Board in Public – 05 June 2025

Questions received.

Question from Member of the Public				
	From	***Question***	***Assigned to:***	***Response:***
1	*Audrey Sharma*	*The Labour government's proposed NHS performance assessment framework suggests managers of the worst performing trusts get no pay rise.* *With continuous long waiting lists, critical reviews from the CQC & Royal College of Surgeons, a maternity care/A&E crisis & a growing police investigation, should this pay cut apply to the Board's senior managers?*	*Glen Palethorpe*	*Thank you for your question.* *For those who may not follow the news, Audrey is referring to revised guidance in relation to setting pay for Very Senior Managers (VSMs) in the NHS. This guidance issued in May does link future VSM pay increases to the NHS oversight framework, which gives each Trust a tier (or rather segment) rating based on overall performance. No award of any annual VSM payrise is expected to be made in those Trust's placed in segment 5 of the framework (where there is rating from 1 (the best) to 5 (the worst).* *I can confirm that the Trust's remuneration committee abides by all such guidance. The Trust's segmentation or tiering, as with all other Trust's in England, has not yet been announced within the revised framework - that is expected to happen in July.* *Audrey does point out that waiting times are too long and there are other areas where the Trust needs to improve. That said the Trust has managed to reduce RTT waiting times over the last year and in the last quarter, as has our UEC performance all were reported at our last Board. Our cancer performance has also improved which has seen the Trust move from the NHS England tier 2 oversight framework for that, and maternity, as you will hear in subsequent Board*

				meetings, is judged to have much improved. That is not to diminish that further work is needed but the Trust has made improvements in those important areas of performance. The judgements NHS England will make on which tier the Trust will be placed in will take these and other matters, such as our delivery of the 2025/26 operational and financial plan, into account. As I say, that decision on where the Trust is placed in the oversight framework will not be known until July, and no VSM pay decision will be possible until then. If a pay rise is applicable the increase recommended is 3.25%. *Having said all of that the pay of the Board members is also a matter of public record and reported in the Trust's annual report, along with confirmation of the application of national guidance.*
2	**Katie Fowler**	*At the last board meeting, we heard about welcome improvements in perinatal mortality rate at UHSussex's maternity units. The board praised Director of Midwifery Emma Chambers's hard work in achieving this. My questions are:*	*Tim Taylor, Chief of Service Women & Children.*	
		i. Is the board willing to acknowledge that a decreased perinatal mortality rate indicates that prior to this, babies were dying avoidably at the Trust?	*Emma Chambers, Director of Midwifery* *Dr Maggie Davies, Chief Nurse*	Perinatal mortality rates reduced nationally in 2023 (the latest data available) according to the recently published MBRRACE State of the Nation report: Perinatal-Mortality-Surveillance-state of the nation report Published May 25.pdf and have continued to reduce at UHSx to date. The Trust has met the NHSE national ambition set in 2017 by the Secretary of State for Health, to reduce the stillbirth rate by 50% by 2025. The aspiration was a rate 2.5/1000 births. The service has in fact significantly exceeded this ambition with the rate currently being 1.05/1000 births.

			Prof. Katie Urch, Chief Medical Officer	We believe this reduction is due to how the Trust has proactively engaged with, and embedded, various nationally led quality improvement initiatives, including the Saving Babies Lives care bundle (99% implemented – outstanding guideline update required – expected by month end), and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme – UHSx has had fully compliant submissions for the last two years The service has been working with the Maternity Safety Support Programme (MSSP) since 2022, on a wider suite of improvement workstreams including workforce, leadership and culture and governance. The progress of this improvement work monitored by regional and national safety leads, has meant that the service is on track to exit the programme in October 2025. All cases of baby loss are reviewed thoroughly and actions completed to address any learning identified. The service has reported all Perinatal Mortality Review Tool (PMRT) cases quarterly since Q1 2022. In addition, a specific report is shared annually to Trust Board regarding cases graded C (care issues that may not have contributed to the outcome) or D (care issues that were likely to have contributed to the outcome) under the PMRT process. Applicable cases are also scrutinised by the Coronial system.
		ii. *Is the board aware that since November 2023, there have been 3 Prevention of Future Deaths reports issued relating to maternity care at UHSussex, one inquest finding of neglect and one inquest finding of issues in care causative to the death?*		All findings from Coroner's hearings are reported to the Trust Board via the Perinatal Quality Surveillance (PQS) Framework monthly report. Senior Trust representatives attend all maternity inquests, and the Director of Patient Safety submits an inquest outcome report to Board quarterly.

				Since November 2023 four PFDs have been issued in relation to maternity cases. Two were issued to the Trust, neither case was found to have been causative. Two were issued to national organisations regarding national guidance, and not to the Trust. 1) 20/11/23 – PFD not issued however, issues in care were found to be causative to the baby's death. The coroner recognised improvement work underway, and therefore, did not issue a PFD. 2) 26/2/24 - PFD for UHSx regarding documentation – not causative. 3) 26/4/24 - PFD not for UHSx – NMC/ RCOG/DOH/ICB re Hyponatraemia guidance. Neglect conclusion. 4) 30/8/24 – PFD for UHSx regarding neonatal consultant cover at PRH, however, not causative in this case. 5) 18/3/25 – PFD not against UHSX – RCOG/NICE regarding antenatal CTG interpretation guidance.
		iii. Is the board aware that MBRRACE perinatal mortality data indicated a spike in deaths at UHSussex in 2022? Additionally, according to an FOI request, 10 of 22 neonatal deaths across the Trust in 2022 were classed as Serious Incidents. Was this raised as a concern by anyone at Senior Leadership or Board level? Was there any attempt by the Trust to identify possible causes for both the spike and the number of serious incidents, including any systemic issues? If not, why not?		The Board were made aware of an increase in perinatal mortality rates during 2022, although the Trust rate remained within 5% of the group average. This was reported via the Perinatal Quality Surveillance (PQS) Framework. In response, a thematic review of stillbirths was completed with external representation from the Maternity Safety Support Programme, alongside a neonatal death thematic review by the then Healthcare Safety Investigation Branch (HSIB, now MNSI). The LMNS also completed a system wide Serious Incident thematic review. These review findings were reported to Board via the PQS report in early 2023. Similar themes were identified from these reviews and were

				already improvement actions within the Maternity Improvement Plan. Summary of themes: o CTG interpretation and escalation o Sharing of records and documentation o Fetal growth surveillance o Telephone triage o Communication and handovers o Workforce gaps These themes form part of the Maternity Improvement Plan, and have been progressed over the last 3 years, to the extent that the MSSP team are moving the service to exiting the programme in October. The increase in neonatal deaths classified as Serious Incidents in 2022 was recognised and the Trust Board was informed via the PQS. An independent thematic review of these cases was completed by HSIB, and the findings were reported to the Trust Board in April 2023. Recommendations made by this report have been completed.
		iv. The CQC downgraded care at all four of the Trust's maternity units to inadequate or requires improvement in 2021. Who was ultimately responsible for the safety and quality of maternity care at the Trust prior to this and who is responsible now?		For clarity, one site is rated Inadequate (Brighton), and three sites are rated Requires Improvement – Brighton and Worthing were formally inspected by the CQC in February 2025, verbal feedback was positive, the inspection reports are awaited. Collectively the Trust Board are accountable for maternity care within the Trust.