NHS
University Hospitals Sussex
NHS Foundation Trust

Quality Account 2024-25

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Part 1: Chief Executive Officer's Foreword

As we reflect on the past year, we would like to open the Quality Account by affirming our ongoing commitment to provide high quality care for our patients, their families and carers. We understand the importance of being an organisation that can be trusted at times of need, and we do all we can to support the population we serve and the communities within which they live.

During the year, our colleagues have cared for more people in Sussex than ever before, and we offer our heartfelt thanks for all their hard work and dedication. It's been a challenging year, and colleagues have been diligent in providing safe emergency, cancer, and elective care while at the same time delivering some remarkable improvements and innovations.

We have a large waiting list, but we managed to reduce it faster than any other Trust in the country, and, despite the unprecedented winter, which saw a complex mix of severe infections of Covid, flu, Norovirus and RSV, we saw improvements in our overall A&E performance.

We know much more remains to be done – we still have one of the largest waiting lists in the country and too many patients spend too long in our emergency departments – but progress is steady, and we want to acknowledge the achievements of all our colleagues.

In the first few months of the financial year, we developed our Single Improvement Plan to help us drive forward the quality improvements that were most needed by our patients and give stakeholders confidence that we have the foundations in place sustainable quality improvements. For much of the year, the plan was the driving force behind our improvement work. Within six months of its launch, we were able to report on significant progress. For example:

- Our work to reduce our waiting list was praised by Prof Tim Briggs, NHS England's national director for clinical improvement and elective recovery
- Our right-sizing theatre capacity programme's move of colorectal cancer surgery was welcomed by Local Authority scrutiny committees and successfully implemented
- Performance on cancer waits was ahead of the Tier 1 improvement trajectory
- We were meeting our monthly trajectory target on ambulance turnaround times
- We had completed the majority of CQC required actions, with clear plans developed to implement the remainder
- Perinatal mortality rates continued to fall, to well below the national average, and we are fully recruited for midwifes

There are other areas in which we still need to improve further, some of which are significant. We know that waiting to access care, whether that be urgent, emergency or planned care is the top concern for our patients and their families, and the Board will be focused on making improvements to that in the coming year. We also know that we currently are not operating within the financial envelope that is available, and we must

bring the cost of services back to balance. We continue to focus on addressing these issues, and a range of other essential improvements, against a background of external scrutiny and support over some of the long-standing issues we also face.

The most significant of these is the fact that some surgical services at RSCH are being investigated by Sussex Police's Operation Bramber. These investigations are within general surgery and neurosurgery. We know that the uncertainty this brings for the patients and families involved is extremely difficult. We also know that while these enquiries are ongoing its difficult for the staff working within those services, and we continue to support our general and neurosurgery colleagues in building on the many important improvements they' have made in recent years. Finally, we understand that the media attention that Operation Bramber attracts can be unsettling for all those we serve and for all our colleagues. We do our very best to provide transparent, timely and clear communications in endeavour to support all involved.

Looking ahead, we will be guided by, our new Trust Strategy (2025-2030), the foundations of which were laid by a large engagement exercise we carried out in 2024/25. We launched our Big Conversation in July, against the backdrop of a new Government that had identified building an NHS fit for the future as one of its five key missions, and commitment from NHS Sussex to collaborative service development to better meet the needs of our population.

As one of the largest trusts in the country, we need a strategy that helps us contribute to these local and national priorities and the Big Conversation was designed to help us achieve this.

It asked our staff, partners, patients and public what they think of us currently, where they would like us to be in five years' time, and what they think are the strengths, opportunities and priorities that will get us there.

We want to thank everyone who took part in the Big Conversation and shared their views on how we should go about building great services for patients, colleagues and our communities.

It was really heartening that so many people got involved: 3,000 colleagues had a say through roadshows, workshops and an online survey. We also heard from 1,500 members of the public and 77 of our partner organisations. In all, we collected more than 12,500 insights from these listening activities.

Staff said they want all our hospitals to thrive, for us to improve services and patient experience, and be known for innovation and excellent care.

Patients' priorities were faster access to better and more personalised care, as well as improved communication and appointment booking processes.

And our partners said they want it to be easier for us to work together, to align with us around strategic goals, and explore place-based integrated working.

These ambitions will be reflected in our new Trust strategy and are improvements we can all agree on. University Hospitals Sussex was created to unlock the benefits of collaborative working between our hospitals: to achieve together what our predecessor Trusts would not have been able to do alone.

Combining two organisations in the aftermath of the pandemic made that difficult, but we are excited by the opportunities we have ahead of us. As 2024/25 transitions into a new financial year, it will be our new strategy, based on the ideas and insights of our staff, partners and communities, that will help us make the changes and improvements we all want to see.

All the hard work of the previous 12 months has set us on the right course for the coming year and we look forward to reporting back in 2026 on the progress we have made for our patients in our performance, achievements and innovation at University Hospitals Sussex.

Dr George Findlay
Chief Executive
University Hospitals Sussex NHS Foundation Trust

1.1 Introduction to the Quality Account 2024/25

What we do

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

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

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

Purpose of the Quality Account

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

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

The purpose of the account is to:

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

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

report, however the trust has undertaken its own internal review to provide assurance that the required elements have been met (See Annex 1).

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

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

Compared to last year's quality account UHSussex have improved assurance self-assessment rating in 8 areas;

- Local Audits
- Patient Reported Outcome Measures
- Learning from Deaths
- Patients rating their care as Good or Very Good (FFT)
- Emergency Department Performance
- Maximum time of 18 weeks from point of referral to treatment (RTT)
- Maximum 6 week wait for diagnostic procedures
- Participation in Clinical Research

Self-assessment ratings have reduced in 2 areas;

- Clinical Coding Error Rate
- National Patient Surveys

No areas were identified as a self-assessment rating of 'No Assurance'

Statements of Assurance from the Board

All NHS trusts are required in accordance with the statutory regulations to provide prescribed information in their Quality Account. This enables the Trust to inform the reader about the quality of their care and services during 2024/25 according to the national requirements. The data used in this section of the report has been gathered within the Trust from many different sources or provided to us from the Health and Social Care Information Centre (HSCIC). The information, format and presentation of the information in this part of the Quality Account is as prescribed in the National Health Service (Quality Accounts) Regulations 2010 and Amendment Regulations 2017.

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

2.1 Our Approach to Quality Improvement

2.1.1 Single Improvement Plan

Approved in June 2024, the Single Improvement Plan (SIP) is a fixed term plan, with associated governance, developed in response to the required undertakings from NHS England (NHSE). 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. Further to reports and recommendations from the plethora of inspections, insights about the quality, safety and performance of the Trust have been gleaned from a variety of sources to inform this single plan for improvement. These include:

- Feedback from stakeholders - including patients, staff, the Integrated Care Board (ICB), NHSE and specialist commissioners, CQC, Healthwatch and the public
- Incidents and outcomes data for patients
- Performance and data modelling and delivery
- Regulatory requirements

The plan was developed over a period of nine months, in collaboration with Sussex Integrated Care Board and NHS England, who confirmed that the plan meets their expectations in June 2024.

The aim of the SIP is to ensure UHSussex continues its improvement progress, including a range of undertakings in response to requirements from NHS England. This programme of work and oversight will drive sustainable improvements in the services to patients provided by the Trust which brings together a series of tactical and strategic interventions that address the root causes of the challenges the Trust has faced in delivering high quality services.

The SIP is comprised of a number of workstreams, as follows:

Over the course of the delivery of the SIP, considerable progress was made against its ambitions. This included:

- Over 90% of CQC must and should do actions completed
- Delivery of quality improvement initiatives including the compliance and assurance framework, quality manual and fundamental standards of care programme
- Implementation of actions following a review by the Royal College of Surgeons
- Reduced numbers of patients waiting more than 65 weeks
- Establishment of a culture programme
- New governance and oversight of specialised services.

A process of alignment of the SIP with the emergent Trust strategy has begun, and analysis of the progress against the undertakings identified that the requirements have been substantially satisfied. As such, in accordance with the terms of reference for the SIP committee, the dis-establishment of the fixed term governance was endorsed and a plan for business-as-usual governance enabled, with periodical review of progress at Trust board.

2.1.2 Excellent Care Everywhere - Five Year Strategy

We will publish UHSussex's first-ever Trust-wide corporate and clinical strategy, 'Excellent Care Everywhere'. This five-year strategy will set out the key ambitions, actions, and commitments needed to achieve our mission of delivering excellent care everywhere, even as demand for our services and the healthcare needs of the local population continue to grow. This mission is not restricted to just patient care but will encompass every aspect of the Trust's strategy over the next five years.

Five key ambitions have been set out in the Strategy to achieve this mission:

- Excellent Care for our Patients - *Fast, fair, high-quality treatment*
- Excellent Care for our People - *Being empowered to be their best*
- Excellent Care for our Communities - *Improving lives together*
- Excellent Care for our Future - *Being ready for the world ahead*
- One UHSussex - *Being better together*

These ambitions were developed after extensive engagement and analysis, with over 12,500 pieces of feedback collected from over 5,000 staff members, patients, and partners, as part of the 'Big Conversation'. Underneath these ambitions, specific actions, with explicit commitments, have also been identified to provide further clarity and direction for achieving our mission over the next five years. The strategic commitments also enable UHSussex to align with the government's three shifts in healthcare delivery:

- from analogue to digital
- from treatment to prevention
- from hospital to community

Our new strategy follows through on the 2021 merger of our legacy organisations, ensuring we unlock the great potential and realise the benefits of being 'One UHSussex', one of the largest NHS Trusts in the Country. Merging two organisations during the Coronavirus Pandemic has been a challenging undertaking. We are now building on this to maximise the benefits of collaborative working between our large and diverse staff network and our different hospital sites. Each of our Hospitals must maintain its own unique identity, but it's important that staff, patients, and partners have consistency of messaging and approach when accessing our services.

With seven Hospitals across five sites and an annual turnover of £1.6 billion, UHSussex significantly influences the Sussex economy. The strategy outlines how the Trust can build on our current influence to improve our communities' social, environmental, and economic well-being and help reduce deprivation and improve population health. We will use our influence as an Anchor Institution to improve people's lives across Sussex.

Our Values

The Strategy also introduces a reset of our core values, ensuring they are easily recognisable and remembered, consistently visible in interactions with patients, the public, colleagues, partners, and prominent in how we lead and manage services. The document outlines our three core values. We are:

- **Compassionate** - we communicate and act kindly
- **Inclusive** - we work collaboratively
- **Respectful** - we behave professionally

We know that the best-performing organisations empower their people and are values-driven, so it is important we show pride in these values and make them more visible in all we do.

Excellent Care for our Patients

This strategy will help to facilitate the creation of vibrant hospital sites that meet the healthcare needs of our communities. It will enable our teams to continue delivering high-quality District, General and Tertiary healthcare services, while addressing key areas of challenge where performance is below the standard expected by staff, patients, and our partners. The ambition to deliver "Excellent Care for our Patients" outlines 4 key actions to enable better, more effective and safer care across UHSussex.

Faster access - *Cutting the time people wait for planned and cancer care*

Longer waits for treatment can often lead to worse patient outcomes. UHSussex is committed to reducing the time patients wait for planned and cancer care, improving patient outcomes, and achieving the national standards for waiting times. This will be achieved through delivering more appointments, procedures and operations; investing in facilities and equipment; improving the discharge process and getting patients home faster; collaborating with community partners to ensure patients get treatment in appropriate locations and helping patients to stay well while they wait.

Creating centres of excellence - *Bringing together skills, expertise and resources from across UHSussex to raise standards of care*

There is much evidence internationally, across the NHS and within UHSussex, that specialist centres of consolidated expertise and pooled resources provide better patient outcomes. In March 2025, UHSussex opened a new Colorectal Cancer Surgery centre of excellence in Worthing to concentrate vital surgical activity at one high-volume site, provide faster access to care and reduce cancellations. UHSussex is committed to opening additional centres of excellence by 2030, including:

- **Stroke Centre** (St Richard's Hospital - Chichester): This new centre of excellence, opening in 2027, will ensure the people of West Sussex have access to high-quality hospital-based stroke care 24 hours a day. It will also ensure that the service sees the recommended minimum number of stroke patients yearly.

- **Sussex Cancer Centre** (Royal Sussex County Hospital - Brighton): UHSussex serves the second-largest cancer patient population of any NHS organisation, and this new Cancer centre of excellence will ensure the organisation has the capacity and cutting-edge equipment required to serve this population when it opens in 2029.

Better Urgent and Emergency Care **-** *Improving access, quality, safety and surroundings for people when they need us most*

Our Urgent and Emergency Care (UEC) departments provide life-saving, time-critical care to patients. Over the next five years, our transformation of urgent care services and pathways aims to ensure every patient receives care in an appropriate setting within our emergency departments and that we achieve national standards on waiting times. This will be achieved through:

- Standardising and improving UEC services
- Investing in our UEC services, including reconfiguring the acute floor in Brighton, a new same-day emergency Care unit in Chichester and Urgent Treatment Centre and Emergency Care upgrades in Worthing.
- Improving the patients' experience while they wait for care

Fairness in access, experience and outcomes - *Providing more specialist care in Sussex and tackling inequality*

We provide a range of specialist services across UHSussex; however, some of the specialist services are comparatively small and patients still have to travel to other hospital Trusts for particular speciality care. Across UHSussex, there are also cohorts of patients who experience severe healthcare inequalities and challenges accessing the services they need. The Trust is therefore committed to growing our specialist service portfolio to improve access to care and our understanding of and approach to tackling healthcare

inequalities. We will also implement processes to make every contact count with our patients, discussing wider health and wellbeing every time we see them.

In addition to these four actions, the Trust has committed to significant investment in digital infrastructure (e.g., a new Electronic Patient Record), better buildings and equipment, staff development and education, research and innovation, the green agenda and site-specific funding to empower local teams to improve their services quickly and easily.

Our 'One UHSussex' (Being better together) ambition will also enable us to improve outcomes and experience across the Trust, through our commitment to aligning services and creating single pathways and waiting lists. Our senior clinical leaders will identify variations in provision and outcomes, bringing teams together to create aligned patient pathways. This will be completed through a phased pathway review and redesign programme, beginning with care for frail patients and emergency and cancer care. Improvement programmes will also ensure services comply with guidelines and recommendations from the National Institute for Clinical Excellence (NICE), Getting It Right First Time (GIRFT) and other national bodies.

Improvement Methodology

Standardised improvement methodologies can be an effective tool to enact change across a large organisation. UHSussex's Patient First improvement methodology has worked well across several services, but uptake and implementation of this method across the Trust is mixed. Utilising this strategy, we will refresh, refocus and build on the strengths of the Patient First improvement methodology to create a community of 17,800 people with the simple tools and support they need to deliver real improvement quickly, for patients and colleagues. Through an open-minded and ambitious policy, we will empower and invest in staff who wish to work at the cutting edge of healthcare. The Strategy also commits to reforming existing resources into a new Improvement and Organisation Development team to enhance focus and communication and support those making improvements on the frontline.

This new approach to change and improvement will form the basis for the delivery of several improvement priorities, including but not limited to:

- Improving provision for people's basic needs
- Implementing single waiting lists
- Reviewing and implementing single pathways
- Improving our corporate and business processes
- Improving productivity
- Improving our approach to booking and managing appointments
- Improving compliance with NICE guidelines
- Implementing GIRFT recommendations
- Improving Theatre Utilisation
- Improving discharge processes

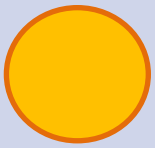
2.2 Priorities for Improvement

2.2.1 Progress against our 2024/25 Quality Account Priorities

The Trust 2024/25 Quality Account set out the following quality account priorities;

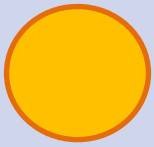
Achievement Rating:	Not Met	Partially Met	Met

Quality Priorities 24/25

Domain	Description	Achievement
Safe Reducing harm and creating a culture of safety	**Improved reporting of incidents from the 2022 National baseline of 54.9 per 1000 bed days** How this was measured: A rate of 60 per 1000 bed days	

Narrative:

Q1 - 50.8			**Q2** - 50.9			**Q3** - 54.2			**Q4 - 55.56**		
Apr	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
49.2	52.7	50.6	50.9	52.3	49.5	55.2	53.9	53.5	56.4	54.7	55.58

Domain	Description	Achievement
	Timely discussions with patients and their families where a harm incident has been identified How this was measured: 100% compliance with Duty of Candour	

Narrative:

Q1 - 85.0%	**Q2** - 87.6.%	**Q3** - 89.3%	**Q4** - 81.66%

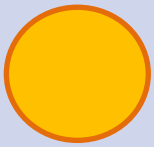
Quality Priorities 24/25

Domain	Description	Achievement
Patient Experience All of our patients have an excellent experience of care	**Patients describe their care as 'very good' or 'good'** How this was measured: 90% score for recommend rate Trust wide using Envoy for the Friends and Family Test (FFT)	

Narrative:

Q1 - 89.0%			**Q2** - 89.5%			**Q3** - 89.2%			**Q4** - 90%		
Apr	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
88.9%	89.4%	88.8%	89.0%	89.7%	89.8%	89.5%	88.5%	89.3%	90%	90.5%	89.5%

Quality Priorities 2024/25

Domain	Description	Achievement
Effective Evidence based and best practice	**Named Clinicians for all NICE Guidance** How this was measured: 100% of NICE guidance has a named Consultant	

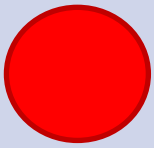
Narrative:

Q1 - 79.5%			**Q2** - 89.5%			**Q3** - 100%			**Q4** - 97.96%		
Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
78.9%	79.2%	80.6%	82.4%	90.6%	95.5%	100%	100%	100.%	93.9%	100%	100%

Timely review of NICE Guidance How this was measured: 80% of NICE guidance reviewed within 45 days of publication	

Narrative:

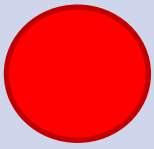
Q1 - 66.0%			**Q2** - 71.9%			**Q3** - 84.1%			**Q1** - 94.2%		
Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
65.3%	66.4%	66.4%	67.3%	72.2%	76.2%	81.5%	83.4%	87.6%	94.6%	90.5%	97.6%

Timely review of National Audit Recommendation Reports How this was measured: 75% of National Audit Reports reviewed within 45 days of publication	

Narrative:

	May 24	**Jun 24**	**Aug 24**	**Dec 24**	**Feb 25**	**Mar 25**
Under 45 Days			100%			6%
45-90 days				11%	17%	
Over 90 days	100%	100%		89%	83%	94%
No. of Reports	1	1	1	9	6	16

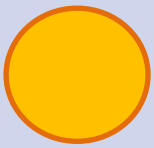
The National target is to review reports within 90 days, which the Trust will be working toward in 2025/26, as opposed to the stretch target set for 24/25.

Timely review of Clinical Documents How this was measured: 100% of clinical documents in date (or review) by 31 August 2025	

Narrative:

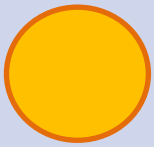
Q1 - 41.6%			**Q2** - 43.4%			**Q3** - 45.3%			**Q1** - 39.56%		
Apr	**May**	**Jun**	**Apr**	**May**	**Jun**	**Apr**	**May**	**Jun**	**Jan**	**Feb**	**Mar**
40.7%	42.3%	42.0%	40.7%	42.3%	42.0%	40.7%	42.3%	42.0%	41.1%	38.7%	38.6%

Full participation in the Specialised Services Quality Dashboards (SSQD)
How this was measured: Data submitted to all SSQDs with routine monitoring each quarter of outliers



Narrative:

Metrics Due in Q3	External Source	Local Source	Provider Metrics Pulled	Compliance Provider Metrics	Overall Compliance
241	87	154	95	62%	76%

Patient First Quality Priorities 2024/25		
Domain	**Description**	**Achievement**
Continuous Quality Improvement	**Development of a centralised action/ recommendations register and learning outcomes framework** How was this measured: Centralised register implemented with a documented process for learning and outcomes	
	Narrative: Process agreed by COEG and work underway to develop MS Lists to enable digital tracking of NICE, National Audit & Local Audit to enable the capture of outcomes and recommendations. This work has been delayed due to capacity.	
	Fundamental Standards of Care How was this measured: 95% Completion rate for the following audits; Patient Experience, Pressure Damage, Nutrition and Hydration, Infection Prevention, Handy Hygiene, Minimum Safety Standards, Medicines Safety Standards and NEWS2.	
	Narrative:	

	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	44%	44%	57%	61%	66%	68%	68%	69%	71%	68%	75%	79%
Pressure Damage	53%	53%	64%	74%	79%	84%	85%	83%	83%	84%	85%	89%
Nutrition & Hydration	48%	48%	61%	69%	79%	78%	84%	83%	85%	82%	86%	91%
NEWS 2	67%	68%	66%	69%	70%	72%	74%	75%	73%	73%	74%	76%

Where Quality Account Priorities have not been met, the Trust will continue to work and monitor these metrics through business as usual mechanisms as outlined;

Monitoring Group	Quality Priority	Assurance Group
Patient Safety Group	Incident reporting per 1000 bed days	Reports quarterly to Quality Governance Steering Group
	Duty of Candour Compliance	Reports quarterly to Quality Governance Steering Group & included within monthly quality scorecard
Clinical Outcomes & Effectiveness Group	NICE Guidance Named Clinician	Reports quarterly to Quality Governance Steering Group
	Timely Review of National Audits	
	Centralised Actions & Recommendations	
	Specialised Services Quality Dashboards (SSQD) compliance	
	Clinical Documentation	Reports quarterly to Quality Governance Steering Group, included within monthly quality scorecard and standing paper on Trust Management Committee
Nursing, Midwifery & AHP Board	Fundamental standards of Care	Reports monthly to Quality Governance Steering Group

2.2.2 Quality Priorities 2025/26

The Quality Account Priorities have been developed within the context of the development and publication of the Trust 5 Year Strategy in 2025.

As such the Trust has considered feedback received through staff and stakeholder engagement events as part of the strategy development ‘Big Conversation’, the Quality Account Workshop held on 6 March 2025, and staff engagement held over April.

Following the Quality Account Workshop 29 items were identified for consideration as Quality Account priorities, of these 15 already relate to action set out in the 5 Year Strategy and these are provided in Annex 2. the remaining items were the subject of wider staff engagement with the following items identified as being a priority and considered as Quality Priorities:

Quality Priorities 2025/26 ***(to be achieved by 31 March 2026 unless otherwise stated)***	
Description	**How we will measure success**
Improve the Identification and management of deteriorating patients including preventing sepsis, ensuring that all admitted patients have a Treatment & Escalation Plan	95% of NEWS2 admitted adult patient observations completed within agreed timeframe
	75% of admitted adult patients have a trust wide Treatment Escalation Plan completed (Completion and reporting of the Critical Care Outreach Team (CCOT) TEP/DNACPR Metric, including comparative analysis with MET Call outcome data. *(Data sourced via ICCA database; reported through Power BI))*
	100% of adult patients who trigger the Sepsis Six Bundle receive this within required timeframes; High Risk - 1 hour / Moderate Risk - 3 hours
	Completion of Trust wide ED Sepsis Audit
	Completion of Trust wide in-patient Sepsis Audit
	95% of PEWS admitted paediatric patient observations completed within agreed timeframe
Improve the recognition and management of end of life patients, ensuring advance care planning	75% of admitted patients who die in hospital will be recognised as being in the last days of life at least 96 hours before death and have a comfort care plan initiated. • 90% of these patients will have anticipatory medications prescribed. • 90% of families/relatives of patients on comfort care plans will be formally informed and involved in care discussions. • 75% of admitted patients will have a documented comfort care assessment and evaluation completed and recorded in PatientTrac
Improved performance and outcomes for Fractured neck of femur patients	Completion of A3 thinking and development of an improvement action plan to address route causes
	Development of a documented pathway for fractured neck of femur pathways across UHSussex
	Reduce National Hip Fracture database Crude & Case Mixed 30-day mortality rate to at or below national average
	Improve National Hip Fracture Database KPI performance
Sussex Integrated Care Board Priorities	The Trust supports the Sussex Integrated Care Board 'Improving Lives Together Strategy' which aims to • Improve health and health outcomes for local people and communities, especially those who are most disadvantaged • Tackle the health inequalities we have • Working better and smarter, getting the most value out of the funding we have • Do more to support our communities to develop socially and economically

2.3 Clinical Effectiveness & Assurance

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

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex fully participated in 83% of eligible audits across all sites. Annual participation checks are now taking place and systems are in place to review national reports and embed recommendations. To reach assurance an improvement in participation, reduction of outlier status, and improvements in the incorporation of National recommendations is required.			

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

During 2024/25 the Trust fully participated in 57 out of 69 national clinical audits, achieving 83% participation in eligible audits as set out in the HQIP National Clinical Audit and Patient Outcomes Programme Directory. The Trust partially participated in a further 10 audits. UHSussex did not participate in the following audits at any of it sites:

- National Cardiac Arrest Audit (NCAA)
- Age-related Macular Degeneration Audit (AMD) - National Ophthalmology Database Audit (NOD)

Throughout 2024/2025 the Trust commenced participation in four new confidential enquiries.

The list of NCA & NCEPOD audits and enquiries, number or registered cases and percentage submitted for each audit are detailed in Annex 2. Some areas have been marked as 'in progress' which means that the data is still being collated for the 2024/25 reporting period. Annex 2 also contains a summary of some of the key audit achievements and planned actions for improvement. UHSussex received outlier status for the following audits, in relation to data submissions;

- Adult Asthma Secondary Care
- National Joint Registry
- Paediatric Asthma Secondary Care

Over the coming year UHSussex will be reviewing systems and processes to improve the electronic ability to collect, validate and submit the required data for these audits.

2.3.2 Local Audits

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex continues high levels of activity with clinical audit and local service evaluations. Systems and processes are now in place to follow up every audit registered including re-audits.			

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

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

Year	Local Audits/Service Evaluations				
	No registered 23/24	No. in progress	No. Completed	No. not completed	No. shown at conference / published
2024/25	345 registered	343	189	88	9
2023/24	238	NA	91	NA	NA

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

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex have implemented a new process to disseminate and review all new guidelines. This is working extremely well. To reach Assurance compliance needs to improve due to the development and implementation of improvement plans.			

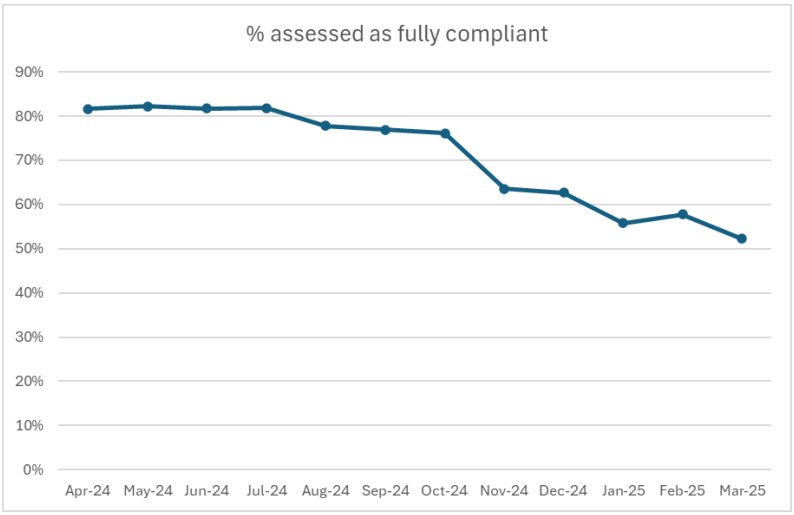
NICE Guidelines, Clinical Guidelines, and Quality Standards are evidence-based recommendations for health and care in England. Whilst guidance published by NICE is not statutory healthcare organisations are expected to take into account recommendations from NICE when developing and delivering services.

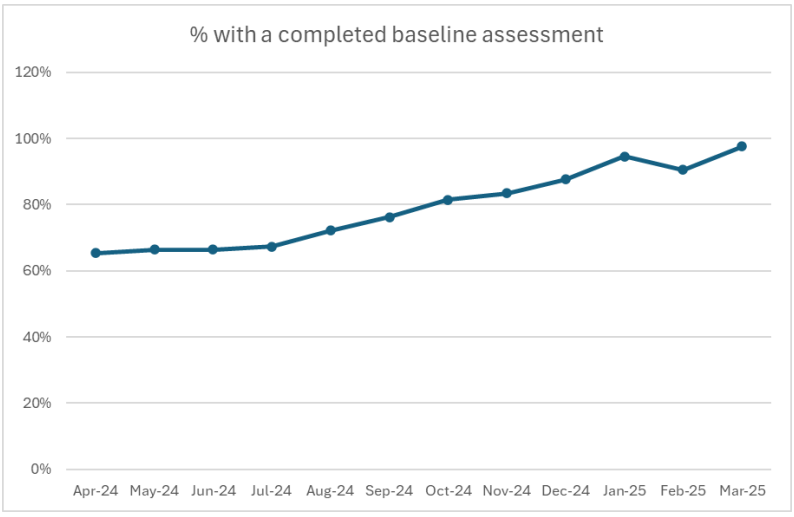
During 24/25 UHSussex adjusted the process of dissemination and implementation of NICE guidance and agreed new LQRs. As a result of these improvements;

- 14 guidelines are outstanding for review since merger.
- The proportion of guidance with a nominated lead has increased from 75% to 100%.
- 97.5% of all guidance published since September 2024 has been reviewed within 90 days.
- The Trust's overall self assessment on compliance now stands at 52% for all guidance published this year as a result of check and challenge processes of evidence to demonstrate compliance.

A further break down of compliance via division is provided in Annex 2.

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





NICE Technology Appraisals (TAs) are statutory guidance for which NHS healthcare services must make funding available and implement within three months from their date of issue. The formulary status for TAs is reviewed at the Medicine, Safety and Governance Group monthly.

During 2024/25 NICE published 98 TA's all of these TA's have been reviewed in accordance with the Sussex Health and Care Partnership Area Prescribing Committee guidelines. The majority of TA's (n=58) have been approved for prescribing, supply and monitoring only in specialist care settings, 20 have been assessed as Non formulary and are therefore not suitable for prescribing in any setting. Nine TA's were assessed as not relevant for example when UHSussex is not commissioned to provide a specific service. One TA has been approved as suitable for prescribing in any setting. Finally, four have specialist recommendation status with ongoing prescribing and monitoring in any setting.

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

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	The majority of UHSussex average scores have declined since the previous year and remain lower than national and peer average scores			

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

Domain	UHSussex Average Score 2023	UHSussex Average Score 2024	National Average Score 2024	Peer Average Score 2024
Cleanliness	97.72%	95%	98%	98%
Food	94.75%	91%	91%	91%
Organisation Food	99.99%	98%	92%	92%
Ward Food	92.70%	88%	91%	90%
Privacy, Dignity, and Wellbeing	87.38%	88%	88%	87%
Condition, Appearance & Maintenance	92.72%	93%	96%	96%
Dementia	78.61%	77%	84%	83%
Disability	82.43%	80%	85%	84%

An action improvement plan is provided in Annex.

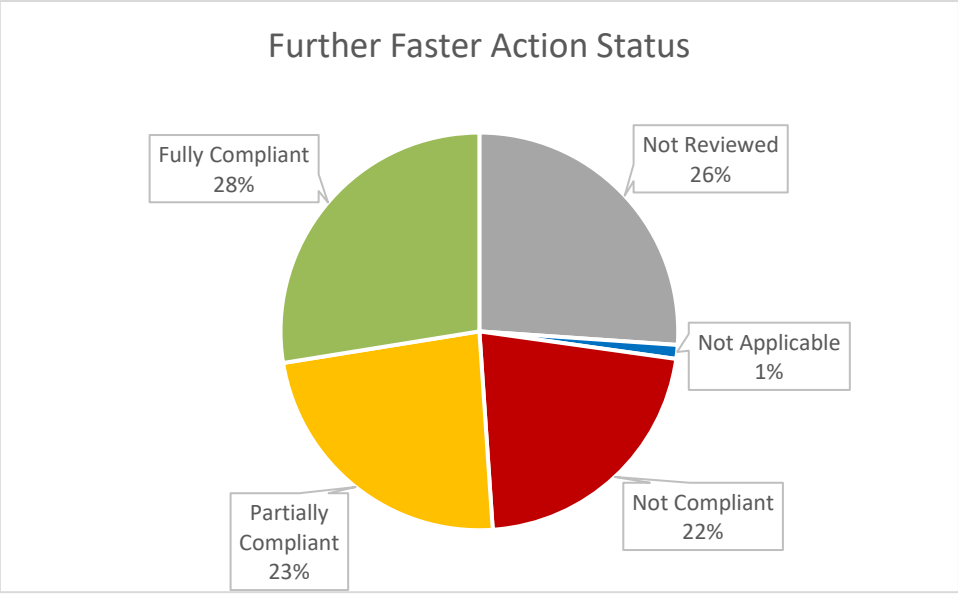
2.3.5 Getting it Right First Time (GIRFT)

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is progressive with the delivery of Further Faster Actions and is the reviewing the systems and processes in place to improve the implementation and oversight of GIRFT Programmes			

Getting It Right First Time (GIRFT) is a national programme designed to enhance the treatment and care of patients through comprehensive reviews of services, benchmarking, and presenting a data-driven evidence base to support change.

During 2024/25, UHSussex participated in six GIRFT system and peer reviews, serving as a spoke site in three of these reviews. The Trust deferred the review of the GIRFT Implementation Plans, which includes both national and local recommendations, due to competing demands within the specialties. As a result, the Trust shifted its focus to participating in the GIRFT Further Faster programme cohort, which aims to reduce the number of patients waiting 52 weeks or more.

A focused review was conducted by the GIRFT national team, led by Professor Tim Briggs, National Director for Clinical Improvement and Elective Recovery, with ongoing reviews and onsite visits to support the Trust in addressing long waiting list. As part of this initiative, the Trust completed a comprehensive review of the Further Faster checklist, which comprised 2,300 recommendations. To date, 73% of these recommendations have been reviewed;



Over the next financial year UHSussex is reviewing the systems and processes in place to improve the implementation and oversight of GIRFT Programmes.

2.3.6 Reporting to Secondary Uses Services (SUS)

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	US Data submission include the required information in over 98% of records			

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

UHSussex submitted records during 2024/25 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data (April 2024 - March 2025), which included the patient's valid NHS number was:

- 99.8% for admitted patient care:
- 99.9% for outpatient care and
- 98.9% for accident and emergency care

The percentage of records in the published data (April 2024 - March 2025), which included the patient's valid General Medical Practice Code was:

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

2.3.7 Data Security and Protection Toolkit Attainment Levels

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	The Trust expects to achieve 95% compliance with the Data Security & Protection Toolkit			

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

In 2023 NHS England committed to realigning the contents of the 2024-25 DSPT to the Cyber Assessment Framework (CAF) which encourage organisations to promote a culture of continual improvement by adopting best practice which requires the proactive monitoring the security risk landscape and emerging security threats.

The Trust's full response for 2024/25 has yet to be submitted as the deadline is 30 June 2024, however UHSussex expects to achieve 95% compliance with the DSPT and will submit an improvement plan to NHS England which for corporate records management in relation to retention and destruction.

2.3.8 Clinical Coding Error Rate

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	In 2024/25 the Trust Met expectations across all areas compared to having previously exceeded expectations for Primary & Secondary Procedure			

University Hospitals Sussex NHS Foundation Trust was not subject to an Audit Commission Payment by Results clinical coding audit during 2024-25. However, a local DSPT clinical coding audit has been undertaken on 200 patients discharged between June and October 2024. In addition, Clinical Coding audit and quality assurance checks have been carried out monthly by an NHS Digital Approved Clinical Coding Auditor.

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

	Percentage of Correct Codes	Toolkit Rating
Primary Diagnosis	94.50	Met Expectations
Secondary Diagnosis	91.92	Met Expectations
Primary Procedure	99.50	Met Expectations
Secondary Procedure	96.44	Met Expectations

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

- Ensure that the Clinical Coding audit, recommendations and summary of changes document are shared with the Clinical Coders and issue guidance where errors or omissions have occurred.
- Ensure that the Clinical Coding team at all sites are recording all comorbidities documented within an admitted care episode whether they are from the mandatory list or not.
- Arrange a training session for coders to cover cardiac arrythmia and other cardiac conditions and to signpost coders to areas where these conditions are documented in the clinical history. anaesthetic charts and preassessment forms.

- Hold National Standard refresher sessions for DGCS4: Using diagnostic test results and DChS.XVIII.1: Sign, symptoms and abnormal laboratory findings.
- Ensure that all coders are updating histology results by the SUS freeze deadline and put in place a central check to give assurance that this is being completed

2.3.9 Patient Reported Outcome Measures

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex has improved its scores since the last reported data set of 2020-21, and is above the national average			

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

- Hip replacement surgery;
- Knee replacement surgery

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

Indicator	**Patient Reported Outcome Measures EQ 5D Index (casemix adjusted health gain)**					
Domain	Helping people to recover from episodes of ill health or following injury					
Type of Surgery	UHSussex 2023-24	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2020-21*	UHSussex 2019-20*
Hip replacement	0.455	0.447	0.598	0.367	0.437	0.464
Knee replacement	0.322	0.318	0.400	0.236	0.295	0.314
Data Source	Healthcare Evaluation Data (HED)					

The table is based on the adjusted average health gain figures for the EQ5D outcome measures. *Prior to 2023/24 the last published reporting was 2021.

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

2.3.10 Patients readmitted to a hospital

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Whilst there has been a small improvement in readmission for patients aged under 18 years, UHSussex remains above he national average.			

The percentage of patients aged:

- 0 to 17; and
- 18 or over

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

Indicator Domain	**Crude Readmission Rate for patients readmitted to a hospital within 30 days of being discharged** Helping people to recover from episodes of ill health or following injury					
Age Group	UHSussex 2024-25	National average 2024-25	Best performing Trust 2024-25	Worst performing Trust 2024-25	UHSussex 2023-24	UHSussex 2022-23
Patients aged 0 to 17 years	10.45%	10.3%	4.42%	21.39%	10.15%	9.74%
Patients aged >18 years	8.60%	8.50%	3.96%	16.36%	9.00%	7.60%
Data Source	Activity and Readmission Data produced using Healthcare Evaluation Data (HED)					

Table based on latest available data (January 2024 - February 2025)

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

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

2.4 Regulatory Compliance

2.4.1 Care Quality Commissioner (CQC) Inspections & Ratings

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is rated as Requires Improvement overall.			

Since the Trust was established in April 2021 the CQC have undertaken several inspections, with the most recent inspections of our hospitals as follows:

- August 2023 - General Surgery at the Royal Sussex County Hospital, Princess Royal Hospital and St.Richards Hospital, and Medical Care (including older peoples care) at the Royal Sussex County Hospital and Worthing Hospital. (Report publication February 2024)
- August 2024 - Children & Young People, Worthing Hospital (Report publication awaited)
- February 2025 - Re-inspection of the Emergency Department at the Royal Sussex County Hospital and the Trusts Maternity services at The Royal Sussex County Hospital and Worthing Hospital. (Report publication awaited)

Previous inspections had included all four Maternity services across each of the Trust's main sites, General Surgery at Royal Sussex County Hospital, the Emergency Department at the Royal Sussex County Hospital, Royal Children's Hospital and Neurosurgery at the Royal Sussex County Hospital.

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

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

Table: CQC ratings by domain for UHSussex

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

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

The CQC also made a series of recommendations or "must do and should do actions". Some of these are practical, such as improving training and appraisal rates and doing more to address staffing pressures, whereas others are cultural such as promoting a better learning culture, doing more to make sure colleagues feel able to speak up, and instilling confidence that concerns will be responded to.

To ensure that the Trust is consistent with the principles of regulation and the Fundamental Standards of Care established by the Care Quality Commission (CQC) under the Health and Social Care Act 2008 (Regulated Activities) Regulations (Part 3) and CQC (Registration) Regulations 2009 (Part 4), thus maintaining and ensuring continuous improvement in the quality and safety of our services, the Trust implemented a monthly CQC Improvement Steering Group with the aim to ensure 'Must Do' and Should Do' actions and recommendations from the CQC inspection reports are assured, evidenced and closed, aligning with the Trust Quality Safety Improvement Programme (QSIP) and Clinical Assurance Framework (CAF). A breakdown of the status of Must Do and should do actions is noted below for;

- Surgery at Royal Sussex County Hospital, Princess Royal and St.Richards Hospital,

- Medicine at Royal Sussex County and Worthing Hospitals

Overarching Actions	Completed and moved to BAU
Must do	28
Should do	13
Total	41 (100%)

Further information pertaining to this action plan in provided in Annex 2.

The Trust also participated in an IRMER inspection of the radiology department at The Royal Sussex County Hospital in January 2025 and more recently a Trust-wide Well-Led review in March 2025. The Trust engages with the CQC monthly to ensure an understanding of our services and provision of insights for continued improvement.

2.4.2 Human Tissues Authority (HTA)

In November 23 the Independent Inquiry into the issues raised by the David Fuller case was published. The report made 17 recommendations; the Trust is currently complaint with 16 of these recommendations, the remainder being full compliance with HTA regulatory standards.
Mortuary staff have ensured compliance with HTA standards operationally, shortfalls have been identified via gap analysis regarding estates. The actions sit within the Mortuary steering group, approved risks sit on the CSS Divisions Mortuary risk register, estates and capital are represented at the steering group and are progressing plans to address these estates shortfalls.

2.4.3 Medicines & Healthcare Products Regulatory Authority (MHRA)

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

In the 2023 inspection, the licence revalidation was referred to the Inspection, Enforcement & Standards Division due to level of non-compliance and number of Critical and Major deficiencies raised. The Trust was able to respond on 20th November 2023 within the permitted timeframe. Subsequently the corrective actions were tracked and any actual or potential non-compliance within timescales were notified to MHRA as per process. Deficiency actions were completed within the timescale proposed (31 May 2024). Actions included the implementation of a new comprehensive quality system and a new quality management system which now includes cross-site procedures. Responsible Person training has been undertaken either as refresher or for additional staff. Internal audit restarted in January 2024 cross-site to ensure that quality is embedded and actions raised are tracked and re-visited. Monthly oversight meetings have been put in place. Staff training is on-going for new systems including change control and deviation reporting and

expiry date checking. Some challenges remain in place at Worthing due to the walk-in cold store failure and the use of temporary standalone fridges.

The reinspection at the RSCH and Worthing sites in June 2024 identified a total of 7 “major” and 5 “other” deficiencies which were a significant improvement from the findings of the initial inspection in 2023. The Trust responded in July 2024 within the permitted timeframe. Subsequently the corrective actions were tracked and any actual or potential non-compliance within timescales were notified to MHRA as per process. Deficiency actions were completed or on-going due to their nature in January 2025. Details of this were submitted to the MHRA on 15th January 2025 following a request from the auditor on 6th January 2025. On 30th January 2025 a final report from the inspection was received stating “Continued support of your wholesale dealer’s authorisation (WDA(H) 35588) pursuant to Regulation 18 of the Human Medicines Regulations 2012 (a “wholesale dealer’s licence”) will be recommended to the licensing authority.” and “Within the scope of the inspection, the company operated in accordance with the principles of good distribution practice referred to in regulation C17 of the Human Medicines Regulations 2012.” A renewed licence was granted on 06/09/2024. A provisional date of 18/06/2027 has been issued for the next inspection.

2.4.4 Specialist Pharmacy Service (Aseptics Inspection)

The aseptic preparation facilities are regulated by the Specialist Pharmacy Service (SPS). The Pharmacy Aseptic Unit at Royal Sussex County Hospital was inspected on the 19th and 20th of June 2024 following previous inspections in July and Dec 2023. The overall rating of medium risk continues to be given due to the age and non-compliance of the fabric of the facilities at Brighton (major deficiency). The deficiency action plan is being worked through with actions either completed or in-process. Actions included: Accountable pharmacist in post, capacity and contingency procedure update, Trust intrathecal policy update, updating environmental monitoring reporting, validation master plan reporting. On February 10th 2025 the RSCH aseptic unit underwent refurbishment to remedy some of the facilities’ deficiencies previously reported. A future reinspection is planned for June/July 2025.

The Pharmacy Aseptic Unit at Worthing and St Richards Hospital were inspected on 4th and 5th March 2025 following visits in Aug 2023 and Jan/Feb 2024. The units maintained the overall risk rating of medium. The major deficiencies were identified in capacity challenges, age of facilities, actioning limits in monitoring/aseptic processing, full use of new Quality Management System and storage in the SRH pharmacy department. They recognised the overall improvements from the last audit. A refurbishment is planned for Worthing and currently 4th on the CSS Priority list.
Alignment of some Aseptic Unit systems cross-site is in process with increased interaction and knowledge share via Preparative Services monthly Board meetings.

2.4.5 General Pharmaceutical Council Worthing Inspection

The GPhC visited Worthing Pharmcy department on 5th March 2025 to carry out an unannounced inspection of the registered pharmacy premises. This was a full routine inspection of the Pharmacy. The last formal inspection of the department was in 2015

The inspector spent several hours with the Deputy Chief Pharmacist, Principal Pharmacist medicines Safety, Quality and Governance and the Pharmacy Technician Team Lead Operations. During this time, he inspected the physical work environment as well as policy, procedure, document storage, education and training and governance standards.

The final report records **all** inspected standards were met and the following areas were noted as areas of good practice:

- **Standard 1:1** The risks associated with providing pharmacy services are identified and managed
- **Standard 1:2** The safety and quality of pharmacy services are regularly reviewed and monitored
- **Standard 1.6** All necessary records for the safe provision of pharmacy services are kept and maintained
- **Standard 2.2** Staff have appropriate skills, qualifications and competence for their role and the tasks they carry out or are working under the supervision of another person while they are training
- **Standard 4.2** Pharmacy services are managed and delivered safely and effectively

The full report will be made available on the GPhC inspection publication website.

2.5 Mortality & Learning from Deaths

2.5.1 Summary Hospital-Level Mortality Indicator

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex SHMI is as expected			

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

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

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

Indicator Domain	**Summary Hospital-level Mortality Indicator** Preventing people from dying prematurely				
UHSussex 2024	National average 2024	Best performing Trust 2024	Worst performing Trust 2024	UHSussex 2023	UHSussex 2022
104.74 *As expected*	100.44	70.54 *Lower than expected*	127.07 *Higher than expected*	104.88 *As expected*	111.59 *As expected*
Data Source	Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset				

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

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

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

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

Indicator Domain	**Percentage of patient admissions with palliative care coded at either diagnosis or specialty level** Preventing people from dying prematurely				
UHSussex 2024	National average 2024	Best performing Trust 2024	Worst performing Trust 2024	UHSussex 2023	UHSussex 2022
2.47%	2.07%	4.08%	0.95%	2.45%	2.8%
Data Source	Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset				

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

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

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

2.5.2 Hospital Standardised Mortality Ratio (HSMR)

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex HSMR is as expected			

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

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

Indicator Domain	Hospital Standardised Mortality Ratio Preventing people from dying prematurely				
UHSussex 2024	National average 2024	Best performing Trust 2024	Worst performing Trust 2024	UHSussex 2023	UHSussex 2022
96.42 *As expected*	99.1 As expected	73.63 *Lower than expected*	226.94 *Higher than expected*	99.12 *As expected*	98.44 *As expected*
Data Source	HSMR data produced using Healthcare Evaluation Database				

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

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

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

2.5.3 Learning from Deaths

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Having reviewed and updated systems and processes UHSussex has removed the backlog of Structured Judgement Reviews, which are now being completed within 60 days. Work has progressed to strengthen Mortality & Morbidity Meetings with better emphasis on learning outcomes from all mortality reviews.			

Learning from Deaths Policy

The University Hospitals Sussex NHS Foundation Trust Learning from Deaths Policy was reviewed and updated in November 2024. As part of the updated Policy the Trust introduced an SJR Referral Triage Panel, meeting weekly and consisting of the Trust Mortality Lead, Mortality & Learning from Deaths Manager and Senior SJR Reviewers, was established. The Panel reviews every referral for an SJR and determines whether to proceed to an SJR, or to refer to clinical teams as part of Mortality & Morbidity (M&M) meeting review and discussion.

Learning from Deaths Reports

During 2024/25 Mortality & Learning from Death reporting was developed, to include a breakdown of adult deaths and case record reviews (SJRs) by deprivation, age and length

of stay. The table below shows demographics and other criteria introduced into UHSussex reporting by quarter.

Table: 2024/25 UHSussex Mortality & Learning from Death additional reporting criteria

24/25 Mortality & Learning from Deaths Additional Reporting Criteria	
Q1	Adult deaths and SJR referrals by Index of Multiple Deprivation (IMD) Decile Reason for SJR referral
Q2	Activity by deprivation and Local Authority Adult deaths by ward Most common cause of death - acute adult deaths Most common cause of death - SJR referrals Number of community deaths Number of SJR referrals triaged as not required and common themes
Q3	Adult deaths and SJR referrals by age group Adult deaths and SJR referrals by length of stay (LoS) LeDeR feedback Measureable improvements Next of kin feedback - community deaths
Q4	Activity by accepted SJR referrals Learning from Deaths update - building stronger feedback loops

Adult Deaths

During 2024/25 4073 adults died under the care of the University Hospitals Sussex NHS Foundation Trust, with:

- 3731 adult deaths recorded as inpatient deaths and
- 342 adult deaths recorded in the Emergency Department.

The table below provides a breakdown of adult deaths per quarter, including those with known Learning Disability (LD) and/or Severe Mental Health (SMH) illness.

Table: 2024/25 Adult deaths under the care of UHSussex by quarter

24/25 Adult deaths	Q1	Q2	Q3	Q4	Total
No. adult deaths recorded	984	916	1055	1118	**4073**
No. of adult patients that died registered as having a Learning Disability (LD)	10	11	10	9	**40**
No. of adult patients that died known to have Severe Mental Health issues (SMH)	8	8	3	3	**22**

The Index of Multiple Deprivation (IMD) datasets are small area measures of relative deprivation. Postcode areas are ranked from the most deprived (D1) to least deprived (D10.)

Table: 2024/25 Adult deaths under the care of UHSussex by Local Authority (Adur, Arun, Brighton & Hove, Chichester, Mid-Sussex and Worthing) and IMD decile

Demographics for 24/25 Adult Deaths	No. of Adult Deaths	Underlying Population	Deaths per 1000
1	117	30,919	3.78
2	202	43,807	4.61
3	264	68,282	3.87
4	212	54,516	3.89
5	376	93,678	4.01
6	547	122,144	4.48
7	416	113,860	3.65
8	391	99,685	3.92
9	374	104,283	3.59
10	301	110,984	2.71
UHSussex Total	**3200**	**842158**	**3.80**
No. in most deprived postcodes (D1-4)	**795**	**197524**	**4.02**
% in most deprived postcodes (D1-4)	**25%**	**23%**	
Deaths by Index of Multiple Deprivation (IMD) Decile (1=most,10=least deprived) Further information can be found at https://data.cdrc.ac.uk/dataset/index-multiple-deprivation-imd Note: Horsham, Crawley and East Sussex Local Authorities excluded as UHSussex do not serve the whole of the population and less than 2 deaths per 1000 population.			

- 25% of adult deaths at UHSussex were within the most deprived postcodes (D1-4), compared to 46% of adult deaths which related to those within the least deprived postcodes (D7-10.)
- D2 postcodes accounted for a small proportion of adult deaths but had the highest number of deaths per 1000 population.
- 17% of adult deaths at UHSussex related to D6 postcodes, with the second highest number of adult deaths per 1000 population.

2.5.4 Medical Examiner Scrutiny and Coroner Referrals

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

During 2024/25 the Medical Examiner Service underwent a recruitment drive, to appoint to vacant Medical Examiner and Medical Examiner Officer posts. Successful candidates started in post or are due to start in April 2025.

Adult Deaths

- 20% of all adult deaths at UHSussex were referred to the Coroner.
- 11% of all adult deaths at UHSussex were investigated by the Coroner.

Community Deaths

New regulations governing Medical Examiners took effect in England and Wales on 09 September 2024. Medical Examiners are now required to scrutinise community deaths and countersign death certificates.

There were twice as many community deaths in West Sussex compared to Brighton & Mid Sussex, with a considerable upsurge in community deaths during quarters 3 and 4.

The table below provides a breakdown of adult deaths that occurred in the community per quarter, with Quarter 1 predating statutory regulations.

Table: 2024/25 Adult deaths in West Sussex and Brighton & Mid Sussex by quarter

24/25 Adult deaths (community)	Q1	Q2	Q3	Q4	Total
Brighton & Mid Sussex		181	298	405	**884**
West Sussex		689	907	1047	**2643**

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

Princess Royal Hospital:

- The weekend and overnight on call Neonatology Consultant is not on site.
  - Neonatal care at the Princess Royal Hospital is in accordance with the British Association of Perinatal Medicine guidelines and there is no national guidance as to the time that an on-call Neonatology Consultant should be expected to attend a hospital in the event of an emergency, or as to whether multiple sites can be covered by one on-call Consultant.
  - Model of care has been reviewed and a review of our neonatal clinical outcomes: Outcomes for babies born at the Princess Royal Hospital over the last 3 years are in-line in terms of safe outcomes. The Neonatal Consultant on-call arrangements do not currently meet the current British Association of Perinatal Medicine standards, but the review of outcomes did not find evidence that the current arrangements we have in place are unsafe. With the ICB, options for providing a separate Neonatal Consultant on-call rota for the Princess Royal Hospital, Special Care Baby Unit (SCBU) are being explored with a view to strengthening our Neonatal Consultant on-call arrangements for the Princess Royal Hospital Neonatal service.

Royal Sussex County Hospital:

- No 24/7 Mechanical Thrombectomy service.
  - We now have mutual aid pathways 24/7 for all sites to University College Hospital (UCL) or University Hospitals Southampton (UHS)
  - Business case approved to extend the local service to 7 days a week, 12 hours a day at the Royal Sussex County Hospital and plans are in place to recruit staff for this extended service.
  - A second bi-planar is being installed at the Royal Sussex County Hospital.

- Emergency Department (ED) corridor care when Trust is at capacity. The ED corridor is not designated to be a clinical area, there is insufficient space, and it is not included within the standard Nursing staffing template for ED.
    - Actions taken to reduce the number of patients who present to the ED who can be seen by other services in the community.
    - Operational Flow Improvement Manager recruited to lead the Hospital Alternative Oversight Programme.
    - Continuous Flow Model - for improved patient flow through the Trust.
    - Surgical Assessment Unit (SAU) opened which represents the first phase of our Acute Floor Reconfiguration which will improve patient and staff experience.

Worthing Hospital:

- A Prevention of Future Deaths (PFD) was issued with the following concerns:
    - Missing Person policy - Walkouts/absconding patients (approved 23 May 2024), in this case there was a lack of recorded and/or shared information across all the agencies and teams with whom he had had contact, or to whom he was known, such that an accurate and fully reflective risk assessment was not achieved, exacerbated by delays in the triage process in the ED.
    - The Trust did not notified to Police as a missing person and nor were Police informed they had left the ED, despite them simultaneously raising a safeguarding risk via a Vulnerable Adult Single Combined Assessment of Risk Form.
    - There was a lack of information sufficiency, flow and sharing across the agencies whilst they were present in, and at and after the point they left, the ED, which might have enabled greater efforts to locate, contact and more urgently treat them.

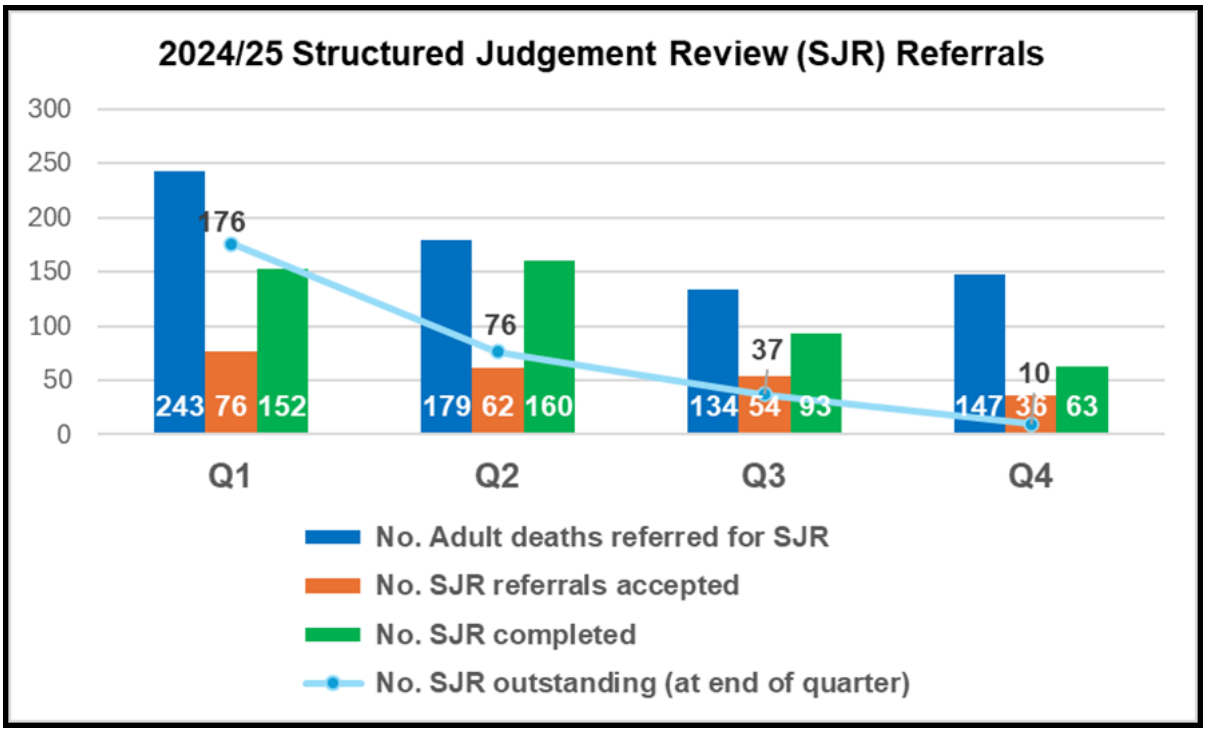
2.5.5 Mortality Reviews

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

At the start of 2024/25 there was a backlog of 213 Structured Judgement Reviews that had accumulated over previous years, with a further 372 accumulated since October 2024. Of these, 118 had been assigned to a Reviewer but not completed. Outstanding cases were reviewed by the Trust Mortality Lead and a small cohort of Senior SJR Reviewers, who assessed end of life quality of care and decided whether to proceed to a comprehensive Structured Judgement Review or refer to clinical teams for local learning.

During 2024/25 703 (17%) adult deaths were referred for independent Structured Judgement Reviews. Of these, 228 referrals were accepted and a total of 468 were completed, which included those outstanding at the end of 31 March 2024.

Figure: Overview of 2024/25 Structured Judgement Reviews



- 32% of SJR referrals were accepted.
- There was a significant reduction in number of SJRs outstanding, quarter on quarter, with 10 SJRs outstanding as of 31 March 2025.
- There were no outstanding SJRs over 60 days or over 90 days from the date of referral as of 31 March 2025.

315 SJRs were reviewed at the Trust Mortality Panel.

Table: 2024/25 Structured Judgement Reviews discussed at Trust Mortality Panel

24/25 Structured Judgement Reviews discussed at Mortality Panel	Q1	Q2	Q3	Q4	Total
No. SJR reviewed at Mortality Panel	117	105	64	29	315

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

Structured Judgement Reviews are carried out by trained SJR Reviewers. To successfully complete SJR Reviewer training, Trainee Reviewers are required to complete a minimum of 4 SJRs under the supervision of a Senior SJR Reviewer.

2.5.6 Learning from case record reviews (SJRs) and investigations

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

- 10% of Structured Judgement Reviews discussed at Mortality Panel identified "good" or "excellent" quality of care.

Structured Judgement Reviews that identified the quality of care as "poor" or "very poor" produced learning themes around:

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

Measurable Improvements

Learning identified from Structured Judgement Reviews resulted in:

- provision/revision of training
- updated protocols/Standard Operating Procedures relating to patient pathways
- implementation of new documentation/resources to improve patient outcomes
- promotion of processes/policies through team huddles, "Theme of the Week" etc.

Establishment of Mortality & Morbidity Surveillance Group (MMSG)

The Mortality & Morbidity Surveillance Group (MMSG) is due to meet quarterly from April 2025 to review learning themes collated from Mortality Reviews and Mortality & Morbidity Meetings with the purpose of identifying actions to improve patient outcomes.

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

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

There were 12 cases that identified a death may have been avoided. Where poor care was identified, this was reported back to the clinical teams following a case review to enable the team to consider how learning could be implemented.

2.6 Patient Experience

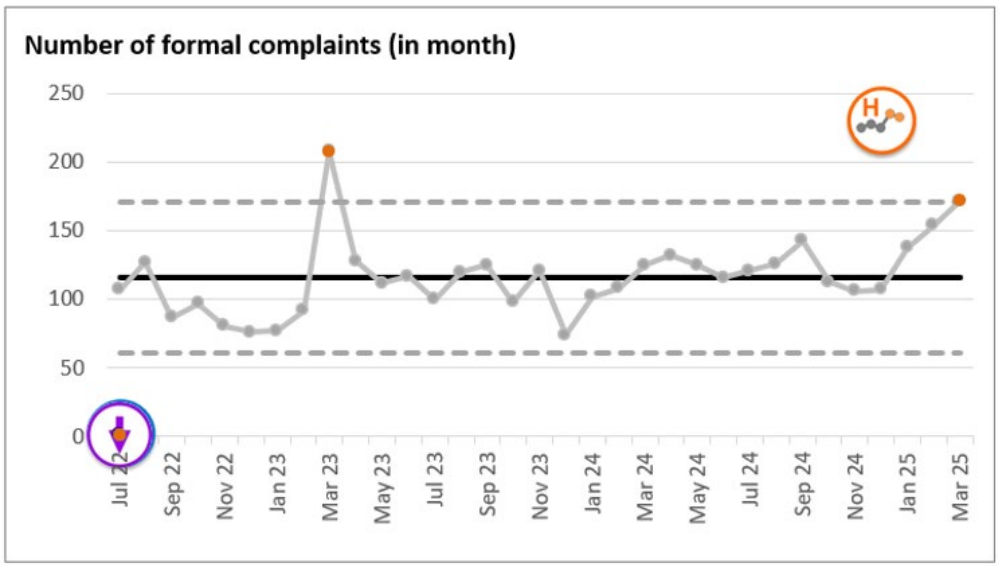
Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Whilst performance against Trust and national standards, such as timeliness and quality of responses, has improved, an increasing number of complaints and concerns received has placed pressure on the patient experience system, and Trust standards were not met.			

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

2.6.1 Complaints and Concerns

Throughout 2024/25 the Trust has revised its policy for responding to concerns and complaints, setting a local standard of aiming to close 80% of complaints within 60 working days. The Trust continued to receive increasing numbers of complaints, with 17% more complaints received in 2024/25 than the previous year. However there has been an improvement in performance against the Trust standard with 61% closed in 60 working days (up from 45% at the end of 2023/24). In other positive progress, complaints open longer than a year have been eradicated, and fewer complaints are open longer than six months.

Figure: Numbers of complaints received by month

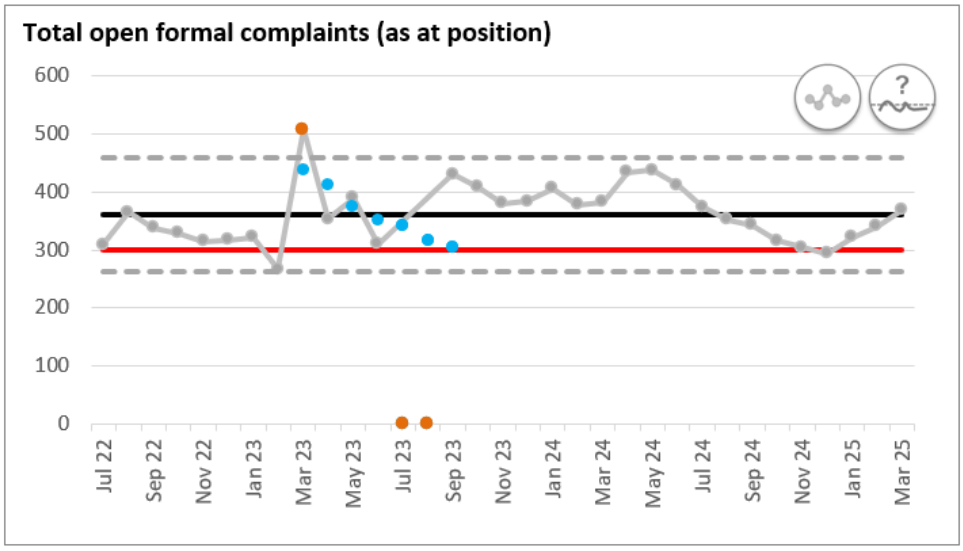


Throughout 2024/25 UHSussex received 1,589 new complaints for investigation (an increase of 17% when compared to the same reporting period the previous year which was in turn an increase of 9% in the year before that).

- 61% of complaints were closed within 60 days (the Trusts response timeframe)
- At the end of March 2025, the Trust had 369 complaints open, which despite the increase in complaints received is lower than the same time last year.
- 8% of complaints were re-opened following the initial response – this is a reduction on last year when 13% were re-opened.

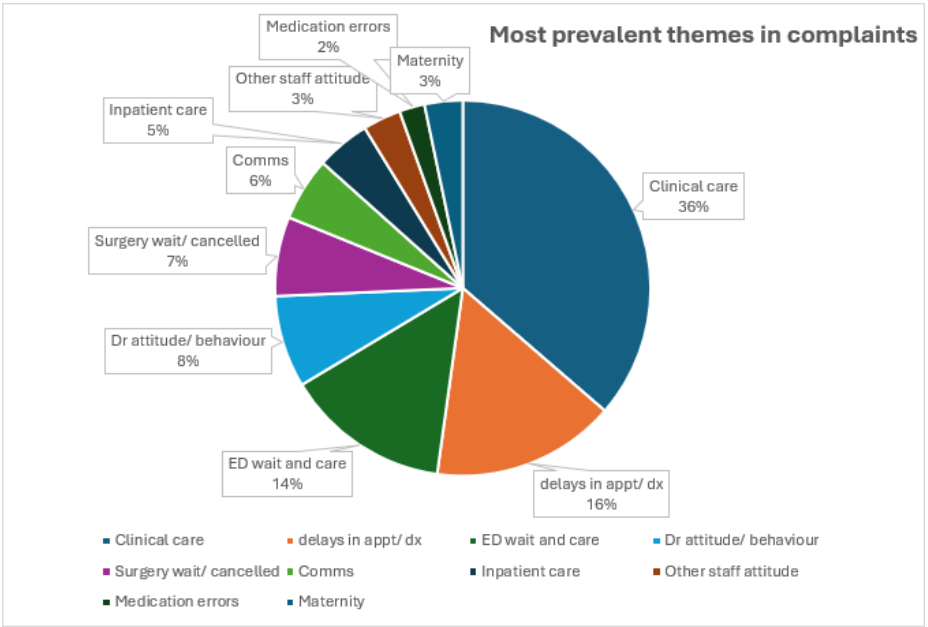
Despite the efficiency and performance improvements supported through an additional complaints manager, the increase in complaints received has assuaged the benefits of the capacity and performance improvement, as identified by the SPC chart below.

Figure: Total open complaints



The most prevalent theme in complaints was clinical treatment followed by delays in appointments and diagnoses, ED waits and care, surgery waits and cancellations, doctor attitude and behaviour and communications. A number of improvement actions are underway to address the drivers of increasing complaints.

Figure: Most prevalent themes in complaints, 2024/25



2.6.2 Parliamentary & Health Service Ombudsman Complaints

Between 1 April 2024 and 31 March 2025 the equivalent of 0.3% (n=5) of complaints received were accepted by the PHSO for investigation.

Of the five accepted for investigation, two were upheld and two were partially upheld. The low % of cases accepted for investigation by the PHSO indicates that despite the challenges in managing the volume of complaints the quality of investigations and responses remains high.

2.6.3 Patient Advice & Liaison Service

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

During the year, the numbers of PALS concerns received has increased, with 13763 concerns received compared to 12,165 in 2023/24 and 11,616 in 2022/23 - an increase of 20% over two years. Increasingly patients are concerned about accessing results, appointments and dates for surgery. Concerns from cancer patients about access to radiology also increased through year.

Figure: PALS themes

PALS Themes	Total
Total	**14695**
Communications	4431
Appointments	3627
Other	1429
Clinical care	1412
Waiting times	1262
Admissions and Discharges	533
Values and Behaviors (Staff)	499
Access to treatment or drugs	408
Patient Care	400
Facilities	323
Trust admin/Policies/Procedures including patient record management	218
Transport (Ambulances)	37
End of life care	29
Prescribing	26
Privacy, Dignity & Wellbeing (PDW)	23
Staff Numbers	21
Commissioning	5
Consent	5
Restraint	3
Integrated Care	2
Mortuary	2

2.6.4 National Patient Surveys

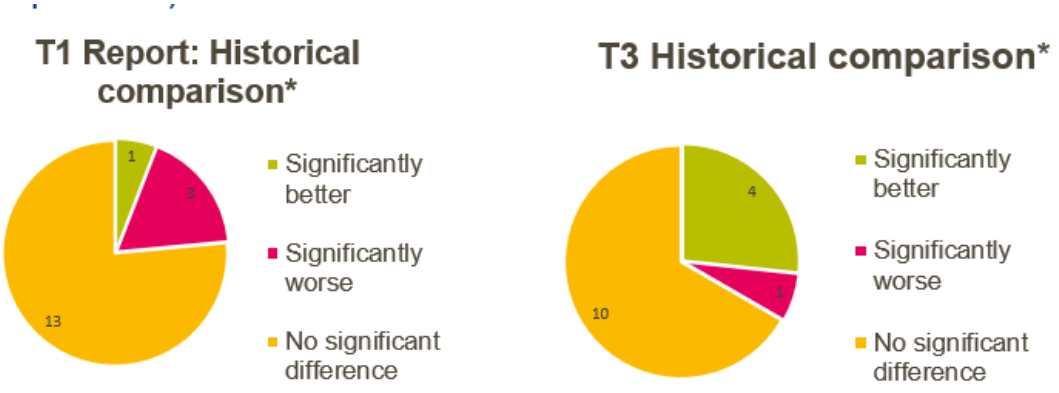
Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	National patient survey results publish in 2024/25 identify a mixed picture of assurance relating to the patient experience. Maternity service users identify improvements in their care and experience since previous years, and some improvements are noted for inpatients and urgent treatment centre patients. However, there remain issues for patients using emergency departments including the length of waiting times and overall experience.			

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

2.6.5 Urgent and Emergency Care Survey

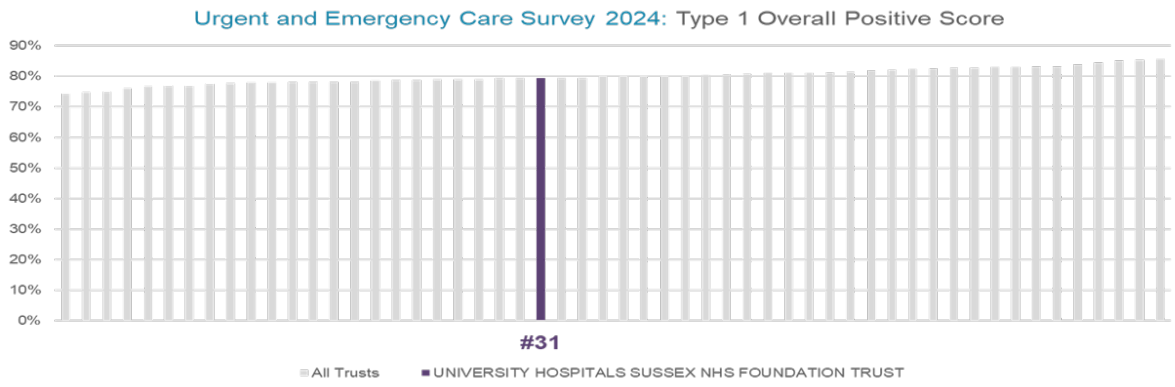
Commissioned by CQC, the urgent and emergency care survey is produced in two parts: type 1 (relating to accident and emergency services) and type 3 relating to urgent treatment centres. 35% of patients invited to complete the survey responded.

In summary, for type one services, in most categories the Trust performance similarly to other Trusts, however it scored significantly worse for three categories and significantly better for one. For type three services, in most categories the Trust performance similarly to other Trusts, however it scored significantly worse for one category and significantly better for three, which demonstrates improvement in urgent treatment centre patient experience.



Type 1 survey results:

The type 1 survey results identify that UHSussex ED services performed close to the national median.



The survey identified that the Trust improved or performed well in the following areas:

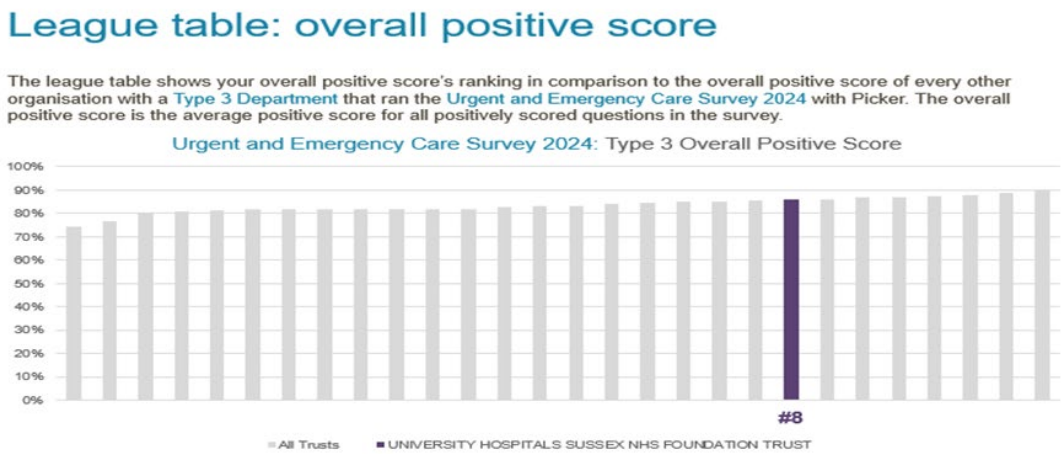
- Being informed of waiting times
- Support with pain management
- Being told who to contact when worried
- Being involved in decisions about care

Improvement opportunities were identified in the following areas and improvements plans for each site are now in place covering:

- Length of time waiting in ED
- Being given enough privacy
- Confidence in doctors and nurses
- Overall experience.

Type 3 survey results:

Overall scores and position in the pack are much improved on previous survey in 2022.

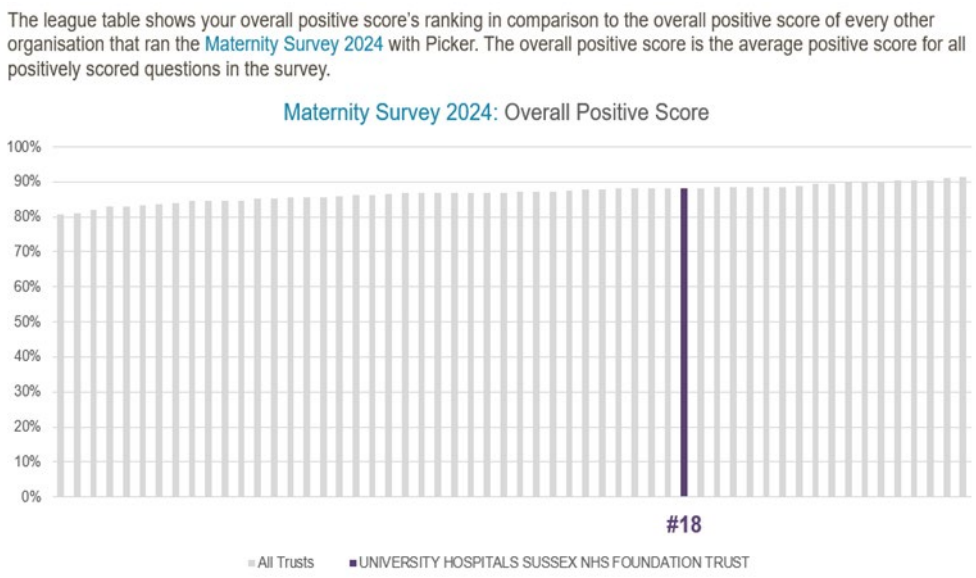


In particular the survey identified that communication, waiting times and pain relief were all performing well. Improvement opportunities were identified in the following areas and improvements plans for each site are now in place covering:

- 4 hour waits
- Keeping patients informed during the wait
- Security in the RSCH waiting room

2.6.6 National Maternity Survey

The national maternity survey results were published in 2024. 281 (45%) of patients completed the survey in 2024 which was above the national average of 40% and 4% higher than last year. The Trust was rated 18th out of the national group using Picker for their survey returns for overall positive score.



A particular improvement was noted in patients reporting that their partner was able to stay with them as long as they wanted in hospital after the birth, being involved in decision about care and having enough information. The Trust scored amongst the highest in the country for being able to get help when needed, being offered a choice of where to have a baby, and management of pain after birth. Opportunities for improvement were identified with regard to having contact details for support about mental health after having a baby and support in the first four weeks after birth. An action plan for maternity teams in response to the survey findings is in place.

2.6.7 National Inpatient Survey

The survey was completed in 2023, and the results were released in August 2024 and 44% of patients invited responded to the survey. The Trust was in the 'about the same' group in most categories however there were improvements in food related experience, and noise at night based on previous year's surveys.

The Trust's overall ranking dropped from the previous year, as although the % rating overall experience 7/10 or greater increased, this is at a lower rate than for most of the Trusts in the country. The best performing and most improved themes were:

- Being able to take own medication when needed, and doctors answering questions
- Getting help from staff, including for meals

The worst performing themes were:

- Waiting for a bed
- Patients being asked for views on care during stay,
- Discharge planning and engagement of families

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

*Data is not nationally available

2.6.8 Friends & Family Test (FFT)

Staff who would recommend the trust to their family or friends

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	The UHSussex score has declined and remains below national average			

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

Indicator Domain	**Percentage of staff who would recommend the Trust as a provider of care to their family or friends** Ensuring people have a positive experience of care				
UHSussex 2024	National Median 2024	Best performing Trust 2024	Worst performing Trust 2024	UHSussex 2023	UHSussex 2022
54.8%	61.5%	89.6%	39.7%	59.6%	57.4%
Data Source	NHS NHS Staff Survey Results – NHS Staff Survey Results NHS Staff Survey dashboard (nhssurveys.co.uk)				

Table based on latest available data (NHS Staff Survey 2024)

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

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

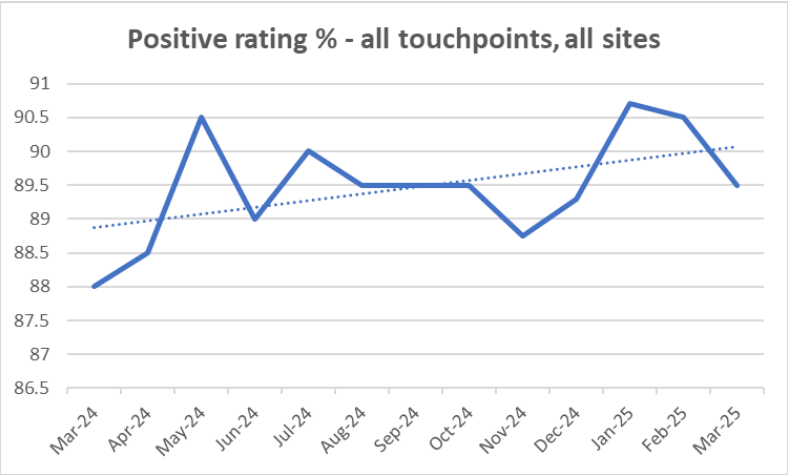
Patients rating their care as good or very good (FFT)

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	FFT data indicates that the Trust target of 90% of patients reporting their care as good or very good has been met. Although there is variability between touchpoints, there is improvement identified in each.			

The friends and family test (FFT) asks patients to rate their experience of care on a scale of 1 to 5 (where 1 is very good and 5 is very poor), and then to explain the reason for the rating. The Trust target is for 90% of patients to rate their care as good or very good, and this was achieved in the final quarter of 2024/25.

Each month, the Trust receives approximately 10,000 survey responses with an average response rate of 23.5% - an improvement on the previous year. The data is reported as a whole Trust, and also by the following touchpoints: emergency departments, inpatient, outpatient, and maternity. During 2024/25, an overall increasing trajectory of patient reported experience is noted.

Figure: Positive Rating % across all touchpoints

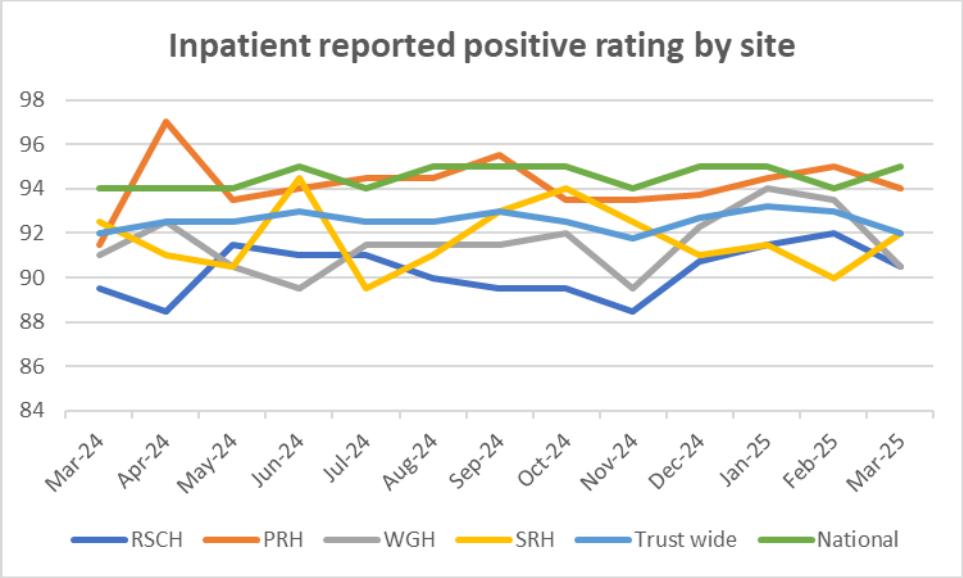


Inpatient reported positivity remained largely consistent in year, with the significant majority of patients describing their care as good or very good. However, at an average of 92%, this is below the national average. This is due to the local configuration of the data, which includes some part of the emergency floor where waits for care result in lower positivity scores.

Indicator Domain	Percentage of inpatients rating their care as good or very good Ensuring people have a positive experience of care				
UHSussex 2024-25	National average 2024-25	Best performing Trust 2024-25	Worst performing Trust 2024-25	UHSussex 2023-24	UHSussex 2022-23
92.5%	95%	100%	88%	92%	93%
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (January 2025)

Figure: Inpatient reported positive experience by site and trust for 2024/25



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

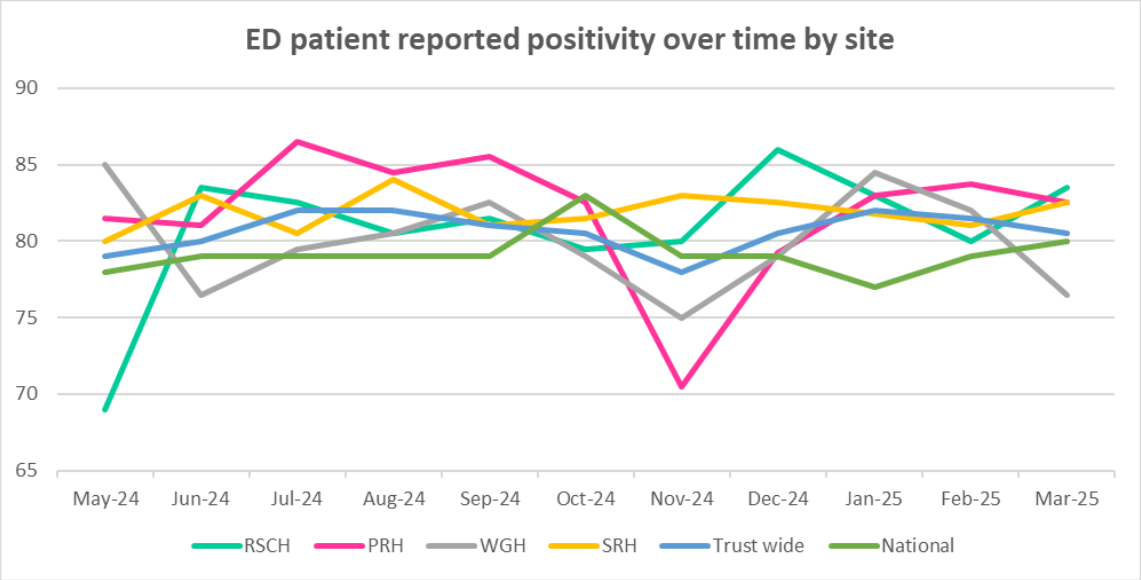
Indicator Domain	Percentage of A&E patients rating their care as good or very good Ensuring people have a positive experience of care				
UHSussex 2024-25	National average 2024-25	Best performing Trust 2024-25	Worst performing Trust 2024-25	UHSussex 2023-24	UHSussex2022-23
80.7%	80%	95%	63%	79.5%	77.3%
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (January 2025)

44% of all FFT responses are from the emergency departments, and as such Trust-wide reporting is confounded by patient experience of EDs. Patient reported positivity of EDs at

University Hospitals Sussex as a whole, remained slightly above the national average at 80.7%.

Figure: Patient reported positive experience of emergency departments by site and trust for 2024/25

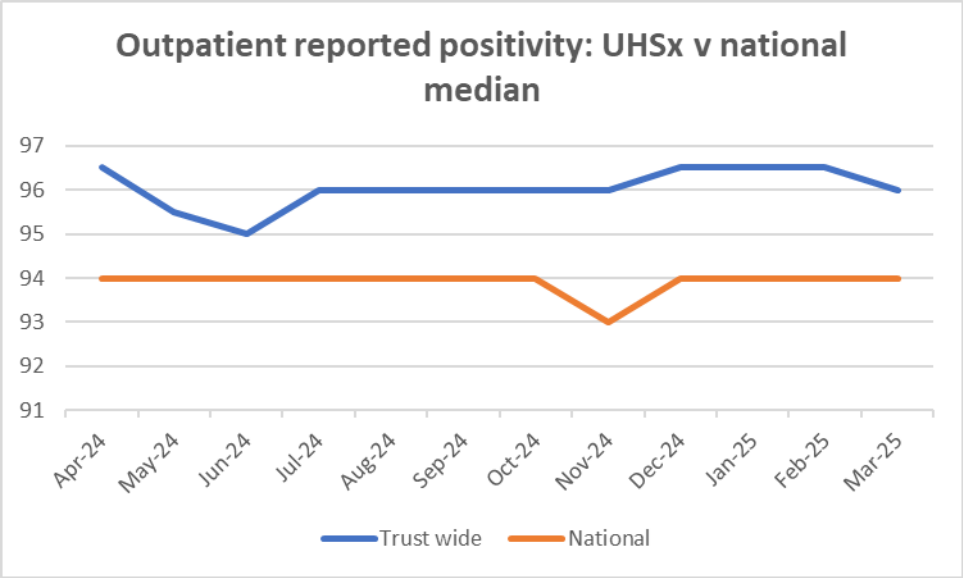


Indicator **Domain**	**Percentage of Outpatients rating their care as good or very good** **Ensuring people have a positive experience of care**				
UHSussex 2024-25	National average 2024-25	Best performing Trust 2024-25	Worst performing Trust 2024-25	UHSussex 2022-23	UHSussex 2021-22
96%	94%	100%	88%	94.5%	Not Available
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (January 2025)

Outpatient reported at 96% on average positivity remained in line or above national average of 94% throughout the year.

Figure: Outpatient report positivity for 2024/25

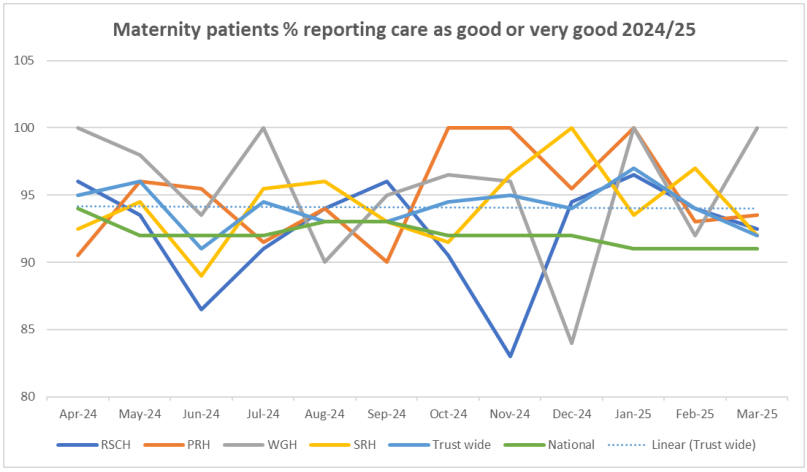


Patients were positive in their feedback about the staff and the quality of clinical care and treatment. Whilst negative reviews were in the significant minority of responses, patients reported that they would have had a better experience if communication and attitudes from consultants had been better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

Indicator Domain	**Percentage of Maternity rating their care as good or very good Question 1 is asked in the Antenatal Care setting Ensuring people have a positive experience of care**				
UHSussex 2024-25	National average 2024-25	Best performing Trust 2024-25	Worst performing Trust 2024-25	UHSussex 2023-24	UHSussex 2022-23
94.00	92	100.00	79.00	*	*
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (January 2025). * No data collected during this period

Figure: Maternity Patients % reporting care as good or very good in 2024/25



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

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

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

2.6.9 Improving how we deliver our patient experience functions

During 2024/5 improvements to the structures and processes within patient experience teams have been implemented. This includes:

- Embedding increasingly efficient processes for management of concerns and complaints, in response to increasing demand from patients as a result of growing numbers of complaints and concerns received – this has resulted in fewer complaints open for longer and more complaints addressed through early resolution
- Bereavement services across the Trust have been integrated within patient experience under a single trust-wide manager to support high quality, consistent responsive services for families following the death of a loved one
    - Closer working with patient safety services in the implementation of the patient safety incident response framework (PSIRF) and representation on the panel of the patient safety incident review group (PSIRG) has enabled improved triangulation of learning from patient feedback and patient safety escalations.
- Implementing the new DCIQ reporting system for patient feedback
- A new improvement tracker has been introduced to capture improvement opportunities and actions generated from national patient surveys and from Healthwatch reports and feedback.
- Implementation of the Welcome Standards – a customer service programme based on patient feedback, and best practice from the private sector. This has improved patient and staff experience of receptions and reduced negative feedback.
- Bespoke engagement of patients, such as on changes to colorectal cancer services, the new cancer centre and the visiting policy has ensured patients are shaping strategic changes within the Trust.
- Co-operation, joint working and innovation with local Healthwatch has also ensured the patient voice has influence within the trust and the services it delivers.

2.7 Patient Safety

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex has a lower rate of reporting than the national average from the National Reporting & Learning System (NRLs) 2022 baseline. NHSE Learning from Patient Safety Events (LfPSE) has not yet set a national baseline for reporting			

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

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

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

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

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

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

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

The Trust's new Patient Safety Syllabus was launched in February 2024. The training suite includes three 'levels' which have all be written and mapped out in accordance with the

Patient Safety training syllabus curriculum. Those individuals identified to be learning response leads are expected to complete all three levels;

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

Duty of Candour training, co-produced by the patient safety partners launched in Q3 of 2024/25.

2.7.2 DCIQ Patient safety Improvement and Risk Management System

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

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

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

February 2024 saw the go-live of the incident reporting module along with the integration from the National Reporting and Learning System (NRLS) to the new NHSE Learning from Patient Safety Events (LfPSE) platform.

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

A new RLDatix (DCIQ) training video is now available on Iris to support the understanding of the incident reporting and handling processes. The patient safety team is also encouraging the reporting of good care. Since implementation in March 2024, the Trust has seen an 18% increase in the rate of incident reporting per 1000 beddays.

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

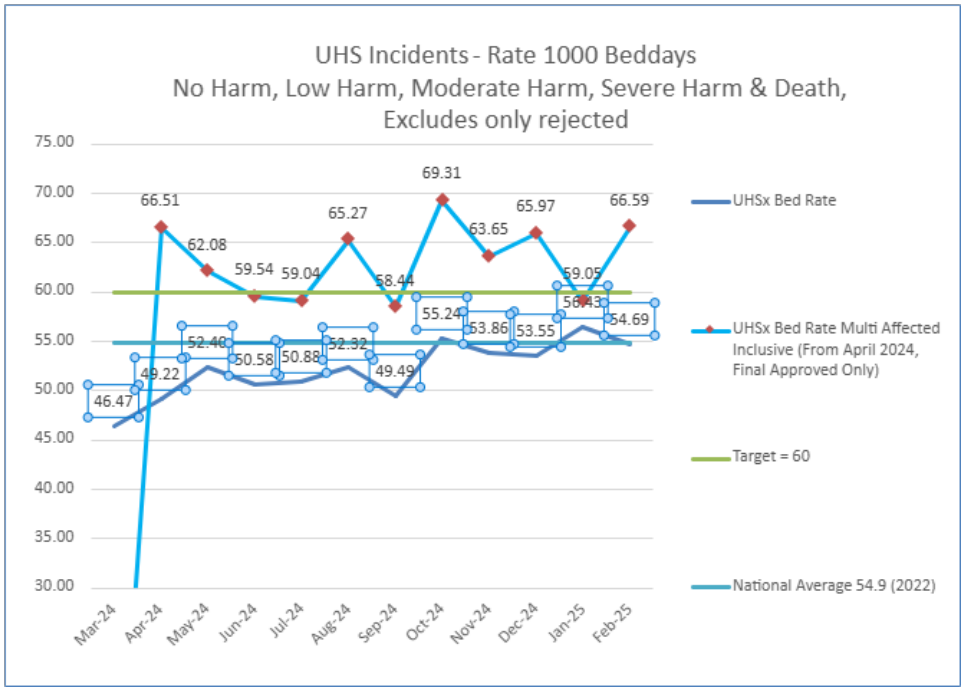
Trust wide it is expected that patients do not suffer harm whilst in our care. However, it is recognised that there are patients who suffer new harm which is acquired during their time in hospital. This has a significant impact on patients, families, carers and staff and within the wider organisation.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

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

The Trust historically used nationally reported and verified data from the National Reporting and Learning System (NRLS) to benchmark its reporting culture against other like for like performing NHS acute/secondary and tertiary care trusts. The National Reporting and Learning System was replaced in 2024 with NHSE Learning from Patient Safety Events (LfPSE). The current national reporting baseline has been paused since 2022 due to the replacement of NRLS with the introduction of LfPSE. The 2024/25 UHSussex Trust target is a reporting rate of 60 per 1000 bed-days.

Following the implementation of a new Trustwide incident reporting system (DCIQ) in March 2024, in 2024/25 the Trust has seen a rise in the rate of reporting to 56.43 (per 1000 beddays) which for the first time since the Trust 2021 merger is above the NRLS *2022 national average of 54.9 and inching towards the Trust target of 60.

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



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

In 2024/25 a significant programme of work has been underway to implement a single standardised, Trustwide incident reporting system allowing for ease of reporting, feedback,

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

Indicator Domain	**Patient safety incidents and the percentage that resulted in severe harm or death** Treating and caring for people in a safe environment and protecting them from avoidable harm					
	UHSussex 2024- 25	National average 2024-25	Highest 2024-25	Lowest 2024-25	UHSussex 2022- 23	UHSussex 2023-24
I) rate of incidents reported per 1000 bed days	52.87	Data is not available			40.75	48.76
ii) rate of incidents that resulted in severe harm or death per 1000 bed days	0.32	Data is not available			0.35	0.19
iii) Number of incidents resulting in severe harm or death	176	Data is not available			246	130
iv) % of severe harm or death over number of reported incidents	0.60%	Data is not available			0.81%	1.32%
Data Source	NHS England: National patient Safety Incident Reports					

Data publication has been paused since 2023 as a result of the introduction of the LfPSE. Data provided is internal only.

2.7.4 Patient Safety Incident Investigations (PSII)

The Trust's records all patient safety and staffing incidents on the electronic incident reporting system (DCIQ). Incidents recorded range in harm levels from near misses, low, moderate severe harm and death.

A revised harm category of psychological harm has recently been added/updated by NHSE and is highlighted as an example for when patients have delayed surgery or mental health patients awaiting specialist treatment. This harm level may be downgraded when incidents have been fully investigated or via the mortality and morbidity (M&M) divisional governance review process.

From April 2024 to March 25, in line with PSIRF, the Trust reported 50 Patient Safety Incident Investigations (PSII) these incidents were all in relation to patient death.

Moderate/severe harm incidents are investigated via early learning and local learning reviews.

Table: Themes from PSII

Incident category	Total
Maternity	13
Bloods, Assessments, Diagnosis, Tests	7
Slip Trip or Fall	6
Treatment / Procedure	6
Never Event	5
Cardiac Arrest	4
Patient Monitoring	3
Patient Medical Review	2
Admission	1
Discharge	1
End of Life Care	1
Nursing Red Flag	1
Total	50

The four most reported serious incident themes which have been reviewed are detailed below.

Table: Review of themes for most frequently reported PSIIs.

Patient Safety Incident Investigation Themes	
Maternity	The Trust reported 13 PSIIs in this category. Ten of these incidents were under MNSI investigation as they met the Each Baby Counts criteria. Three of these incidents relate to neonatal deaths.
Bloods, Assessments, Diagnosis, Tests	The Trust reported 7 PSIIs in this category. They relate to missed or delayed diagnosis that potentially contributed to patients' deaths. The majority of these incidents (5/7) occurred under emergency and urgent care services across the Trust.
Slip Trip or Fall	The Trust reported 6 PSIIs in this category.
Treatment / Procedure	The Trust reported 6 PSIIs in this category. They relate to treatment delays that might have contributed to patients' deaths across various services.

Table: Incidents reported by PSII criteria

Patient Safety Incident Investigations criteria	No.
Death thought more likely than not due to problems in care	35
Incident meeting Each Baby Counts criteria (under MNSI investigation)	10
Incidents meeting the Never Event criteria	5

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

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

2.7.5 Never Events

Five Never Events were reported in this period

- 2 wrong implants
- 1 administration of medication by the wrong route
- 1 wrong site surgery;
- and 1 wrong site injection.

Table: Reported Never Events

Never Event	Site	Date
Never Event - wrong implant/prosthesis	Sussex Eye Hospital - Surgery PRH/RSCH	May 2024
Never event - wrong site injection	Southlands - Surgery WH/SRH	August 2024
Never event - administration of medication by the wrong route	RSCH - Specialist	February 2025
Never event - wrong site surgery	Worthing - Surgery WH/SRH	March 2025
Never Event - wrong implant (wrong contraceptive device)	Worthing - Obstetrics	March 2025

2.7.6 Maternity and Newborn Safety Investigations (MNSI)

The following cases met criteria for investigation by MNSI:

Datix Ref:	STEIS (SI Ref:)	Type (under EBC criteria)	Opened (declared as PSII)	Closed
9825	2024/5061	Intra-uterine death	15/05/2024	13/11/2024
14588	2024/6075	Neonatal cooling	26/06/2024	18/12/2024
14307	2024/6050	Intra-uterine death	26/06/2024	20/01/2025
13931	2024/6042	Neonatal cooling	26/06/2024	11/02/2025
16309	2024/6634	Neonatal cooling	26/07/2024	27/03/2025
29046	2024/9513	Neonatal cooling	13/11/2024	N/A - still open
35094	2025/670	Neonatal cooling	15/01/2025	N/A - still open
36119	2025/526	Neonatal cooling	15/01/2025	N/A - still open
39985	2025/1139	Neonatal cooling	12/02/2025	N/A - still open
41007	2025/1260	Neonatal cooling	26/02/2025	N/A - still open

2.7.7 Regulation 20: Duty of Candour

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex improved compliance with Duty of Candor Regulations to 92.95% compared to 89% the previous year			

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

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

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

An overall average score of the 3 components forms the Trust compliance score of 92.95% for 2024/25 financial year.

A new Duty of Candour training module, introduced by the Trust Patient Safety Partners has been available on IRIS to support the understanding of the process in accordance with the Trust Duty of Candour and Being Open Policy since Q2 2024/25.

The Duty of Candour training and PSIRF deliver more clarity and emphasis on psychological harm caused by incidents, with clear guidance to categorize low, moderate and severe psychological harm.

To improve the quality of Regulation 20 Duty of Candour compliance reporting, the new DCIQ incident module has revised the data collection tools and process to ensure Trust compliance, which have been improved across Q3 2024/25.

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

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is assessments is below national average			

Indicator Domain	**The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism** Treating and caring for people in a safe environment and protecting them from avoidable harm				
UHSussex 2024-25	National average 2024-25	Best performing Trust 2024-25	Worst performing Trust 2024-25	UHSussex 2023-24	UHSussex 2022-23
90.75%	95%	99.44%	14.27%	*	*
Data Source	NHS Digital NHS England » Venous thromboembolism (VTE) risk assessment 2024/25				

Table based on latest available data (April 2024 to December 2024) * The VTE data collection and publication was suspended after December 2020, and recommenced in Q1 of 2024.

3.7.9 Rate of C.difficile infection

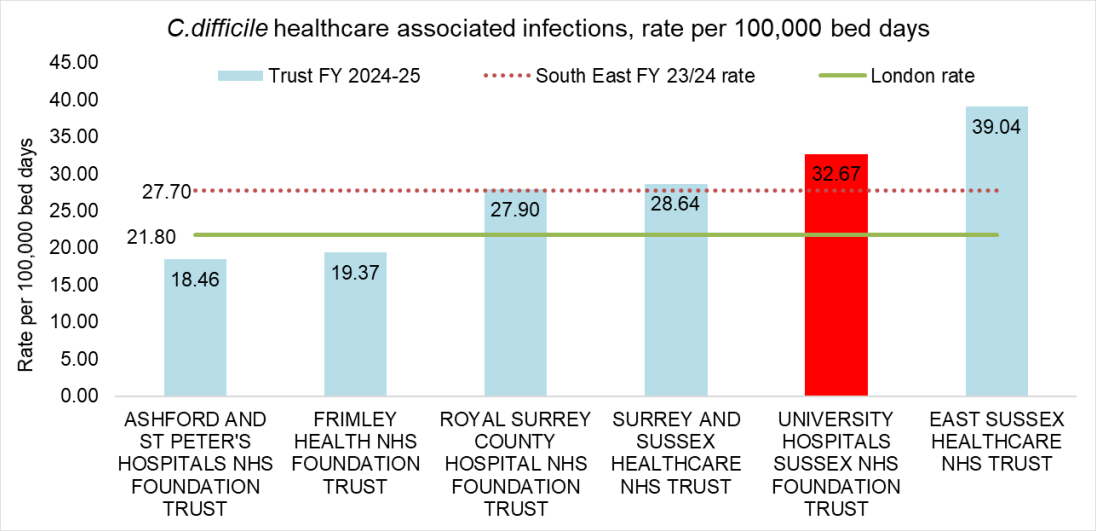
Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	The Trust had a higher than anticipated rate of CDI in 2024-25. The CDI action plan has been implemented in January 2025.			

During 2024/25 the Trust recorded 209 CDI cases (ambition 152), equivalent to 32.7 per 100,000 occupied bed-days, 57 cases above trajectory.

No definite outbreaks or cross-transmission events were confirmed, although site-level data show month-to-month variability, with community-onset healthcare-associated (COHA) cases contributing 33 % of the total. Spikes coincided with norovirus activity when stool testing increased. Factors driving the excess include antimicrobial-stewardship gaps, sustained operational pressure, concurrent norovirus outbreaks, and the wider national up-trend in CDI.

Indicator	The rate per 100,000 bed days of trust apportioned cases of C. difficile infection that have occurred within the Trust amongst patients aged 2 or over				
Domain	Treating and caring for people in a safe environment and protecting them from avoidable harm				
UHSussex 2024-25	National average 2024-25	Best performing Trust 2024-25	Worst performing Trust 2025-25	UHSussex 2023-24	UHSussex 2022-23
32.7	Data not published/available			13.93	18.96
Data Source	https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure				

Table based on latest available data April 2024 to March 2025



In Q4 2024/25, implementation of a Trust-wide CDI improvement plan correlated with a reduction in cases. Key actions of which include:

- Enhanced data-collection template aligned to DCS and PSIRF requirements.
- Monthly Multidisciplinary CDI Review Panel (IPC, microbiology, pharmacy, nursing, epidemiology) to scrutinise themes.
- Regular feedback to clinical staff on CDI rates, prescribing patterns and IPC compliance via IPOG, TIPC and Divisional deep-dives.
- Targeted education and audit to strengthen hospital and community antimicrobial stewardship.
- Intensified environmental decontamination across clinical areas.

IPC Link Champions act as conduits for rapid dissemination of learning and good practice across wards and services.

2.7.10 Sepsis

UHSussex SHMI for sepsis suggests that mortality for this condition is within the expected range, with a lower number of observed deaths against the number of expected deaths.

Metric	
SHMI	98.7
SHMI95%CI Lower	88.18
SHMI95%CI Upper	110.12
Expected number of deaths	324.23
Number of patients discharged who died in hospital or within 30 days	320
Number of mortalities occurring in the hospital	263
Number of provider spells	1409
Number of mortalities occurring out of hospital	57

Part 3: Other Quality Information

3.1 Guardian of Safer Working Annual Report

Rota Gaps & Plans for Improvement

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex has a robust exception reporting process with key data (including GOSW fines and Immediate safety concerns) presented to People Committee and LFG (local faculty group) fora. Rota gaps are reported quarterly by Medical workforce with a forward plan and clear evidence of recruitment / backfill strategy. UHSussex has an active junior doctors forum with cross departmental representation including medical workforce, operational and educational teams.			

In 24/25 there has been an overall increase in exception reports (ER) at UHSussex with 1785 in total (compared to 1394 23/24).

Site	Exception Reports 2024/25	2024/25 Hotspots	Exception Reports 2023/24
Worthing General Hospital & Southlands Hospital (WGH)	461	Acute Medicine (18%) Cardiology (14%)	424
Royal Sussex County Hospital, Royal Alexandra Children's Hospital, Brighton General Hospital, Sussex Eye Hospital (RSCH)	795	Cardiology (15%) Infectious Diseases & GU Medicine (11%)	558
Princess Royal Hospital & Hurstwood Park Neurosurgical Centre (PRH)	69	Urology (22%) Diabetes & Endocrinology (20%)	48
St Richards Hospital (SRH)	460	Acute Medicine (24%) Cardiology (14%)	364

The majority of ERs at UHSussex are submitted by trainees in medical specialties, with the predominant themes relating to workload and staffing;

- 72% at Worthing & Southlands Hospital's
- 79% at St Richards Hospital RH
- 56% at Royal Sussex County Sites
- 83% at Princess Royal & Hurstwood Park Neurosurgical

7 immediate safety concerns (ISC) have been submitted and agreed (2 WGH, 4 SRH, 1 RSCH Site) the majority (6/7) resulting from unanticipated staffing gaps. These left depleted on-call teams providing unsafe out of hours care, all resulted from staff sickness. Review of ISC by Chiefs of service have resulted in significant changes to rota patterns (and recruitment of medical registrar grades at SRH site to ensure replete rotas) to deliver a more resilient and safe staffing model.

79 Guardian fines have been issued this year across UHSussex (WGH 24, SRH 10, RSCH 44, PRH 1) resulting in a total Guardian fines allocation of £6274.63. Guardian fines fund balance is currently £31,894.

9 Pantrust Resident doctors fora (RDF) have taken place in 24/25 with invited speakers including the Trust Freedom to speak up Guardian and Guest Speaker (Health & Wellbeing Engagement Programme Manager) discussing 'Sexual Safety Charter in Healthcare' / speaking up in the workplace on sexual misconduct. The RDF has allocated funding from Guardian fines for 11 doctor lead projects, including well-being/social activities and equipment (camping / pottery events) and enhancing rest space (additional sleep provision and enhancing outdoor space).

UHSussex have expanded the digital rostering platform HealthRota® for use in exception reporting. HealthRota for exception reporting was implemented for approximately 1100 resident doctors on April 1 2025. This followed a successful pilot at RSCH/PRH sites in February 2025. This required significant resource development for doctors an supervisors and a stakeholder consultation process.

ER reforms have been agreed by the BMA Resident doctors committee and NHS employers and must be implemented by all Trusts by 12 September 2025. These will have major implications for ER processed locally and nationally. Reforms will result in significant changes to the sign off process for ER with emphasis on '[not exposing doctors to] detriment' from ER. The vast majority of ERs (those under 2hrs; 94% at UHSussex in 24/25) will be processed by HR / medical workforce within 7 days of submission with clinical and educational supervisors removed from the process. Under the contractual changes challenges to claims must be by exception, not the norm and choice of remuneration (payment versus TOIL) made by the reporting doctor. New confidentiality clauses impose substantial Trust fines for 'data breaches' where individual doctors are identified or suffer detriment by ER. It is anticipated this will result in higher numbers of ERs at UHSussex and an increased number of fines with resultant financial pressures.

To implement these changes by 12 September 2025, HealthRota Usergroup leads are seeking clarity from NHS Employers to prioritise essential software modifications. At UHSussex the medical workforce team will require restructuring, training and additional resourcing to offer resilience of expertise. Director of Medical Education DME (Dr Paul Smith) will ensure site DMEs deliver a standardised approach for agreeing education ERs and actions to reinstate educational opportunities. Dissemination of ER themes and trends at local faculty group (LFG) meetings will remain essential with stringent focus on ensuring anonymity of reporters. The Guardian of Safe Working (GOSW) will have expanded responsibilities with complete access and oversight of ER data, offering pastoral support to

high volume reporters in addition to investigating unsafe working practices. This may necessitate appointment of a second GOSW at RSCH/PRH sites. The Trust must navigate and eliminate the risk of data breaches and additional fines for those without access to ER which may result in significant financial penalties.

There is a short timeline for implementation of reforms which may impact proposals to expand ER to Locally employed doctors at UHSussex from August 2025. UHSussex must accept and embrace ER reforms, recognising that this may be the only way to accurately remunerate ‘true hours worked’ and in turn meet the needs of the RD workforce in delivering efficient handover, workable rotas and safe working practices to benefit patients and staff.

3.2 Health Inequalities

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	The Trust continues to roll out in-patient smoking services and look for ways to support the Core20PLUS5			

2.7.12 Smoking Cessation

During Q4 the Trust has been able to fully recruit a number of Tobacco Dependency Advisors to enable the implementation of the NHS Long Term plan inpatient smoking pathway, in addition to the continuation of the Smoke Free Pregnancy Service delivery in 2025/26.

Inpatient Smoking Cessation Service

The Tobacco Dependency Programme has ambitions to fully deliver the Acute Inpatients model across all 4 main hospital sites in 2025/26 with initial roll out at St Richards Hospital and Princess Royal Hospital in Q1 & 2 and expansion to Worthing General and Royal Sussex County Hospital by Q3, ensuring that all admitted patients are assessed for their smoking status, offered Very Brief Advice and Nicotine Replacement Therapy to remain smoke free whilst on site and receive an opt-out referral to a Tobacco Dependency Adviser with 24 hours for a full consultation and onward referral to community smoking cessation services.

In addition, the programme aims to support the implementation of the Trust Wide Smoke Free policy and secure on-site smoking cessation support for staff who smoke via partnership working with our Local Authority providers

The 2024/25 Local Quality Requirements for Inpatient Smoking Cessation Service were;

Electronically record the smoking status of adult inpatients on admission:

Target: Incremental improvement toward achieving 90% threshold by Q4.

Performance	Q1	Q2	Q3	Q4
Achievement	36.5%	39.7%	41%	42.1%

Identified smokers given 'very brief advice':

Target: Incremental improvement toward achieving 90% threshold by Q4.

Performance	Q1	Q2	Q3	Q4
Achievement	72.2%	83%	73.4%	74.3%

Identified current smokers offered nicotine replacement therapy within 6 hours of arrival to ward:

Target: Incremental improvement toward achieving 70% threshold by Q4.

Performance	Q1	Q2	Q3	Q4
Achievement	10.3%	12.0%	9.6%	11.1%

Identified current smokers offered an in-depth Tobacco Dependency Advisor consultation inline with NHS England Delivery model expectations:

Target: Incremental improvement toward achieving 50% threshold by Q4.

Performance	Q1	Q2	Q3	Q4
Achievement	No Data	23.6%	37.4%	42.6%

Number of current smokers accepting a referral for Advanced Community Pharmacy Smoking Services:

Target: Incremental improvement

Performance	Q1	Q2	Q3	Q4
Achievement	No Data	18	23	19

Number of current smokers accepting a offer of a Swap 2 Stop Vape:

Target: Incremental improvement

Performance	Q1	Q2	Q3	Q4
Achievement	No Data	0	0	0

Number of current smokers reporting a quit status (CO verified or self-reported) at 28 day follow up:

Target: Incremental improvement

Performance	Q1	Q2	Q3	Q4
Achievement	No Data	11	8	5

Smoke Free Pregnancy Service

Moving forward the Smoke Free Pregnancy Service aims to drive improvements through National initiatives including the National Maternity Incentives scheme and continuation of the National Swap2Stop Vape scheme.

Utilising Novel Technologies in Q4 such as iCO remote monitors and Attend Anywhere for virtual appointments has allowed increased engagement with rural and harder to reach patients and will be built upon in 2025/26.

The Local Quality Requirements for Smoke Free Pregnancy Service were;

Percentage of people in maternity settings CO monitored at booking (in month appointments):

Target: 90% CO monitored at booking

Performance	Q1	Q2	Q3	Q4
Achievement	94.5%	94.9%	91.8%	94.6%

Percentage of people in maternity settings CO monitored at 36 Weeks (in month appointments):

Target: 90% CO monitored at 36 weeks.

Performance	Q1	Q2	Q3	Q4
Achievement	88.7%	88.6%	89.5%	87.8%

Percentage of pregnant smokers referred to service:

Target: 95% of pregnant smokers referred.

Performance	Q1	Q2	Q3	Q4
Achievement	90.6%	96.5%	94.2%	95.2%

Percentage of pregnant smokers referred, contacted and offered a Tobacco Dependency Treatment Service within 1 working day:

Target: 85% of pregnant smokers referred are contacted and offered a TDT appointment within 1 working day

Performance	Q1	Q2	Q3	Q4
Achievement	93.3%	94.4%	91.4%	94.0%

Percentage of pregnant people booked as smokers who are smokefree at delivery

Target: 30% of pregnant people booked as smokers are smoke free at time of delivery

Performance	Q1	Q2	Q3	Q4
Achievement	30.3%	38.4%	34.1%	38.2%

Percentage of pregnant smokers SATOB (Smoking at booking/total births in month)

Target: No Target (Outside of service control)

Performance	Q1	Q2	Q3	Q4
Achievement	8.27%	6.64%	6.52%	6.65%

Percentage of pregnant smokers SATOD (Smoking at delivery/total births in month)

Target: Less than 6% of pregnant smokers smoking at time of delivery

Performance	Q1	Q2	Q3	Q4
Achievement	6.27%	4.64%	4.67%	4.96%

2.7.13 Hep C, HIV & Liver Fibrosis

Since June 2024 19,354 people have been tested for HIV and Hepatitis C via the RSCH Emergency Department with;

- 6 new HIV diagnosis
- 15 new Hepatitis C diagnosis

In addition to RSCH Emergency Department testing, 200 patients where diagnosed and treated for Hepatitis C in the community setting, with 81.9% of patients starting their treatment within 4 weeks.

1800 people were given a FibroScan during the period, with 94% of patients with results suggestive of fibrosis or cirrhosis requiring further investigation or HCC surveillance attending their 1st surveillance appointment against a target of 60%. 3 confirmed hepatocellular carcinoma were identified as a result of screening.

2.7.14 Maternity Continuity of Care

NHS England's approach aims to ensure continuity of care for women of Black, Asian and minority ethnic communities and for the most deprived groups. The Trust has continuity of care teams across the Brighton and Haywards Heath areas, who offer their service to those at risk of health inequalities. Now that the midwifery vacancy position is so improved, further similarly focused teams are in development in the Chichester and Worthing areas.

2.7.15 Early Diagnosis of Cancer

NHS England's approach aims to ensure 75% of cases are diagnosed at stage 1 or 2 by 2028. During the period 2024/25 UHSussex diagnosed 65% of cases at Stage 1 or 2, compared to 46% the previous year.

2.7.16 Chronic Respiratory Disease

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

2.7.17 Hypertension Case Finding

NHS England's approach aims to ensure a focus on diagnosis and optimal management of hypertension including optimal lipid management. This intervention is mainly aimed at Primary Care delivery; however, the Trust is exploring ways that it can support delivery and has been piloting Hypertension case finding with HIV outpatients. Since phase two of the project launched in January 2024;

- 276 patients consent to the home BP Project of which;
- 89 patients (32%) did not return a diary
- 68 patients (25%) were identified to have stage 1 hypertension
- 15 patients (15%) were identified to have stage 2 hypertension

2.8.18 Recording of Health Inequalities Data Including Ethnicity

UHSussex is committed to ensuring that it holds data which enables us to understand the impact our services and care has on ethnically minoritised groups, and those most at risk of health inequalities. Over the year we have been working to develop segmented data across the organisation, (including within Maternity and Learning from Deaths).

Target: Health Inequalities data to be recorded across Quality Dashboards to include a minimum threshold of 60% for data completeness. The following data is the percentage of records where ethnicity was either not stated or was recorded as not known (target <40%).

Performance	Q1	Q2	Q3	Q4
Emergency Department	18.7%	19.6%	19.2%	19.3%
Inpatients	13.7%	13.9%	14.2%	14.2%
Outpatients	15.9%	16%	16.3%	16.2%

3.3 NHS Staff Survey

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Overall, the Staff Survey has been assessed as 'Assurance'. This is based on three criteria: • **Response rate**: 8,191 (47%) of staff responded. While this is slightly below the 2023 rate (50%) and NHS benchmark average for 2024 (49%), it reflects a high degree of engagement that provides reliable (statistically significant) data across almost all scores, and remains the Trust's single largest staff engagement activity. • **Process**: Results were analysed and reported to key stakeholders and committees rapidly, and data are made available to managers and staff via an interactive digital dashboard that enables local analysis of results, benchmarking against Trust and NHS scores, and development of tailored Action Plans. The c. 1,600 freetext comments have also been analysed, and are informing e.g. the development of the 'Growth & Development Pathway' (Values & Behaviours Framework) and other Trust planning. • **Overall results**: At People Promise level, one PP Element improved significantly (We work flexibly), and is above the NHS benchmark average. Changes in the other six Element scores were not statistically significant. By PP Theme, one (Morale) did not change significantly from 2023. The other Theme (Staff Engagement) saw a statistically significant fall of 1.1% (from 6.66 in 2023 to 5.59 in 2024). However this tracks the national trend for Staff Engagement, which reduced by the same percentage in 2024. The Trust therefore remains slightly below the benchmark average overall, however exceeds NHS benchmark scores in a number of areas that are particularly associated with the **Trust Values** (e.g. inclusion, care from immediate manager and interest in health and wellbeing, feeling valued by and attached to your team, colleagues' kindness and understanding, treating each other with respect, role clarity, flexible working, recognition for good work and showing appreciation, uptake of appraisal).			

The NHS Staff Survey is one of the largest workforce surveys in the world. It gives people working in the NHS the opportunity to share their views and experiences about work, leadership, wellbeing and inclusion. The results provide a vital source of feedback for Trust Boards, regulators and the public - and play a central role in improving the quality of care. There is strong research evidence that positive staff experience is linked to safe, effective, compassionate care for patients.

At UHSussex, 8,191 colleagues completed the 2024 NHS Staff Survey representing 47% of the workforce. The results are benchmarked nationally against other comparable NHS

organisations, helping us understand how our staff experience compares with the wider NHS.

Involving our staff

Staff are involved in shaping the direction of the Trust through a range of formal and informal channels. In late 2023, we launched a new Culture Programme, alongside our 'Big Conversation' to inform our new Trust Strategy, which have engaged extensively with staff across all sites and staff groups.

Ongoing opportunities for staff involvement include our inclusion Staff Networks, engagement forums, Divisional and local listening events, regular Pulse Surveys, Patient First improvement collaboratives, Trust Ambassadors programme and range of Staff Champion networks/Communities of Practice (e.g. Green Champions, Health & Wellbeing Champions), and participation in strategy development, co-design workshops, and staff experience workstreams.

In addition, the results of the NHS Staff Survey are shared via an interactive dashboard accessible to all Divisional and Corporate leadership teams, enabling local analysis and action planning tailored to each area's specific priorities.

What our staff told us

The survey asks questions structured around the NHS People Promise, which sets out what people working in the NHS should experience every day, to feel recognised, supported, included, and empowered to speak up and develop.

After a year of strong improvement in 2023, the 2024 results show a more mixed picture:

- The theme 'We work flexibly' improved significantly and is now above the national average, reflecting our ongoing efforts to support flexible working.
- Staff morale improved slightly overall, with particularly strong scores in some teams, including Estates, Additional Clinical Services, and Women & Children's services.
- The Trust improved in six of the nine People Promise themes and declined in three, this reflects a more positive trajectory than the national average among comparator NHS Trusts.

However, areas for improvement remain:

- Staff engagement declined, largely due to fewer staff saying they would recommend the Trust as a place to work or receive care.
- Recognition and reward remains one of the lower scoring themes, both locally and nationally.
- There are notable differences in experience between staff groups, often mirrored nationally, for example with Medical & Dental staff, Healthcare Scientists, and students reporting lower morale, wellbeing, and feelings of inclusion.

How we are responding

Local review and action planning are underway. Each Division and Corporate team are developing a tailored Staff Survey Action Plan for implementation in 2025/26, which will be aligned with the new Trust Strategy once launched in Spring 2025.

Several cross-cutting improvement themes have already emerged:

- Speaking up and psychological safety - making it easier and safer for staff to raise concerns and be heard
- Recognition and reward - strengthening how we acknowledge and value staff contributions
- Violence prevention and reduction, including a focus on sexual misconduct

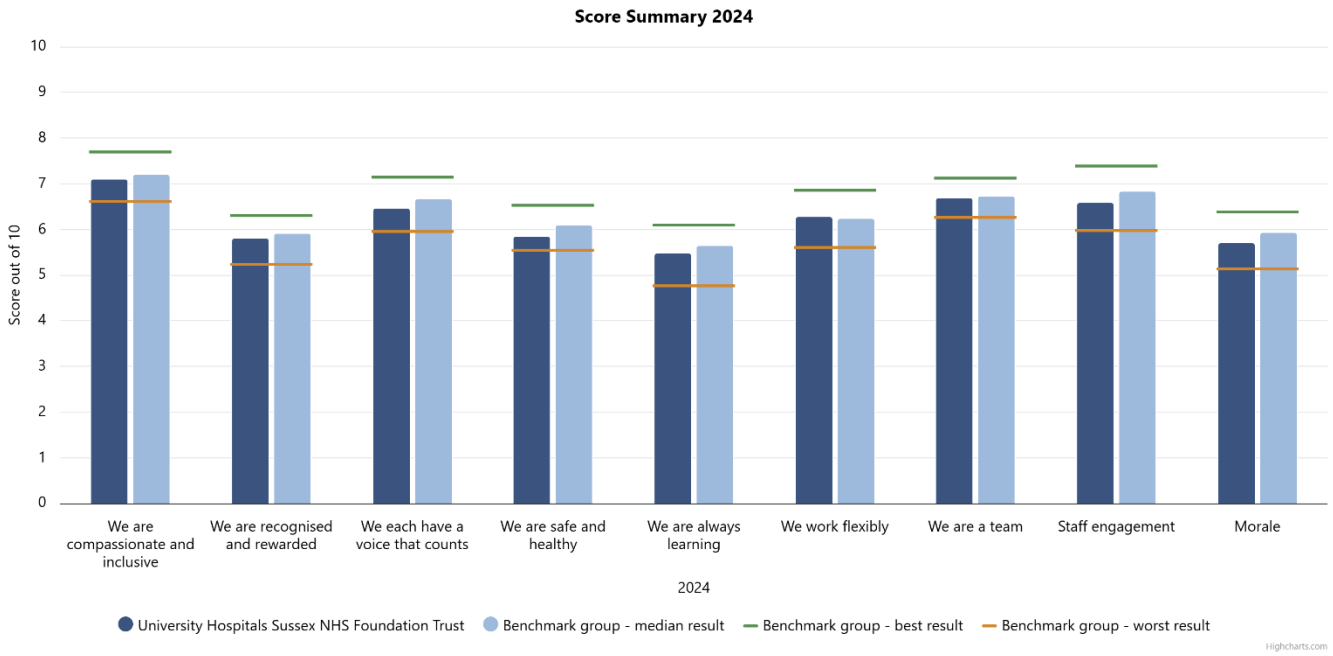
These plans form part of our wider commitment to delivering the NHS People Promise, improving staff experience, and ensuring University Hospitals Sussex is a place where people feel proud to work.

Our commitment

We are grateful to every colleague who took part in the 2024 survey. Staff experience is central to quality, safety, and compassionate care – and we remain committed to listening, learning, and acting on what our people tell us.

For more information

National and local results of the NHS Staff Survey, and survey documents, are available via the interactive NHS Staff Survey Dashboard.



3.4 Operation Performance Relevant to Quality of Care

3.4.1 Emergency Department Performance

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is not meeting the required standard of 78% of patients seen, treated and admitted/discharged within 4 hours but has made improvements when compared to the previous year			

The Trust has improved several of it's UEC measures across 24/25 when compared with 23/24.

These include the percentage of patients seen and treated/discharged in 4 hours, 12 hrs in department from a peak of nearly 10% in January to 8.8% at year end, ambulance handovers and bed occupancy. The number of patients with a long length of stay is around the same although the number of medically ready for discharge is higher (these are patients who are ready to leave hospital but require input from another provider)

UHSussex is not meeting the required standard of 78% of patients seen, treated and admitted/discharged within 4 hours but is in a better position than it was in the last financial year. Further information with regards to the metrics are in the tables below:

A&E and Emergency Flow	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
UHS <4 hr Performance	69.05%	69.60%	69.00%	70.27%	71.31%	71.60%	71.50%	71.86%	69.24%	68.13%	69.40%	70.20%	71.50%	
A&E 4 Hour Breaches	11,692	10,738	11,881	10,692	10,694	10,020	9,957	10,391	11,274	11,546	10,678	9,743	10,811	
A&E 12 hours in department	2,865	3,018	3,073	2,763	2,940	2,641	2,878	3,215	2,986	3,162	3,393	2,878	2,662	
% 12 Hours in Department	8.4%	8.6%	8.0%	7.7%	7.9%	7.5%	8.2%	8.7%	8.2%	8.7%	9.7%	8.8%	8.8%	
A&E Attendances	33,977	35,265	38,278	35,968	37,271	35,312	34,936	36,932	36,654	36,229	34,943	32,702	37,888	
< 4 Hour Attendances	22,285	24,527	26,397	25,276	26,577	25,292	24,979	26,541	25,380	24,683	24,265	22,959	27,077	
Ambulance Handovers	7,152	6,808	7,101	6,843	6,955	7,010	6,994	7,247	7,212	7,271	7,272	6,383	7,017	
Ambulance Handover <15 minutes	53.0%	49.2%	52.9%	54.7%	51.2%	55.3%	49.5%	47.8%	48.3%	46.5%	45.3%	49.9%	52.7%	
Ambulance Handovers > 60 minutes	7.2%	8.7%	6.7%	4.9%	5.9%	4.6%	6.0%	7.1%	6.0%	6.5%	6.3%	4.9%	2.4%	
Emergency Admissions > 1 LOS	5899	5542	5716	5500	5533	5501	5515	5838	5738	5702	5812	5125	5639	
Bed Occupancy	95.6%	95.7%	95.4%	95.2%	94.7%	94.7%	95.3%	96.0%	96.1%	95.1%	95.0%	93.9%	93.6%	
Average LOS (Excl LOS 0)	9.90	10.10	10.40	10.30	10.50	9.90	10.40	9.90	9.80	10.30	10.50	10.20	10.20	
>= 7 day LOS Patients	1064	1090	1096	1024	1032	1011	999	1028	1029	991	1042	1085	1052	
>=21 day LOS Patients	490	517	523	490	468	469	469	462	470	449	449	470	475	
Ave. MRD per day	328	324	335	294	293	320	326	327	307	293	313	332	346	

A&E and Emergency Flow	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
UHS<4hr %	69.05%	69.60%	69.00%	70.27%	71.31%	71.60%	71.50%	71.86%	69.24%	68.13%	69.40%	70.20%	71.50%	
RSCH	56.66%	54.34%	54.50%	55.30%	56.51%	56.74%	60.47%	60.28%	58.37%	55.22%	57.89%	58.65%	59.56%	
PRH	70.45%	70.43%	68.13%	71.50%	74.04%	73.15%	75.42%	73.33%	64.17%	60.72%	62.36%	64.42%	66.75%	
RACH	79.09%	87.38%	87.45%	88.67%	90.13%	91.29%	89.67%	88.72%	79.87%	91.04%	89.09%	90.66%	90.57%	
Worthing	60.60%	59.12%	58.70%	60.09%	63.54%	64.59%	62.15%	62.14%	60.29%	59.53%	62.55%	63.64%	61.87%	
SRH	61.14%	63.76%	63.54%	64.51%	61.47%	64.33%	61.05%	64.31%	64.02%	61.35%	59.54%	59.66%	65.12%	
National	*74.2%*	*74.4%*	*74.0%*	*74.6%*	*75.2%*	*76.3%*	*74.2%*	*73.0%*	*72.1%*	*71.1%*	*73.0%*	*73.4%*	*75.0%*	

Patients seen within four hours

The Trust achieved 71.5% in March 25. This is a 2.5% improvement from March 24. The national average improved by 4.1% over the same period, however UHSussex achieved an improved position and provides a foundation on which to build.

Patients waiting for more than twelve hours

This metric has improved when compared to a high in January, but it continues to be variable by site. In the last 2 months of the year there has been an improvement of 3% less patients breaching 12 hrs at RSCH. The other sites have struggled with the 12-hour metric, and this has meant that the overall UHSussex position has not improved when compared with March 24.

Ambulance handover > 60 mins

This metric has improved significantly across the year and moved from 7.2% of our ambulances taking more than 60 mins to be handed over in March 24 to 2.4% in March 25. UHSussex achieved the initial target of less than 4% of ambulances taking more than 60 mins to offload.

Long length of stay

These metrics are slightly improved on March 24 but are not significantly better. However, the number of medically ready for discharge patients is higher in March 25 than March 24. This group of patients will be impacting the over 21-day metric as the medically ready cohort of patients have a longer length of stay, pushing them into the over 21-day bracket.

24/25 UEC Improvement Programme Objectives

The UEC Improvement Plan, aims to deliver against the following four key NHSE standards and operational targets for each of the five main hospital sites within UHSussex:

- 78% of patients in ED seen, treated, admitted or discharged within 4 hours by March 2025
- Reduce the number of patients waiting over 12 hours from arrival in ED to 10%
- Achieve 0% 60 mins handover delays
- 10% reduction in number of patients with a Length of Stay of over 7 days

The UEC Improvement Plan is comprised of:

- Divisional/site level priority projects: addressing local improvement needs.
- Trust level programmes: bringing together common improvement themes from across the organisation.
- Regulatory and NHSE guided improvement requirements.
- Quality/best practice recommendations from bodies such as GIRFT, ECIST, NHS Impact
- Alignment and support to the Trust Winter Plan.

The Year 2 Improvement Programme is:

- Alignment to Trust Strategy.
- Delivery Roadmap at project level agreed to meet National Standards requirements.
- Improved data driven decision making to address unwarranted variation.

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

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex continues to improve the number of patients waiting over 18 weeks, but remains below the national average			

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

Indicator	**Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway**				
UHSussex 2024-25	National average 2023-24	Best performing Trust 2023-24	Worst performing Trust 2023-24	UHSussex 2023-24	UHSussex 2022-23
48%	59.2%	98.0%	44.5%	42.9%	46.8%
Data Source	NHS England Consultant-led Referral to Treatment Waiting Times Data 2024-5				

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

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

3.4.3 Maximum six-week wait for diagnostic procedures

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex has improved the number of patients waiting over 6 weeks for diagnostic procedures, and is below the national average			

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

Indicator	Percentage of patients waiting more than six-week wait for diagnostic procedures				
UHSussex 2024-25	National average 2024-25	Best performing Trust 2024-25	Worst performing Trust 2024-25	UHSussex 2023-24	UHSussex 2022-23
14.3%	17.5%	0.0%	78.0%	30.0%	22.2%
Data Source	NHS England Monthly Diagnostics Data 2024-25				

Table based on latest available data (February 2025)

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

3.5 Participation in Clinical Research

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex improved the recruitment of participants and is establishing a Commercial Research Delivery Centre			

Research and Innovation drive continuous quality improvement in healthcare and help NHS organisations attract and retain a high calibre workforce. We have set out a vision for UHSussex as a place where all patients and staff have the opportunity to participate in high-quality research and innovation which is relevant to them, and where we work with partners across Sussex to ensure the whole population benefits from health and care research and innovation. We will achieve this by broadening engagement in research across our organisation and throughout our workforce, and through the Brighton and Sussex Health Research Partnership with the Sussex Health and Care Partnership Integrated Care System, other health and care service providers in Sussex and academic partners including the Brighton and Sussex Medical School (BSMS).

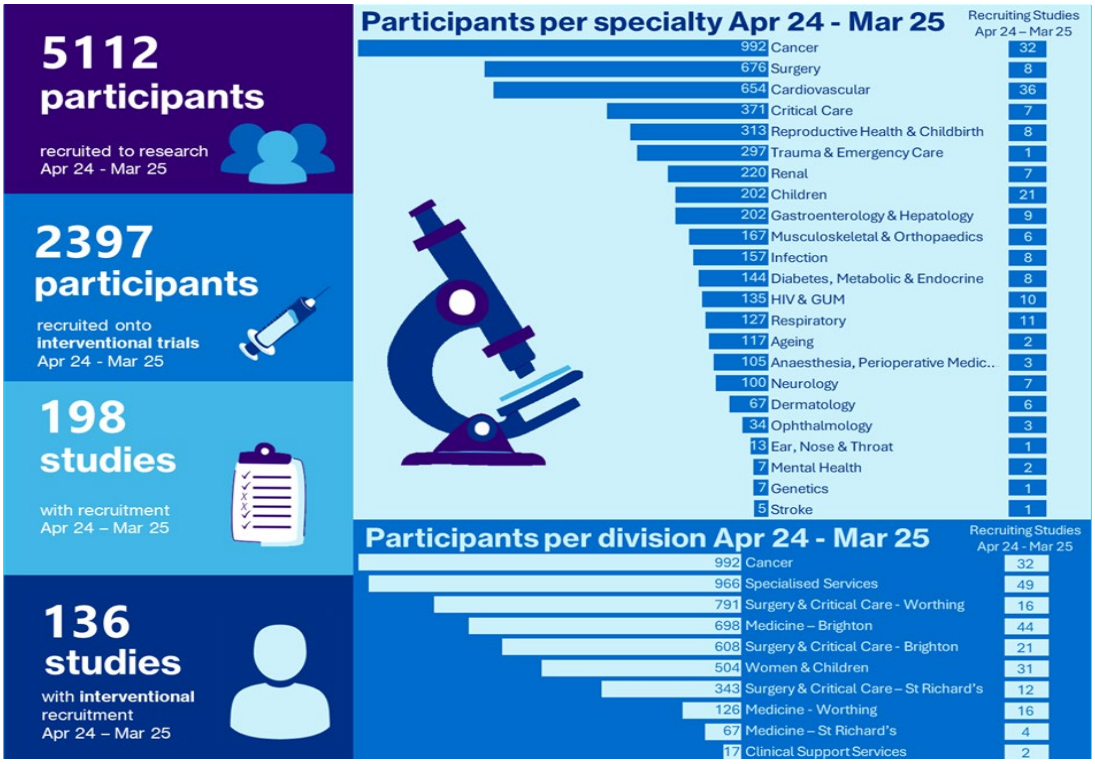
The Sussex Health and Care Research Strategy has been completed and has been endorsed by NHS Sussex's Board**.** ***Improving Lives Together through Research*** sets out health and care partners' collective vision for health and care research, and how it will help improve care and health and care services, for the next five years.

The Strategy's publication also marks our reconfiguration to the Sussex Health and Care Research Partnership. This change reflects the changes in the way our research is being undertaken, with a shift away from acute healthcare settings and into social, community, and primary settings – even our own homes. It also reflects that our partnership has grown to include diverse and specialist healthcare providers across the length and breadth of Sussex.

This year the Research and Innovation breakthrough objective has focused on increasing the opportunity for patients to access new and innovative treatments, by increasing the number of commercial and interventional recruiting studies.

Over 2024/25 we have focused on growing and broadening the opportunities for our patients and staff to take part in research. A total of 5,112 participants were recruited into 198 studies running across a range of clinical specialities. We have achieved our NIHR Regional Research Delivery Network (RRDN) annual target for growth in recruitment of participants into National Institute of Health Research (NIHR) portfolio studies. When benchmarked against other NHS acute Trusts, our rank is 24th for number of studies recruiting during 2024/25. Of the studies open to recruitment 136 (68%) were interventional studies that offered 2,397 patients access to potentially lifesaving clinical trials of new medications, devices, or procedures. In line with our strategic objective, we

have increased the number of recruiting commercial studies by 5% compared to the previous year.



The Trust's research outputs continue to excel across cancer, cardiovascular disease, infectious diseases, renal, paediatrics and women and children's medicine. Following developmental work with other specialities including respiratory, gastroenterology and surgery, opportunities to grow patient participation in trials will widen in the coming years.

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

Our UHSussex outpatient research awareness survey demonstrates the importance of continuing to develop our research offer trust wide. Feedback shows that patients have fairly high levels of awareness that UHSx is involved in clinical research (59%) and that many patients are very interested in taking part (47%), however, only a minority (13%) have research discussed with them as part of their clinical care.

We are delighted that UHSussex has been awarded almost £3.5 million to establish a Commercial Research Delivery Centre (CRDC). The centre, which is one of 21 being set up across the UK as part of a £100 million government investment, will enhance the speed and efficiency of commercial clinical research, providing more people in Sussex with access to cutting-edge treatments. Led by Professor Martin Llewelyn, the Clinical Director of Research and Innovation at UHSussex, the CRDC will not only help us grow our clinical research offer to patients but will help us develop research skills in the people who work in health and care and bring opportunities for job and economic growth across the region. The community facing profile of the CRDC will support our ambition to develop UHSussex as the region's hub for health and care research and allow us to support the growing emphasis on research to prevent disease and research conducted in community settings.

3.6 Voluntary Services

Assurance Self-Assessment 24/25	No Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 23/24	No Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is making good use of its volunteers			

At the end of the financial year of 2024/25, UHSussex had 634 registered volunteers who had contributed their time throughout the year to support and deliver various functions and activities across the Trust, with 11% of the total number being inactive or unable to volunteer.

This is a decrease from the previous financial year due to the cleansing of data and updating of application processes within the department, using Assemble the internal Volunteer Management System

Each registered volunteer for the Trust fulfils a role that impacts upon enhancing both patient and staff experience and the experience of visitors, relatives, and carers.

Service delivery; volunteer activities support or lead therapeutic interventions and access to services.

Operational support: carrying out tasks that enable efficiency and effectiveness within the delivery of services. And the involvement and improvement of services through lived experiences.

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

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

As part of the new 5-year strategic framework, we will be looking at introducing a micro-volunteering offer and a Trust-wide corporate volunteering offer.

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

With the appointment of the Head of Voluntary Services in January 2024, a new 5-year strategy and operational plan to ensure is now being implemented. Putting into action the Trusts' support of the NHS Long-term plan, enabling the delivery of the recommendations of the NHS Volunteering Taskforce as effectively as possible.

Excitingly, we are a part of a new project working in partnership with the charity Helpforce, NHS Sussex and the East Sussex Healthcare Trust on their "Back to Health Sussex" project. With the aim of improving discharge and patient flow services with the input of volunteering roles within the Trust and in improved relationships with our partners in the communities in which the Trust is based.

The importance of the role of volunteers within the NHS has never been more important than in the current financial climate. As financial and health pressures continue to grow and increase pressures on already existing demands. A clear, effective and impactful Voluntary Services strategy will enable the Trust to move forward to deliver the Communities element of the Trust's new strategy, which volunteers have helped to create. Ensuring that the very best care is always offered to those who receive it.

Annex 1: Assurance Report on Quality

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

Description of prescribed Information	Areas applicable to UHSussex Foundation Trust	National Average	UHSussex Performance	page number
(a) The value and banding of the hospital-level mortality indicator ('SHMI') for the trust for the reporting period; and	Inpatient Care – all sites	100.44	104.74	Page 27
(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	Inpatient Care – all sites	2.07%	2.47%	Page 28
The Trust's patient reported outcome measures (PROMs) Scores for: (i) Groin hernia surgery (ii) Varicose vein surgery (iii) Hip replacement surgery (iv) Knee replacement surgery Reported during the period	Elective orthopaedic surgery	(i) NA (ii) NA (iii) 0.447 (iv) 0.318	(i) NA (ii) NA (iii) 0.455 (iv) 0.322	Page 20

Description of prescribed Information	Areas applicable to UHSussex Foundation Trust	National Average	UHSussex Performance	page number
The percentage of patients aged (i) 0 to 17 and (ii) 18 or over Readmitted to a hospital which forms of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	Inpatient Care – all sites	10.30% 8.50%	10.45% 8.60%	Page 21
The Trust's responsiveness to the personal needs of its patients during the reporting period	Data not nationally available			
The percentage of staff employed by or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	Staff employed by, or under contract to the Trust	61.5%	54.8%	Page 43, 45-47
Friends and Family Test - Patient. The data made available by National Health Service Trust or NHS Foundation Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients	Adult inpatients	95.0%	92.5%	
Patients discharged from Accident and Emergency (types 1 and 2)	ED attendees	80%	83.7%	

Description of prescribed Information	Areas applicable to UHSussex Foundation Trust	National Average	UHSussex Performance	page number
The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	Inpatients across all sites	South East Region Average 27.7	32.7	Page 58
The number and where available rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death	Reporting across all sites	Not published	52.87	Page 52

Annex 2: Additional Data Sets

A2.1 Quality Account Priorities

Following the Quality Account Workshop the following items where raised as suggested quality account priorities, but are already considered within the 5-Year Strategy.

Care: Better, Faster, Fairer Care	
Faster Access:	Continue to reduce RTT
	Delivery of cancer 62 day target
	Deliver a Waiting Well programme (with suitable safety netting) to optomise patients for surgery and tackle health inequalities
	Reduce cancellations and numbers of lost to follow up
Better Urgent & Emergency Care:	Improve the timeliness of Emergency Surgery
	Improved discharge processes with all patients having an up to date EDD
Fairer Care for Sussex:	Continue PSIRF delivery to improve patient safety
	Effective implementation of the visiting policy Implementation
	Fundamental Standards of Care - Compliance with the 'so what' not just completing the audit e.g. reduction in falls/pressure
Care: Communities Improving Lives Together	
Supporting health & wellbeing:	Delivery of effective smoking cessation services
	Improved Health Inequalities data to increase insight
One UHSussex: Being better together	
One way of doing things where it makes sense for patients	Standardisation of processes and practice across pathways so staff can be agile across sites
	GIRFT embedding and delivering transformation
One Approach to Compliance & Oversight	Further embedding, standardisation and strengthening of divisional and site quality & safety functions
	Delivery of a programme of clinical assurance reviews

A2.2 Participation status for 2024-25 National Audit Programme

National clinical audits	2024/25 Participation status across eligible sites
National Major Trauma Registry (NMTR)	Full participation
National Lung Cancer Audit (NLCA)	Full participation
National Vascular Registry	Full participation
National Joint Registry (NJR)	Full participation
National Neonatal Audit Programme (NNAP)	Full participation
Sentinel Stroke National Audit Programme (SSNAP)	Full participation
National Paediatric Diabetes Audit (NPDA)	Full participation
UK Parkinsons Audit	Full participation
National Prostate Cancer Audit (NPCA)	Full participation
Society for Acute Medicine Benchmarking Audit (SAMBA)	Full participation
National Audit of Care at the End of Life (NACEL)	Full participation
National Maternity and Perinatal Audit (NMPA)	Full participation
National Audit of Cardiac Rehabilitation	Full participation
National Early Inflammatory Arthritis Audit (NEIAA)	Full participation
National Child Mortality Database (NCMD) Programme	Full participation
Paediatric Intensive Care Audit Network (PICANet)	Full participation
National Neurosurgical Audit Programme	Full participation
Perioperative Quality Improvement Programme (PQIP)	Full participation
UK Cystic Fibrosis Registry	Full participation
Patent Foramen Ovale Closure (PFOC) Registry	Full participation
National Pancreatic Cancer Audit (NPaCA)	Full participation
National Ovarian Cancer Audit (NOCA)	Full participation
National Non-Hodgkin Lymphoma Audit (NNHLA)	Full participation
National Kidney Cancer Audit (NKCA)	Full participation
British Hernia Society Registry	Full participation
BAUS Data & Audit Programme - Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Full participation
BAUS Data & Audit Programme - Penile Fracture Audit	Full participation
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Full participation
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Full participation
Myocardial Ischaemia National Audit Project (MINAP)(NCAP)	Full participation
National Heart Failure Audit (NCAP)	Full participation
National Bowel Cancer Audit (NBOCA) (GICAP)	Full participation
National Oesophago-Gastric Cancer Audit (NOGCA)(National Gastro-Intestinal Cancer Audit Programme (GICAP))	Full participation
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) (NCAP)	Full participation
National Hip Fracture Database (NHFD) - FFFAP	Full participation
Intensive Care National Audit & Research Centre (ICNARC) - Case Mix Programme	Full participation
National Audit of Cardiac Rhythm Management (CRM) - National Cardiac Audit	Full participation

Programme (NCAP)	
National Pregnancy in Diabetes Audit (NPID) - National Adult Diabetes Audit (NDA)	Full participation
COPD Secondary Care- National Respiratory Audit Programme (NRAP)	Full participation
Adult Asthma Secondary Care - National Respiratory Audit Programme (NRAP)	Full participation
UK Renal Registry National Acute Kidney Injury Audit	Full participation
UK Renal Registry Chronic Kidney Disease Audit	Full participation
National Adult Cardiac Surgery Audit - National Cardiac Audit Programme (NCAP)	Full participation
Transcatheter Mitral and Tricuspid Valve (TMTV) Registry - National Cardiac Audit Programme (NCAP)	Full participation
National Congenital Heart Disease Audit (NCHDA) - National Cardiac Audit Programme	Full participation
Audit of NICE Quality Standard QS138 - National Comparative Audit of Blood Transfusion	Full participation
Bedside Transfusion Audit - National Comparative Audit of Blood Transfusion	Full participation
National Cataract Audit - National Ophthalmology Database Audit (NOD)	Full participation
Transition (Adolescents and Young Adults) and Young Type 2 Audit - National Adult Diabetes Audit (NDA)	Full participation
National Gestational Diabetes Audit - National Adult Diabetes Audit (NDA)	Full participation
Left Atrial Appendage Occlusion (LAAO) Registry - National Cardiac Audit Programme (NCAP)	Full participation
Breast and Cosmetic Implant Registry - Outcome Registries Platform	Full participation
NDA Integrated Specialist Survey	Full participation
National Adult Diabetes Audit (NDA) core audit	Full participation
NCEPOD Blood Sodium	Full participation
NCEPOD Emergency Paediatric Surgery	Full participation
NCEPOD Acute Limb Ischaemia	Full participation
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	Partial participation
National Emergency Laparotomy Audit (NELA)	Partial participation
BAUS Data & Audit Programme - BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Partial participation
National Audit of Inpatient Falls (NAIF) (FFFAP)	Partial participation
National Diabetes Footcare Audit (NDFA) - National Adult Diabetes Audit (NDA)	Partial participation
Paediatric Asthma Secondary Care - National Asthma and COPD Audit Programme (NACAP) - (NRAP)	Partial participation
National Diabetes Inpatient Safety Audit (NDISA) - National Adult Diabetes Audit (NDA)	Partial participation
Time critical medications (RCEM)	Partial participation
Care of Older People (RCEM)	Partial participation
Adolescent mental health - Emergency Medicine QIPs RCEM	Partial participation
National Cardiac Arrest Audit (NCAA)	Not participating
Age-related Macular Degeneration Audit (AMD) - National Ophthalmology Database Audit (NOD)	Not participating

A2.3 Actions planned or undertaken as a result of participation in the National Audit Programme

Title	Action planned or taken
National Early Inflammatory Arthritis Audit (NEIAA)	To ensure local measures are taken to ensure compliance with the five key recommendations in the national report -To encourage local clinical team participation in the audit process -To increase consultant staffing -Increase use of nurse-led clinics to facilitate treatment escalation -Increase the number of dedicated clinics for patients with EIA at Worthing
National Hip Fracture Database (NHFD)	Review of the care pathway across all four sites. Improve time to analgesia by increase number of staff trained to give Fascia Iliaca Block (FIB) blocks
National Audit of Inpatient Falls	A medical lead for falls will be identified to support the Harm Free Nursing Team. Work to ensure the 4ATs screening tool is used across all A&Es Improve on the 30 min time of inpatient fall to analgesia for people suffering #NOF by increasing the number of staff trained in FIB blocks
National Ovarian Cancer Audit	Ensure on going Completeness and improve data quality Reduce waiting times by temporarily increasing activity efficiently Review survival outcomes on annual basis and reflect on any shortcomings with a view to improving on the same
NCEPOD End of life care	To normalise conversations about palliative care, advance care plans, death and dying advanced ACP training will be rolled out to senior clinicians alongside looking at increasing the provision of training to all staff. To put effective systems in place to share existing advance treatment plans between care providers part of the electronic patient record implementation work will ensure record digital ACP [ReSPECT] that can be communicated to other providers.

A2.4 Participation status for 2024-25 National confidential enquiries programme

National confidential enquiries	Report published	Eligible	Percentage submitted
Endometriosis	July 24	Yes	25%
End of Life Care	Nov 24	Yes	38%
Juvenile Idiopathic Arthritis	Feb 25	Yes	67%
Rehabilitation following critical illness	Awaiting report	Yes	95%
Emergency Paediatric Surgery		Yes	In progress
Blood Sodium		Yes	In progress
Acute Limb Ischaemia		Yes	In progress
Acute illness in people with a learning disability 24/25		Yes	In progress

A2.5 Actions planned or undertaken as a result of participation in the local Audit Programme

Speciality	Project Title	Actions to improve the quality of care
Endocrinology	Assessment of Treatment Escalation Plan (TEP) and DNACPR Documentation in Hospitalised Patients	Awareness raising of the importance of completing Treatment Escalation Plans and DNACPR forms via posters, induction, annual email reminder. During clerking add TEP form to booklet. Digital Workflow Enhancements - Add a yes/no checkbox on the Careflow Connect handover sheet (hospital software) to indicate whether a patient has a TEP. This serves as a reminder for both nurses and doctors Re-audit 2025
Ambulatory Care Area	Audit of Blood Transfusions and Iron Infusions delivered via Worthing Hospital ACA (Ambulatory Care Area	Adoption of a unified Anaemia management pathway which includes appropriate selection of patients who may need an iron infusion (using the Iron Infusion Guideline written in 2023) as well as crossmatching the required units of blood in advance should transfusion be required. To ensure adequate resourcing of the Medical Day Case Unit (Amberley) in cases that are semi-urgent as well as adequate resourcing of Same Day Emergency Care (SDEC aka ACA) in cases that are considered urgent.
T&O Surgery	Introduction of Day case Arthroplasty Pathway and Audit on the outcome- 1st	The results were very successful. Patient and staff counselling about the change to better inform them of the rationale for the change.

	Stage Audit	
Paediatric	Evaluation of antibiotics use for babies treated for suspected sepsis at PRH	Establish a dedicated pathway for the urgent transfer of neonatal blood culture samples from Princess Royal Hospital to the laboratory at Brighton. Ensure clear and timely documentation of the provisional 36-hour blood culture report in progress notes by SCBU medical team. Contact microbiology team to avoid overwriting blood culture results after five days of no growth; instead, include an addendum to maintain report accuracy. Consider change of the unit local antibiotics guidelines to be 36 hours as national NICE guidance. Aim to achieve 100% adherence to the national NICE antibiotic use guidelines. Conduct a re-audit within a defined timeframe to assess improvements.
Physiotherapy	Quality notes Audit Newhaven	Review and amend documentation to include: Medical summary – treatment to date and why patient remains an inpatient. Include handover element in function that includes level reached at acute hospital. Re-design problems / plan and goals section Complete documentation policy so staff are aware that changes to assessment forms need to be agreed via board. Produce SOP for Newhaven Rehabilitation Therapy Team to include: Assessment / Treatment and Documentation expectations. Share results with the team and discuss potential challenges. Band 8a Clinical Specialist post developed – re audit with 6 months of starting. Agree outcome measures to be used and audited with the unit.
Audiology	Audiology Cochlear Implant (CI) Referral Audit	To revisit eligibility criteria in next AR meeting and QPSE, especially focussing on 3K inclusion To continue using alternative approaches if time prevents discussion (eg CI letter) Consideration of CI prompt in Worthing notes templates to be discussed further To reaudit monthly to monitor for changes

A2.6 NICE Guidance Data

Compliance with NICE guidance received in last 12 months as of March 2025

1 *guidelines may be applicable to more than one division*

	Metric	Cancer	Corporate	CSS	Medicine	Specialist	Surgery	W&C
March 25	**% baseline assessment overdue** (published in last 12mths)	0%	0%	0%	10%	0%	0%	8%
	% assessed as fully compliant (excl. Withdrawn and not relevant)	86%	40%	43%	38%	38%	62%	50%
	% assessed as partially/non-compliant (excl. Withdrawn and not relevant)	14%	60%	57%	48%	48%	34%	50%
	Baseline assessment backlog (published >12mths ago) [1]	2	0	1	7	2	0	4

A2.7 PLACE High Level Improvement Plan

Activity	Action	Start	End	Owner	Status
Dementia Clocks	Ordered. In manufacturing, supply date in June	Oct 24	Aug 25	Facilities & Estates	In progress
Dementia toilet door signage	Completed SRH and WGH. Delivered to PRH and RSCH	Nov 24	Apr 25	Facilities & Estates	In progress
Mealtimes (Ward Food)	*Circulate to Nursing for their action plan to be devised.*			*Nursing*	*To be transferred*
Dementia design	*Circulate results of PLACE to Capital*	*Apr 25*	*Apr 25*	*Capital*	*To be transferred*
Dementia artwork	Facilities part of project team for rollout of images. SF to confirm owner	Jan 25	Ongoing	TBC	
Cleaning – high level (vents and entrances)	Ensure all high levels in the entrances are clear and free from debris. F&E to create plan for cleaning.	April 25	Oct 25	Facilities & Estates	In planning
CAM – Chairs	*Different styles for patient types required.*	*Apr 25*		*Nursing/ Procurement*	*To be transferred*
CAM – Flooring	Flooring list compiled, TBA with site directors	Apr 25	Mar 26	Estates/ Capital – minor works	In progress
Disability – Hearing Loops	*Review Hearing Loop availability across sites*	*TBC*		*IT? TBC*	*To be transferred*
Disability – Lift audible and visual announcements	Review availability across sites. SF to discuss with DG	Apr 25	May 25	Estates	
Disability – MUST audits	*Review required to understand why dropped in 23/24*	*TBC*		*Nursing*	*To be transferred*

A2.8 CQC Must Do Actions and Progress - Medicines and General Surgery

Action	No of Associated actions	Target completion date	RAG	Governing Committee
1. Not all staff completed mandatory Training (Trustwide)	1	30/09/2024	Complete	People Committee, SDR, SIP
2. Not all staff received training about how to support patients with learning disability, dementia and autism (Trustwide)	2	31/03/2025	Complete	People Committee
3. There were not always enough staff to keep patients safe (SRH & WTG)	6	31/06/2025	Complete	People Committee
4. Medicines were not used once opened and were not stored in line with manufacturers guidance. Patient group directives for treatment of neutropenic sepsis was out of date. (PRH surgery, WTG surgery, SRH surgery). Not all medicines were stored safely. Monitoring and oversight of controlled medicines at SRH did not follow national guidance. (PRH surgery, WTG surgery, SRH surgery)	9	30/11/2024	Complete	Medicines Management Group and Quality Governance Steering Group
5. The Trust must ensure all incidents and near misses are acted on. (Trustwide)	4	31/03/2025	Complete	Quality Committee
6. Staff did not always complete risk assessments (WTG medicine)	4	31/12/2025	Complete	Nursing and Midwifery Board and QGSG
7. Infection prevention and control monitoring and auditing was not effective at identifying risks. (WTG and SRH surgery)	7	31/12/2024	6 / 1	Trust Infection Prevention and Control Committee & Quality Governance Steering Group
8. The ventilation recommendations for general theatres at RSCH had not been implemented. (RSCH surgery)	5	31/08/2024	Complete	Estates & Facilities Committee and /or Health & Safety Committee
9. The Trust must ensure that equipment including heating systems are suitable for purpose and properly maintained (WTG medicine)	2	30/09/2024	Complete	Estates & Facilities Committee
10. The Trust must ensure that staff in theatres are supported to work within their clinical competency and that there are suitable arrangements for monitoring this. (RSCH surgery)	1	31/12/2024	Complete	People Committee
11. There was no system to ensure the nutrition and hydration needs of patients were met. (RSCH medicine)	3	31/11/2024	Complete	Fundamental Standards of Care Quality Governance Steering Group and Nursing and Midwifery Board

12. The Trust must ensure that it responds to all patient complaints as per their policy. (PRH surgery)	3	31/06/2024	Complete		Quality Committee
13. Audit and monitoring systems were not effective. (Trustwide)	4	31/03/2025	3	1	Quality Committee
14. National guidance documents were not reviewed in a timely manner. (Trustwide)	4	30/09/2024			Clinical Outcomes & Effectiveness Group
15. There was no out of hours discharge policy (Trustwide)	2	31/03/2025	1	1	Trust Management Committee & Finance & Performance
16. National waiting list targets were not met and there was a lack of strategic plan to improve this. (Surgery Trustwide)	5	30/03/2025	Complete		Finance & Performance Committee /SIP
17. Performance and workforce data could not demonstrate hospital site performance. (Trustwide)	1	30/08/2024	Complete		People Committee
18. Patient records and document systems did not support staff to easily access records. (Trustwide)	2	31/03/2025	Complete		Information Governance and Technology Group
19. The trust must ensure communication structures for staff are clear, easy to follow and that there are feedback mechanisms implemented for staff who raise individual concerns. (Trustwide)	5	N/A	Complete		People Committee
20. Staff did not always receive appropriate support, training, professional development, supervision and appraisal. (RSCH)	5	31/12/2024	Complete		People Committee
21. Identification and management of escalation areas had an adverse effect on surgical capacity and patient flow from recovery areas.(Surgery)	2	30/08/2024	Complete		Finance & Performance
22. Poor culture in theatres at RSCH hampered effective working.	6	30/9/2024	4	3	People Committee
23. The Trust must ensure the monitoring of anesthetic machine checks is recorded and aligns with best practice guidance. (WTG and SRH surgery)	4	30/09/2024	Complete		Quality Committee
24. The Trust must ensure that the systems used to monitor WHO checklist compliance, including brief and debrief, are effective in demonstrating compliance and able to show areas for improvement effectively in line with NPSA guidance	4	30/10/2024	Complete		Quality Committee
25. Paper records were accessible to unauthorised persons (WTG medicine)	3	30/09/2024	Complete		Information Governance and Technology Group

26. *X-Ref - To ensure communication structures for staff are clear and easy to follow:* Divisions need to use communication toolkits to ensure that Communication & feedback mechanisms are available to all staff	-	31/12/2024	Complete	Quality Governance Steering Group
27. Trust should have updated signature sample lists across all medical wards (WTG medicine)	1	30/09/2024	Complete	Quality Governance Steering Group
28. The management of hazardous waste, including sharps materials, did not meet national guidance and legislation.	2	30/09/2024	Complete	Health & Safety Committee

Of the remaining sub-actions these will be addressed through evidence for:

- A sepsis audit plan; awaiting approval of revised sepsis policy upon which to base the audit
- Data for out of hours discharges is collated and acted upon; challenged by the absence of a bed management system
- RSCH theatre culture and the link to wider UHSussex culture and OD plan; DDoN providing evidence with wider narrative from Chief of Culture and Organisational Development
- Clinical competency in theatres; Divisional Director of Nursing providing evidence
- Reducing the number of times patients are moved; challenged by the absence of a bed management system
- Infection Prevention and Control plan to roll out deep dives in development.

Annex 3: Statements from Stakeholders

Annex 3.1 Statement from Sussex Integrated Care Board

NHS Sussex

Maggie Davies
Chief Nursing Officer
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West Sussex

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9 June 2025

Dear Maggie

University Hospitals Sussex (UHSx) NHS Foundation Trust Quality Account 2024/2025

Thank you for giving NHS Sussex ICB the opportunity to comment on the Quality Account for 2024/25. We appreciate the on-going collaborative working and open communication with clinicians, notably at the Quality Review Meetings (QRMs) and meetings which commissioners are invited to attend.

We would like to acknowledge the ongoing positive work to further drive forward quality improvement most notably through the Single Improvement Plan, including a trust culture programme, implementing actions after a Royal College of Surgeons review and new governance and oversight of specialised services. Another substantive piece of work the Trust has begun working on has been the five year Urgent and Emergency Care (UEC) plan to ensure every patient receives care in an appropriate setting within the emergency departments.

During 2024/25, the Care Quality Commission (CQC) twice inspected the Trust, and these reports are awaiting publication. The ICB acknowledges the trust has completed over 90% of the 28 CQC recommended "*must and should do actions*" from the August 2023 inspection; including staff training, staff appraisals and the Fundamental Standards of Care workstream to maintain and ensure continuous improvement in the quality and safety of services provided, with activity planned for remaining actions.

The ICB recognise the Trust's self-assessment rating within the Quality Account identifying improvement in nine areas compared to last year. Progress against the ten 24/25 Quality Account priorities show oversight of where progress has been made for example, Patient First Quality Priorities and where opportunities for improvement remain e.g. timely review of clinical documentation and national audit recommendation reports which will be driven and monitored through established governance routes such as internal Clinical Effectiveness & Outcomes team, Patient Safety team, NHS England specialist services and via QRMs.

The Trust showed improvement within the national maternity survey 2024 for choice of where to have a baby, getting help when needed and pain management after birth. The Trust has highlighted developmental opportunities in the survey and continuation of the Smoke Free Pregnancy Service delivery in 2025/26.

The Trust's NHS Staff survey results for 2024 showed a mixed picture compared to 2023, and the Trust has identified improvements required to recognition and reward, declined staff engagement, morale, wellbeing, and inclusion, with a plan that will align to the new Trust Strategy in Spring 2025 to improve staff experience, and ensure that University Hospitals Sussex is a place where people feel proud to work.

Reducing waiting times and achieving national waiting time standards has been challenging, with a reported increase in contacts relating to waiting times to the Patient Advice and Liaison Service by 20% over the last two years. The Trust focus is to provide faster access though increasing appointments, procedures and operations, discharge procedure improvements and collaboration with community partners to ensure patient experience is improved. Work also continues in emergency departments where the length of wait remains a patient issue locally and via both the 2024/25 national patient survey and Care Quality Commission (CQC), urgent and emergency care survey.

NHS Sussex understands the importance of the priorities identified by the Trust going forward into the 2025-26 year which include:

- Improving recognition and management of deteriorating patients including Sepsis.
- Improve recognition and management of end of life patients
- Improved fractured neck of femur pathways and patient outcomes

NHS Sussex looks forward to the continued collaborative working with the Trust and partners over the coming year.

Yours sincerely

Allison Cannon

Chief Nursing Officer

On behalf of NHS Sussex

Annex 3.2 Statement from Trust Lead Governor

This very comprehensive report makes very impressive reading. The detail of the scope of this report is wide and encompassing due to the commitment of the Trust to ensure due diligence across the whole spectrum of areas requiring quality assurance.

The Trust has undertaken it's own internal review to assist with the accountability and responsibility that is necessary to produce such a report. The fact that the Trust has improved assurance self-assessment in nine areas with sound priorities for further improvement and a statement of assurances that are imbedded in the Trusts five-year strategy is testament to the Trusts willingness to accept advice and guidance from and the CQC to ensure patients receive quality care.

Annex 3.3 Statement from Healthwatch Brighton & Hove and Healthwatch West Sussex

Healthwatch welcomes the opportunity to review the Quality Accounts but cannot comment on the full content, much of which is outside of our remit. We are always keen that NHS bodies clearly communicate how they've captured patient experiences, what they've heard and how they've used this to support change and improvement in satisfaction and health outcomes. Healthwatch values the partnerships working that we have with University Hospitals Sussex NHS Trust and we attend their patient experience committees to share insight, asks questions and escalate concerns. We also monitor Trust activity through local and national performance indicators

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

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

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

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

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2024/25 and supporting guidance Detailed requirements for quality reports 2024/25
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2024 to March 2025
    - papers relating to quality reported to the board over the period April 2024 to March 2025
    - feedback from commissioners dated 9 June 2023
    - the trust's 2024-25 complaints report for the period April 2024 to March 2025 published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the national patient survey results published between April 2024 to March 2025
    - the 2024 national staff survey
    - CQC inspection reports published between April 2024 to March 2025
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board:

Philippa Slinger

Chair, University Hospitals Sussex NHS Foundation Trust

Date: 25 June 2025

Dr. George Findlay

Chief Executive Officer, University Hospitals Sussex NHS Foundation Trust

Date: 25 June 2025

Annex 5: Glossary of Terms and Acronyms

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

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

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

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

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

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

Healthrota Digital rostering platform for managing doctors roistering

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

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

IRIS The Trusts e-learning site

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

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

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

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

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

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

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