with people living with dementia and delirium we see a drop in distressed behaviour referrals and an increase in staff satisfaction and morale.

Clinical Grade	Total number of staff to be compliant	Compliant	% number compliant
Trained Nurses	529	318	60.1%
Health care Assistants	517	325	62.8%

NHS
University Hospitals Sussex
NHS Foundation Trust

Target wards for CAIT training.

- **Target wards have been picked to ensure that whilst we have CAIT trainers in post there is a clear focus and direction.**

- Wards have been chosen where there are higher percentages of patients with either dementia, a cognitive impairment or delirium. such as the care of the elderly wards and the emergency floor/ AAU. Or where there is a high demand for security, RMN or violence and aggression incidents logged in relation to a person with a cognitive impairment, dementia or delirium.

- key wards have been identified as needing to reach 65 % target by April 2025 , 75% target by September and 95 % target by April 2026 this will be for both Trained nurses and health care assistants. .
- Key metrics will be collected to review the impact of the training . Additional dates will be added to key sites to help with an uptake of training alongside a flexible offering.

- Additional wards will be added once the original wards have reached 75% compliance all dates are available for all staff to attend, and we would expect that UHSussex as a whole sees a compliance rate of 50% over the next twelve months.
  .

Target compliance plan

- There are dates available on all sites across UHSussex monthly.
- Be-spoke training is available and encouraged for ward areas where there is a need to increase the uptake. This has been very successful in ED at RSCH where there is a 90% compliance rate.
- The CAIT trainers, dementia team and volunteers' trainers visit individual wards and departments to support staff to sign up for the training and role model the effects of the communication styles.
- A flexible approach to training is available to support staff needing to access the training.
- All health care assistants are required to attend a CAIT day as part of the care certificate
- All staff that attend the preceptorship day receive CAIT training.

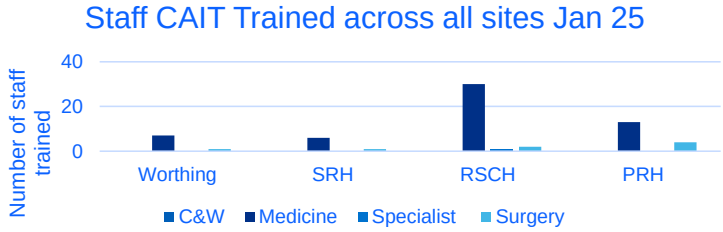
NHS
University Hospitals Sussex
NHS Foundation Trust

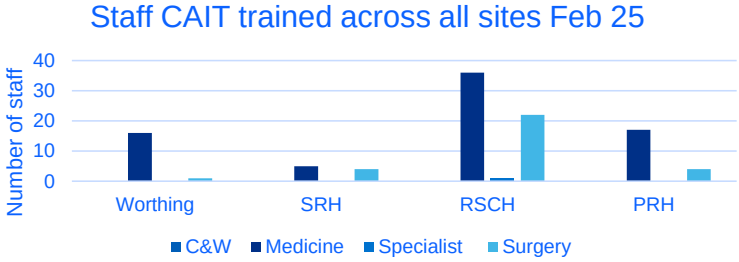
Cait Training Figures,

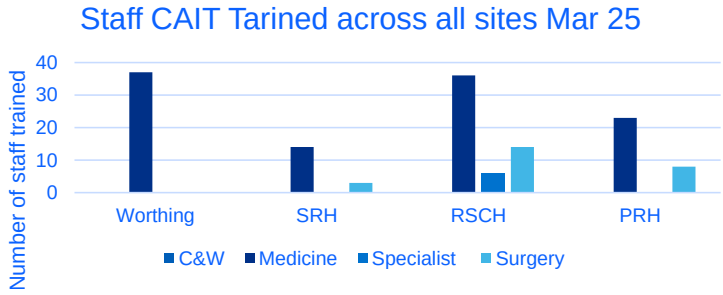
Jan-25	Worthing	SRH	RSCH	PRH
C&W	0	0	0	0
Medicine	7	6	30	13
Specialist	0	0	1	0
Surgery	1	1	2	4
Total				

Feb-25	Worthing	SRH	RSCH	PRH
C&W	0	0	0	0
Medicine	16	5	36	17
Specialist	0	0	1	0
Surgery	1	4	22	4
Total				

Mar-25	Worthing	SRH	RSCH	PRH
C&W	0	0	0	0
Medicine	37	14	36	23
Specialist	0	0	6	0
Surgery	0	3	14	8
Total				





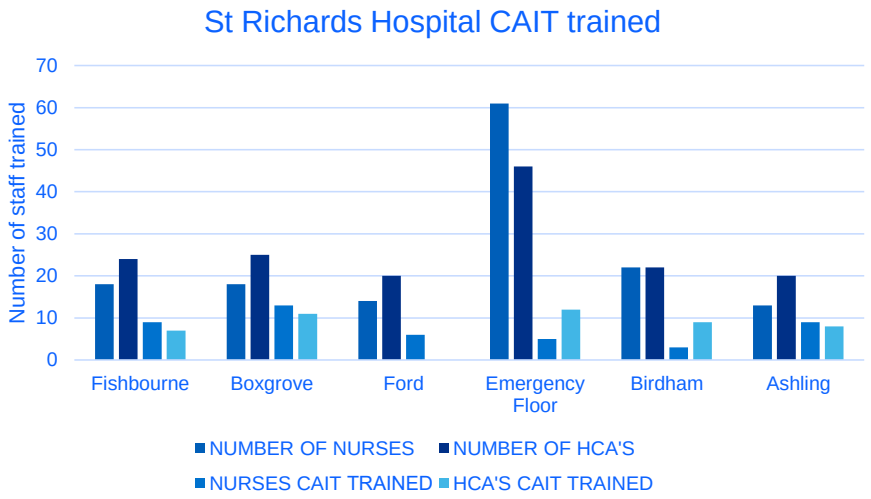


There have been a consistent number of staff trained over the last quarter

St Richards Hospital (SRH)

NHS
University Hospitals Sussex
NHS Foundation Trust

WARDS	NUMBER OF NURSES	NUMBER OF HCA'S	NURSES CAIT TRAINED	HCA'S CAIT TRAINED	PERCENTAGES OF NURSES TRAINED	PERCENTAGE OF HCA'S TRAINED
Fishbourne	18	24	9	7	50%	29%
Boxgrove	18	25	13	11	72%	44%
Ford	14	20	6	0	42%	0%
Emergency Floor	61	46	5	12	8%	26%
Birdham	22	22	3	9	14%	41%
Ashling	13	20	9	8	69.00%	40%

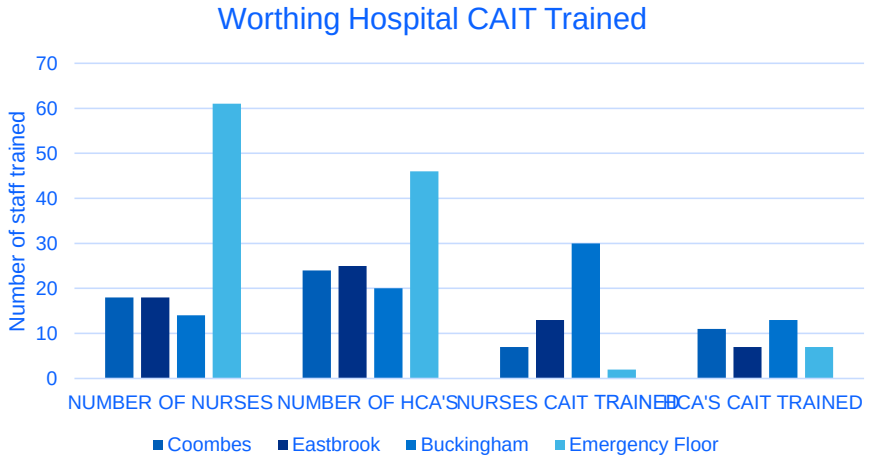


St Richards is the main hospital site that will need a targeted intervention with a particular focus on Ford ward and the emergency floor. To obtain the 65% compliance needed.

Worthing hospital (WGH)

University Hospitals Sussex NHS Foundation Trust

WARDS	NUMBER OF NURSES	NUMBER OF HCA'S	NURSES CAIT TRAINED	HCA'S CAIT TRAINED	PERCENTAGES OF NURSES TRAINED	PERCENTAGE OF HCA'S TRAINED
Coombes	18	24	7	11	38%	45%
Eastbrook	18	25	13	7	72%	28%
Buckingham	14	20	30	13	214%	92%
Emergency Floor	61	46	2	7	3%	15%

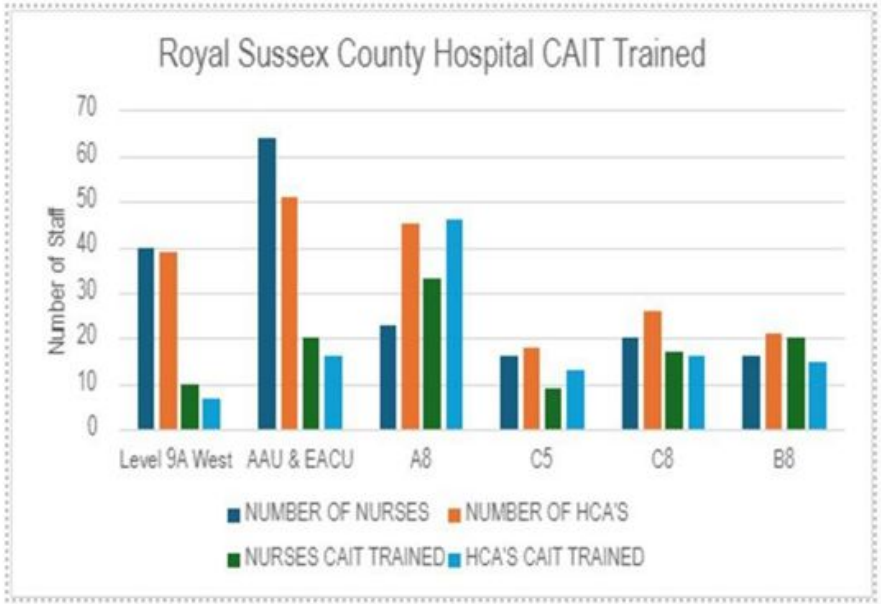


Buckingham ward is leading in terms of compliance for WGH.
Focused work will be required on the emergency floor, Coombes and Eastbrook to support a 65 % Compliance rate.

Royal Sussex county Hospital (RSCH)

University Hospitals Sussex NHS Foundation Trust

WARDS	NUMBER OF NURSES	NUMBER OF HCA'S	NURSES CAIT TRAINED	HCA'S CAIT TRAINED	PERCENTAGES OF NURSES TRAINED	PERCENTAGE OF HCA'S TRAINED
Level 9A West	40	39	34	25	85%	64%
AAU & EACU	64	51	23	25	36%	49%
A8	23	45	33	49	143%	108%
C5	16	18	12	14	75%	78%
C8	20	26	20	17	100%	65%
B8	16	21	22	15	137.00%	71%

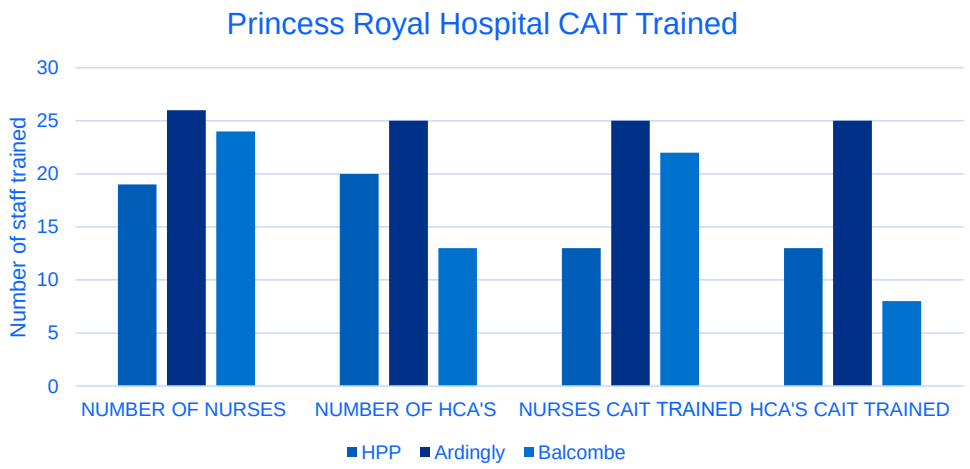


AAU and 9 a west will be the target areas with the rest of RSCH achieving either near target or above.

Princess Royal Hospital

University Hospitals Sussex NHS Foundation Trust

WARDS	NUMBER OF NURSES	NUMBER OF HCA'S	NURSES CAIT TRAINED	HCA'S CAIT TRAINED	PERCENTAGES OF NURSES TRAINED	PERCENTAGE OF HCA'S TRAINED
HPP	19	20	13	13	68%	65%
Ardingly	26	25	25	25	96%	100%
Balcombe	24	13	22	8	92%	61%



The majority of the wards at PRH have met a 65% compliance rate with some targeted work needed to raise the compliance for the HCAS on Balcombe.

Dementia Strategy and Operational guidelines.

University Hospitals Sussex NHS Foundation Trust

• The Dementia operational guidelines are still under review at the Dementia Organisational Group and will come for final approval at the 2025/26 Q1 **Safeguarding committee.**

• The final stakeholder meetings at RSCH and PRH have commenced in February with an expectation that the new 5- year Dementia strategy will be completed by the end of Q1 2025/26.

Dementia and Delirium Risks

NHS
University Hospitals Sussex
NHS Foundation Trust

Risk	Action Plan
Risk No: 2129 Risk Rating (9)	
Brunswick ward an older people's acute inpatient mental health ward run by Sussex partnership at Mill view hospital in Brighton has closed from November 24 There is a potential risk that patients requiring an inpatient bed on Brunswick ward will not receive the care and treatment they require in a timely manner. With an increase in length of stay and poor patient experience with the potential for distress due to Brighton and Hove patients needing to move out of area. Further risk includes an increase in patients attending the emergency department with complex needs around their dementia or mental health due to a lack of available beds.	• Monitoring of length of stay is ongoing for any patients that are waiting for an older person's inpatient psychiatric bed • Escalation to director of Sussex partnership older persons provision is ongoing where there are blocks or delays. • Working group to focus on the provision of older people's mental health service from SPFT is ongoing.
RISK No: 1803 Risk rating (9)	
The consultant Psychiatrist based on A8 (The Dementia unit) for one day a week has now left their position due to a lack of contract resolution. The dispute is around the number of hours now required to support the ward due to the rise in dementia beds from 21 to 32. The risks associated with not having a psychiatrist based on the ward are a rise in violence and aggression, increased length of stay. Poor patient experience, higher use and need for a 1-1 special or registered mental health nurses.	• The older people's mental health team and psychiatrist are supporting the ward on a referral basis. • Regular meetings are held within frailty to determine next steps and an action plan to remedy the situation.

Dementia and Delirium Risks

University Hospitals Sussex NHS Foundation Trust

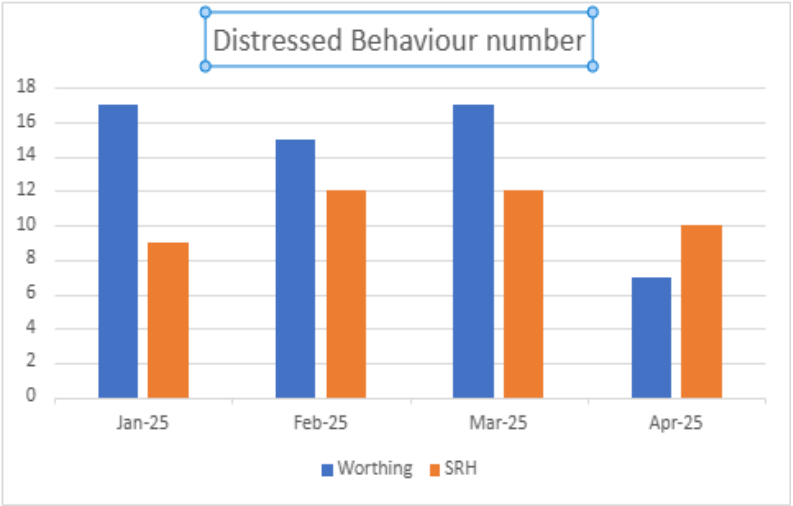
Risk	Action Plan
RISK No 1889: Risk Rating (6)	
The loss of the older people's mental health team at WGH. The older people's mental health team has now been merged with the working age team to combine one mental health team prior to the merger much of the staff working for the older people's mental health team resigned. This risk has been added to the risk register as there is an impact on patient care through lack of care planning and patient reviews from the mental health team combined with a lack of skills in managing the complex nature of people with a cognitive impairment alongside mental health issues or behaviours that are challenging.	• A UHSussex working group has been set up and chaired by the care of the elderly consultant, Jasmine Health comprising good representation from all four hospital sites. The initial brief is to ascertain the current services that each hospital site receives in terms of older people's mental health provision. This is to provide a base line to measure the services that are needed .There have been difficulties finding out the information required and the director of older people's provision within SPFT Padmaprabha Dalby is assisting with this and will report back during January. • Clinical Staff are asked to datix a wait time over 72 hours to mental health liaison service to enable triangulation with the risk to enable identification of the extent of the problem.

University Hospitals Sussex NHS Foundation Trust

Referrals into the Dementia teams for patients Displaying Distress

(the information for RSCH and PRH is not available due to long term staff sickness)

	Worthing	SRH
Jan-25	17	9
Feb-25	15	12
Mar-25	17	12
Apr-25	7	10



University Hospitals Sussex NHS Foundation Trust

Items for Escalation.

Concerns and Escalations

- The Dementia teams have ongoing challenges with staffing but still manged to maintain an excellent service. Ensuring their resilience through the next couple of months will be a priority.
- CAIT trainer's secondments currently expire on the 1st Oct 2025
- The work on getting feed- back from carers is ongoing

NHS
University Hospitals Sussex
NHS Foundation Trust

Mental Health Quarter 4 Report 2025

Date: April 2025

Author: Andy Nuttall, Head of Nursing for Mental Health.

Introduction

The role of a Head of Nursing for Mental Health was identified by UHSussex as a requirement to focus on the needs of mental health patients accessing UhSussex acute services. The post-holder commenced secondment on the 1 November 2023, and this role has now become substantive.

The Head of Nursing for Mental Health has a particular focus on the Enhanced Care Support Worker (ECSW) project, and around the Trust's adherence to the Mental Health Act
The Q4 report will provide an update on the ECSW project and MHA training data and MHA activity across the Trust.
Also included will be risks associated with Mental Health that are on the Risk Register

Enhanced care support workers(ECSW) update

NHS
University Hospitals Sussex
NHS Foundation Trust

- At the end of Q4, there are 25 (ECSWS) currently providing enhanced care to a vulnerable patient group. Three have left the role. Exit interviews are completed on all ECSWs leaving the role to enable evaluation and feedback.

- The ECSW's have been offering therapeutic engagement to the people they are caring for and the project aims to have the required equipment available for the ECSW and the patient group. Additional funding for resources to be provided for the ECSW's to offer engagement with patients has been secured, and gratefully received, from the Continuous Improvement Project Manager for Service Transformation. This has resulted in the purchase of resources that ECSW are encouraged to utilise to interact with patients.

- The ECSW's have been offered on-going training and have achieved their Care Certificates.

- The ECSW’s are currently having their appraisals completed collaboratively by Head of Nursing for MH and their ‘local’ leader, e.g. ward manager

ECSW update (continued)

- The ECSW project has gone through an evaluation phase, focussing on patient experience, on the experience of the staff providing the care, and of the experience of the rest of staff in the areas the ECSW will be allocated to. The incidents of violence and aggression, of self-injury and of people absconding have been monitored, and the use of the DATIX system is, on initial interpretation, showing these incidents have reduced The project also aims to provide clear evidence of efficiency and use of financial resources.
- The 'Tenable' Audit tool has been used to compile survey results from the Patients, the ECSW and the staff in the departments/wards where the ECSW are based
- A business case for proposals for options for Phase 2 of the ECSW project will be presented to the Executive Team in April 2025

Education and Training Additional Mental Health update

NHS
University Hospitals Sussex
NHS Foundation Trust

'An Introduction to the Mental Health Act' training package has been prepared collaboratively with the local mental health provider (SPFT) and delivered by the UHSussex HoN for MH with the SPFT MHA team training lead.
The training covers commonly used Sections of the MHA, the MHA processes, patients' rights, and the responsibilities of clinical site teams

The tables below highlights the target areas for MHA training, with clinical site teams being the priority, followed by the emergency departments B7 nursing staff:

In addition to the prioritised staff shown, an additional **71** nursing staff at RSCH ED have received the MHA training

The MHA training is available face to face or via a video presentation on IRIS:

Overview of MHA Clinical Site Managers responsibilities

Total number of clinical site management trained across in MHA

University Hospitals Sussex NHS Foundation Trust

Site management	Total No of staff	Total trained	% trained
RSCH / PRH	19	17	89%

Site management	Total No of staff	Total trained	% trained
WGH	15	15	100%

Site management	Total No of staff	Total trained	% trained
SRH	15	12	80%

Two members of Staff from SRH are on long term sick and It is expected that they will complete their MHA training on return .
The training is available on iris and comprises a 1-hour video or face to face sessions are availble from the HON for mental health..

Additional Mental health training and Education available for staff

NHS
University Hospitals Sussex
NHS Foundation Trust

Alongside the MHA training, UHSx Health Care Support Workers (HSCW's) have received MH awareness training delivered by the HoN for Mental Health.
This training includes identifying common Mental Health disorders in the context of an acute hospital and includes therapeutic engagement with people with Mental Health difficulties.

245 HCSW's have received the training since April 2024,

- The HoN for MH has delivered MH awareness training to **14** substantive RSCH Security staff, and **28** RSCH Estates and Facilities staff, following a patient safety incident
- The HoN for MH has delivered Mental Health Act training, in the context of Children and Young people, to **69** clinical staff in the calendar year, as part of the Children and Young People Mental Health training course
- The HoN of Nursing for has commenced Mental Health Awareness training for the **Emergency Floor at WGH** and has commenced Mental Health Awareness Training for the St Richards Emergency Department staff and **all St Richards ED staff** will receive this training in the next **7** planned sessions in 2025

Head of Nursing for Mental Health Activity update

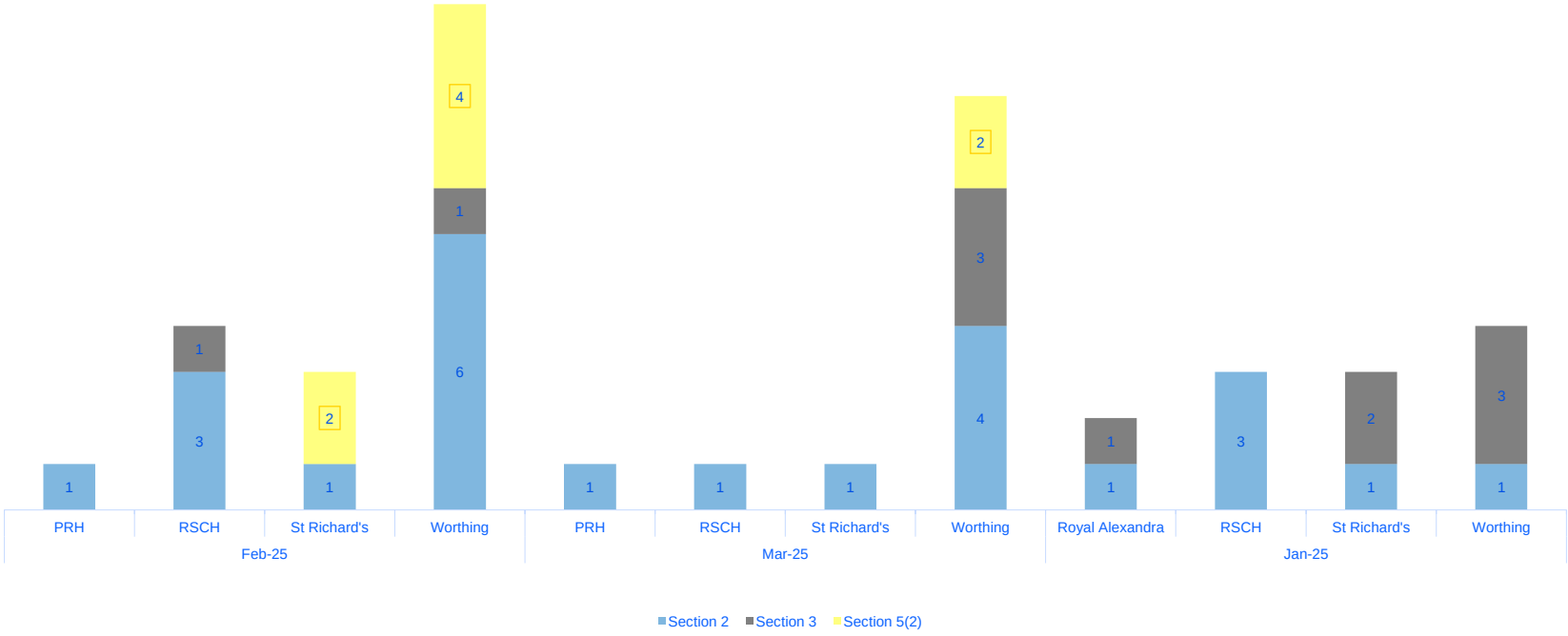
NHS
University Hospitals Sussex
NHS Foundation Trust

- Head of Nursing for Mental Health now substantially appointed
- Head of Nursing for MH chairs ED/MHLT interface meetings for the leadership groups of the emergency departments and MHLT's to provide a forum to aid collaborative working and provide service updates
- HoN supports complex cases across adults and children's services
- HoN has attended HR workshop around Supporting Staff Mental Health related absence within the Trust
- HoN involved in action plan for External MHA and Enhanced Care audit: 24 25 - UHSx - Enhanced Care - TOR - DRAFT.docx

MHA activity across UHSx

NHS
University Hospitals Sussex
NHS Foundation Trust

MHA Detentions UHS - Q4, JAN25 - MAR25



MHA activity across UHSussex – key points

University Hospitals Sussex NHS Foundation Trust

- For the detained patients at RACH, Bluefin Ward at WGH, and at Howard Ward at SRH there are regular MDT's and escalation calls with system partners
- Significant decrease in the number of detentions at RSCH due to the closure of the enhanced observation unit as an admission area on the acute floor and that area becoming an area part of the ED that is considered a 'public place' and therefore patients cannot be detained to, known as 2C
- For patients in the 2C area of the RSCH, there will be regular 'touchpoint' calls attended by Safeguarding representatives, gaining an oversight of the demand and acuity, and around LoS
- Areas of high mental health activity at WGH, the Emergency Floor, Erringham and Buckingham Wards to be prioritised for MHA training

Current Mental Health Risks (from Risk Register)

University Hospitals Sussex NHS Foundation Trust

Risk 70. Rating 20.

- Delay in assessment, treatment and ongoing management of mental health patients at St Richards and Worthing Emergency departments and Emergency Floor.
- **Controls in place**: Observational Policy. Use of RMNs to safety observe mental health patients. Daily escalation of mental health patients in department requiring inpatient beds Security guard support in both ED's. ECSWs in EDs to support mental health patients

Risk120. Rating 16

- Risk of physical and psychological deterioration for vulnerable young people on inpatient wards awaiting specialist mental health/FEDS/social care placement on paediatric wards
- **Controls in place:** Interagency working. Education and training. Patient risk assessment. CAMHIB Child Adolescent Mental Health Improvement Environmental safety review. New policy created. Legal framework advice and support. Appointment to 2 WTE psychiatrist posts. FEDS team support - virtual ward round at RACH

Risk 252. Rating 20

- Lack of mental health inpatient bed capacity local and nationally impacting patient and staff safety - Acute Floor including EOU (enhanced observation unit) and Emergency Dept (ED) at RSCH and PRH
- **Controls in place:** Mental Health support, escalation & 1:1. ECSW in place in EOU. Enhanced Observation Unit set up. Lead RN for EOU. Daily review of demand for RMNs reviewed and booked via agency for EOU. Use of Agency Nurses to fill RMN shifts following daily risk assessment. Mental health liaison team review patients daily and link in with Psychiatrists twice weekly or if as required

Current Mental Health Risks (from Risk Register)

University Hospitals Sussex NHS Foundation Trust

- **Risk 297. Rating 9.**
- Inability to provide the appropriate management and care of patients with mental health and eating disorders - LMB Wards
- **Controls in place**: Close management of the nursing rota to ensure maximum staffing fulfilment. Regular review of patient needs and behaviours to identify those who require enhanced observation care. Additional staff identified to support patients requiring enhanced observation care. Use of the Mental Health Liaison Team (MHLT) to support with assessment and care planning. Escalation of concerns and particular risks throughout the day and to site team and directorate management team. Staff completion of statutory and mandatory training in areas relevant to MH
- **Risk 1436. Rating 12**
- Patients in inappropriate care environment in the acute Emergency Dept when require Mental Health Bed. DOLS and Mental Health Act does not apply in ED.
- **Controls in place:** Partnership work is ongoing to look at legal frameworks for detention for patients in the ED department, Flow charts to ascertain the correct legal framework in which to hold a patient are being written and reviewed.

NHS
University Hospitals Sussex
NHS Foundation Trust

Patient Experience Report

Q4 2024/25

1. Headlines and key takeaways

University Hospitals Sussex NHS Foundation Trust

- **Performance:** Based on available FFT data, the significant majority of patients (90.2% in Q4) are satisfied that they have a good or very good experience, based on more than 32,000 responses. This is comparable to each quarter throughout 2023/24 and Q1, Q2 and Q3 2024/25.
- **Complaints**:470 complaints were received in Q4 – this is an increase from 325 complaints were received in Q3 and the highest number of complaints received in any quarter since the formation of the Trust in 2021. 430 complaints were closed which is the highest number of complaints closed in any quarter, however this improvement has been mitigated by the increased number received. Only 27complaints remain open over 6 months, down from 100 at the end of Q3. The main drivers of complaints and PALS are clinical care, ED experience, surgery, appointment and diagnosis delays and cancellations, doctor attitude and behaviour, waiting list issues, and discharge (mainly relating to concerns about decisions to discharge prematurely).
- **PALS:**3,573 concerns were received by PALS (comparable with previous quarter) with 213 plaudits (fewer than the previous quarter at 325).
- Specific staff and patient engagement work has been undertaken on the new visiting policy which is going live in April and is supported by a range of materials and updated online advice.
- A refreshed patient experience 'vision' in support of the new Trust strategy is under development with engagement to be undertaken through Q1 2025/26
- Patient stories are now being received by Board.
- **Risks: to patient experience**: patient satisfaction with; ED experience, waiting times, appointment and waiting list management, staff

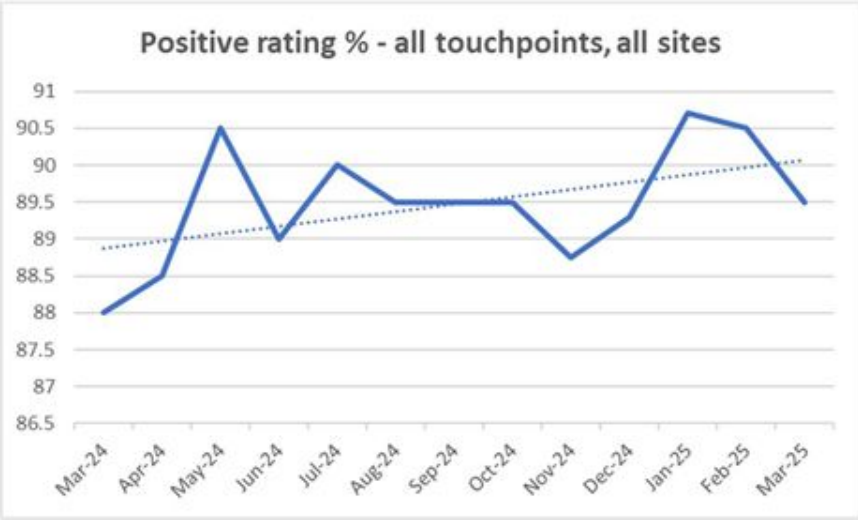
Complaints	Currently open	Jan 25	Feb 25	Mar 25	Total new
	369↑	138	154	172	470↑
PALS		1227	1202	1145	Total UHS Q3 3573

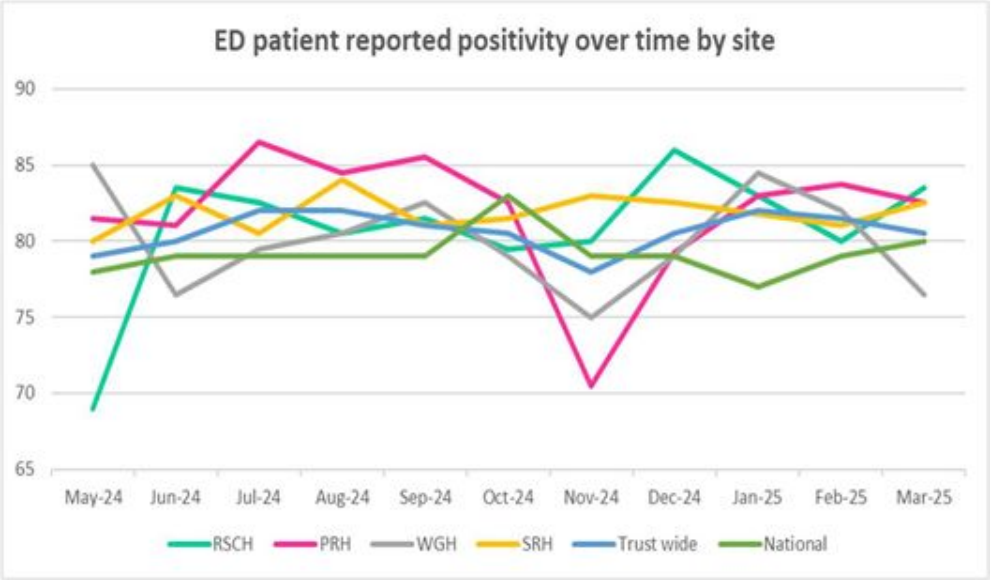
Key:
↑Increased in positive direction since previous quarter
↑Increased negatively since previous quarter
↓Decreased negatively since last quarter
↓Decreased positively since last quarter
➔Same as previous quarter

FFT (average% positive ratings for Q4)	ED positivity rates						Inpatient positivity rates						Maternity			
	WGH	SRH	RSCH	Alex	Eye	PRH	WGH	SRH	RSCH	Alex	Eye	PRH	WGH	SRH	RSCH	PRH
	76.5↓	82 ➔	82 ↑	84	89↓	83↑	92 ↑	91↓	91↑	95↓	95↓	94↑	94↑	96 ➔	95↑	95↓
National average	80% (January 2025)						Inpatient 95% (January 2025) Outpatient 94% (January 2025)						91% (January 2025)			

NHS
University Hospitals Sussex
NHS Foundation Trust

2. Friends and Family Test Data

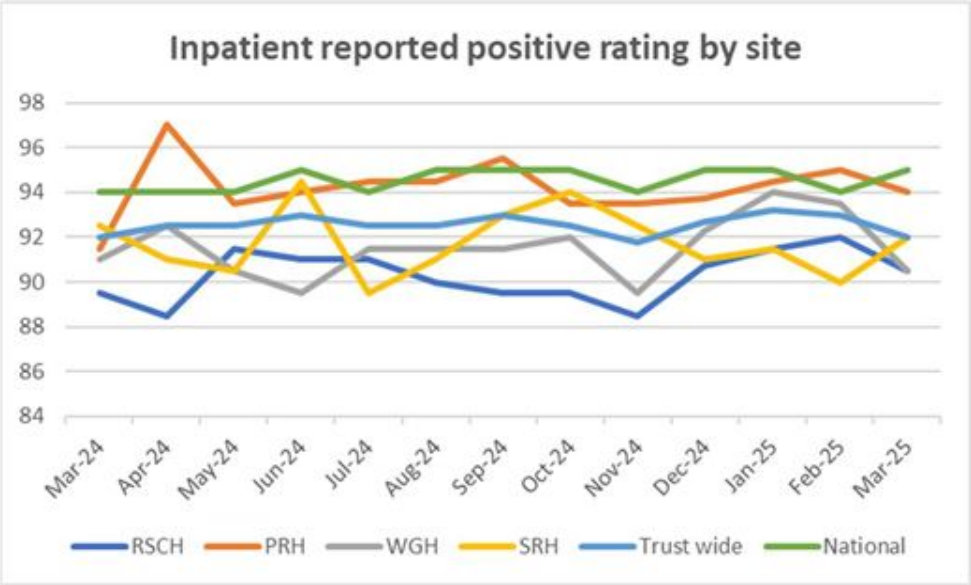




There has been a small improvement in patient reported experiences over the past 12 months, with the current trajectory upward. However at the end of Q4 the trust target of 90% was just missed (89.5%)

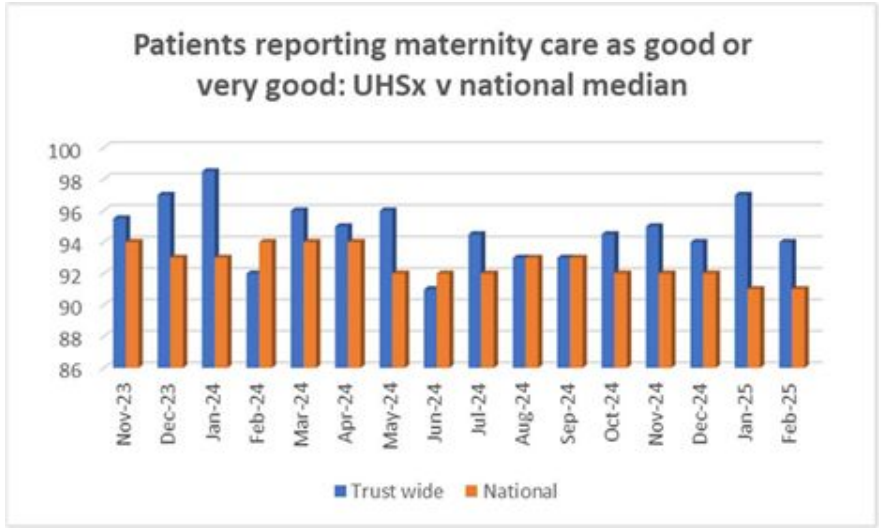
Well I spent hours on a trolley in accident and emergency being from one side of the wall to another having already spent hours in princess royal people shouting and carrying on under staffed the doctors came and saw me in a very over crowed corridor not pleasant

- Trust-wide A&E average positive reported experience is trending close to the national average (latest national data published by NHSE 80% in January 2025). Patient reported experience of A&E closely aligns to 4-hour performance.
- A difficult quarter for patient experience at WGH is noted with deteriorating trajectory for patient experience in the ED.
- At RSCH the comments from patients indicate positive reports of the compassion and attentiveness of the staff but concerns about the overcrowding and corridor.



- Inpatient reported experience remains below the national average, with the exception of at PRH, however local figures are confounded with a downward affect due to the inclusion of some emergency floor services where waiting impacts adversely on positivity.
- In time, the fundamental standards of care programme is expected to increase patient reported experience.

Skill of surgeon was excellent, the process was well managed, but the ward was very short staffed and despite the best efforts of the few there were inevitable gaps in care. Agee more staff and the experience would have been very good, but I understand resource management can be a challenge.



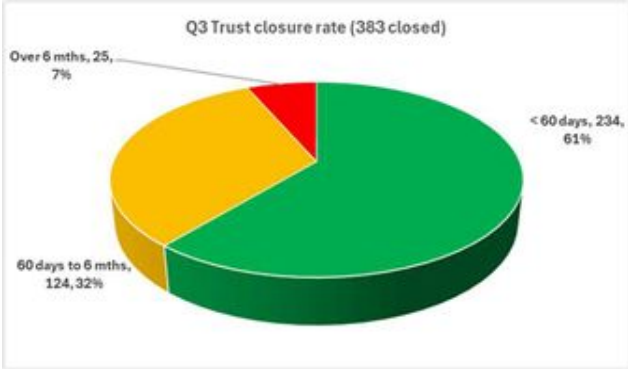
- Overall outpatient reported experience is 95% - above the national average of 94%
- Maternity reported experience is the most volatile due to the smaller sample size, however performance remains in line or above national average.

Fantastic midwives and doctors on the labour ward. Felt heard, appreciated the clear communication and overall care once admitted was fantastic.

5. Complaints

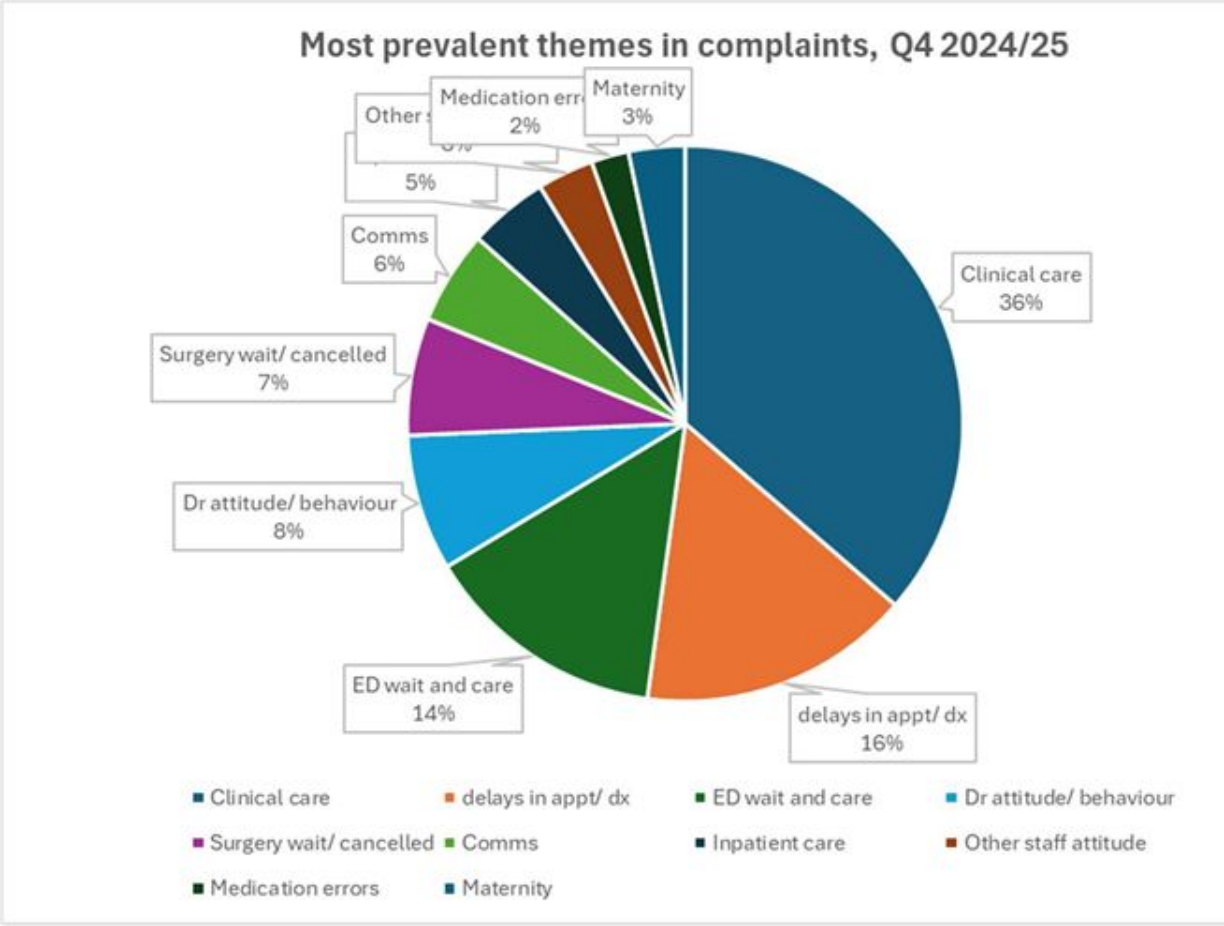
NHS University Hospitals Sussex NHS Foundation Trust

- Numbers of complaints in Q4 are the highest ever in a single quarter since the Trust was formed - 470. Despite increasing numbers and rates of complaints closure – 388 – this improvement has been outweighed by the increase in complaints received.
- The most prevalent themes in complaints received in quarter 2, and where the increases are being seen are in the following areas:
  - Clinical care- planned care
  - ED experience and care
  - Waiting lists and appointments including cancellations and delays
  - Doctor attitude
  - Inpatient care
- Improved processes have reduced the number of long-open complaints, and improved the % closed within 60 working days to 60%, up from 54% at the end of Q3. There is variation by division however.



	Jan	Feb	Mar	Total
Cancer	9	5	13	27
Clinical Support Services (CSS)	10	7	6	23
Corporate	3	3	4	10
Corporate Operations		1	1	2
Facilities and Estates	1	4	2	7
Medi WGH SRH	19	29	27	75
Medi RSCH PRH	17	25	25	67
Non UHSussex Service		1		1
Specialist	17	13	24	54
Surgery WGH SRH	18	18	18	54
Surgery RSCH PRH	24	27	33	84
Women and Children	24	23	19	66
Grand Total	142	156	172	470

Most prevalent themes in complaints and actions



The following actions are being taken in response to themes from complaints:

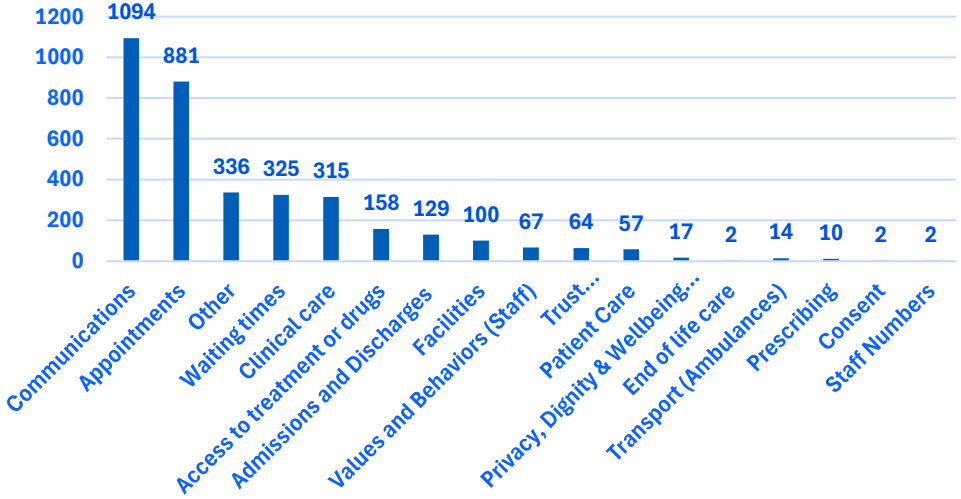
- Summit in Q1 25/26 to understand root causes of complaints and identify improvement actions
- Rightsizing theatre capacity programme is seeking to optimise theatre usage to reduce cancellations. Cancellation policy has been approved.
- Triangulation of complained about clinicians linked to medical appraisals, with new comms training being scoped.
- ED improvement plans for all sites
- New visiting policy to strengthen family engagement in care
- Fundamental standards of care programme
- Complaints about doctors and other clinical staff are being triangulated and linked to appraisals.

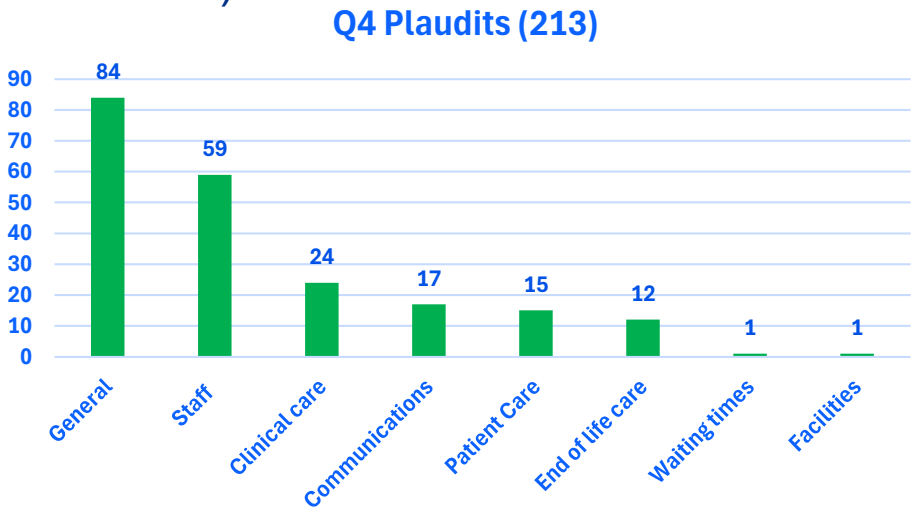
When compared to the same period in 2024, the greatest increases in complaints by theme are related to clinical care, delays in appointments/ diagnosis/ tests, doctor attitude and behaviour and waits for surgery/ cancellations.

6. PALS – Q4

University Hospitals Sussex NHS Foundation Trust

- 213 plaudits – were received, with staff, communications, clinical care being in the top themes.
- 3573 concerns were received– the top 3 themes were Communications (unable to contact wards/departments, GP's advising pts to contact PALS for updates or results, not being able to get timely medications), appointment issues (need to change date/time, cancellations of appts, waiting times for appts, no follow up appts), and clinical care (unhappy with treatment or care, issues with equipment or medication, issues post surgery and some aftercare)





	Plaudit	Lost Property	Informal	Total
Jan 2025	75	20	1207	1302
Feb 2025	95	12	1190	1297
Mar 2025	43	15	1130	1188
Total	213	47	3527	3787

8. Engagement: Visiting Policy

The Health and Social Care 2008 (Regulated Activities) (Amendment) Regulations 2023 make significant changes to the rules for visitors including promoting a "Human rights-based approach", balancing right to family life with delivery of care. There is evidence that open visiting boosts trust and confidence

The policy references other policies, including:

- Carers' policy including John's campaign – Dementia team
- Security policy – Security team / F&E) – *'Procedure for the Prevention, Reduction of Violence and Aggression (PRVA) – Visitors and members of the public'*
- Sanctioned visitors / VIP visiting policy (Comms)
- Maternity policy regarding partners staying

Engagement on a review of the policy has been undertaken using a variety of approaches:

- Four hybrid hospital site-based and online workshops
- Patient Engagement and Experience Group, with Healthwatch, other patient and family carer representation and ICB
- Chief Nurse and senior clinical leads meetings, leadership briefing and all Staff Briefing
- Research visiting hours at other trusts
- Surveys sent to colleagues and Trust governors and all trust members

Outcomes from engagement and evaluation of other trusts is that recommended new standard visiting hours are 10-8, with person-centred flexibility recommended, including for patients who are end of life, have additional needs, children and in maternity services.


NHS
University Hospitals Sussex
NHS Foundation Trust

Visitor guidance

Working together for the benefit of our patients.

We know that visitors play an important role in supporting our patients throughout their stay with us. So we offer open visiting in our general adult inpatient wards *(this excludes some areas such as maternity, children's, end of life care and dementia)* between **10am and 8pm each day**. During this time up to two adults can be at the patient's bedside. Please talk to the nurse in charge on the best times to visit during these hours or for any questions you have.

Our staff will:

- Show our Trust values
  We value compassion, teamwork, inclusion, communication, respect and professionalism.
- Respect our patient's wishes and dignity
  There may be times when visitors will be asked to leave the area, please work in partnership with us to support all patients.
- Do all we can to protect patients from infection
  This may mean restricting visiting times or moving patients.
- Keep people informed
  With the patient's consent, keep the next of kin or named contact informed and supported on any decisions about care.
- Support carers
  So that, in line with our carers' policy, those with carers passports can still support those they care for. And provide information to unpaid family and friend carers on sources of support such as carer support organisations.
- Maintain the environment
  Do our best to create a clean, calm and restful environment.

We ask visitors to:

- Be considerate to everyone on the ward
  We have a zero tolerance to abuse. Please be mindful of others and keep noise to a minimum. Please put phones on silent.
- Stay away if you have an infection
  Please do not visit if you have a respiratory infection or diarrhoea and/or vomiting within the previous 48hrs.
- Follow infection control principles
  Including washing your hands before and after visiting and not sitting on the bed.
- Support us in protecting patient dignity
  We may need you to step away to maintain a restful environment or for patient dignity.
- Help us get your loved one home
  Bringing in the patient's clothing, footwear and wash bags, and encouraging them to change into fresh clothing, can help a patient to recover quicker.
- Help us keep patients active and support at mealtimes
  Where appropriate to do so, help the patient to be mobile and if needed, support with eating and drinking.
- Respect patient confidentiality
  Understand that information cannot be given out without the patient's consent.

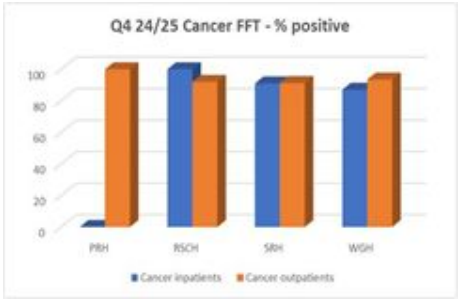
If you have any concerns at any time then please raise these with the nurse in charge. If you're not satisfied with the response then you can contact our Patient Advice and Liaison Service (PALS) at uhussex.pals@nhs.net. Please see our website for more information about visiting and what to expect: www.uhussex.nhs.uk/patients-and-visitors.

New supportive materials, including a poster setting out expectations of the trust and of visitors has been prepared, and online information is being updated.

9. Divisional dashboards Q3 –24/25

NHS University Hospitals Sussex NHS Foundation Trust

Cancer – Q4 24/25



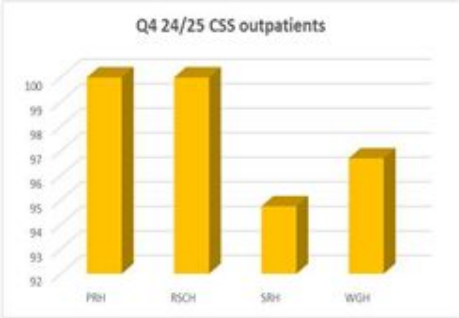
New complaints	11↓
Open complaints	16↑
Closed	11
Themes	Delays in treatment, missing or incorrect information, cancellations

C&W – Q4 24/25

New complaints	52↓
Open complaints	44↓
Closed	54
Themes	Clinical care, gynae PRH consultant attitude, waiting list issues/ delays, maternity

Clinical Support Services (CSS) – Q4 24/25

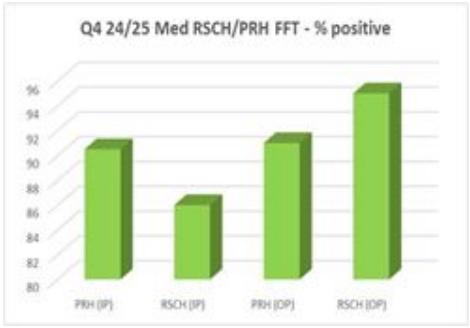
New complaints	14↓
Open complaints	13↓
Closed	16
Themes	Phlebotomy – delays in appointments, staff attitude (SLD), diagnostics



Specialist– Q4 24/25

New complaints	35↓
Open complaints	31↓
Closed	41
Themes	Inpatient care (SRH), clinical care – planned, surgery/ waiting list issues

Medicine RSCH/PRH – Q4 24/25



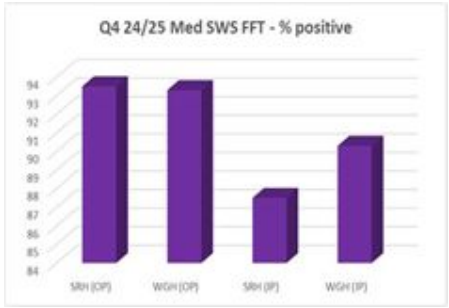
New complaints	49↑
Open complaints	50↓
Closed	61
Themes	Clinical care – ED, EOLC, inpatient care, planned care

Surgery RSCH/PRH – Q4 24/25

New complaints	56↑
Open complaints	38↓
Closed	65
Themes	Clinical care, waiting lists/ appointments

Medicine SWS – Q4 24/25

New complaints	59↓
Open complaints	66↓
Closed	80
Themes	Clinical care – A&E, doctor attitude, EOLC, clinical care – planned, inpatient care



Surgery SWS – Q4 24/25

New complaints	43↓
Open complaints	33↓
Closed	45
Themes	Waiting lists/ appointments, clinical care - planned

10. Q4 2024/25 and Q1 2025/26 Priorities and Improvement - update

NHS University Hospitals Sussex NHS Foundation Trust

Quarter 4 Priorities (Q3 report 2024/25)	Update on Q4 priorities	Q1 Priorities 2025/26
▪ Mobilise 'Go Live' plan for new visiting policy including development of a visitors' charter ▪ Conduct stakeholder engagement with prospective FFT providers ▪ Further engagement for new Cancer Centre ▪ Reporting on national surveys ▪ Deliver RSCH & PRH ED reception teams to deliver Welcome Standards training ▪ Deliver more post Welcome Standards training support ▪ Develop plan for business-as-usual staff training in as part of culture work ▪ Increasing availability of QR codes and other online options for FFT survey completion, in addition to auto SMS & IVM prompts	▪ Visiting policy – further engagement on supporting materials prior to launch in April, including visitors' charter ▪ A proposal for the FFT provider has been made and engagement with provider has been opened ▪ Further healthwatch enter and views supported ▪ Further patient engagement workshop on new cancer centre • RSCH & PRH ED reception teams to deliver Welcome Standards training – this is delayed due to a lack of cover whilst staff attend • Plan for post welcome standards support developed and going to charitable funds committee in April • Welcome standards and patient experience integrated within trust values work including OD training development and values to behaviours framework ▪ Increasing availability of survey options QR codes and other online options for FFT survey completion with radiology ▪ New patient stories for board ▪ ED deep dive into experience at RSCH ▪ Supporting peer reviews	▪ Development of new five year 'vision' for patient experience and engagement, in support of new strategy ▪ Healthwatch enter and views, including in ED ▪ Launch new visiting policy ▪ Welcome standards training for remaining sites where possible, and plan for implementing within BAU training ▪ Managers action planning from staff survey ▪ Further review of complaints signing processes ▪ Patient experience and voice influence within new end of life care working group ▪ Further patient stories for board ▪ Strengthen improvement tracker

Patient Experience Strategy on a Page 2022-2025

University Hospitals Sussex NHS Foundation Trust

What our patients say

More than 90% of UHS patients report receiving good or better care (Friends and family test, 2021)

UHS patient feedback consistently identifies the following themes which provide opportunities for improvement....

- *'Waiting'*
- *'Communication'*
- *'Staff attitudes and behaviour'*

What we want to achieve and how we will achieve it

Our True North = >95% experiences good or very good

Principles \ Ambitions	Better engagement – nothing about me without me	Addressing inequalities – voice and influence for the least heard	Learning and action on patient experience
Data and insight led Patient centred Active listening Place-oriented Fairness and equality Solution focused Prevention/ early action Accountable	1. Nothing about me without me 2. We will increase response rates to patient surveys 3. We will increase engagement through visible and accessible digital methods 4. We will improve experience of discharge – home for lunch 5. We will embrace technology to improve patient experience	6. We will engage differently and better with less heard groups and communities 7. We will improve how those with barriers to services navigate places and services **Promoting positive experience – prevention and early intervention** 8. We will improve staff wellbeing 9. We will implement a new approach to concerns and complaints responses 10. We will improve the experience of 'waiting' patients	13. We will embed learning from patient experience to shape improvement 14. We will listen to and learn from patients on key themes 15. We will ensure there is accountability for patient experience 11. We will strengthen the role of volunteers in improving patient experience 12. We will implement patient-led customer service excellence programme

How we will know if we have made a difference

- FFT % -ve comments - waiting, comms
- Reduction concerns: discharge/ dates
- FFT take up
- SDM (to be confirmed
- FFT satisfaction
- Complaints re-opened
- Complaints responses on time
- Internal patient information up to date
- PFIS unit with patient driver metric
- Influence on service developments – case studies
- Volunteers hours
- Discharge time median <12pm
- %recommending trust as a place to work

8. Patient Experience Strategy Metrics Reporting

NHS University Hospitals Sussex

Outcome	Commit-ments	Narrative	Metrics/ performance	Progress	RAG
A1 - fewer negative comments related to waiting	1,3,8,13,14	Actions include: • True norths for S&P (65 week waiters and ED seen within 4 hours); • Breakthrough objective for S&P (Median hour of discharge to be between 10 and 10:59am) • Duty of candour letter pilot in EDs • Redevelopment of ED	i. Number negative comments re waiting in FFT	1230 (Q4) ↑	
			ii. Patients waiting no more than 65 weeks by March 2025	1,251 (Feb) lowest since covid	
			iii. Median hour of discharge (aim <12pm)	Trust % discharges < midday 26% (Jan)-	
			iv. Patients waiting >4 hours in ED against target of 22%.	29.8% (Feb) ↓	
A2 – fewer negative comments relating to communications	1,3,8,13,14	Actions include: • Patient BO programme/ welcome standards • patient access transformation corporate project progressing	i. Number negative comments re communications in FFT	784 (Q4) ↑	
A3 – fewer negative comments relating to staff attitude	1,3,8,13,14	Actions include: • Welcome standards, including customer service training • Sharing of positive patient feedback to support staff wellbeing and motivation • Welcome standards –independent validation contract signed	i. Number negative comments re staff attitude in FFT	1523 (Q3) ↑	
			ii. Number participating in customer service training	Post Welcome Standards Training workshops designed as part of culture work at the Trust	
B1 reduced percentage of concerns citing dates for appointments	1,13,14	• See A1	i. % complaints citing dates for appointments (benchmark is 3.63% based on Q1-3 in 2022/3)	6% (Q2) ↓	
			ii. % PALS citing dates for appointments (24% (Q4) benchmark)	36% (Q2) ↑	
B2 reduced percentage of concerns citing discharge	1,4,13,14	Actions include: • Breakthrough objective – reducing median hour of discharge – home for lunch • Implement electronic discharge planning and safer discharge	i. % complaints citing discharge 5% (Q1-3 in 2022/3) benchmark	3% (Q2) ↓	
			ii % PALS citing discharge 3.5% (Q3 in 2022/3) benchmark	1% (Q2)	

Outcome	Commitments	Narrative	Metrics/ performance	Progress	RAG
C1. FFT response levels	1,2,3,6,7	Actions include: • New FFT provider commissioned and is using SMS and IVM (interactive voice messaging) for patients without access to a mobile phone. • In all touchpoints/ sites response rates are increasing with the new provider • TARGET: >33% • Benchmark: 24% November 22	i. FFT: response rates – ED	19% (Q4)	
			ii. FFT: response rates – maternity	16% (Q4)	
			iii. FFT: response rates – inpatients	24% (Q4)	
			iv. FFT: response rates – outpatients	29% (Q4)	
			v. FFT: response rates – Surgery RSCH/PRH	24% (Q4)	
			vi. FFT: response rates – Medicine RSCH/PRH	20% (Q4)	
			vii. FFT: response rates – Medicine WGH/SRH	20% (Q4)	
			viii. FFT: response rates – Surgery WGH/SRH	20% (Q4)	
			ix. FFT: response rates – Women's and children's	16% (Q4)	
			x. FFT: response rates – CSS	99% (Q4)	
			xi. FFT: response rates – Specialist	19% (Q4)	
			xii. FFT: response rates – Cancer	15% (Q4)	
D. FFT positive ratings (95% or above)	1,2,3,6,7, 10, 11,13,14	Actions include: • Implementation of the trust strategy, including those detailed in section A above • Divisional governance and improvement initiatives	i. FFT: positive rates – Surgery RSCH/PRH	94% (Q4)	
			ii. FFT: positive rates – Medicine RSCH/PRH	86% (Q4)	
			vii. FFT: positive rates – Medicine WGH/SRH	84% (Q4)	
			viii. FFT: positive rates – Surgery WGH/SRH	95% (Q4)	
			ix. FFT: positive rates – Women's and children's	93% (Q4)	
			x. FFT: positive rates – CSS	99% (Q4)	
			xi. FFT: positive rates – Specialist	94% (Q4)	
			xii. FFT: positive rates – Cancer	96% (Q4)	

Outcome	Commit-ments	Narrative	Metrics/ performance	Progress	RAG
E. Reduce number of complaints re-opened	4,9,13,15	Actions include: • New complaints process and quality assurance implemented	Number of complaints re-opened (annual) – 153 for 2022-23 (benchmark 21-22 = 108)	**35 (8.5%) Q2**	
F. % of patients receiving a first formal response < 60 days	9,15	Actions include: • New complaints process and quality assurance implemented • New complaints metric set at 60 days	Complaints closed <60 working days for Q1 was 50%	**55%**	
G. number of PFIS units selecting patient experience as a driver metric	9,13,14,15	Actions include: • Divisional catch ball sessions and SDRs to assign watch and driver metrics.	All 9 divisions have the True North as a watch metric and 5 division have it as a driver for the breakthrough objective		
H. the needs of potential and existing patients whose voices are currently less heard will have demonstrably led to improvements in services	3,8,11,12,15	Actions include: • Working with the system on targeted engagement • Using FFT to undertake inequalities focused reports • Working with the Equalities Team –EDI head • Applying an equalities lens to the Patient First Improvement System	Less heard groups are routinely engaged in improvement activities, including on LoS, ED re-development and stage 2 Voice of less heard patients reflected in Welcome Standards training		
I. Number of volunteering hours increases	8,11,15	Volunteer Strategy in development – due 2023	Metrics TBD		

Outcome	Commit-ments	Narrative	Metrics/ performance	Progress	RAG
J. Shared decision making and digital engagement – my health and care record registrations	6,7,15	Actions include: • Digital strategy • Roll out of PKB (my health and care record) include enhancing content available to patients • Promotion through staff and patient engagement • Ensuring divisions offer patients digital methods of communication and management such as messaging and PIFU	Rollout of PKB for patient messaging, PROMS etc is on indefinite hold •No funding available from ICS to renew PKB in 25_26 and beyond – on trust risk register, trust has taken forward £450k financial risk to renew contract (completed 31/3/25) •Synertec contract in place. Synertec project to increase annual pt facing letters from current 1m to 3.2m.	Current registration of PKB registration pan Sussex now exceed .5 million.	
K. 'Staff voice that counts' Staff are confidence that the organisation would address their concerns when raised.	8, 12,13,15	•Staff Engagement score in February 2025 is 6.50, which is an increase from 6.47 in January 2025 and is the highest score since July 2024 (6.91). •This score is based on 803 Monthly Pulse Survey responses.	2024 NHS Staff Survey •Embargo lifted on results with effect from 13 March 2025 and results published nationally. •Key headlines of results have been uploaded to the intranet. •In summary, high-level results are broadly stable compared to last year: • 6 People Promise scores had no significant change and one scored significantly higher – we work flexibly. • One Theme score decreased substantially, while one scored similarly to last year. •Analysis is currently underway, and results shared with Divisions. •Interactive tool and template poster are available to review and share results.		

Outcome	Commit-ments	Narrative	Metrics/ performance	Progress	RAG
L. internally produced patient education materials will receive patient input, will be up-to-date, and will be available in print or via the Trust website (conforming with the accessible information standard).	6,7,15	From October – December we received 40 enquiries at the Health Information Point. Details about the point are now included on the digital screens in all 11 public libraries across Brighton and Hove. Our teaching sessions on health literacy and better communication with patients are soon to be embedded in some of the Trust's clinical programmes. .	Four of the patient education videos on diabetes and the 'Why am I waiting?' video in ED now have British sign language added to them. Team worked closely with the UHSussex charity and Action Deafness to enable this. Following collaboration with the Trust's Research Engagement Group, team are adding information to all patient education leaflets about how to get involved in Trust research. A member of the patient education team left the Trust for another post in mid-February and some tasks, like the patient education leaflet audits, are paused until the post is filled.	From January – March 24 we enquiries received at the Health Information Point. 802 leaflets currently on the Trust website and 100% of those meet the web accessibili ty standards. Last quarter the patient edu cation team worked on 51 leaflets across the Trust.	

University Hospitals Sussex
NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust

STRATEGY AND MAJOR PROJECTS ASSURANCE COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Strategy and Major Projects Assurance Committee is to support the Trust in achieving its strategy.

1.02 The Strategy and Major Projects Assurance Committee will do this through;

- Oversight the Strategy Delivery Plan;
- Oversight of Major Projects aligned to the key milestones within the Trust's established strategy;
- Oversight of delivery of the strategic commitments within Trust's strategy; and
- Ensuring the Trust learns from, and applies any lessons for improvements to future projects.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Three further nominated non-executive Directors
- Chief Strategy Officer (Lead Executive for the Committee)
- Deputy Chief Executive (Alternate Lead Executive for the Committee)
- Chief Financial Officer

(noting that the executives membership is here representing the whole executive team)

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

2.05 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Director of Capital Development

- Director of Facilities and Estates
- Director of Strategic Finance
- Director of Workforce Planning and Deployment
- Director of Strategy
- The respective project SROs

2.06 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.07 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting to present their reports.

2.08 Other Trust managers and clinicians may be invited to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible, especially project SROs if specific projects are being discussed.

2.09 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

Strategy

3.05 The Committee will provide assurance to the Board on the strategy delivery plan achievement though the receipt of a routine oversight report.

Major Project Governance

3.06 The Committee will consider the adequacy and effectiveness of the governance of each major project, to provide assurance to the Board that these will support the projects' successful delivery of its stated outcomes.

3.07 The Committee will consider the adequacy of established project oversight and performance reporting and that the established key performance indicators are aligned to the project outcomes.

3.08 The Committee will seek assurance that for major service redesign consideration has been given to the need for mandated or local consultation.

3.09 The Committee will seek assurance that projects have incorporated any identified learnings from previous major projects benefits realisation reviews.

Major Project Delivery

3.10 The Committee will seek assurance that each project will deliver its stated outcomes, this will be through the receipt of routine information on

- feedback from any public, service users and staff consultation,

- the delivery against the established project key performance indicators across the various related workstreams, covering workforce, operations and finance and organisational / team development especially for service change,

- the reported project risk management actions, and

- any escalated issues from the established management group.

Major Project Benefits realisation

3.11 The Committee will receive post implementation benefits realisation reports for each major project. It will consider the breadth of the review undertaken, the learning identified and the process for cascading this learning for future projects (not just major projects) and any significant learning points are retro applied to current projects.

3.12 The Committee will seek assurance through routine reporting on the delivery of all identified improvement actions.

3.13 The Committee will seek assurance that effective communication has been undertaken to promote the success of the project and any learnings.

ICS and system collaborations

3.14 To receive and review reports from the ICS meetings, Sussex Provider Collaboration on the inter-relationship between their major projects and those within the Trust's Strategy.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the where appropriate any matters requiring review or decision-making to other Board Committees or management groups with appropriate delegated authority to take any management decision.

4.04 The Committee shall receive reports from the Committees sub-groups setting out any matters requiring escalation to the Major Projects Committee.

4.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual report disclosures and will be submitted in the first quarter of the following financial year.

4.06 The Committee Chair shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead Executive for the Committee, or the Alternate Lead Executive for the Committee. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 4 times in each financial year and dates will be set by the end of the previous financial year.

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

5.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions are to be formally ratified the Committee and/or Board at the next meeting.

5.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting which is taking place without all parties being physically present the Chair shall be responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

5.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual) during a meeting. Members conflicted on any items of business on a committee

meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

5.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members. Papers should be provided not less than five calendar days before the meeting and the agenda and papers should be circulated not less five calendar days before the meeting, to provide sufficient time for due consideration.

6.00 TERMS OF REFERENCE

6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by Committee May 2025

6.04 Next full review: by April 2026, recognising that this will be the first year of operation of this Committee.

University Hospitals Sussex
NHS Foundation Trust

Appendix - Reports considered by the Committee

Below is a list of the expected reports the Committee would receive over the year

- Strategy Delivery Plan showing significant project portfolio
- Strategy Ambition and major project delivery scorecards
- Project Benefits Realisation Reports