

Meeting of the Board of Directors

10:00 to 13:30 on Thursday 13 November 2025

Washington Suite Boardroom, 2nd Floor, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH**AGENDA – MEETING IN PUBLIC**

Item:1	Time: 10:00	Welcome and Apologies for Absence <i>Apologies: None at present</i>	<i>To note</i>	Verbal	Presenter: Philippa Slinger
		Confirmation of Quoracy <i>A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present this being eight Board members. With a minimum of two Executives and two Non-Executive Directors.</i>	<i>To agree</i>	Verbal	Presenter: Philippa Slinger
Item:2	10:00	Declarations of Interests	<i>To determine if any action is required</i>	Verbal	Presenter: All
Item:3	10:00	Minutes of UHSussex Board Meeting held on 04 September 2025	<i>To approve</i>	Enclosure	Presenter: Philippa Slinger
Item:4	10:05	Matters Arising from the Minutes	<i>To note</i>	Enclosure	Presenter: Philippa Slinger
Item:5	10:10	Questions from the public To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	<i>To respond</i>	Verbal	Presenter: Philippa Slinger
Item:6	10:30	Report from Chief Executive	<i>To receive and note overview of the Trust's activities</i>	Enclosure	Presenter: Dr. Andy Heeps
<u>STRATEGY and CULTURE</u>					
Item:7	10:40	UHSussex Strategy update	<i>To discuss and note</i>	Enclosure	Presenter: Rox Smith
Item:8	11:00	Patient Experience - Patient Feedback and Insights	<i>To discuss</i>	Enclosure	Presenter: Nicole Chavaudra
Item:9	11:20	One UHSussex update	<i>To receive and note actions taken</i>	Enclosure	Presenter: Dr. Andy Heeps
	11:35	5 Minute Break			

Performance and Risk

Item:10	11:40	Integrated Performance Report	<i>To receive and note</i>	Enclosure	Presenter: Dr. Andy Heeps
	11:50	<i>At the conclusion of the report the Chair will invite Board members to ask questions and discuss any pertinent areas of the Integrated Performance Report and agree any necessary actions.</i>			
Item:11	12:15	Maternity Update	<i>To note</i>	Enclosure	Presenter: Emma Chambers
Item:12	12:30	Board Assurance Framework report	<i>To approve</i>	Enclosure	Presenter: Glen Palethorpe

ASSURANCE REPORTS FROM COMMITTEES (taken for information and assurance with escalation only being discussed)

Escalated Items Only:

Item:13	12:40	Report from the Research Innovation & Digital Assurance Committee from the meeting held on the 5 November 2025 To note assurance and action recommendations from the Committee	<i>To note assurance from Committee and action recommendations from the Committee</i>	Enclosure	Presenter: Jackie Cassell
Item:14	12:45	Report from Patient & Quality Assurance Committee - from the meetings held on the 30 September and 4 November To note assurance and action recommendations from the Committee (approval of IP&C annual report)	<i>To note assurance from Committee and action recommendations from the Committee</i>	Enclosure	Presenter: Lucy Bloem
Item:15	12:55	Report from People & Culture Assurance Committee - from the meetings held on the 4 November To note assurance and action recommendations from the Committee	<i>To note assurance from Committee and action recommendations from the Committee</i>	Enclosure	Presenter: Prof. Paul Layzell
Item:16	13:00	Report from Finance & Performance Assurance Committee - from the meetings held on the 25 September and 6 November 2025 To note assurance and action recommendations from the Committee	<i>To note assurance from Committee and action recommendations from the Committee</i>	Enclosure	Presenter: Philip Hogan

Item:17	13:10	Report from Strategy & Major Projects Assurance Committee - from the meetings held on the 6 November 2025 To note assurance and action recommendations from the Committee	<i>To note assurance from Committee and action recommendations from the Committee</i>	Enclosure	Presenter: Prof. Paul Layzell
Item:18	13:15	Report from Audit Committee - from the meeting held on the 14 October To note assurance and action recommendations from the Committee	<i>To note assurance from Committee and action recommendations from the Committee</i>	Enclosure	Presenter: Mike Driver
<u>WELL LED & COMPLIANCE</u>					
Item:19	13:20	Company Secretary Report For information only	<i>For information only</i>	Enclosure	Presenter: Glen Palethorpe
<u>OTHER</u>					
Item:20	13:25	Any Other Business To receive any notified urgent business and action	<i>To receive any notified urgent business and action</i>	Verbal	Presenter: Philippa Slinger
Item:21	13:30	Date and time of next meeting: The next meeting in public of the Board of Directors is scheduled to take place at 10.00 on Thursday 04 December 2025. To resolve to move to into private session <i>The Board now needs to move to a private session due to the confidential nature of the business to be transacted</i>		Verbal	Presenter: Philippa Slinger

Supporting Appendices:

Item 11	Maternity	Perinatal Quality Oversight Model Report & Dashboards ATAIN & Transitional Care Q4 Saving Babies Lives Q4 and Q1 Perinatal Workforce Report October 2025 Maternity Services Assurance Vision & Roadmap	<i>To receive and note</i>
Item 14	Patient & Quality Assurance Committee	Infection Prevention & Control Annual Report 2024/25 Mortality and Learning from Deaths Q2	<i>To receive and note</i>

Minutes



Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 04 September 2025, held in the Washington Suite Boardroom, Worthing Hospital, Lyndhurst Road, Worthing and via Microsoft Teams Live Broadcast.

Present:

Philippa Slinger	Chair
Professor Paul Layzell CBE	Non-Executive Director
Lucy Bloem	Non-Executive Director
Professor Jackie Cassell	Non-Executive Director
Professor Gordon Ferns	Non-Executive Director (until Item 11)
Philip Hogan	Non-Executive Director
Bindesh Shah	Non-Executive Director (until Item 11)
Mike Driver CB	Non-Executive Director
Kate Steadman	Non-Executive Director
Dr Andy Heeps	Interim Chief Executive
Dr Maggie Davies	Chief Nurse
David Grantham	Chief People Officer
Nigel Kee	Chief Operating Officer
Jonathan Reid	Chief Financial Officer
Roxanne Smith	Chief Strategy Officer
Professor Catherine (Katie) Urch	Chief Medical Officer

In Attendance:

Emma Chambers	Director of Midwifery
Glen Palethorpe	Company Secretary
Tamsin James	Board and Committees Manager (Minutes)
Catherine Bridger	Board and Committees Manager (Production)

TB/09/25/1	WELCOME AND APOLOGIES FOR ABSENCE	ACTION
1.1	The Chair welcomed all those present to the meeting, noting there were no apologies for absence, and extended a warm welcome to both Mike Driver and Kate Steadman, who had joined the Trust as Non-Executive Directors, to their first Board of Directors meetings in Public.	
1.2	The Chair also acknowledged Dr Andy Heeps attending in his new role of Interim Chief Executive, and extended sincere thanks to Dr George Findlay who had stepped down from his role as the Trust’s Chief Executive, recognising Dr Findlay’s contributions and achievements during his tenure with the Trust.	
1.3	The Chair advised the meeting that Bindesh Shah and Professor Gordon Ferns would need to step away later in the meeting.	
TB/09/25/2	DECLARATIONS OF INTERESTS	
2.1	There were no interests declared.	
TB/09/25/3	MINUTES OF THE MEETING HELD ON 05 JUNE 2025	
3.1	The Board received the minutes of the meeting held on 05 June 2025.	

- 3.2 The minutes of the meeting held on 05 June 2025 were **APPROVED** as a correct record.

TB/09/25/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

- 4.1 There were no formal matters arising.

TB/09/25/5 QUESTIONS FROM THE PUBLIC

- 5.1 There were no questions received from the Public for answering at the Board today. The Chair stated that questions were always encouraged as it provided the Board with valuable opportunities to be engage with the public.

TB/09/25/6 PATIENT STORY

- 6.1 Maggie Davies introduced the Patient Story to the Board and explained the rationale for hearing such stories at the Board was to ensure Board members discussions were grounded in the reality of patient care, and to ensure patients remained at the forefront of Board member's minds as they reached decisions.
- 6.2 Maggie explained that the patient story was derived from their waiting for care and communication challenges with the Trust, explaining that a patient, referred in 2022, had an appointment scheduled for May 2024. Due to a miscommunication, a telephone appointment was mistakenly arranged as a face-to-face consultation, which the patient did not attend and was subsequently marked as a Did Not Attend. Following this, the patient made nine attempts to secure a replacement appointment, including contact with the Booking Hub, but was unsuccessful. The delay significantly affected the patient's mental health, with the case remaining unresolved until May 2025. In response to such issues, the Trust introduced an automated virtual assistant system – NetCall - in November last year, which had supported the reduction in average call waiting times from 25 minutes to 4 minutes and improved call response rates from 40% to 90%. These developments aligned with the Trust's forthcoming strategy, shaped by stakeholder engagement and patient feedback, aimed at improving access to treatment and overall patient experience.
- 6.3 The Board heard from Lucy Bloem who shared that patient experience was a key discussion point at the Patient & Quality Assurance Committee meetings and at the recent Governors' meeting, highlighting the significant impact of effective communication can have on a person's experience. Lucy referenced a successful example from cancer services, where a proactive communication campaign greatly improved patient experience of the Service. She stated that this had raised important questions about the Trust's current approach: what are we doing to improve accessible communication, particularly in light of the expansion of services such as the Worthing Urgent Treatment Centre (UTC) and Same Day Emergency Care (SDEC).
- 6.4 Nigel Kee acknowledged that some patients were waiting longer than we would like, and whilst the situation had improved compared to previous years, there remained work to do to reduce waiting times and support patients during their wait, he offered assurance to the public regarding the enhanced communications systems in place to improve engagement, and went on to share the processes underway for reviewing of patient pathways for those waiting longer than expected.
- 6.5 Maggie Davies highlighted that patients were signposted to the "Waiting Well" online resource as part of a broader initiative, which is aligned with the Trust's strategy. In respect of mobile communications, the Board heard that the Trust

is exploring improvements to mobile communication as a more effective and accessible communication model to improve routine texts.

- 6.6 Professor Gordon Ferns raised a question regarding patients attending clinical appointments and the impact of late cancellations on those patients who required more urgent appointments. Nigel Kee shared that several measures had been taken, and that most specialties now maintained a list of patients who could attend a consultation at short notice, allowing slots to be allocated quicker and reduce wasted clinic time.
- 6.7 The Chair went on to share her experience during a recent visit to the booking team at Princess Royal Hospital, whereby concerns were raised about the new patient transport system requiring a two-week notice period, which was not feasible for more vulnerable patients who required quicker access. Nigel Kee stated the new patient transport provider took over in April, and the contract was held by the ICB, and whilst improvements were being experienced, it was helpful to receive the regular feedback on experiences to enable the Trust to engage in post-contract monitoring with the ICB.
- 6.8 Maggie explained that the PALS team operates across the Trust's four larger sites and handles a high volume of telephone enquiries, providing essential support and guidance to families. Despite being a small team, their role in signposting and navigating services remained critical supporting families through complex and often emotional situations. It was shared that there was significant work ahead to streamline processes and enhance the support offered, through refining a model to help ensure consistency and improve outcomes.
- 6.9 The Board reflected on patient experience and were encouraged by the developments to improve defined patient pathways within the Trust. The Board asked that the work being undertaken in quantifying the impact on complaints in relation to waiting times since the introduction of NetCall be provided to the Patient & Quality Assurance Committee for oversight and tracking of trends.
ACTION for the Director of Patient Experience & Engagement via the Patient & Quality Assurance Committee **ACTION**
- 6.10 The Board **NOTED** the update.

TB/09/25/7 CHIEF EXECUTIVES REPORT

- 7.1 Dr Andy Heeps introduced the report and drew out the following pertinent areas.
- 7.2 Andy reflected on the developmental Well-Led review conducted by Niche Health and Social Care Consulting having been a significant and challenging milestone for UHSussex. While the report acknowledged areas of progress, it also delivered clear and, at times, difficult feedback regarding governance, culture, and leadership, highlighting the need for greater consistency, transparency, and inclusivity.
- 7.3 Andy outlined that the elective patient waiting lists had reduced by 30% over the past 18 months, however efforts were being intensified for the longest-waiting patients, particularly over the next six months. It was highlighted that several specialties were showing improvements as outlined within the Integrated Performance Report; which also reported the National Oversight Framework arrangements for elective care, which had placed UHSussex in Tier 1 for elective care and Tier 2 for cancer, reflecting progress but also the need to accelerate recovery.

- 7.4 Andy reflected on August 2025 being a busy month to date, with variable ambulance handover performance particularly at the Royal Sussex County Hospital site in Brighton. Following the CQC visit to the RSCH Emergency Department in March 2025 continuous flow measures were being monitored to improve corridor care to ensure we consistently delivered the highest standards of care.
- 7.5 Andy acknowledged the National Maternity and Neonatal Review following the launch of a National independent investigation into maternity and neonatal care, to be led by Baroness Amos, whereby up to ten trusts would be examined in depth, with a focus on culture, behaviours and outcomes. The Secretary of State had referred publicly to families in Sussex who have experienced tragedy. While no trusts had been formally named, for inclusion in this investigation, Andy explained that the Trust recognised the importance of this process and, if included, we would work openly and fully with the review team and act swiftly on their findings.
- 7.6 In respect of future Integrated Care Board (ICB) arrangements Andy announced that Stephen Lightfoot had stepped down from his role as Chair of NHS Sussex, and that Ian Smith had been appointed as Chair across the Surrey and Sussex ICB as part of changes taking place across the NHS. Andy also added that the recruitment for the Trust's new Chief Executive was expected to begin in the coming weeks.
- 7.7 Andy shared that the CQC published its assessment of children's and young people's services at Worthing Hospital, based on an inspection in June 2024. The services were rated Good overall, following Inspectors highlighting the positive safety culture and the kindness of our staff, while also noting the need to strengthen staffing levels and reduce waiting times.
- 7.8 Professor Gordon Ferns questioned the nature of the ambulance handover delays. Nigel Kee explained that all four Emergency Departments were showing measurable improvements, however the RSCH site remained busy, with ongoing initiatives in progress, and there remained continued collaboration with the ambulance service.
- 7.9 Professor Gordon Ferns also questioned that with the establishment of the new ICB, was there an expectation of the introduction of competitive commissioning at the regional level, and whether this was seen as an opportunity or a risk? Andy stated that Commissioning for next year would remain within the Sussex footprint, and the Sussex model was shifting towards strategic commissioning, focusing on outcomes rather than competition. While the full structure of the ICB was still evolving, the current expectation was for providers to collaborate rather than compete. The Chair added that collaborative meetings had been undertaken with the voluntary sector, hospices, and local authorities' representatives, working toward a more nuanced approach to contracting and supporting a more flexible and progressive commissioning model.
- 7.10 A discussion was undertaken regarding the Fire Safety compliance update outlined within the Chief Executive report, with questions raised regarding Statutory and Mandatory Training compliance across the core disciplines. It was noted that the Trust was acting promptly to address the issues, and Andy assured the public that there was no immediate risk to patients or staff. Progress would be monitored through the Trust's health and safety committee and reported back to the Board to provide assurance that risks were being managed.

ACTION for the Director of Facilities & Estates: A further conversation was then undertaken regarding the Trust's fire safety officers, and it was asked for the People & Culture Committee to receive detail in relation to ***ACTION***

the Trust's Fire Safety Officer training and compliance requirements and improvements.

- 7.11 Further discussion was undertaken by the Board regarding ED performance which had led to corridor care challenges, it was acknowledged that during August 2025 attendances were high and flow within the hospital had been hampered due to a number of factors including industrial action, as a result there was currently a review of several hypotheses as to the underlying drivers of this performance reduction, including annual leave patterns and workforce levels over the summer. The team was now refocusing efforts in September, recognising this was a key priority, and continued oversight remained essential. A conversation was held regarding Winter care arrangements and the mitigations in place to better respond to surges in demand and ensure robust and effective escalation processes. Nigel Kee expressed that work was ongoing with system partners to define collective asks for the winter period. A key operational requirement is achieving a minimum of 10–12 discharges per day from Worthing to maintain flow.
- 7.12 The Chair emphasised that the Board must adopt a zero-tolerance approach to corridor care under any circumstances. While acknowledging the operational challenges, the Chair was clear that such conditions do not represent acceptable standards of care for patients in any of our hospitals, and that the Board must remain resolute in upholding this commitment.
- 7.13 The Board **NOTED** the Chief Executive report.

TB/09/25/8 EXCELLENT CARE EVERYWHERE – ONE UHSUSSEX – RESPONSE TO THE DEVELOPMENTAL WELL-LED REVIEW

- 8.1 Dr Andy Heeps provided the Board with an update on the report presented today in relation to the publication of the Niche Health & Social Care publishing the UHSussex developmental Well-Led Review, which acknowledged progress since the 2022 CQC inspection, particularly in Cancer, Maternity, and Elective recovery, and improvements in partnership working and executive team stability were noted. However, the review also highlighted significant ongoing challenges in leadership, culture, and governance including a tolerance of poor colleague behaviour. Andy stated that the Trust fully accepted the findings of the Niche report, and shared his apologies in response. Moving forward, it was shared that UHSussex must establish a new organisational culture, underpinned by the launch of the 2030 Strategy.
- 8.2 Andy explained that creating a new culture started with clearly defined behaviours, underpinned by our values framework led by the Senior Leadership Team, which would itself be embedded through refreshed appraisal processes. The leadership development approach would be consistent and aligned to these behaviours, using a shared language to drive improvement. Tools such as 360-degree feedback, and by simplifying HR policies and systems would contribute to delivering meaningful impact for both patients and workforce.
- 8.3 Andy further explained that both he and the Chair had met with the NHS England Regional Director whereby an agreement was arrived at on the definition of progress through revised metrics and a refresh of the Integrated Performance Report which needed to be presented in a more cohesive format.
- 8.4 In the context of staff facing challenging behavior from staff: the Board further discussed conflict management skills which had always been a key part of staff training, hearing that whilst it was important to distinguish between behaviour arising from mental health conditions and unacceptable conduct from

individuals with full capacity, the Trust remained resolute that abuse or mistreatment of staff was not tolerated under any circumstances. As such, the Board went on to commend the Trust's security teams for their steadfast support in managing challenging situations with professionalism and resilience.

- 8.5 The Board discussed their appreciation of a clear and concise presentation of the well led report whilst encouraging a refresh of the IPR which was to continue to be presented at each quarterly Board meeting in Public. It was heard that in respect of the refresh there would be a focus on priorities with performance against these being reported in greater depth, that included culture metrics aligned to the Trust Operating Model. Rox Smith advised that as we shaped the strategy and roadmap, there would be an exploration on how the Board could engage and reflect on how to respond to data, not just the numbers, but the conversations they prompted to promote clearer deliverables, and deeper cultural dialogue that supports the Trust's diverse workforce. The Chair expressed that the next Board workshop would focus more deeply on EDI issues, aiming to bring them to the forefront. While this isn't something that can be resolved immediately, over the coming months we should consider how to integrate EDI into everyday language and practice.

- 8.6 The Board **NOTED** the update.

TB/09/25/9 INTEGRATED PERFORMANCE REPORT

- 9.1 The Chair introduced the performance report for University Hospitals Sussex and informed the Board that this report shows the Trust's performance to June 2025 and sets out the progress being made to deliver the Trust's Patient First Strategy, the NHS National Oversight Framework and the wider NHS Operating Plan. Dr Andy Heeps reminded the Board that the structure of this report remained in the format of the prior strategic domains and then invited Executive colleagues to provide a brief update on their sections of the Integrated Performance Report.

PATIENT

- 9.2 Maggie Davies explained that during Quarter 1 more than 40,000 patients provided feedback on the care they received within the Trust. 90.5% of those patients were satisfied that they had a good or very good experience above our target of 90% with notable progress in Maternity, Inpatient, and Emergency department areas. The fundamental standards of care programme continued to drive ward-level improvements. However, this was in contrast to the number of complaints received which was higher than the number received in Q4, these mainly relating to appointments, poor communications and difficulties in contacting clinical specialties.
- 9.3 The Board discussed the increase in complaints, despite improvements being recorded within FFT satisfaction and other metrics, noting that ongoing challenges, particularly around patients waiting, had contributed to additional complaints, and that sustained work within the PALs team identifying hotspots and ensuring early engagement with families remained key, and continued collaboration with divisional colleagues was essential to strengthen improvement..
- 9.4 Concerns were raised regarding the length of time complanants are waiting as outlined earlier in the meeting. The Board heard from Maggie that the challenges were multifactorial, there are mprovement plans in place, adding that there was progress to be noted in addressing the longest-standing complaints

PEOPLE

- 9.5 David Grantham drew out the engagement, appraisal, vacancies and turnover headlines and reported that Q1 had predominantly been steady across these People metrics. An increase in sickness absence was noted and prompted the Board to discuss the implementation of a range of interventions and strengthening of support within the sickness absence management team to address this.
- 9.6 The Board held a discussion on the challenged workforce efficiency targets and their impact on delivery and performance metrics. , Mitigation was given as controls over resourcing and resource deployment to ensure consistency and reinforce the support for appropriate resource deployment.
- 9.7 The Board discussed the levels of progress within the metrics and how the challenges were to be addressed through enhanced engagement activities and communications within the new Strategy. Using the National Exemplar programme as an example it was highlighted that the UHSussex People programme was built around the seven People Promises and supported by benchmarked metrics aligned with best practice, but more work was required to ensure consistent delivery.

SUSTAINABILITY

- 9.8 Jonathan Reid provided an update reflecting on the Trust's current position being ahead of plan, the Month-3 report first highlighted this improvement, which remained consistent through Month-4 and was expected to continue into Month-5. The break-even target remained challenging and Jonathan explained that the position is, in part, supported by non-recurrent matters and is unsustainable without addressing key drivers; particularly workforce pressures and divisional expenditure. All planning assumptions are being reviewed with further testing of the "grip and control" measures in place.
- 9.9 The Board discussed the workforce, bank and agency expenditure levels and how these factors were being mitigated, with one approach being monitored through the better use of rostering tools, allowing improved forward planning. It was noted that Andy had commissioned some work to better understand the barriers to delivery and had requested deeper analysis of both leadership and workforce deployment to determine next steps which would be factored into a key discussion at Finance & Performance at the end of September.

QUALITY

- 9.10 Maggie Davies highlighted a sustained trend in incident reporting with 3,356 incidents primarily classified as low harm or no harm. Risk reporting improvements were being highlighted at QSGS due to continued input via the Datix IQ platform. Women & Children's services were maintaining a high reporting rate of 78.8 incidents per 1,000 bed days, compared to 56 per 1,000 bed days at Princess Royal Hospital. Staff engagement was supported through shared training and development, particularly around patient safety. Duty of Candour compliance remained strong in the quarter.
- 9.11 Bindesh Shah asked for clarification whether unfilled shifts were covered by bank or temporary staff. Maggie Davies expressed that whilst fill rates had improved, they remained below target. The fill rate section indicated who is on duty during each period, and that improvements had been seen due to strengthened vacancy control, better retention, and close monitoring. However the Board did reflect on the financial impact across the Trust which needed to have clearer rationale. Band 3 development is progressing well, though a gap

remains. We do not use agency HCAs, but enhanced care workers are in place to support mental health needs. The Band 2 to Band 3 progression programme, historically challenging, is now gaining traction despite national recruitment difficulties.

- 9.12 Further discussions were held regarding the reliability of SHMI data due to coding inconsistencies and whether it provided limited assurance as a mortality measure. Katie Urch stated that both SHMI and HSMR were interrelated and should not be considered in isolation, however the triangulation of data was already in place and clearer insights into Mortality would be reflected within the improved IPR

SYSTEMS & PARTNERSHIPS

- 9.13 Nigel Kee provided a brief update on the performance metrics within Cancer, Diagnostics, RTT, and A&E performance for Quarter 1, outlining a steady rate of improvement. A discussion was held regarding those patients within the 65 week wait and 78 week wait cohorts. The Board noted the clinical oversight improvements underway to support and treat those patients with complex pathways which would be discussed further in the next Finance & Performance Assurance Committee later in the month.

RESEARCH & INNOVATION

- 9.14 Katie Urch shared that the Trust is actively pursuing its strategic goal to increase participation in research studies, aiming to reach the top 20% nationally. There has been a noticeable rise in recruitment of trained staff, with an improved number of training initiatives and proactive study openings across all divisions. Katie added that Research leads are working collaboratively across the Trust to maximise opportunities, including leveraging charity funding and expanding commercial research output.

TB/09/25/10 MATERNITY ASSURANCE REPORT

- 10.1 Emma Chambers drew attention to the reports included within the meeting papers and provided an update to the Board on the Maternity review announced by the SoS, drawing out that the while no Trusts had been formally named, the Trust recognised the importance of this process and, if included, would work openly and fully with the review team and act swiftly on their findings.
- 10.2 Emma advised on the recent Insight Visits to each site, led by the regional chief midwife, who had provided generally positive feedback, with a small number of issues raised which were already known to the service and being actioned, these were mainly regarding estate and workforce allocation.
- 10.3 In Q1 the Trust received an outlier alert from NMPA (National Maternity and Perinatal Audit) regarding 3rd and 4th degree tear rates relating to activity in 2023. This had already been recognised and a programme of quality improvement work during 2024 had reduced those rates, and further targeted interventions more recently have reversed a temporary rate increase at PRH. Following a question regarding the tear rates from Jackie Cassell, Emma assured the Board that tear rates were currently within normal range on all sites and continued to be closely monitored.
- 10.4 Emma highlighted the 2 full-day weekday lists plus ad hoc weekend lists running at in LMB at RSCH for planned caesareans, as an interim solution. There were also 2 team members nominated by families and shortlisted for a

Trust Star Awards. The Worthing team who provided bereavement care to a family won the Worthing Hospital Hero award

- 10.5 The perinatal mortality rate continued to be stable and significantly below the latest available national rate. The neonatal death had previously showed a transitory rise which prompted a thematic review of cases. However, no themes were identified, and rates had returned to below the mean in July 2025.
- 10.6 The Chair prompted Emma to provide insight into improvements across the service, and Emma stated that the Trust's commitment was to continuously improve and minimise harm, and whilst this may never eliminate harm entirely, everything possible would be done to reduce it. The Trust remained committed to fostering a restorative culture by working closely with teams and reaching out sensitively to families who had experienced tragic or difficult events offering the right support throughout the investigation process. Further assurance was provided in respect of workforce support available to those workforce members impacted by such tragic outcomes.
- 10.7 The Chair questioned the improvements in place to maintain and strengthen public confidence in the Trust's maternity service. Emma explained that the Trust had provided performance information transparently to aid this, including publishing information on the Trust's website so that local service users could easily access it, and many families were providing feedback on their positive experiences. Andy Heeps asked if the Trust was seeing a drop in maternity booking, Emma responded that the numbers remained stable and while there would always be more to do, to continue to provide confidence in our services, this provided some reassurance that the Trust was delivering safe and compassionate care. Lucy Bloem as Chair of the Patient & Quality Assurance Committee concurred with Emma's update.
- 10.8 The Board added that if any family or service user would wish to feedback on their experience, they were welcomed to contact Maggie Davies, as Chief Nurse or Emma Chambers, as Director of Maternity directly.
- 10.9 The Board **NOTED**:
 - The Maternity Assurance report
 - The Perinatal Quality Surveillance report
 - The ATAIN and Transitional Care Q3 reports
 - The Perinatal Mortality Review Tool Q4

The Board held a short break at this point. Upon their return both Bindesh Shah and Professor Gordon Ferns had left the meeting, however it remained quorate in their absence.

TB/09/25/11 BOARD ASSURANCE FRAMEWORK

- 11.1 Glen Palethorpe presented the Board Assurance Framework report for quarter two and explained that the Board at its meeting in June agreed the opening 11 Strategic Risks that made up the BAF noting its alignment to the Trust's new strategic ambitions. The BAF also retained a nominated executive lead for each risk albeit the BAF is considered by the Executives within the Risk Oversight Group once a quarter, and oversight would continue to be maintained through the dedicated board committees and recommendations were made within the Chairs' reports regarding Q2 scores.
- 11.2 Glen summarised the paper and the key discussions held at the various Committee, specifically in relation to risk 2. The People and Culture Assurance Committee requested the Board consider if the opening score of 16 was indeed too low and if risk 7 conversely was scored too highly when compared to the

other Strategic risks. Glen reminded the Board that strategic risk 1 was agreed by the Board and confirmed by the Patient and Quality Assurance Committee that it was unlikely to change all year and that in respect to a question earlier in the meeting around staffing, this linked to strategic risk 3, which remained at a score of 12, which had been considered by the People and Culture Committee and had noted that this was being proactively managed.

11.3 The Board held a discussion around culture and strategic risk 2, questioning whether the initial scoring was too low and whether it should consistently be higher compared to the other ten strategic risks. The Board then discussed the relevant scoring of risk 7 which did not appear to be reducing at this stage. In reviewing other risks, two key questions arise: how the Board reflects back to the Committee on risk clarity, and whether the risk descriptions were sufficiently understood.

11.4 The Board **AGREED**:

- that strategic risk 2 should have been scored at 20 and thus for quarter 2 should remain at that level
- the other Quarter 2 scores for the 10 Strategic risks, asking that for strategic risk 7 the Research and Innovation Assurance Committee reconsider this score at quarter 3 having regard for its balance with the other strategic risks scoring 20.

TB/09/25/12 REPORT FROM THE RESEARCH, INNOVATION & DIGITAL STRATEGY ASSURANCE COMMITTEE

12.1 Jackie Cassell, Chair of the Research Innovation & Digital Assurance Committee updated the Board on their recent meeting and the assurances received in relation to Research, Innovation and Digital.

12.2 The Board **NOTED** the Research Innovation & Digital Assurance Committee Chairs report.

TB/09/25/13 REPORT FROM PATIENT & QUALITY ASSURANCE COMMITTEE

13.1 Lucy Bloem, Chair of the Patient & Quality Assurance Committee updated the Board on their recent meeting and the assurances received in relation to Patient & Quality. Lucy drew attention to the Annual Reports requiring approval today, informing the Board these had all been scrutinised by the Committee.

13.2 The Board **APPROVED** the following annual reports:

- Mortality & Learning from Deaths Report 2024-25
- End of Life Care Report 2024-25
- Patient Safety & Duty of Candour Report 2024-25
- Patient Experience Report 2024-25
- Safeguarding Children & Adults Report 2024-25

13.3 The Board **NOTED** the Patient & Quality Assurance Committee Chairs report.

TB/09/25/14 REPORT FROM PEOPLE & CULTURE ASSURANCE COMMITTEE

14.1 Paul Layzell, Chair of the People & Culture Assurance Committee updated the Board on their recent meeting and the assurances received in relation to People & Culture. Paul drew the Board's attention to the annual reports requiring approval today informing the Board these had all been scrutinised by the Committee.

14.2 The Board **APPROVED** the following annual reports:

- Freedom to Speak Up 2024-25

- Guardian of Safeworking 2024-25
- Annual Workforce Equality Report 2024-25

14.3 The Board **NOTED** the People & Culture Assurance Committee Chairs report.

TB/09/25/15 REPORT FROM FINANCE & PERFORMANCE ASSURANCE COMMITTEE

15.1 Philip Hogan, Chair of the Finance & Performance Assurance Committee updated the Board on their recent meeting and the assurances received in relation to Finance & Performance.

15.2 The Board **NOTED** the Finance & Performance Assurance Committee Chairs report.

TB/09/25/16 REPORT FROM STRATEGY & MAJOR PROJECTS ASSURANCE COMMITTEE

16.1 Paul Layzell, Chair of the Strategy & Major Projects Committee updated the Board on their recent meeting and the assurances received particularly in regard to the Acute Floor Reconfiguration delivery.

16.2 The Board **NOTED** the Strategy & Major Projects Assurance Committee Chairs report.

TB/09/25/17 REPORT FROM AUDIT COMMITTEE

17.1 Philip Hogan who stepped in to Chair the Audit Committee in July 2025 updated the Board on the recent meeting and the assurances received.

17.2 The Board **NOTED** the Report from the Audit Committee and the assurances from the Committee delivered through the former Committee Chair's annual report.

TB/09/25/18 COMPANY SECRETARY REPORT

18.1 Glen Palethorpe introduced the Company Secretary Report, which reflected the Trust's new appointed Non-Executive Directors and Governors, along with the confirmation of the Trust's Annual General Meeting taking place virtually from 6pm on Tuesday 30 September 2025.

TB/09/25/19 OTHER BUSINESS

19.1 The Board were briefed on the strategy launch scheduled for 1 October 2025 marking the beginning of a significant rollout phase, and that media engagement would be integrated into the broader communications strategy.

19.2 The Chair thanked the Board for their diligence and input to the meeting today, particularly during such challenging operational and financial times and amid high public expectations for healthcare delivery.

TB/09/25/20 DATE OF NEXT MEETING

20.1 It was noted that the next meeting of the Board of Directors in Public was scheduled to take place at **10.00 on Thursday 13 November 2025 in Worthing**

Tamsin James
Board & Committees Manager
September 2025

Signed as a correct record of the meeting.

..... Chair
..... Date

Agenda Item: Board of Directors meeting in Public, Thursday 13 November



MATTERS ARISING
Trust Board in Public

	Meeting Date	Minute Ref	Action	Person Responsible	Deadline	Update	Status
1	04-Sep-25	PB/09/25/6	The Board reflected on patient experience and were encouraged by the developments to improve defined patient pathways within the Trust. The Board asked that the work being undertaken in quantifying the impact on complaints in relation to waiting times since the introduction of NetCall be provided to the Patient & Quality Assurance Committee for oversight and tracking of trends.	Patient & Quality Assurance Committee / Director of Patient Experience & Engagement	Nov-25	The referral was received by the Patient & Quality Assurance Committee, a detailed discussion was held and an updated report was endorsed for presentation to the Board (Item.8)	Propose to Close
2	04-Sep-25	PB/09/25/7	A conversation was undertaken regarding the Trust's fire safety officers, and it was asked for the People & Culture Committee to receive detail in relation to the Trust's Fire Safety Officer training and compliance requirements and improvements.	People & Culture Assurance Committee / Director of Facilities & Estates	Nov-25	The referral was received by the People & Culture Assurance Committee and time will be created within the January 2026 agenda to receive the detail in relation to the Trust's Fire Safety Officer training, compliance and improvement.	Propose to Close

Agenda Item:	6.	Meeting:	Trust Board in Public		Meeting Date:	13 November 2025	
Report Title:	Chief Executive's Report						
Sponsoring Executive Director:	Dr. Andy Heeps, Interim Chief Executive						
Author(s):	Dr. Andy Heeps, Interim Chief Executive						
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only			
	N/A	Yes	Yes	N/A			
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances <i>(please detail)</i>			
	N/A	N/A	N/A	N/A			
Regulatory Reporting Requirement		No statutory requirement. This is a standing Chief Executive's report to the Board, providing updates on key national, regional and local issues relevant to the Trust's performance and strategy.					
Summary of the report describing What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i> So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i> What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s) being made)</i>		This report provides the Board with an overview of key national, regional and local developments affecting UHSussex. It highlights the introduction of the new NHS five-year planning framework, the forthcoming national maternity review visits, improvements in elective and diagnostic performance, continued pressures in urgent and cancer care, preparations for resident doctors' industrial action, and progress in culture and leadership through the <i>Excellent Care Everywhere</i> strategy.					
Recommendation <i>(linked to What Next section)</i>		The Board is asked to: 1. Note the updates set out in the Chief Executive's Report. 2. Consider the implications of national, regional and system developments for UHSussex. 3. Seek assurance that risks are being managed appropriately, with further detail to be provided through the relevant Committees where required					
Assurance / Scrutiny route already undertaken <i>(please explain where matter previously considered, and assurance provided)</i>		This is the Chief Executive's standing report and is presented directly to the Board. Where specific issues require deeper assurance, these are considered through the relevant Board Committees (e.g. People & Culture Assurance Committee for workforce and culture; Patient & Quality Assurance Committee for safety and maternity).					
Link to Trust Strategy <i>(note which theme)</i>	Patients	People	Future	Communities	One UHSussex	Culture	
	Yes / N/A	Yes / N/A	Yes / N/A	Yes / N/A	Yes / N/A	Yes / N/A	
Link to annual delivery plan	Delivery of the Annual Delivery Plan depends on the organisational culture, leadership and governance foundations described in this report. The Well-Led review response, elective recovery, urgent and emergency care plans, and maternity safety improvements are all critical enablers for achieving delivery plan milestones.						
Link to BAF <i>(explain which BAF risks this)</i>	This report relates to several BAF strategic risks, in particular:						

matter impacts on and what the impact is change in score/ change in assurance profile etc	• Risk 2 – Culture (current score 16, target 12): progress on Well-Led response is central to assurance. • Risk 3 – Workforce (12, target 12): strengthened leadership and behaviours support retention and staff experience. • Risk 6 – Service configuration (15, target 12): new urgent care facilities and strategy alignment reduce risk. • Risk 11 – Change capacity (16, target 12): enhanced governance and leadership development increase organisational capacity. Overall impact: expected strengthening of assurance profile, with risk scores reducing only once delivery is evidenced.					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	N/A	N/A	N/A	N/A	N/A	N/A
Other impacts	Equality and Diversity (if yes has HEIA completed)		Environmental	Legal	External Registrations (if yes please indicate which)	
	N/A		N/A	N/A	N/A	

Chief Executive's Report

My second report to the Trust Board as Interim Chief Executive again provides updates from across our hospitals and aims to give some wider context to the Board's discussions by highlighting recent national and regional developments that are relevant to our plans and performance.

National Policy and Regulation

NHS Planning Framework

The new NHS National Planning Framework introduces a rolling five-year planning model, replacing the previous annual cycle. For acute hospital trusts, this means a shift toward more strategic, integrated planning that aligns workforce, activity, quality and financial goals over the medium term.

Trusts are expected to produce credible five-year plans that demonstrate financial sustainability and support the broader ambitions of the 10 Year Health Plan. Immediate priorities for 2025/26 include improving access to care, achieving a 1% reduction in cost base, and delivering a 4% productivity gain. Trusts will also have more flexibility in using local funding, though this comes with increased accountability under the updated NHS Oversight Framework.

National Maternity and Neonatal Review

I joined a national briefing with Baroness Valerie Amos and her Independent Maternity Review team held to provide more information about the review process. Baroness Amos reaffirmed that the review's focus is on understanding systemic challenges that affect maternity safety across England and identifying what needs to change nationally, not about blame or individual accountability. She was clear that the process should be constructive and learning-focused, acknowledging the anxiety that investigations of this kind create for staff. The review team recognises the cumulative impact of recent Care Quality Commission (CQC) inspections, regulatory reviews and media coverage across many trusts, and intends to conduct visits in a way that does not further damage morale.

Baroness Amos also confirmed that the review will visit all maternity sites at each trust. She may not personally attend every site, but her team will undertake engagement activity at each, ensuring that staff across the Trust have an opportunity to contribute.

Our maternity service has demonstrated significant, independently verified improvement in safety, staffing and patient experience since our units were downgraded by the CQC in 2021. This review is therefore an important opportunity for us to demonstrate this progress and the seriousness with which we continue to approach learning and improvement in maternity services.

CQC Children's and Young People's Services Inspection Feedback

The CQC has provided some high-level feedback on its inspection of Children's and Young People's services (including maternity) at St Richard's Hospital on September 11 and 12.

Alongside some areas for improvement, the inspectors observed a positive culture between maternity and obstetrics teams and reported that women they spoke to said they were happy with the care they received.

Inspectors continue to have concerns regarding the length of time it takes for young people with mental health issues to be reviewed by the external Children and Adolescent Mental Health Services liaison team although they commended the mental health training made available and noted that staff at St Richard's felt the training had helped them feel "more confident" caring for children and young people with mental health needs.

We now await the draft inspection report to complete our formal response and finalise the action plan.

NHS Providers Chief Executive Visit

NHS Providers Chief Executive Daniel Elkeles praised the Trust's efforts to improve emergency care on a visit to the Royal Sussex County Hospital, particularly through partnership working and adapting good practice from other parts of the NHS.

He highlighted three elements of our Hospital Alternative Oversight (HALO) programme as examples of this. Our 'red bag' initiative to improve management of care home residents' medications, care plans and belongings has improved discharge planning and given nursing homes the confidence to accept their residents' return outside normal hours. This has led to a 46% reduction in overnight stays for these patients and a 40% reduction in the time they spend in ED. Our Unscheduled Care Navigation Hub co-locates a team of hospital clinicians with SECamb colleagues to discuss patients with paramedics, referring GPs and community teams before they are brought to hospital, and identify alternatives to ED for them. The clinician of the day supports around 30 interventions daily and diverts around half of them, leading to a net fall in ambulance arrivals of 10 per day. Our virtual ward capacity also continues to grow following a switch to a pathway focus from a specialty one, with referrals up 27% so far this year.

Regional and ICB Update

NHS Surrey and Sussex Chair

NHS Surrey Heartlands Integrated Care Board (ICB) Chair Ian Smith has been appointed Chair of the new NHS Surrey and Sussex ICB. Ian brings more than 40 years of leadership experience across healthcare and other sectors and will oversee the transition to a single ICB by April 2026. I was pleased to welcome Ian to UHSussex in October where we discussed our strategy and our improvement plans around culture and performance.

NHS Surrey and Sussex Chief Executive

Karen McDowell is also now in post as the new ICB's Chief Executive. Karen has more than 30 years NHS experience including chief finance officer roles and has been Chief Executive of the Surrey Heartlands ICB since 2023. As we welcome Karen and look forward to working with her, I would also like to say a thank you to Adam Doyle, who has been a good friend to the Trust as NHS Sussex Chief Executive, and wish him all the best in his new role as CEO of the NHS Kent and Medway ICB.

University Hospitals Sussex

Performance

This section provides a focused update on the Trust's delivery against key constitutional access standards in September, highlighting both improvements and continuing challenges. Please refer to the Integrated Performance report for further detail.

Elective and Diagnostics Performance

There were improvements in diagnostics (significantly above national average 6 six-week performance), and elective waits (referral to treatment waiting times – RTT) in September. In elective care (Referral to Treatment Times – RTT), September saw the Trust successfully achieve all its recovery targets related to long waits and overall RTT performance.

- While elective waits remain a material issue—a position reflected in the Trust's Tier 1 support classification from NHS England—the operational teams continue to drive incremental improvements in our relative ranking for the longest waits.
- The continued focus on reducing RTT backlogs is crucial as this directly impacts patient experience and supports the Trust's ambition to improve productivity through enhanced outpatient and theatre utilisation within budget.

Cancer Wait Times

Cancer performance in September saw the Trust track against its established 62-day recovery target, although it remained below the national average. Performance against the Faster Diagnosis Standard (FDS) also fell below trajectory.

- The primary challenge for both standards has been the significant peak in demand for skin cancer patients during the summer months, which exceeded available capacity.
- Mitigating actions initiated in September are already showing a positive impact into October. Improving performance here is critical, as early intervention fundamentally affects patient outcomes and experience, and is intrinsically linked to the effectiveness of our rapid diagnostic pathways.

Urgent and Emergency Care (UEC)

Urgent and Emergency Department (ED) performance remained challenging throughout Quarter 2, with 68.95% of patients seen within four hours in September. Despite a slight improvement in the month, overall 12-hour performance and care in escalation areas, saw an improved position in Q2 compared to the previous year (2024).

- The Trust has renewed its UEC Improvement Programme, aligning directly with our Trust strategy to transform the emergency care environment (including the new Urgent Treatment Centre and Same Day Emergency Care units).
- The programme's core intention is to facilitate patient flow from the Emergency Department through to inpatient wards and onwards to early supported discharge, achieved in partnership with our community, social care, and mental health colleagues.
- Key operational targets include enhanced patient streaming to Urgent Treatment Centres (UTC) and Same Day Emergency Care (SDEC) to decongest the front door. This work is essential to improving performance indicators, influencing financial efficiency, supporting staff morale, and ultimately improving health outcomes.

Resident Doctor Industrial Action

Resident doctors across England are due to take industrial action from 13 to 18 November 2025, following the rejection of the government's final offer earlier this week. While we have robust mitigation arrangements in place to maintain patient safety and essential services, the action will inevitably have some impact. In parallel, we are progressing work on the NHS England 10-Point Plan to improve resident doctors' working lives, including issues such as car parking, access to rest and locker facilities, and the provision of hot food 24 hours a day. These are being addressed in collaboration with local representatives to agree practical and sustainable solutions.

All-staff Conference

More than 650 colleagues attended our annual all-staff conference, which was again generously funded by MyCharity. This year's event focused on our new Trust strategy and started the conversation on how we set about achieving its ambition of providing *Excellent Care Everywhere*. As well as browsing a vibrant marketplace showcasing offers and opportunities, delegates heard some inspirational talks from our staff and keynote speaker Dr Jo Salter – Britain's first female fast jet pilot – and were able to network with colleagues from across all sites.

CQC prosecution

On Monday 27 October, the Trust pleaded guilty at Brighton Magistrates Court to a single charge brought in a CQC prosecution over the death of 16-year-old Ellame Ford-Dunn, who took her own life after absconding from Worthing Hospital in 2022. This was a tragedy that devastated her family, friends and every UHSussex colleague involved in her care, and remains a trauma they all carry with them to this day.

While general hospital wards are not appropriate places for people with acute mental illnesses to be cared for, we had a responsibility to protect Ellame when she was with us and I am truly sorry we were unable to do that. The CQC charge was brought in relation to our missing persons policy. We accepted that charge and recognise that the policy and training around it were not as clear as they needed to be. We have made changes and improvements in response.

This case has also served as a stark reminder of the difficulties of caring for people with acute mental illnesses on general hospital wards or in A&E, and why it's vital that the health and care system finds better ways to look after these patients when they are at their most vulnerable and distressed, and locally we are committed to working with our partners to do that. Sentencing in the case was deferred until November 26, when we expect to receive a fine that will be paid to the CQC.

Worthing Urgent Treatment Centre

Worthing Hospital's new Urgent Treatment Centre (UTC) welcomed its first patients in September. The unit has been relocated closer to ED to improve flow through the department and enable more efficient patient support. Although the overall footprint remains unchanged, the redesigned space now includes the welcome addition of a dedicated paediatric waiting area. The vacated UTC area will now be transformed into a new Same Day Emergency Care Unit (SDEC).

St Richard's Same Day Emergency Care Unit

October saw the official opening of a new £6 million Same Day Emergency Care (SDEC) unit at St Richard's Hospital that will transform urgent care for people in the Chichester area. Its dedicated, multi-specialty team of expert clinicians provides

prompt assessment and diagnosis on the same day, helping avoid unnecessary overnight stays in hospital. The unit is more than 10 times the size of its predecessor, has 18 clinical spaces and is already seeing more than 300 patients a week. It provides assessment and treatment for medical, surgical, urological and orthopaedic patients, with common presentations including chest pains, deep vein thrombosis, cellulitis, acute kidney injury, abdominal pain and gallbladder/biliary issues. Patients are referred by their GP or from other teams in the hospital. The SDEC is another huge strategic investment in modernising our urgent and emergency care facilities, which is a key ambition of our new strategy, *Excellent Care Everywhere*.

Speak Up Week

UHSussex took part in national Speak Up Week to raise awareness of the power of speaking up, and the importance of what we do in response to concerns raised. The focus of our new Trust Strategy on values and behaviours is a recognition that creating an environment in which everyone feels safe, supported and heard is crucial in ensuring we can all thrive at work. However, we know from staff survey insights and our Well-Led Review that we need to improve our speaking-up culture and build colleagues' confidence in their concerns being heard and acted upon. So as well as hosting drop-in sessions for The Guardian Service, which has been supporting us since 2023, we marked Speak Up Week by making three short e-learning modules developed by the National Guardian's Office an essential priority for all leaders. We hope this will help to increase knowledge and understanding of speaking up, listening up and following up across the Trust.

Black History Month

The Trust collaborated with our system partners to stage a range of events marking October's Black History Month, not just to recognise the contribution of Black people to the NHS but also as an opportunity to support equity in care. The programme included a system-wide conference, a wellbeing event to explore the impact of menopause on diverse communities, and a network event spotlighting stroke – which disproportionately affects Black communities – and the importance of early recognition, treatment and prevention.

St Wilfrid's Hospice

I visited St Wilfred's Hospice to meet chief executive Lois Howells and explore how we can work together for the benefit of patients nearing the end of their lives. Working more closely with other providers, voluntary, community and social enterprise organisations is a priority of our new Trust strategy's ambition to provide *Excellent Care for our Communities*, and I look forward to having more of these conversations to help us start doing that.

RSCH Helipad

The rooftop helipad at the Royal Sussex County Hospital continues to progress towards becoming operational in 2026, subject to minor remedial works and final regulatory approvals. Once in service, the helipad will allow critically ill patients - particularly those experiencing trauma, cardiac arrest or stroke - to be flown directly to hospital care. This will significantly reduce response times and improve outcomes for patients across Sussex and beyond.

Worthing Hospital Horizon Lounge

October saw the opening of the Horizon Lounge at Worthing Hospital, a calm welcoming space where colleagues can come to take a breather, recharge, and look after their own wellbeing during busy shifts. Funded by MyCharity, this is the latest staff health and wellbeing space to open across our hospitals as part of the Trust's commitment to looking after our people.

Everyday Stars Staff Recognition Scheme

We also launched a new digital staff recognition scheme last month: Everyday Stars. The scheme gives everyone an easy way to thank a colleague and celebrate them for embodying our core values: being compassionate, inclusive, and respectful. Everyone has five digital stars they can award each month to colleagues who deserve a thank you. Participants can track the stars they give and receive on our Staff Hub, achieve milestones and 'like and comment' to keep the positivity flowing.

Operation Bramber

Sussex Police continue to review historic cases of surgery and neurosurgery patients at the Royal Sussex County Hospital, assisted by independent medical experts. Operation Bramber is a matter of profound concern for our community, our staff and the families affected, and the Trust takes these historical allegations of clinical negligence extremely seriously. We are fully cooperating with Sussex Police and providing them with every resource and document requested as quickly as possible to ensure they can carry out their work thoroughly.

Our primary obligation is to patient safety today. Our Chief Medical Officer and clinical teams maintain very close scrutiny of all patient outcomes and performance across the Trust to ensure the public can be confident in the quality of care we are providing now. Our outcomes data for general surgery and neurosurgery remains within expected ranges.

Chief Corporate Affairs Officer

You will be aware that our interim leadership arrangements during the search for our new Chief Executive have left our executive team with one fewer member than normal. To address this, instead of appointing an interim Deputy Chief Executive we have decided instead to prioritise strengthening our corporate affairs capabilities as part of

our organisational response to the Well-Led Review published in the Autumn. I am therefore very pleased that Michelle Arrowsmith has joined us as Interim Chief Corporate Affairs Officer on secondment from Derby and Derbyshire ICB, where she held the post of Chief Strategy and Delivery Officer/Deputy CEO. Her significant strategic and system leadership experience will be invaluable to the UHSussex team.

Mike Rymer

And finally, some sad news for the Trust as we learned of the passing of Mr Mike Rymer, a highly respected consultant obstetrician and gynaecologist, former Medical Director of Worthing and Southlands Hospitals and a Board member of Brighton and Sussex University Hospitals NHS Trust. Mike had a long and impactful career in Sussex, caring for countless patients as a doctor, supporting numerous colleagues as a mentor, and providing expert leadership in a variety of senior roles. His unwavering support for those he worked with, along with his staunch commitment to patient care, is something for which he will always be remembered.

Dr Andy Heeps
Interim Chief Executive

November 2025

Agenda Item:	7.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025
Report Title:	Excellent Care Everywhere: Update on Strategy and Delivery Plan				
Sponsoring Executive Director:	Roxanne Smith, Chief Strategy Officer				
Author(s):	Jenny Preece, Deputy Director Strategy				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only	
	N/A	Yes	Yes	Yes	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	Yes / N/A	Yes / N/A	Yes / N/A	Yes / N/A	
Regulatory Reporting Requirement					
Summary of the report describing What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i> So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i> What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s)being made)</i>		Following publication of our new Trust Strategy on 1 st October 2025, this paper updates on the launch and roll-out of the strategy and includes an executive summary of our new Delivery Plan (which is assured through the Strategy and Major Projects Committee of the Board.)			
		This item will include playing a short video about the strategy and how it was created. The paper updates on the lively programme of communication and engagement underway, making a reality of our commitment to continue the Big Conversation, and which is starting to raise awareness of our new strategy.			
		Annexed to the paper is an executive summary of the new Delivery plan, which will have been discussed by Strategy and Major Projects Committee on 6 th November. The new delivery plan gives us a new 5-year view of everything we are working to achieve. It will become a significant tool in our management of the organisation, enabling us to much better manage delivery, interdependencies and prioritisation across the organisation, to hold SROs to account and give assurance to the Board that the strategy commitments are being delivered.			
		The launch of the Strategy, followed at pace by the Delivery Plan, is a significant step in our organisational recovery. This first Delivery Plan shows significant work happening across the organisation to deliver on our new strategy, but also recognises the need for further action to increase delivery confidence.			
Recommendation <i>(linked to What Next section)</i>		The Board is asked to note • Publication of our strategy and progress in roll-out, • The summary Delivery Plan (annex a) • Proposed next steps to improve delivery confidence and building understanding of the strategy and make it real.			

Assurance / Scrutiny route already undertaken <i>(please explain where matter previously considered, and assurance provided)</i>	Full update and Delivery Plan discussed at Strategy and Major Projects Committee, 6 th November 2025					
Link to Trust Strategy <i>(note which theme)</i>	Patients	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan						
Link to BAF <i>(explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)</i>	Responds to all BAF risks, especially 11 'We are unable to support, guide and deliver the level of change required to successfully deliver the strategy'					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	Yes	Yes	Yes	Yes	Yes	Yes
Other impacts	Equality and Diversity <i>(if yes has HEIA completed)</i>	Environmental		Legal	External Registrations <i>(if yes please indicate which)</i>	
	N/A	N/A		N/A	N/A	



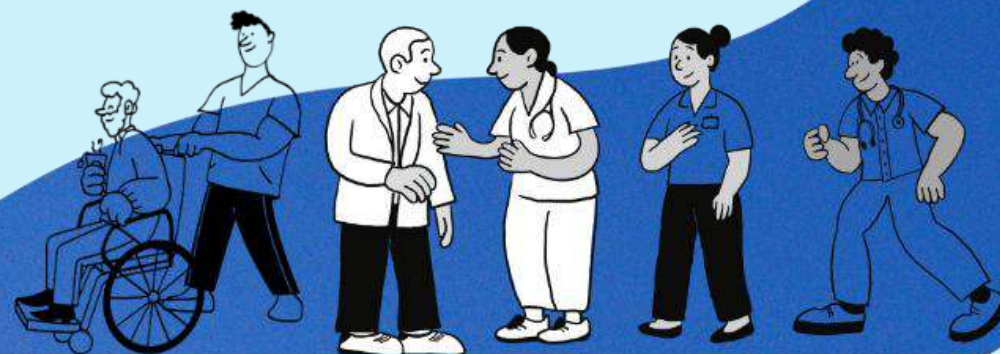
University Hospitals Sussex
NHS Foundation Trust

Excellent Care Everywhere

Trust Strategy Update

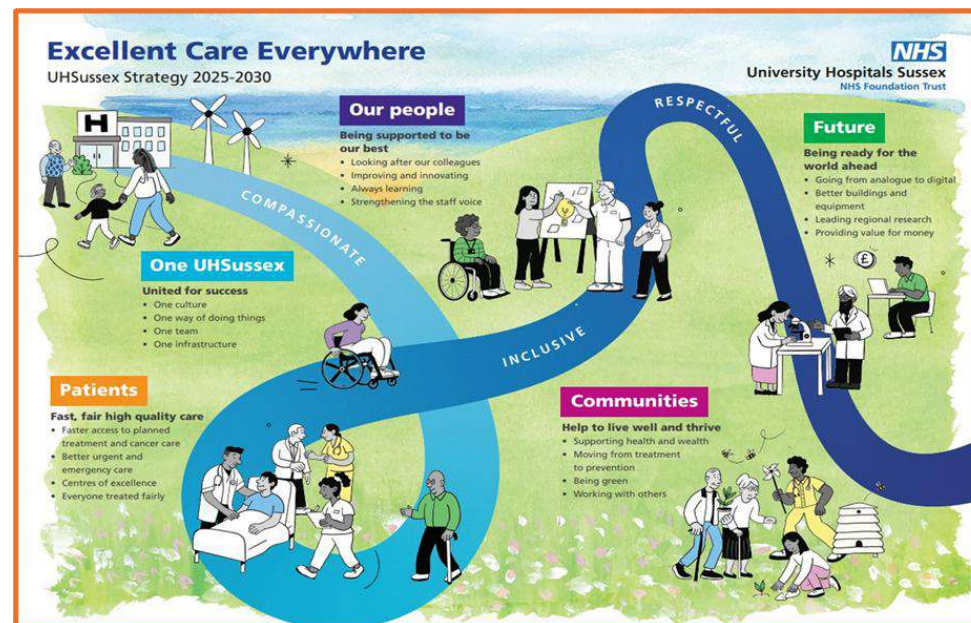
UHSussex Trust Board

13 November 2025



Summary

- Our new five year Trust Strategy, **Excellent Care Everywhere**, was published on 1st October 2025
- Building on the Big Conversation, a lively programme of communication and engagement activity is promoting awareness and understanding of the new strategy, using media channels and across our sites and with partners.
- The new whole-trust Delivery Plan was considered by the Strategy and Major Committee on 6 November 2025
- This paper updates on the work so far, and next steps.
- The Board is asked to note:
 - Publication of our strategy and progress in roll-out,
 - The summary Delivery Plan (annex a)
 - Proposed next steps to improve delivery confidence and building understanding of the strategy and make it real.





University Hospitals Sussex
NHS Foundation Trust

Introducing our strategy

Play
video



Launch

• Our communications and engagement approach is grouped into three phases:

- **Launch (October):** The initial awareness phase
- **Understanding (Nov-Dec):** Beginning to develop understanding
- **Embed (Jan onwards):** Supporting work to translate strategy into actions, aligning with tangible examples of implementation from the delivery plan, and showcasing the continuation of the Big Conversation.

The activities included in these phases are designed to inform, educate, and inspire audiences through cultivating conversation and connection.



Active communication

We have promoted the strategy across multiple platforms, demonstrating how the strategy responds to feedback and delivers positive improvements for our people, patients and communities.

Core channels:

- **Youtube:** A leadership-led introductory video has achieved nearly 7,000 views on YouTube and across social media.
- **Leader and staff Teams briefings:** 180 leaders and 1,000+ staff briefed on the strategy, supported by a toolkit for ongoing team discussions.
- **Leaders' toolkit** supporting team conversations
- **2025 Staff Conference:** 600 attendees explored each ambition through speakers and breakout sessions
- **Weekly leader emails:** Regular CEO emails and COO updates link current issues to our "Better, Faster, Fairer Care" ambition.
- **New podcast channel:** Launch interview with Interim CEO Andy Heeps discusses change, leadership, and upcoming challenges.
- **Chief Strategy Officer profile:** Multi-channel interview with Rox Smith builds confidence in leadership and highlights the strategist's role.

Social series:

We've curated a series of graphics that articulate some of the key examples of feedback translated into action. These span themes such as A&E improvements, joined-up working, learning and development, and research investment.

To date, these graphics have generated:
15,000+ views on Facebook
3,300+ impressions on LinkedIn



External stakeholders and media:

We've started engaging external stakeholders through targeted briefings and media outreach. Media coverage helped amplify our message beyond the organisation. Further media and stakeholder engagement is planned to support broader awareness and partnership working.

SussexWorld

'Landmark moment' - Sussex hospital trust's new five-year strategy pledges 'shorter waiting times and better emergency care'



Staff Conference 2025

- This year we hosted our third UHSussex Staff Conference, focused on our new Strategy and Vision for 2030 to deliver “Excellent Care Everywhere”.
- The event brought together 600 colleagues and volunteers from across all our sites - sparking curiosity, connection, and collaboration.
- We heard from inspiring guest speakers, including Britain's first female fast jet pilot **Dr Jo Salter** MBE, Consultant Radiologist **Sameer Gangoli** and Senior Medical Photographer **Stacey Hussell**, who shared their powerful stories of innovation, leadership, and impact.
- And we reflected on what it means to be One UHSussex and how we develop a new and unified culture across our Trust
- Staff were given the opportunity to discuss the challenges and opportunities ahead as One UHSussex, across practical break-out sessions throughout the day
- The staff conference provided another opportunity to continue our **Big Conversation** with staff, as we look to enhance the staff voice as we deliver the new strategy

Highlight Video from the conference



Developing visual awareness

To bring the strategy to life, we've developed a strong visual identity, which can be seen across digital and physical touchpoints:

Digital

- Strategy flipbook - Opened 1,857 times
- Branded Teams backgrounds, digital signage, and screensavers (reaching 14k users). Email signatures are being adopted and will be rolled out more widely.
- A new interactive strategy webpage and Staff Hub page, supported by promotional panels and sliders across both platforms. Strategy on a Page document viewed 3,432 times.
- Key website pages, for example recruitment, now reference the strategy across collateral, such as job adverts, descriptions, and candidate packs (replacing previous Patient First language and visuals).
- Our branding agency is now working up further guidelines for use, including for the adoption of new PowerPoint templates which will be available from November.

Printed

- A refreshed leaflet and poster design are beginning to be seen across our sites, replacing 'Better Care never stops' branding.
- Over 1,000 copies of the Autumn strategy-branded newsletter are being distributed across waiting rooms and staff rooms. A digital version is also available.



Measuring impact

We are monitoring engagement through our internal Pulse survey.

The October data shows the launch communication activities have already had an impact.

Following the publication of the new Trust strategy, how do you feel about the Trust's future? (Oct 2025)

Answer	Responses	%
Much more positive	23	20.18%
Slightly more positive	25	21.94%
Neither negative or positive	34	29.82%
Slightly more negative	3	2.63%
Much more negative	2	1.75%
Don't know	27	23.68%
Grand Total	114	100.00%

Focus on delivery

- We are moving at pace to put in place the delivery plan which will make a reality of the strategy.
- This was reviewed by the Strategy and Major Projects Committee on 6th November. An executive summary is at Annex A of this paper.
- The Delivery Plan gives us a new 5 year view of everything we are working to achieve.
- It will enable us to much better manage delivery, interdependencies and prioritisation across the organisation and to give clear assurance that the strategy commitments are being delivered.

[illegible]

Sample pages for illustration – see Annex A for Executive Summary of the Delivery Plan

Delivery Plan

The Executive Summary of the Delivery Plan is attached at Annex A .

This is the first time we have had a whole-organisational delivery plan as UHSussex. It has been compiled following publication of Excellent Care Everywhere and discussion at the Strategy and Major Projects Committee, with lead Directors across the organisation. It represents a baseline on which we will build further assurance and enhanced delivery management.

The plan shows data shared by SROs places us on track against planned milestones in 95% of the 83 programmes and work packages currently underway.



Next steps

A major theme of the engagement so far is that people want to understand how the strategy will be delivered, and what this will mean, tangibly, for them.

Building Delivery assurance

- The Delivery Plan itself is an important part of the answer to this. It will be followed by development of divisional-level plans, with staff engagement to help everyone to understand their role and their opportunities in the context of the strategy.
- Following steers from the Strategy and Major Projects Committee (SMPC), we will be developing the Delivery Plan further to enhance delivery assurance and align the long term strategy-view, annual business planning.
- The Strategy team will develop a new 'Delivery Unit' function, working with SROs to provide quarterly updates to SMPC on progress in delivering against our strategy.

Building understanding – and making it real

As we move into the next stage of engagement, we will be both creating more opportunities to extend the Big Conversation and aligning real examples of delivery with the strategy, including:

- Partner events for our external stakeholders – sharing our strategy, show-casing some of our work with partners, and gathering insight.
- Launch of 'Excellent care starts with you' recruitment campaign in November
- Refresh of Trust induction, incorporating our new strategy, to be launched in new year.
- Regular series of 'toolkits' highlighting developments related to the strategy and opportunities to get involved – to be downloaded for teams to use and shared at Hospital Forums and other leadership events.
- Upcoming plans, e.g. Education plan, Inclusion plan, have been developed in line with the strategy as it was finalised, and will be visually aligned.
- The new trust values and strategy language will be embedded into our HR and Education policies by Christmas, with further work to build the new values and behaviour framework into our appraisal system, planned to follow once the framework is agreed.
- Increasing visibility of the new strategy across our physical and digital infrastructure, including installation of large (A0 size) posters at main receptions, and other strategic sites, and replacement of 'where better never stops' branding.
- Development of a strategic comms plan, using the Delivery plan to develop a forward plan to inform external and internal communications, with a focus on showcasing successful delivery and introducing new developments which take the strategy forward.

Annex



University Hospitals Sussex
NHS Foundation Trust

Excellent Care Everywhere

Delivery plan – Executive Summary





Introduction to Executive Summary (1/2)

This is the first time we have had a whole-organisational delivery plan as UHSussex. It has been compiled following publication of Excellent Care Everywhere and discussion at the Strategy and Major Projects Committee, with lead Directors across the organisation. It represents a baseline on which we will build further assurance and enhanced delivery management.

The plan shows data shared by SROs places us on track against planned milestones in 95% of the 82 programmes and work packages currently underway. This reflects huge effort and focus across the organisation, and the fact that the strategy content was well-socialised throughout its development and builds on existing strengths, so there are few areas where we are starting from the beginning. We have clear governance routes in place for 83% of these programmes (measured as overseen by a Board Committee or Exec-led Board). The new Clinical Transformation Programme Board and Strategy and Major Programmes Board have addressed some important gaps and further improvements in this will be seen as the Target Operating Model is settled.

This positive picture is underpinned by data which shows that there are some immediate issues which inform assurance at this stage, and will be addressed as part of our next steps:

- Mixed Clinical Leadership capacity to engage with change and cascade to their services while managing operational pressures.
- Time-limited uncertainty about some areas of accountability, while the Target Operating Model work is concluded.
- Challenges in phasing and prioritising change for maximum impact and to make best use of our finite change capacity.
- The identified need for a strong Organisational Development function, and much better compliance and assurance monitoring.
- Potential capital, estates, digital and change team capacity risks – and the need for a consistent approach to deployment and prioritisation of our central change resource.

There will appear to be a disconnect between the overall positive assessment of progress against our key priorities at this time, and the challenges we are facing in performance across the organisation. Critically, this is because the strategy delivery plan is looking through a different lens, it is assessing whether the work we have in train to achieve our 5 year objectives is on track. And, as this is the first quarter of monitoring, many programmes are in the early stages of delivery and monitoring and measuring impact.



University Hospitals Sussex
NHS Foundation Trust

Introduction to Executive Summary (2/2)

As we mature in our approach, we will be much better able to describe where and how we are seeing the dial shift in key areas and what we are evaluating and tracking to establish that. It is also true that new, significant programmes of work will begin over the next two quarters and these will create bigger capacity challenges that will likely mean we will need to make some active choices around things we may wish to speed up and other things we may need to slow down or pause. The delivery plan gives us a much better opportunity to make those decisions, and consider the dependencies and consequences for achieving our ambitions if and when we need to make those kinds of decisions'.

Next steps:

We will now further develop the Delivery Plan, alongside annual business planning, we will be looking at our overall commitments through the lens of Jim Mackey's new three phases within the national 10 Year Plan: 1) next year delivery, 2) restoration of constitutional standard by the end of the spending review period; and 3) beyond this point a broader move to neighbourhood health, prevention and use of digital.

This will enable us see how the organisation needs to phase its efforts for maximum impact and help us to remain closely aligned with the national plan and new multi-year planning cycle. The plan is also being aligned with our new Integrated Performance Report coming to Board this month (November). The Delivery Plan will be enhanced 'bottom up' through the professional plans and insight from the Big Conversation, starting with the forthcoming Nursing and Midwifery Plan. Divisional-level plans will be developed with clinical leadership and staff engagement, further embedding the strategy, understanding of what it means in each area, and the discipline of delivery.

The Strategy team will develop a 'delivery unit' functionality which will move us to a higher level of overall delivery assurance which will inform future updates to this Committee. We will do this by reviewing programmes with each of our SROs, using a Delivery Unit-style approach which supports consistent and critical thinking. This will cover factors such as quality of planning, delivery confidence, alignment of objectives, clarity of KPIs and management of interdependencies and phasing. This will enable us to:

- support SROs to strengthen programme management where necessary
- support triangulation across areas of work, and deployment of central change resource
- give the Committee a richer view of performance, capability and risk to inform assurance going forward.



Snapshots of progress across our ambitions

Ambition 1: Excellent care for our patients

OVERALL

We have **20 programmes to track in our first ambition of excellent care for our patients, of which 18 are on track.**

Our **planned care performance is improving**, and we are above trajectory for reducing 65 waits. This suite of programmes includes both the immediate tactical priorities and medium-term investment required to maintain and build on this improvement.

The **UEC priority is currently off track**, both due to slipped KPIs in the improvement programme and to the impact of water infection issues which require mediation in the Acute Floor Reconfiguration Project. This also reflects our 4hr ED performance is below the national average.

Programmes in this section are fundamental to our performance (access), quality and a reduction in inequality, which are high priority nationally as well as locally. The new Clinical Transformation Programme Board and Strategy and Major Projects Boards are having impact in improving decision-making and monitoring for these programmes, and this will continue to build.

1.1 FASTER ACCESS

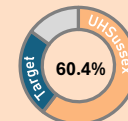
University Hospitals Sussex delivers one-fifth of reduction in NHS waiting lists in England in 2024



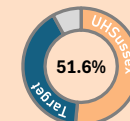
In 2024, UHSussex reduced our waiting lists by 27,500 patients. This represented 19.1% of the total reduction achieved in England

-29%

decrease in patients waiting for consultant-led elective (non-urgent) treatment from our peak in Sep-23 (from 160k to 113k in Sep-25)

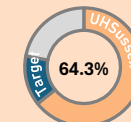


62 Day Cancer Treatment (Aug-25)



18-week RTT (Sep-25)

1.2 BETTER UEC



4-hour ED performance, target 78% (Sep-25)

Our Strategy commitments to improving UEC

£7m

Worthing ED & UTC

£4.5m

SRH SDEC

£5m

Funding for new Urgent Treatment Centre for PRH has been approved via NHSE



1.3 CENTRES OF EXCELLENCE (COE)

Colorectal Cancer Surgery COE (Worthing)
Since opening in May 2025

0 cancellations (in-line with target)

5 days average length of (in-line with target)

+15 increase of c.15 patients per month (below target due to phased recruitment)

Sussex Cancer Centre business case **approved** by the Joint Investment Committee (NHSE/ DHSC)



Future of our Specialised Commissioning services to be discussed at the CTPB in October

1.4 FAIRNESS FOR ALL

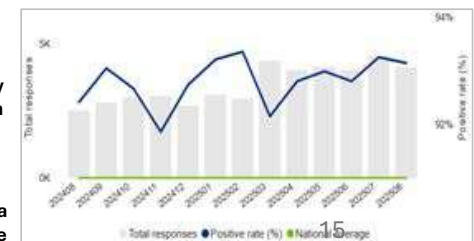
7 Key Health Inequality domains being tracked by the Clinical Outcomes team



Health Improvement Advisors for Tobacco Dependency team fully recruited & staffed

>4k Responses to the Friends and Family test (FFT) Survey in Aug-25 with

93% Patients reporting a positive experience



Snapshots of progress across our ambitions

Ambition 2: Excellent care for our people



OVERALL

We have **10 programmes to track in our second ambition of excellent care for our people at present and delivery is on track.**

While current milestone delivery is very strong, a lot of our current work is in the initiation stage and so is yet to have impact for people in the organisation. We will have a very ambitious delivery programme here, which will be assured by People and Culture Committee, including our plans for Workforce Inclusion, Education and Training, health and wellbeing and a new improvement methodology.

In tandem with the culture programme (which is part of Ambition 5, One UHSx) it is mainly through the People ambition that we will address the findings of the recent Niche Well-led report, and improve our overall staff engagement and morale.

The relationship between staff engagement and morale, quality of patient care and attracting and retaining the staff we need is fundamental to our improvement journey and the successful delivery of our strategy.

2.1 LOOKING AFTER OUR COLLEAGUES

We have committed to reviewing our safety and violence prevention programme with a focus on sexual misconduct, harassment, and discrimination. Reducing violence against staff remains a key priority

574 incidents related to violence and harassment against staff in Q2 2025/26.
433 in Q1 of 2025/26

22% increase in referrals to the staff psychological support service in 2024/25 compared to 2023/24



We are expanding our training in Civility Saves Lives, Active Bystander, and Human Factors to promote psychological safety

2.3 ALWAYS LEARNING

>2,000 student and trainee doctors and nurses each year

75.1% average satisfaction with medical training across our sites, compared to

78.7% in 2024

2026 we will be launching out new integrated Education Plan, informed by Staff feedback and best practice

2027 we will have identified our future skills needs via a five-year Workforce development Plan

2.2 IMPROVING AND INNOVATING

In Jun-25 we launched our new **Clinical Transformation Programme Board**, which provides a forum where the most senior clinical leaders in the Trust can recommend our clinical priorities. So far 5 large programmes of work have been approved and recommended for further action by the Board



The first phase of our Improvement review is underway and due to be finalised by Nov-25

The new improvement methodology (adopting NHS impact principles) is due to be implemented by Mar-27

2.4 STRENGTHENING THE STAFF VOICE

In Sep-25 our Communications team started the search for members of our new **Staff Panel**



2025 National Staff Survey currently running with a response rate of

36% at week 6 of 11
NHS Staff Survey



An average of **20** referrals per month to the to the Freedom to speak up guardian service as of Aug 2025

The Guardians are roving across UHSussex sites between the 13th and 17th of Oct to raise awareness during 'Speak Up Week'

Snapshots of progress across our ambitions

Ambition 3: Excellent care for our Communities



OVERALL

We have **14 programmes or work packages** to track under Communities. All except for one are currently 'on track' – patient experience and engagement requires more support due to the scale of commitment to this in the Strategy. We have committed to continuing our Big Conversation approach with partners and patients and this will be a strand that runs and develops throughout the delivery plan.

In this area of ambition, we are acting in a **leadership role as part of the rapidly evolving Sussex system**. The shift from hospitals to community is expected nationally to come in the second half of the NHS 10 Year Plan period, and we are building approaches now which will give us opportunities to get ahead of this timeline.

The ICB will commission services on a **new integrated neighbourhood care model** for the first time in 2026/7, supported by a 1% top slice in acute budgets. We have contributed to the design of this new model and have some examples of good practice (e.g. HALO). We will be further ramping up engagement over the coming period to ensure this delivers meaningful change (including reduction of avoidable admissions) for patients and that activity follows the money.

Internally we are commencing the **refresh of the Green plan** and starting to broaden our focus on wider community engagement through our developing commercial strategy, improved approach to supporting volunteers and our charities, and by joining a national study for Anchor Trusts.

3.1 SUPPORTING HEALTH & WEALTH

20%

We are on trajectory to increase our spending with local companies to 20% by 2027/8. growth



NIHR Applied Research Collaboration North East and North Cumbria

We are in the process of joining the national anchor trust research project, led by ARC Greater Manchester and funded by NIHR ARC Health and Care Inequalities National Priority Consortium

The aim of the project is to examine the impact of NHS spending on local economies as true Anchor Institutions

3.2 TREATMENT TO PREVENTION

NHS Sussex

Sussex now has a single Provider Collaborative which is taking on service development functions previously held by the ICB.

As Chair of the provider collaborative, we are working with partners to transfer the local health system (including through the major services review)



The Provider Collaborative is developing a core offer for the 13 ICTs across Sussex, with an initial focus on the cohort of individuals at risk of frailty with needs.

3.3 BEING GREEN



By Mar-26

we will have refreshed our trust wide Green Plan.

3,000 tonnes of carbon

The development of Worthing Heat Network is in progress and by 2027, it will help to save 3k tonne of carbon per year



New Solar panels are also planned for PRH, Southlands and SRH

3.4 WORKING WITH OTHERS



£4.7m

of expenditure from My UHSussex Charity in 2024/25

650+

volunteers supporting patients across UHSx delivery approximately

100k

Hours of volunteer services in 2024/25

The Hospital Alternative Oversight Programme (HALO) is a collaboration between UHSussex, SECamb, SCFT, Sussex ICB and B&H Council and has seen a reduction in unnecessary ED attendances across 1,122 interventions

77% ED avoidance

Strategy Progress report: Ambition 4: Excellent care for the future



OVERALL

Under Future we have 24 programmes to track, including our major **digital transformation** and **research and innovation** programmes, both of which are currently on track and closely assured through the RIDS Committee.

Our research and innovation programme is strong, and nationally recognised with significant ambition to expand over the period. Our digital programme is well established and huge carrying significant risk for the organisation as it manages the day to day demands of struggling infrastructure alongside our investment in EPR and the rationalisation of systems below it.

The Board takes assurance on our **financial recovery plans** through F&P Committee. We have significant and ambitious delivery planned to stay on track and these are of course fundamental to the delivery of the strategy as a whole. While managing these critical immediate challenges, we are also tackling underlying inhibitors in our Value for Money priority - improving receipts through coding, developing new multi-year programmes for improving productivity, and our new work developing commercial mindset (and raising income) which will mature in the first year of the strategy.

Sale of the St Marys Hall site in Brighton is on track (at an approx. value of £7m) and is now under offer, with all teams expected to be relocated before April 2026.. This is an important step on our journey to providing **better buildings**. Our hospital directors now all have delegated budgets for small scale improvements on our sites, and we are developing the tracking and communication necessary to demonstrate and amplify the impact this is having on local pride in place.

4.1 GOING FROM ANALOGUE TO DIGITAL



Electronic Document Management System (eDMS) rollout completed at RSCH, PRH, and RACH

eDMS live at RSCH, PRH and RACH in 2025. As of Aug-25

155k

patient records have been digitised – transforming how patient information is accessed across the Trust

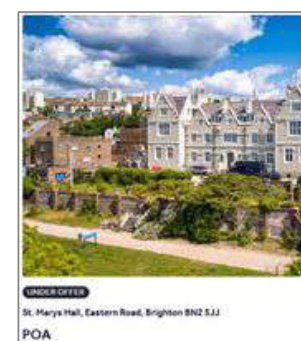


EPR

We've now received bids from two potential EPR suppliers, and the evaluation process is underway.

From Mar-25 more letters and correspondence have be sent digitally through your Patient Knows Best (PKB) account and the NHS App

4.2 BETTER BUILDINGS AND EQUIPMENT



In 2025, the St Mary's Hall Site in Brighton was put up for sale as part of our aim to sell buildings or exit leases that are under utilised, expensive or unsuitable

The building is now under offer, with teams starting to move to new and more appropriate office locations across the Trust

4.3 LEADING REGIONAL RESEARCH

NIHR

£3.5m

of funding received in 2025/26 to open a new Commercial Research delivery Centre – Opened October 2025

28

Of commercial trials recruiting in 2025/26 compared to

33

in the whole of 2024/25

197

studies recruiting in 2025/26, compared to

256

for the whole of 2024/25

3,308

Recruits in 2025/26 with over 1,000 in July 2025

4.4 PROVIDING VALUE FOR MONEY

£113m



£31.4m of efficiency savings confirmed as of M6 2025/26

£0.08m above target

(£3.3m)

Overall financial position at M3 2025/26

£0.48m

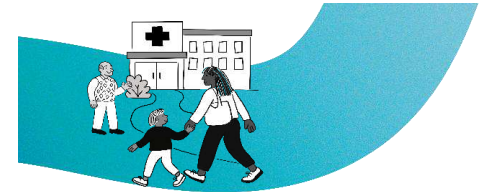
Ahead of the submitted plan

£1.2m

investment by Pharm@Sea and UHSussex to open a new wholly owned subsidiary pharmacy at PRH (Feb 2025)

Snapshots of progress across our ambitions

Ambition 5: Excellent care together



OVERALL

We have plans to formalise governance around the one UHSX programme so it has a comparable status and role to FRDB with that level of CEO leadership and whole org oversight. There are currently **14 work packages or programmes of which 12 are on track.**

Launching the strategy and this delivery plan are key components of our One UHSussex ambition and we are delighted with the initial positive engagement that it has received including **The 2025 Staff Conference** which was attended by about 600 colleagues and which focused on values and behaviours and the strategy.

We have also had strong interest in our strategy launch online, including well over 6,000 social media views and 500+ YouTube visits.

In addition to this focus, we are making further progress on our Culture programme starting with our **values and behaviours work** following the engagement of an external advisor with significant experience in large NHS Trust work. Engagement with senior leadership has begun and this will form part of our strategy toolkit roll out in the next quarter.

Finally, we are making good progress with the **staff survey** which, despite still having until 28th November, 36% of our staff have already completed.

5.1 ONE CULTURE



In October we launched the new Everyday Star awards, providing a new way to celebrate staff who demonstrate our values and deserve a thank you!



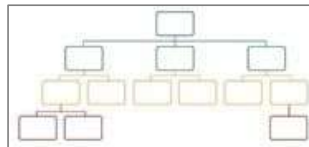
This is on top of another successful year for our star awards with over **1200** nominations for the 2025 awards

87% of staff have an up-to-date appraisal, which forms a key part of our aim to ensure all staff are set fair and clear expectations



We're launching our new recruitment campaign which show cases how 'excellent care starts with you'

5.3 ONE TEAM



We are currently developing a new Target Operating Model (TOM) and Senior Leadership structure, to help reduce duplication and clarify leadership responsibilities

By 2028

we will provide equitable terms and conditions for all. We will do this by continuing to harmonise legacy terms and conditions and consulting with staff groups and unions on standardising contracts for new staff

This work has started and will continue over the next 3 years

5.2 ONE WAY OF DOING THINGS

Across the next five years of our strategy, we will be reviewing services, currently split into multiple waiting lists, to create single PTLs across the Trust



Our digital programme is working through alignment and consolidation of multiple systems and directories



5.4 ONE INFRASTRUCTURE

Digital innovation transforming booking process and saving time for teams



Since Jun-25 the NHS Federated Data Platform (NHS FDP) has been transforming how teams manage theatre bookings, significantly saving time, improving data accuracy and boosting efficiency across departments.



A delivery plan is currently in development, to ensure the benefits of the commitments outlined in our Strategy are fully realised. This plan is due for approval at the Strategy & Major Projects Committee on the 6th of November



Next steps

We will continue to develop the Delivery Plan as a tool to support management of the organisation. Immediate priorities include:

- This Delivery Plan will be developed including:
 - alongside business planning, to set our commitments through the lens of Jim Mackey's new three phases within the national 10 Year Plan: 1) next year delivery, 2) restoration of constitutional standard by the end of the spending review period; and 3) beyond this point a broader move to neighbourhood health, prevention and use of digital.
 - to align with the new Integrated Performance Framework (coming to the Board in November) giving clear view of the the relationship to performance indicators
- We will further socialise and build ownership, including through:
 - Whole-leadership team stress testing of the delivery plan, and discussion about the opportunities it gives us to support management of the organisation
 - Divisional-level and professional-level plans which enable teams to understand how their annual plans, and divisional priorities relate to the overall strategy, and to prioritise
 - Further insight as the Big Conversation continues across the organisation
- As our programmes mature into delivery, we will increase delivery assurance by
 - Establishing a Delivery Unit functionality within the Strategy Team, which will support SROs to strengthen programme management where necessary support triangulation across areas of work, and deployment of central change resource – focusing on developing KPIs, targets, trajectories and key proxies for progress.
 - Provide quarterly reports on progress to this Board, which give the Committee an overview of performance, capability and risk to inform assurance, alongside the specific oversight of the work programmes which sits with individual committees and boards.

UHSussex Strategy 2025-2030



Being supported to be our best

- Looking after our colleagues
- Improving and innovating
- Always learning
- Strengthening the staff voice

United for success

- One culture
- One way of doing things
- One team
- One infrastructure

Fast, fair high quality care

- Faster access to planned treatment and cancer care
- Better urgent and emergency care
- Centres of excellence
- Everyone treated fairly

Help to live well and thrive

- Supporting health and wealth
- Moving from treatment to prevention
- Being green
- Working with others

Being ready for the world ahead

- Going from analogue to digital
- Better buildings and equipment
- Leading regional research
- Providing value for money

Agenda Item:	8.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025
Report Title:	Insights from Patient Feedback Report				
Sponsoring Executive Director:	Maggie Davies, Chief Nursing Officer				
Author(s):	Nicole Chavaudra, Director of Patient Experience, Engagement and Involvement				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only	
	N/A	Yes	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement		CQC Regulation 16 defines the requirement for Trusts to provide CQC with a summary of complaints, responses and other related correspondence or information when required to do so. The Trust also has statutory obligations to engage patients, undertake national patient surveys (as commissioned by the CQC), and undertake regular surveys via the friends and family test			
Summary of the report describing What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i> So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i> What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s)being made)</i>		This report sets out how University Hospitals Sussex receives, hears, and analyses the voice of patients, including how this influences the delivery of services through proactive surveys such as those commissioned by CQC, and through contacts from patients, such as via PALS and complaints. The positive feedback from patients about their experience of care is detailed, with improvements noted in the inpatient survey regarding food and communication. Taking the main themes from both positive and less positive feedback from inpatient surveys, an analysis is presented to describe which are the main opportunities for improving patient experience. These opportunities include reducing waiting times, fewer delays to care and improving staff behaviour and communication. The performance of the Trust in managing and responding to complaints is also set out. An increasing trajectory of complaints being received is noted, with an increasing trajectory also observed in the other large trusts across the country indicating a national trend for more, and more complex, complaints in the NHS. The role of artificial intelligence in complaints is described, as part of a nationwide increase in complaints across industries and within the NHS. Improvements in the length of time taken to respond to complaints, and the number of complaints re-opened is also evidenced. The variation between divisions, including divisional capacity and structures for managing complaints, and the associated risks, are noted. The report also summarises improvement activity in response to insights from previous years, and the impact they have had on patient experience. This includes			

	improvements in customer service, food availability for inpatients and engagement of families. The report describes where improvement action to address the drivers of increasing volumes of complaints is required to prevent continued negative impact on patient experience and performance relating to complaints management. To prevent continued negative impact on patient experience and performance relating to complaints management, action is required on reducing delays, and communication issues to include responsiveness of clinical services to patient enquiries and medical behaviour. Actions underway to address these drivers are described in report.					
Recommendation <i>(linked to What Next section)</i>	It is recommended that the Board: i. NOTE the content of the report and the assurance provided ii. NOTE the drivers of increasing complaints and poor patient experience					
Assurance / Scrutiny route already undertaken <i>(please explain where matter previously considered, and assurance provided)</i>	This report has previously been scrutinised through Quality Governance Steering Group (20 October 2025), and Patient and Quality Committee [4 November 2025]. This report provides assurance that feedback from patients is analysed and understood, including the key drivers of negative patient experience, with improvement actions taken. Assurance is provided that the performance of complaints management processes is monitored, understood and reported via Quality Governance Steering Group and Patient and Quality Committee. Despite increasing volumes of complaints received, there is assurance that there is improving or maintained performance in complaints closure times, re-opened complaints, and PHSO due to process improvements and efficiencies. Due to increasing volumes of complaints received and open at any time, along with limited capacity within the complaints team and divisional quality teams, there is limited assurance that performance will be maintained over coming months if the trajectory of complaints received continues to increase. This is included within the risk register.					
Link to Trust Strategy (note which theme)	Patients	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan						
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc	This report links to BAF strategic risks 1, 2, 6 and 11. Risk 1. There is a risk that if complaints volumes exceed the organisation ability to respond in a timely and quality way, we will be unable to maintain safe, effective and compliant care.					

	Risk 2. There is a risk that if we do not address the drivers of poor patient experience, the culture of the organisation will not support the delivery of the Trust's mission of excellent care everywhere. Risk 6. If this risk – that We are unable to configure our services and sites to enable us to deliver the Trust's annual performance plan leading to patients having a poor experience and increased safety risks due to extended waits for their treatment – is not mitigated, the trajectory of complaints will continue to increase. Risk 11. If this risk – that we are unable to support, guide and delivery the level of change required to successfully deliver the strategy - is not mitigated, the trajectory of complaints will continue to increase, and patient experience will remain compromised.					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	Yes	Yes	Yes	Yes	Yes	Yes
Other impacts	Equality and Diversity (if yes has HEIA completed)		Environmental	Legal	External Registrations (if yes please indicate which)	
	N/A		N/A	N/A	N/A	



University Hospitals Sussex
NHS Foundation Trust

UHSx Patient Feedback and Insights

November 2025



Introduction

This report sets out how University Hospitals Sussex receives, hears and analyses the voice of patients, including how this shapes the delivery of services through proactive surveys, and through contacts from patients, such as via PALS and complaints. Examples are shared of how the voice of patients has shaped improvements.

Taking the main themes from both positive and less positive feedback, an analysis is presented to describe which are the main opportunities for improving patient experience. These opportunities include reducing waiting times, acting on follow up actions and appointments in a timely way and improving staff behaviour and communication.

The performance of the Trust in managing and responding to complaints is also set out. An increasing trajectory of complaints being received is noted, with an increasing trajectory also observed in the other large trusts across the country indicating a national trend for more, and more complex, complaints in the NHS. Improvements in the length of time taken to respond to complaints, and the number of complaints re-opened is also evidenced.

The demographic profile of patients participating in surveys and raising complaints is explored. This profile is identified to be reflective of the population as a whole in terms of ethnicity, with inpatients more likely to be older (in line with the profile of hospital inpatients), and complaints more likely to be in the 35-69 age group. A high prevalence of complaints from patients living in the BN2 postcode area is noted, with the reasons for this not fully understood.

The report also summarises improvement activity in response to insights from previous years, and the impact they have had on patient experience. This includes improvements in customer service, food availability for inpatients and engagement of families.



How do we hear the voice of patients?



C120,000 responses via '**Friends and Family Test**' – Patients are asked to rate their experience from 1 (very good) to 5 (very poor) and asked to provide the reason why. This data is available by site, service, ward and division, and by a word search function.



Hundreds of patients respond annually to **national patient surveys**, commissioned by the CQC, which are distributed at nationally defined intervals and include surveys for emergency care, inpatients, maternity, children and young people, cancer and others.



The Trust now receives over 2000 **complaints** a year, with a further c18,000 concerns received through **PALS** which are resolved informally. This is on an increasing trajectory, and each contact provides valuable feedback for learning.



Bespoke and targeted **engagement** with patients is enabled to ensure the voice of patients has influence over planned change and transformation. The engagement approach is designed to meet the objectives of each project.

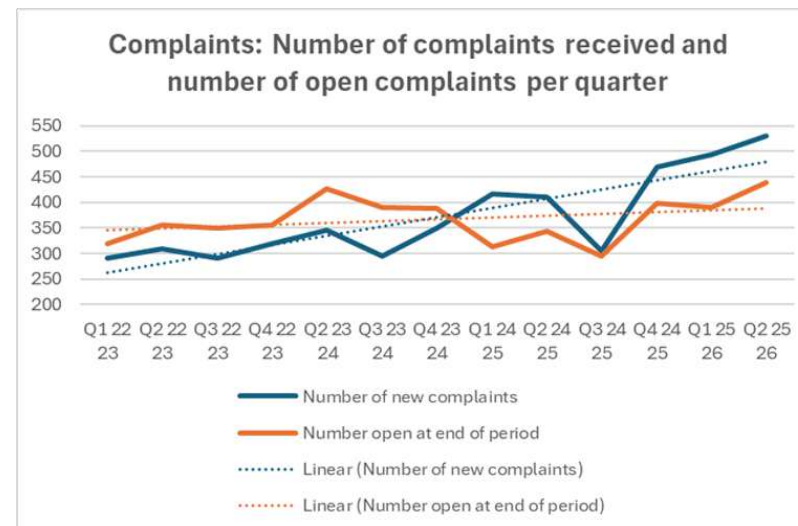


Partnership working, in particular with organisations such as Healthwatch which are focused on engaging the voice of patients and communities, provides unique and complementary insights on the experience of service users.

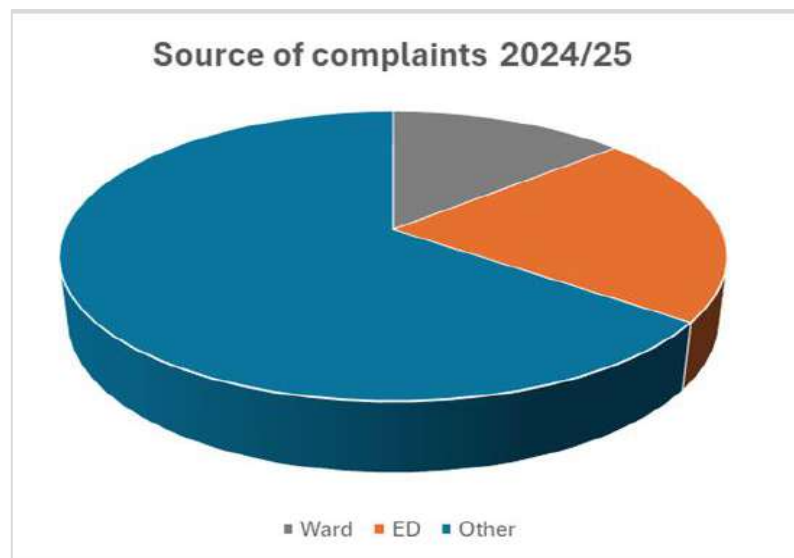
Main themes – feedback from patients and their families

- ▶ Most feedback is positive about care. Most concerns **do not** relate to inpatient or ED experiences.
- ▶ Increases in complaints received have been partially mitigated by increasing efficiency and improvement in complaints management processes.
- ▶ The summary themes from different sources of patient concerns are as follows:
 - From **PALS** – appointment issues, delays in following up or lack of communication
 - From **complaints** – waiting (for appointments, surgery, treatment, tests, follow up actions and results), clinical care, lack of or poor communication, staff attitude and behaviour. The volume of complaints is on an upward trajectory, with a 65% increase since 2022/23.
 - **Surveys** – waiting for admission or a bed, noise at night, waits and communication in ED
 - **FFT** – waiting/ delays – usually on site to be called (5.25% of all reviews), staff behaviour (1.75% of all reviews), pain management (1% of all reviews). Overall, % of positive reviews is increasing.
- ▶ The main concerns raised by patients are included in the new Trust Strategy, with the patient experience priorities to be integrated into the delivery plans.

Volume of complaints



Sources of complaints



Improvements: You said, we did



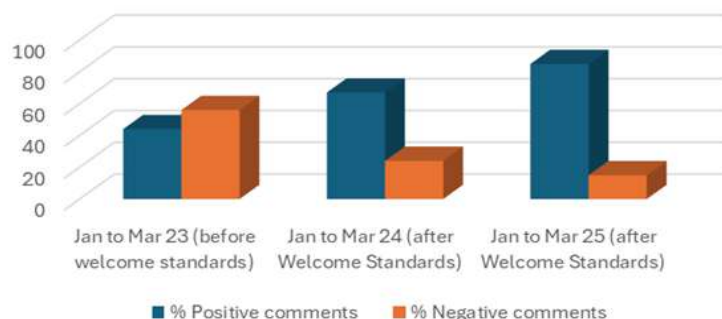
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Improvements have been prioritised in response to patient feedback themes. Examples include:

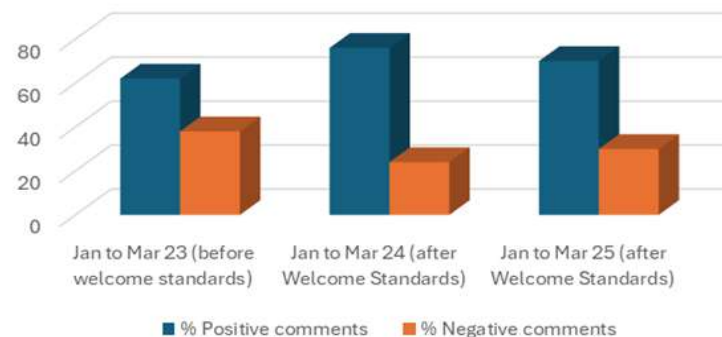
- ▶ **New systems for tracking overdue follow ups** which provide data to support divisions in managing waits, and use of patient-initiated follow-up, although there is more to do in establishing a trust-wide approach to this. New KPIs for cancer services are helping to assure that timely advice and guidance, clinical reviews and results are being undertaken by doctors.
- ▶ **Welcome standards training** for receptions and greeting roles has resulted in a reduction in complaints about reception staff. This programme is shortlisted in the HSI 'data-led transformation' award category, 2025.
- ▶ **New visiting times engagement and policy** has focused on supporting improved communication with families – 85% of patients surveyed now report that visiting times are helpful for them. Previous changes to visiting in maternity resulted in improved patient survey results and positive feedback from maternity and neonatal voices partnership.
- ▶ **New discharge processes and protocols** have been pioneered, led by the senior nursing teams, with a lower % of complaints about discharge planning received (3.7% of all complaints from 4.1% in 2023/24)
- ▶ **Improved food offer**, led by hospital directors of nursing. Improvements from the 2023 survey included access to food, with 81% of patients reporting positively about access to food (up from 76% the previous year)
- ▶ Patient engagement shaping a **new colorectal cancer service** in 2025 – a speciality which generated high numbers of complaints in 2024/25

Examples of improved patient experience of receptions

SRH ED Welcome standards impact: % positive comments about reception customer services before and after



PRH ED Welcome standards impact: % positive comments about reception customer services before and after



Main themes – positive feedback



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127537 reviews received in the year to October 2025, of which 91% were positive. The % of positive reviews has increased over the past 18 months – patients are increasingly satisfied with the quality of care. The main drivers of positive reviews were:

- ▶ **The staff** – attitude, kindness, care, professionalism and quality of treatment
- ▶ **The service** – efficiency and timeliness

More than ten times as many positive reviews about staff than negative.

Positive reviews about individual staff area also received in complaints and plaudits via PALS.

Most prevalent feedback in FFT 24/25

Top 10 Words			
+ Positive		- Negative	
1. Staff	30302	1. Hours	2667
2. Good	14763	2. Staff	2224
3. Friendly	12868	3. Waiting	2102
4. Time	12713	4. Time	1925
5. Service	10904	5. Wait	1883
6. Excellent	10284	6. Doctor	1608
7. Seen	10123	7. Seen	1382
8. Professional	9035	8. Pain	1315
9. Care	8645	9. Nurse	1232
10. Efficient	8554	10. Long	1107

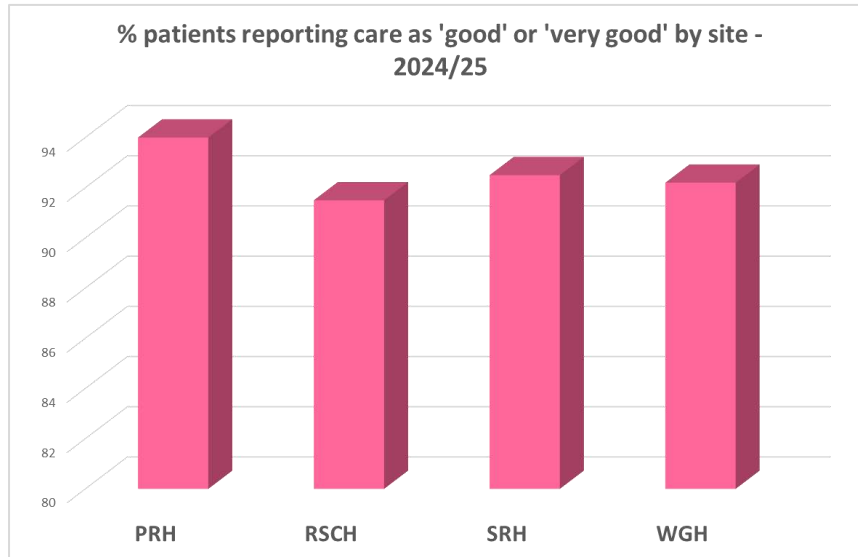
I have to have blood taken every 6mths. Every time I have attended, I have been seen on or before my appointment time. ALL staff that I have encountered in the department have treated me with kindness and courtesy.

The staff were very friendly, caring, and courteous. They were genuinely interested in providing quality service. The atmosphere was friendly and nice.

Overall, everything was very good. Everyone was very nice, and I was impressed with the bedside manner of the nurses, anaesthetist, surgeon, porters and admin staff

Patient experience by site

% patients reporting experience as good or very good by site

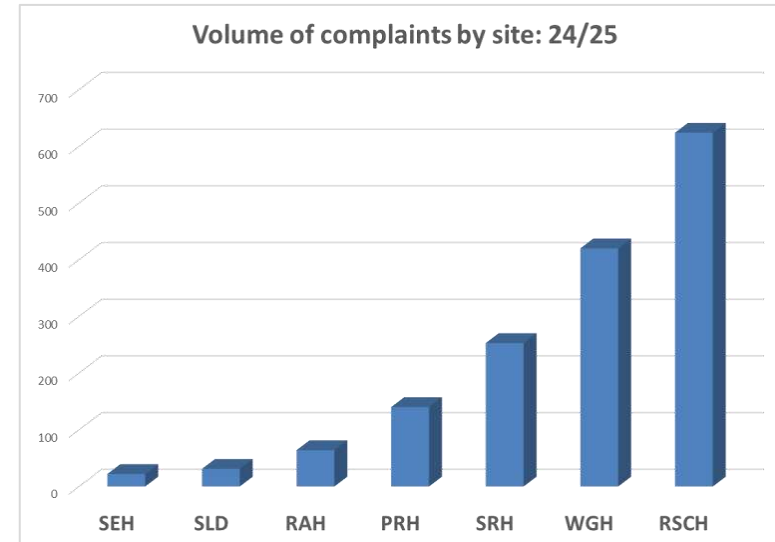


The 127, 537 reviews received in the year to October 2025 identified similarly high levels of positive experience across sites.

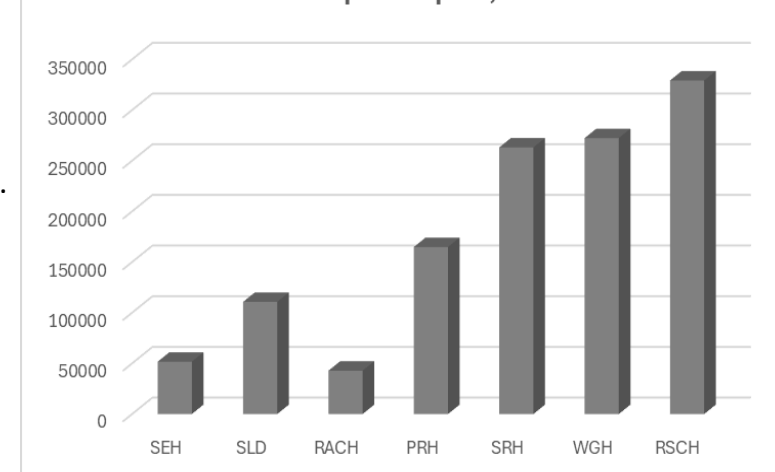
Despite this generally high, and increasing, rate of patients reporting their care to be good or very good, the volume of complaints received has continued to increase, with a variation in volumes received by site. There is some correlation with the volume of activity by site.

As described in the sections to follow, for many patients the wait for care or follow up action is a driver of the complaint, and the high numbers of complaints at RSCH is consistent with data on waiting times and size of waiting lists.

Number of complaints by site



No of OPAs per hospital, 2024/25



Issues with delays and appointments – thematic review



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Delays, waits and disruptions is the most prevalent theme in all sources of negative patient feedback.

In the recently published inpatient survey, the Trust scored worse in comparison to the average for the length of time on the waiting list before admission, and quality of information whilst waiting. This resulted in the Trust being second from bottom in the region for 'admission to hospital' and dropped overall ranking. The Trust was not in the bottom five of the region for any other domain.

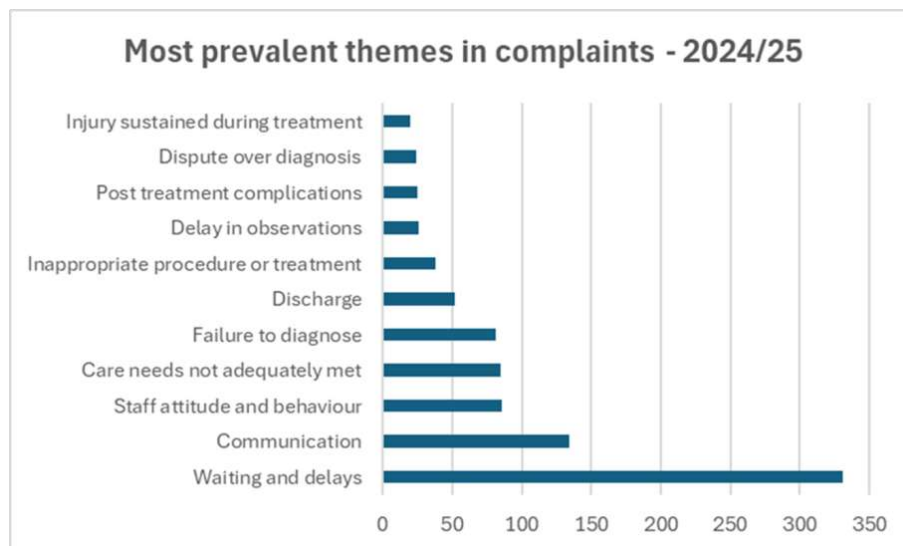
Appointment issues are the second most prevalent cause of concern for contacts to PALS.

Seen on time, very caring and professional staff throughout from admission to clinicians, explained procedure and aftercare thoroughly. The only downside was making the appointment itself. Received a letter with ambiguous message about being on a waiting list although mine was a not a routine case. Then struggled for several days to get through on phone. Voicemails and emails were not answered. Eventually got through and was offered appt quickly, which was a huge relief. On the day, all was very good.

Inpatient Survey 2024 – UHSX performance against the region for 'admission to hospital'

Admission to Hospital			
	Highest	Lowest	
Queen Victoria Hospital NHS Foundation Trust	8.4	Isle of Wight NHS Trust	6.1
University Hospital Southampton NHS Foundation Trust	7.1	Ashford and St Peter's Hospitals NHS Foundation Trust	5.9
Royal Berkshire NHS Foundation Trust	7.0	Buckinghamshire Healthcare NHS Trust	5.9
Oxford University Hospitals NHS Trust	6.9	Dartford and Gravesham NHS Trust	5.9
Royal Surrey County Hospital NHS Foundation Trust	6.9	Medway NHS Foundation Trust	5.7
University Hospitals Sussex NHS Trust	5.8		

Most prevalent themes in complaints 24/25



'I contacted the inpatient appointment clerk and was shocked to learn my father was not on their waiting list. The referral was acknowledged by a letter, this was followed by a further letter stating that 'to reduce our waiting times for cataract surgery we are centralising our services on the Southlands site at Shoreham by sea' **Complaint**

The most prevalent reason for a complaint is concern about waiting, delays and cancellations.

Complaints about waiting include the following categories:

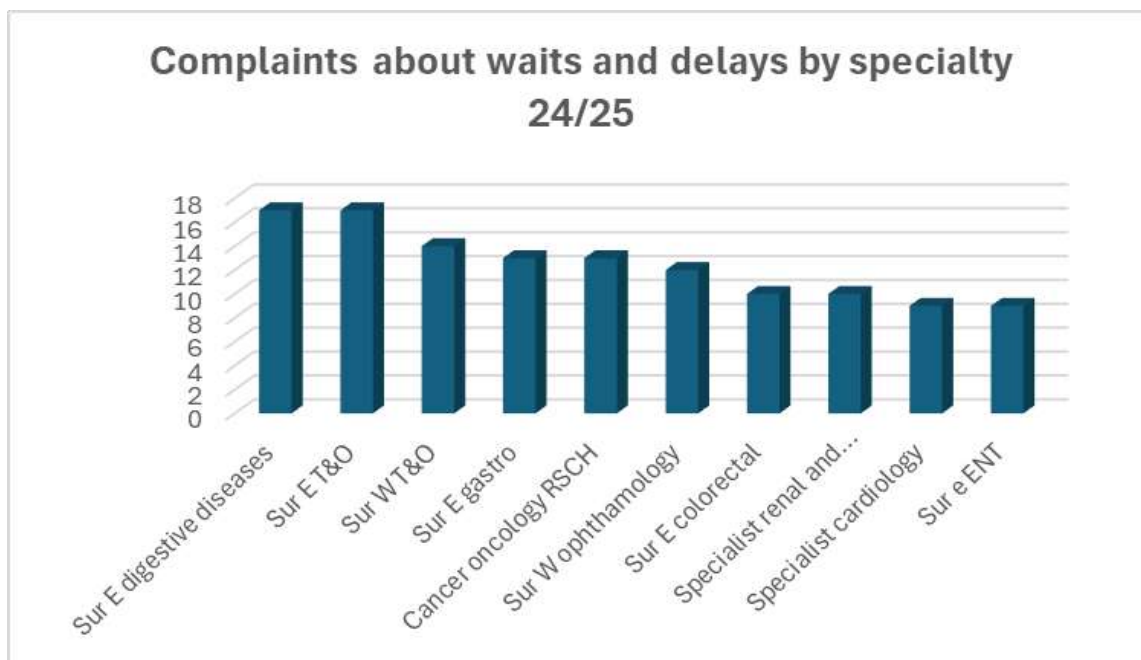
- ▶ Waiting for first appointments and delays in procedures
- ▶ Waiting for follow up appointments, or loss to follow up
- ▶ Delay or failure by doctors to follow up referrals, test results and diagnostics/ scans
- ▶ Appointment cancellations or errors

Complaints about waits for first appointments have increased in line with overall trajectory of increasing complaints. However, complaints about follow ups have increased exponentially.

An increase in concerns about delays is likely to be in part connected to a rise in use of AI by complainants. With AI functions increasing accessibility of the details of clinical guidelines, including recommendations regarding timescales for treatment, patients are more informed about potential risks of delays, and the number of patients quoting clinical guidelines in complaints has increased.

Waits and delays are interdependent with concerns about communications, with patients raising complaints because they have not been kept informed of their treatment plan, timescales or next steps, or because actions committed to were not completed, as demonstrated in figures vii.

Complaints about waits and delays by specialty



Concerns about waits and delays are most prevalent in surgical specialties, and most prevalent at RSCH, which is driving the higher volumes of complaints relating to the RSCH site – rather than the quality of care. There is also some correlation with specialties with the longest waits.

Complaints and concerns are often exacerbated when patients struggle to speak to someone in the clinical team who can answer their questions.

This most prevalent theme also triangulates with patient safety insights, with loss or delay to follow up the most prevalent theme in harms to patients where the grading is moderate or above.



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Please could somebody explain to me how this has taken so long, six and a half months from MRI scan to results consultation and now one month and no written confirmation of results.

Complaint

We also expect the NHS to offer immediate, fully funded egg donor treatment. Having to wait more than nine months for a gynaecology appointment is not only exacerbating the risk of my endometriosis recurring but also depriving me of timely hormonal and symptomatic treatment which I urgently need.

Complaint

The care and attention I have received has been excellent. However, this has not been matched by the ability to communicate with staff. The inability to speak to someone has caused me considered stress which has been detrimental to my poor existing health and wellbeing.

Complaint

Concerns about inpatient care



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Complaints regarding inpatient care make up less than 10% of all complaints received. When triangulated, complaints and inpatient survey data by site, it is identified that Worthing is performing less favourably. The main themes in these complaints were staff availability on the ward, time to seeing a doctor, and basic care.

The Worthing site scored worse than the comparators for waiting for a bed on a ward, taking own medication when need to, information on leaving hospital and knowing what would happen next, for food available outside of mealtimes and staff contradicting each other about care and treatment. These insights from patients are consistent with data held about waits and other quality data, such as patient safety.

Complaints about wards by site



Lower performing scores from inpatient survey relating to Worthing

		2020	2021	2022	2023	2024
Q5	Did not have to wait too long to get to a bed on a ward		78%	73%	68%	55%
Q42	Before leaving hospital knew what would happen next with care		82%	88%	84%	71%
Q24	Staff did not contradict each other about care and treatment		70%	72%	69%	55%

Some care was exemplary but at other times there was no staff evident. **Worthing inpatient**

*I was moved to the surgical ward, even though I hadn't had an operation. I never saw a doctor in over 24 hrs. Then I had to chase the next day 3 times, to see a medical doctor. **Worthing inpatient***

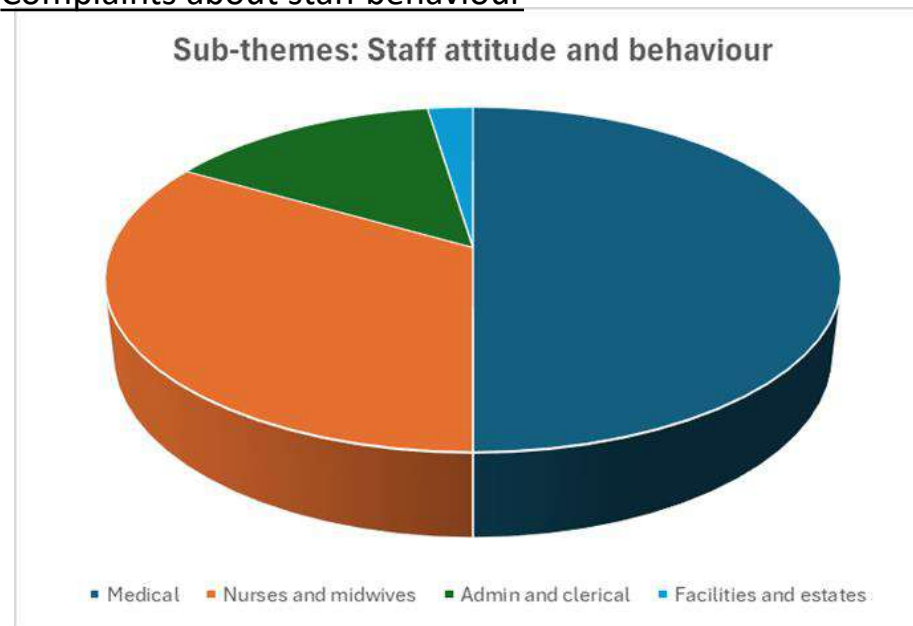
*The staff on emergency ward were lovely. But I had no visit from dr on morning of discharge. I was awaiting MRI results from previous day to find out if I needed surgery. Then all of a sudden I was transferred to a ward thinking i was having surgery. I was there 3 hours until I saw a dr who said u can go home they surgeons said you don't need surgery? Sorry I didn't realise you were here? **Emergency floor patient***

Staff attitude and behaviour

The most prevalent staff group in complaints about staff attitude, and where the greatest increase in complaints has been, is medical (doctor) staff behaviour.

A process to align complaints insights with medical appraisals is in place to manage complaints about individual doctors, and a programme of training on communication skills and professional conduct for doctors is in development.

Complaints about staff behaviour



'Dr X was mocking my use of GLP-1 injections by commenting that "it doesn't look like they're working" while looking directly at me. This was degrading, unprofessional, and deeply upsetting- I also witnessed bullying behaviour, as Dr X belittled nursing staff, telling one to "find a new job" and throwing rubbish on the floor for others to pick up, which was entirely unacceptable in front of patients' **Complaint**

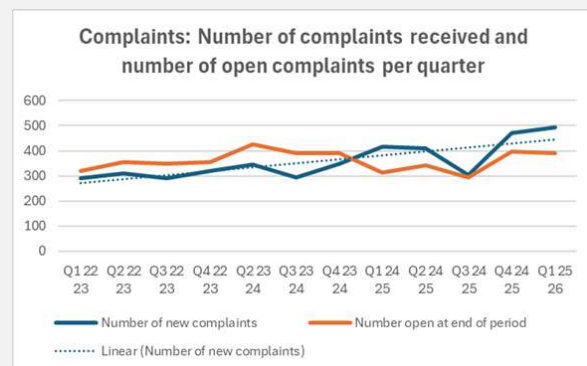
The doctor rushed, didn't listen to my concerns, was dismissive, did a cursory clinical examination. Ruled out one diagnosis and didn't consider differential diagnosis. The discharge letter was completely inaccurate regarding my symptoms. Because he was disinterested and did not listen. **FFT response**

Complaints management – headline data



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Number of complaints received

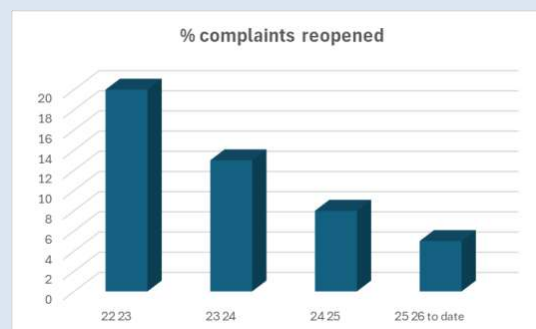


An increasing trajectory of complaints received, consistent with large Trusts across the country, is observed. Improvements in process and efficiency have reduced the number of long open complaints and the % and number which are re-opened.

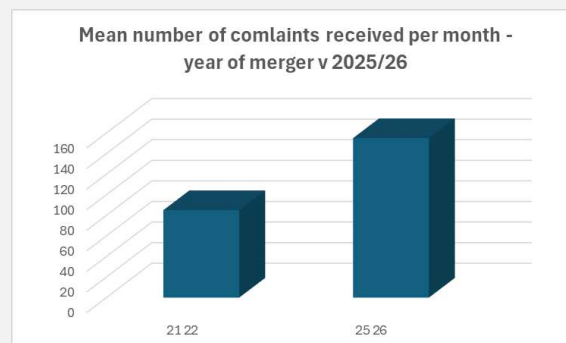
Compared with other trusts in the south-east, UHSx performs well in PHSO investigation numbers.

However, the mitigation to increasing volumes provided by improving the complaints management process is finite and countering the increasing number of open complaints whilst maintaining performance requires addressing the causes of poor experience for patients.

% complaints re-opened



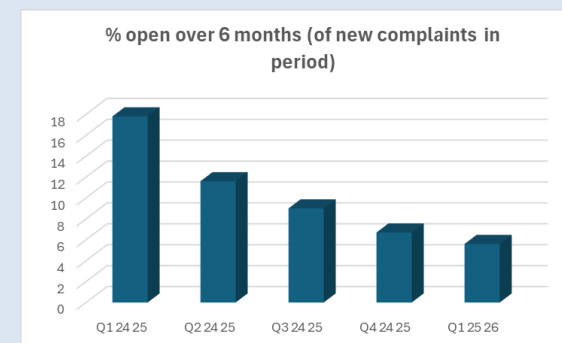
Monthly complaints received: 2021 v 2025



PHSO



% complaints open over 6 months



Complaints management – comparative data



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Complaints management metrics are not defined nationally, and as such, comparison across Trusts is imperfect. From the data published by other large trusts, the trend of increasing volumes of complaints is universal, with many Trusts experiencing challenges with maintaining performance against closure targets and re-open rates as a result.

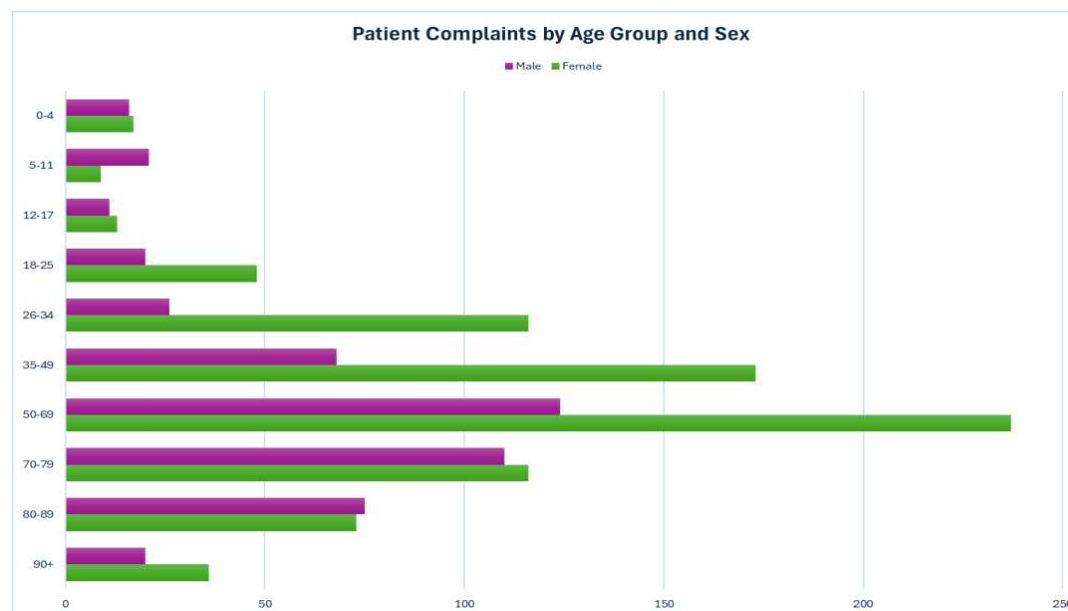
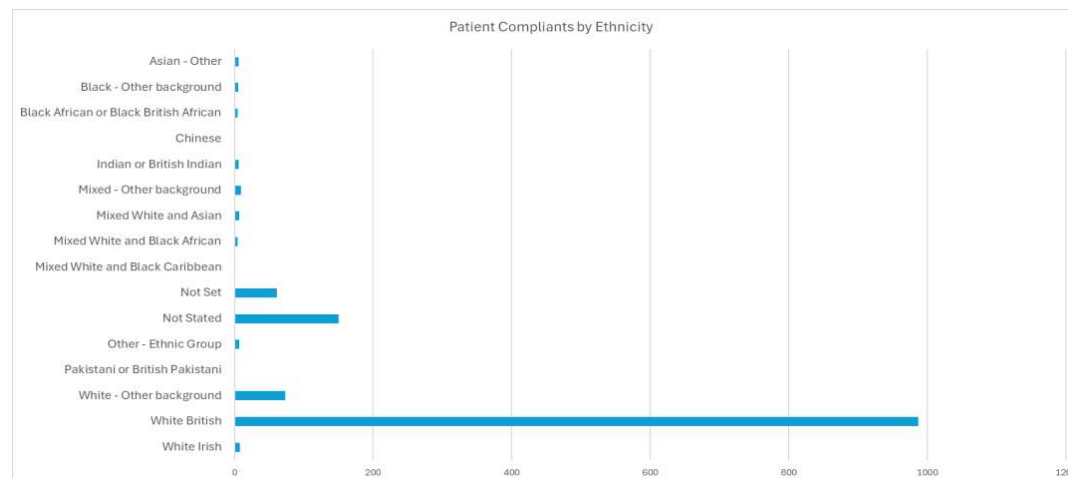
NHS Hospitals Trust	Number of complaints received–direction	Compliance with performance standard (closure)	Re-opened	Number received in 2024/25	Notes
Sussex	↑ 30% on previous year	→ Compliance (mean 60WD)	↓ 5%	1589	Target 60WDs. Estimated 2,050 complaints in 25/26
Barts	↑ 29% on previous year	↓ compliance	↑	2121	Negotiate timeframe for response with complainant – currently 70% against target of 80% compliant
Manchester	↑ on previous year	→ Compliance	↓ 16.9% (23/24)	2107 (23/24)	24/25 data not published. Timescale negotiated with patient
Cambridge	↑ 23% on previous year	Not clear	Not published	911	Negotiate timeframe for response with complainant – currently 57%
Oxford	↑ 13% on previous year	Not clear	↑	1518	50% closed in 25 WDs
Kings	↑ 4% on previous year	↓ compliance	→5%	1184	Report 65% increase in complex complaints
Birmingham	Not published				

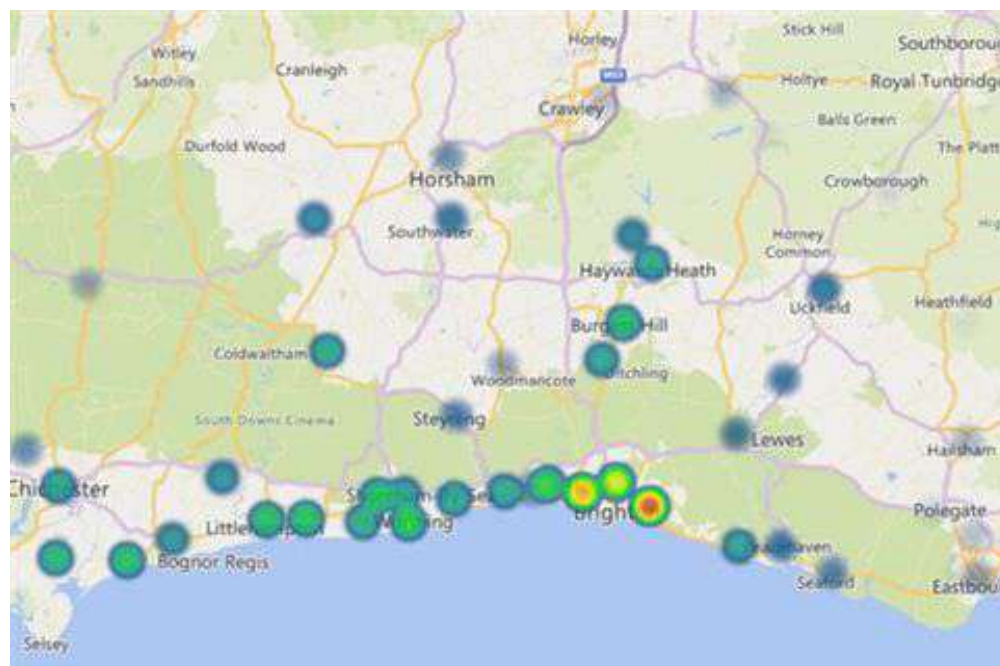
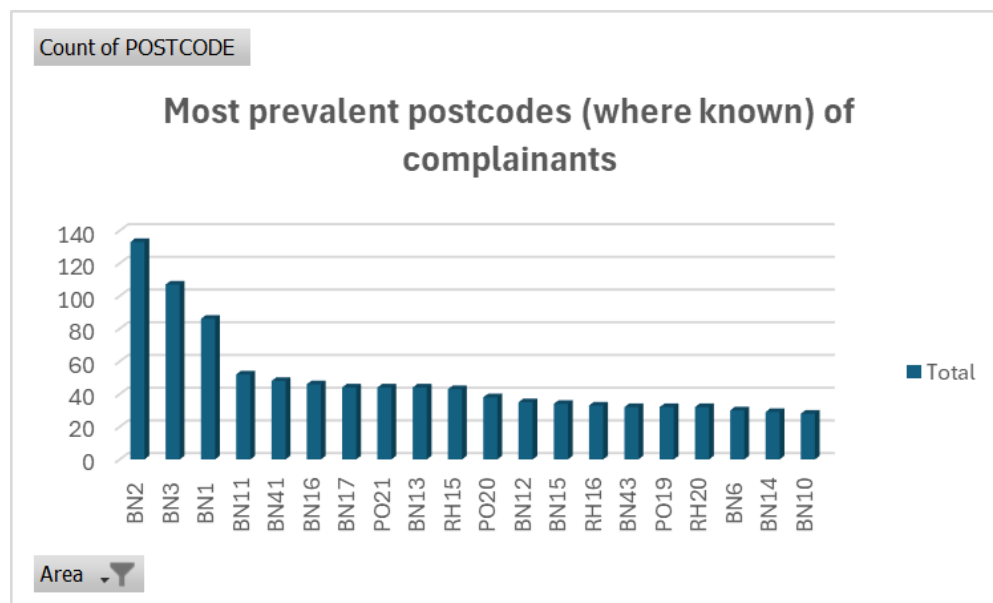
Demographic profile of patients providing feedback

The profile of patients feeding back to the Trust using national **patient surveys**. 96% of respondents to the inpatient survey identified as 'white' compared to the population as a whole in Sussex (c91% white – census 2021).

However, older people and those with a long-term condition were over-represented in survey respondents, in line with the older profile of hospital users. 68% of respondents were aged 66 or older, and as the younger population is more diverse, the difference may be explained by age as a confounding factor. Surveys are available in a range of formats to support inclusion.

The demographic profile of patients issuing complaints is slightly different with patients aged 35-69 most prevalent. C91.5% of complaints where the ethnicity of the patient is known were from 'White British' patients. As such, the profile of complainants has a similar ethnic profile to the population as a whole.





The most prevalent postcodes for complaints are in the Brighton area.

There is correlation between density of population and volume of complaints, however the prevalence of complaints received from the BN2 postcode area is not understood. Compared to other localities served by the Trust, BN2 has a higher density of wards in the most deprived quintiles than other parts of the Sussex population served by the Trust.

What comes next

Implementation of the new Trust Strategy will see many of the driver of poor patient experience addressed. The Big Conversation told us that patients want shorter waiting times, excellent standards of care, to be listened to, to be able to get appointment and treatment easily, and better communication and administrative processes.

Specific actions to address the concerns raised by patients include:

- ▶ A programme of communication skills training for doctors, including at scale, in hot spot areas and for individuals where there a frequent complaints, is in development for implementation from April
- ▶ Operational teams are engaging a new company to support with management of follow ups
- ▶ Operational teams are engaging a new company to support with management of follow ups
- ▶ Plans for an integrated contact centre are included within the strategy
- ▶ Development of a trust-wide PIFU process is planned
- ▶ Nursing Quality Assurance Group and processes will continue to triangulate insights from quality sources to direct improve activity and monitoring to target inpatient areas.
- ▶ Plans are being developed for higher risks specialities, such as cancer, ophthalmology and degenerative diseases to ensure patients requiring monitoring or treatment are seen and reviewed in a timely way
- ▶ Expanding service KPIs to other specialities regarding medical tasks such as advice and guidance, clinical reviews, sharing of test results and letters are actioned in a timely way.
- ▶ The potential for expanding netcall to support communications with patients awaiting follow up is being explored.



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Excerpt from the new Strategy – Excellent Care Everywhere

Patients said they want:

- Shorter waiting times for appointments, treatments, and urgent and emergency care.
- Excellent standards of patient care - receiving the most appropriate treatment, delivered by kind staff who have time to provide the care needed.
- To be listened to and receive personalised care that considers them as an individual.
- To be able to get to appointments and treatment easily, to have care closer to home, to have access to parking, and to be able to use public transport to get to appointments.
- Better communication and administrative processes both with patients, and between different departments.

"Staff are friendly and want to help – efficient, warm and caring. They're knowledgeable and inspire with confidence"

Member of the public

"Look at the whole picture not just the one thing the person is being seen for that day."

Member of the public

Agenda Item:	9.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025
Report Title:	One UHSussex - Developmental Well-Led Review – Next Steps				
Sponsoring Executive Director:	Dr Andy Heeps, Interim Chief Executive				
Author(s):	Dr Andy Heeps, Interim Chief Executive				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only	
	N/A	N/A	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	Yes	
Regulatory Reporting Requirement					
Summary of the report describing What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i> Since publication of the Niche developmental well-led review, the Trust has made sustained progress against all four pillars of its response. A co-designed Values and Behaviours Framework has been tested with staff and is being refined for launch in December. Procurement is underway for an external partner to deliver a culture programme across the Trust. So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i> Tricordant's final Trust Operating Model recommendations propose four cross-Trust divisions, each led by a Managing Director and supported by embedded corporate functions. Consultation will begin in December with a go-live target of 1 April 2026. An external governance review provides a clear blueprint for committee and assurance structures to sit around the new model. An external review of HR policies and processes has been commissioned to ensure policies are fair, consistent and aligned with new behavioural standards. What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s) being made)</i> This work is beginning to rebuild confidence in the organisation's leadership, culture and structure and create our new One UHSussex culture. The framework and leadership programme will give clarity about expectations and accountability, while the new operating model will create a simpler, more coherent Trust with balanced professional leadership and fit-for-purpose corporate support. Staff engagement has been positive, though many leaders are understandably anxious about change through a challenging winter. The Board's continued visibility and reinforcement of this work remain essential to maintaining momentum. What Next In December we will launch the Values and Behaviours Framework and open formal consultation on the new Trust Operating Model. February–March will focus on leadership programme rollout, readiness checks and change controls, aiming for TOM go-live on 1 April 2026.					
Recommendation <i>(linked to What Next section)</i> Note progress across all four pillars Note the December launch of the Values and Behaviours Framework.					

	Note the TOM consultation approach and timeline, including target go-live on 1 April 2026 and incorporation of corporate functions and governance changes.					
Assurance / Scrutiny route already undertaken <i>(please explain where matter previously considered, and assurance provided)</i>						
Link to Trust Strategy <i>(note which theme)</i>	Care	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan	N/A					
Link to BAF <i>(explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)</i>	The findings of the Developmental Well-Led Review have implications for all current Board Assurance Framework (BAF) risks, particularly those relating to leadership capacity and capability, culture and behaviours, staff experience, governance effectiveness, and delivery of strategic objectives. The recommendations and associated cultural narrative may affect both the current risk scores and the assurance profiles. As part of the response programme, all BAF risks will be reviewed to ensure they reflect the issues identified, with adjustments made to scoring, controls, and assurance sources as appropriate. This will ensure the BAF remains an accurate tool for Board oversight during the implementation of the developmental well-led programme.					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	N/A	N/A	N/A	N/A	Yes	N/A
Other impacts	Equality and Diversity <i>(if yes has HEIA completed)</i>	Environmental		Legal	External Registrations <i>(if yes please indicate which)</i>	
	N/A	N/A		N/A	Yes – CQC, NHS England	

Building One UHSussex: Progress Update on Our Response to the Developmental Well-Led Review

Dr. Andy Heeps, Interim Chief Executive

November 2025

Introduction

When Niche Health and Social Care Consulting published its developmental well-led review in July, the Board accepted all twenty-two recommendations in full and agreed a single, integrated response built around four pillars: Behaviours and Culture, Leadership Development, Structure and Governance, and Policy, Process and Systems. This paper provides an update as of November 2025, four months into delivery. It shows steady progress across each pillar, increasing alignment with our *Excellent Care Everywhere* strategy, and the early impact of stronger oversight and shared ownership across the organisation.

Behaviours and Culture

Our co-designed Values and Behaviours Framework has now been widely tested across the Trust, including at the October Staff Conference, where more than a thousand colleagues took part in discussions about what good behaviour looks and feels like at UHSussex. Feedback from those sessions has been encouraging: staff recognised themselves in the framework's focus on compassion, respect and inclusion, and valued that it describes behaviours at every level from team member to executive.

There is, however, a view that it needs to go a step further in a few key areas. Colleagues have asked for a stronger emphasis on taking personal accountability, acting truthfully, contributing actively to improvement, and being a consistent and supportive team player. They also highlighted the importance of setting clear expectations about behaviour within accepted social and professional norms—particularly those that ensure physical and sexual safety for everyone. That feedback is now being built into the final version.

Once approved in December, the framework will be embedded into recruitment, appraisal and recognition processes, and will underpin refreshed policies on conduct and performance. It will become the anchor for how we work together day to day, linking directly to the People ambition of *Excellent Care Everywhere*. Alongside its launch, we will seek to introduce a simple composite measure of organisational culture so that the Board can track progress in the same way we track quality and finance.

Leadership Development

We are nearing completion of the procurement process to appoint an external partner who will deliver a comprehensive programme of leadership and culture development across the organisation. This partner will help us translate the new values and behaviours framework into everyday practice—supporting leaders at all levels to build psychological safety, hold constructive conversations, and model the standards expected of others. The programme will begin early in 2026, starting with the senior leadership group and then cascading through divisional and directorate leadership teams as the new operating model takes shape.

This work will ensure that leadership development becomes part of the Trust's routine discipline rather than a one-off intervention. It will also support succession planning and create a common language of leadership that reaches across professional

boundaries. Together, these changes will deliver the Leadership ambition of our strategy: capable, compassionate and inclusive leaders everywhere.

Structure and Governance

We have now received Tricordant's final recommendations for the new Trust Operating Model. The proposal represents the most significant organisational redesign since merger, moving UHSussex to four cross-Trust divisions, each led by a Managing Director who will sit on the Executive Management Group and attend the Board and its committees. This model introduces senior clinical leadership at site level and standardises the triumvirate structure within 35 clinical directorates, so that accountability and professional balance are consistent everywhere.

Importantly, the new model extends beyond clinical divisions. It incorporates the corporate functions, ensuring that support services are fit for purpose, consistent and aligned with the needs of frontline teams. Embedded business partners from finance, HR, digital, performance and quality will work within each division while maintaining clear professional links to corporate centres of excellence. This approach aims to combine local responsiveness with strong standards and efficiency.

Alongside Tricordant's work, we have received the governance review from Leanne McLean, former Interim Chief Nurse. Her recommendations will inform the governance and assurance arrangements that sit around the new operating model, clarifying a scheme of delegation, escalation routes and the interface between divisions, sites and the Board. Taken together, the two reviews provide a coherent blueprint for how accountability, assurance and leadership will operate across the Trust.

Formal consultation on the new model will begin in December and run through January, with a planned go-live date of 1 April 2026. We recognise that this will coincide with a challenging winter and that many leaders will feel uncertainty about the future shape of their teams. We are being open about that and will provide regular updates and support throughout. The imperative, however, is clear: getting the structure right is essential to long-term clarity, stability and performance. This work lies at the heart of our *Excellent Care Everywhere* ambitions.

Policy, Process and Systems

An external review of our HR policies and processes has now been commissioned by the interim CEO. The review will benchmark our approach against comparable trusts, assess whether policies are fair and transparent, and test how well they reflect our new values. Early engagement has already identified that our performance, capability, grievance and dignity-at-work policies need simplification and clearer guidance for managers. Interim findings are expected in January 2026 and will inform a staged refresh through the spring.

This review is an important foundation for rebuilding confidence in our people systems. Staff have told us repeatedly that inconsistent or overly complex procedures undermine trust. By aligning policy reform with the new behavioural standards and leadership expectations, we will create a fairer, simpler framework that supports early resolution and mutual respect.

Oversight and Alignment

Each pillar continues to have an Executive Director lead, with the Interim Chief Executive acting as Senior Responsible Officer. Progress is reviewed monthly by the Board. The response is fully integrated with the *Excellent Care Everywhere* delivery plan so that structural, cultural and improvement work move forward together.

Forward Look

Between now and the spring, the priorities are clear. The Values and Behaviours Framework will be finalised and launched in December. The leadership development partner will be appointed and begin detailed design work over the winter. Consultation on the Trust Operating Model will run through December and January, with implementation preparation in February and March for go-live on 1 April 2026. The HR policy review will deliver its initial findings in January, allowing alignment with the launch of the new framework and leadership programme.

Risks and Dependencies

Delivery is on track, but three dependencies are critical. First, the success of the new operating model depends on the behavioural and leadership work progressing in parallel; new structures alone will not change culture. Second, winter pressures may reduce the capacity for engagement and consultation, so we are keeping communication focused and using short, high-impact sessions to reach key groups. Third, the sequencing of HR policy reform must stay closely aligned to the new behavioural framework to avoid sending mixed signals about what is expected of staff and managers. These risks are being actively managed through the programme governance arrangements.

Conclusion

Four months on from publication of the Niche review, the Trust has moved from reflection to delivery. The new Values and Behaviours Framework, the leadership development programme and the redesigned operating model together form the foundation for lasting change. We are realistic about the challenges ahead and the pressure the winter will bring, but the direction is clear. By aligning structure, culture and leadership around our shared purpose, we will create One UHSussex: a Trust where people feel safe, respected and supported, and where patients experience excellent care everywhere.

Dr Andy Heeps
Interim Chief Executive
November 2025

Agenda Item:	10.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025	
Report Title:	Integrated Performance Report					
Sponsoring Executive Director:	Andy Heeps, Interim Chief Executive					
Author(s):	Various Executives					
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only		
	N/A	N/A	Yes	N/A		
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)		
	N/A	N/A	N/A	N/A		
Regulatory Reporting Requirement	The Board is expected to receive routine reporting on the Trust's performance.					
Summary	Please see enclosed the integrated performance report for University Hospitals Sussex. It shows our performance to September 2025 and sets out the progress we are making to deliver the Trust's priorities, the NHS National Oversight Framework (and associated league tables launched from July-25) and the NHS Operating Plan, framed against the new Trust Strategy which will develop further over the next few months with its associated delivery plan. Where possible and meaningful we will use Statistical Process Control to illustrate special cause variation beyond normal variation to help focus on key changes to performance. We have also included some of the key corporate projects underway to support our future success. This report provides the Board with an overview and headlines of the Trust's performance, and is aligned to the new trust strategy five key ambitions: our patients, our people, our communities, our future, and One UHSussex. The metrics shown fit under these ambitions, and follow that structure. This supports our ten year goal and overall aim of excellent care, everywhere, which aligns with NHS national objectives and our local aims.					
Recommendation <i>(linked to What Next section)</i>	The Board is asked to NOTE and DISCUSS this report.					
Assurance / Scrutiny route already undertaken <i>(please explain where matter previously considered, and assurance provided)</i>	This is the standing report and is presented directly to the Board, however specific elements of performance have been scrutinised via the relevant Board Committees.					
Link to Trust Strategy <i>(note which theme)</i>	Patients	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan	This report provides a summary overview of the delivery of the Trust's annual plan					
Link to BAF <i>(explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)</i>	This report relates to several BAF strategic risks, covering people, quality, performance and finance.					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	Yes	Yes	Yes	Yes	Yes	Yes
Other impacts	Equality and Diversity <i>(if yes has HEIA completed)</i>		Environmental	Legal	External Registrations <i>(if yes please indicate which)</i>	

	N/A	N/A	N/A	N/A





University Hospitals Sussex
NHS Foundation Trust

Integrated Performance Report

September 2025

Excellent
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Chief Executive summary

Excellent
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Everywhere

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Chief Executive Summary

Please see enclosed the integrated performance report for University Hospitals Sussex. It shows our performance to September 2025 and sets out the progress we are making to deliver the Trust's priorities, the NHS National Oversight Framework (and associated league tables launched from July-25) and the NHS Operating Plan, framed against the new Trust Strategy which will develop further over the next few months with its associated delivery plan. Where possible and meaningful we will use Statistical Process Control to illustrate special cause variation beyond normal variation to help focus on key changes to performance. We have also included some of the key corporate projects underway to support our future success.

As categorised in the body of the report the new trust strategy has five key ambitions: our patients, our people, our communities, our future, and One UHSussex. The metrics shown fit under these ambitions, and follow that structure. This supports our ten year goal and overall aim of excellent care, everywhere, which aligns with NHS national objectives and our local aims.

We will illustrate our performance against the metrics within these ambition areas, describe what has happened, whether it is significant, whether it is in keeping with our key plans, and strategy objectives, and where we are behind target or planned recovery, the key actions we are taking next to improve the position.

In reading the report it is important to understand the individual indicator, but also how the metrics may interact, or triangulate with each other. We have an additional section against our metrics which starts to describe these interdependencies. By way of example, the below table illustrates examples of how various measures often inter-relate:

Themed areas	KPI1	KPI2	KPI3	KPI4	KPI5
Emergency Pressure/Flow	A&E 4 hr wait	A&E Attendances	Ambulance handovers	Bed Occupancy	No Criteria to Reside
Planned Care Backlog	Diagnostics Performance	Elective Activity	Planned care backlog	Waiting List Size	Referral Demand/Clock Starts
Safe staffing and care quality	Staffing Levels	Safety incidents	Patient Experience FFT		
Early diagnosis and treatment delays	Cancer Waiting Times	Diagnostics	Oncology Workforce (Capacity)	Cancer Referrals (Demand)	
Cost Control and workforce sustainability	Financial Position	Bank and Agency Spend	Staffing Vacancy Rate		
Patient experience and safety flags	FFT	Complaints	Serious Incidents	A&E Wait Times	Elective Waits

Chief Executive Summary page 2

Overall Trust performance during September remained stable, with continued pressure across urgent and emergency care pathways and incremental improvement in planned care recovery. Workforce, finance, and quality indicators remain broadly in line with trajectory, although several areas require ongoing focus to ensure delivery of year-end targets. The Trust has an exciting range of ongoing major projects which will enhance patient care across various services as part of our strategic plans.

Our Patients

Performance against the Standard Hospital Mortality Index (SHMI), has improved comparatively over the past three reported months, and has remained within an expected range throughout the year. This information runs in arrears to June so as to capture other trusts relative performance against our own.

Incident rates per 1000 bed days are tracked each month and by their severity. The Trust strives for improved levels of incident reporting to encourage continuous learning as part of an open and transparent culture. Latest incidents are within expected range for acute trusts. Key themes from incidents, include falls and pressure ulcers as key contributors, alongside waiting time delays for elective appointments, which the Trust continue to improve as part of elective recovery plans. Falls Rate per 1,000 bed days September 2025, was 4.58, with an average rolling year 4.46 against a target of 4.2. Overall, Trust data is tracking along the mean average and within the upper control limit, for both the number of falls and the number of falls per 1,000 bed days. Work continues with harm free care alongside divisions to undertake risk assessments relating to bed rails, and blood pressure levels, to reduce risk. The pressure ulcer damage rate, has been below the mean average (Apr-24 – Sep-25) over the past 5 months and has reduced since March 2025 from 185 to 149 in month. The mattress audit and replacement programme are actions to reduce pressure ulcers further. Pressure ulcers and falls both impact patient experience, outcomes and length of stay and recovery in hospital.

Trust constitutional access standard performance saw improvements in diagnostics (significantly above national average 6 week performance), and elective waits (referral to treatment waiting times – RTT) in September. Whilst elective waits remain a material issue for the Trust, reflected in the Trust being in Tier 1 for elective support from NHSE, the Trust hit all its recovery targets associated with long waits, waiting list size, and RTT performance in September. This impacts patient experience, and has a relationship with our financial performance, including ambition to improve productivity for outpatient and theatre utilisation within budget where possible. The Trust is gradually improving its relative rank for longest waits. This remains a key focus area for the operational teams.

Cancer performance for 62 day performance whilst below national average, was on track against its recovery target September. Faster diagnosis performance was below trajectory. In both cases the largest challenge has been for skin patients which has a significant peak in demand during summer which exceeds capacity. Actions to mitigate this have started to positively impact into October. Early intervention can affect patient outcomes and experience, and has inter-relationships with rapid diagnostic review one of the key causes for delay.

Chief Exec Summary page 3

ED performance at the Trust has remained challenging in quarter 2. In September, the Trust saw 68.95% of patients within four hours. 12 hour performance and corridor care saw an improved position in Q2 despite an uptick in 12 hour waits in September, in comparison to 2024. Work to improve UTC and emergency care environment forms a key part of the Trust strategy. The Trust also has renewed its UEC improvement programme with the intention to help facilitate flow of patients from A&E, to inpatient wards and early supported discharge with help from our community, social care and mental health partners. The trust is targeting improved streaming of patients to urgent treatment centres, same day emergency care (SDEC), to decongest the front door, with quick and enhanced therapy support, improve performance against the safer care bundle and target shorter length of stay, pre and post the point at which a patient no longer requires acute care. This all impacts positively on flow and performance indicators, and influences financial costs, staff morale and nursing cover requirements, patient experience indicators, and health outcomes.

Our People

Sickness levels at the trust have risen marginally in quarter 2 of this year, but remained below the mean average at the Trust over the past 14 months and track peers (broadly in line with Regional averages and better than other Sussex providers). Work to target areas with most sickness continues including F&E and nursing hotspots. Governance and reporting have been enhanced, alongside a mental health action plan. High levels of sickness can impact staff morale, patient care, and cost to fill in clinical areas. There are interdependencies with vacancy rates, and bank/agency costs.

As part of Trust and NHS resilience plans the Trust is undertaking front line staff flu vaccination. At time of writing, 30.1% of staff had received flu vaccination, with an ambition for the year of 50%. The programme continues to help protect staff and patients as we enter the winter period.

Vacancy rates have reduced September to 9.2% and is now within target. A range of recruitment initiatives are being undertaken to further reduce substantive vacancies, although some are held as part of cost control. It is critical that the Trust has a sufficient core workforce to deliver patient care and minimise the use of agency or bank deployment unless necessary. High vacancy levels can impact negatively on quality, staff engagement and activity/performance.

Statutory and Mandatory Training and Appraisal rates performed well over the past quarter, with step change improvements in both of these areas.

Our Communities

Patient experience remained at 90% target to September, albeit a marginal drop, relative to August. A&E FFT remains most challenged with 80%, with links to A&E waiting times, 4hr performance. Work to improve this environment through UTC and other emergency department strategic developments should therefore aid further improvement to patient experience scores.

Chief Exec Summary page 4

Our Future

Performance against statutory financial requirements to break even were on track in September. It is important to note that there is risk into the remainder of the year, as the continued positive variance relies on delivery of its cost improvement programme, in the context of potential further industrial action, continued RTT performance requirements, and delivery of challenging efficiency targets.

Plans to reduce bank and agency spend are behind the challenging 22% agency spend reduction plan this financial year. There are mitigations planned which should help reduce the forecast overspend. There are risks to this delivery as we head into the winter period however. There is a direct correlation to sickness and vacancy rates, which influence this metric.

R&D recruitment to interventional studies continues to improve in relative rank terms, and is a fraction away from our target to be in the top 20% for research studies. There are various actions noted in the body of the report which describe plans to further develop our R&D strategy.

In the body of the report is a brief synopsis of major projects being undertaken within the trust as part of the Trust strategy. These include the Sussex Cancer centre, to improve facilities and patient experience and care for cancer, the helideck, to help support the trust's specialist trauma provision, the Stroke centre, to improve stroke care, development of a clinical research centre, to enhance the research facilities, reconfiguration of RSCH acute floor to support improvements to emergency care and flow, and plans to develop an electronic patient record (EPR) as part of the trust's digital strategy to support digital integration of systems, standardise data capture, and improve reporting. The Trust has also invested in theatre ventilation improvements to improve theatre productivity and resilience and RAAC concrete replacement scheme at St Richards hospital.

One UHSussex

Staff engagement scores are tracking below national average staff survey results, and are a key facet of the trust strategy to improve, aligned with the Trust people plan. Delivery objectives and milestones are being targeted to improve staff engagement.

National performance assessment framework

The Trust has been informed that it is placed within Segment 4 of the revised National Oversight Framework (NOF). The revised framework now contains five segments from best performing segment 1 to those requiring mandated support segment 5. The Trust has submitted its provider capability assessment which as with all providers will be used by NHS England to determine if any new Trusts need to move into segment 5 and into the national Trusts provider improvement programme.

The Trust continues to engage with NHS England and the ICB through their formal oversight processes in respect of all aspects of our performance, which through these quarterly meetings provide assurance on the delivery of Trust's annual plan.

Summaries

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Metric Summary

Strategic Ambition	Performance Measure	Latest	Month	Previous	Direction	24/ 25 Month	Target	Plan	National
Patients	A&E and Emergency flow - % treated and admitted/discharged within 4 hours	Sep-25	68.9%	69.9%	Worse	71.50%	78%	74.60%	75%
	A&E and Emergency flow - Ambulance Handovers > 60 minutes	Sep-25	2.60%	1.4%	Worse	6.0%	< 2024/5		7.60%
	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	Sep-25	2823	2443	Worse	2495	< 2024/5		
	Cancer - 28 day faster diagnosis standard	Aug-25	72.5%	74.3%	Worse	76.7%	80.0%	76.7%	74.6%
	Cancer - To achieve the 62 day standard	Aug-25	60.40%	62.70%	Worse	60.4%	75.0%	60.40%	69.10%
	Diagnostics - % Breaching 6 week target (DM01 modalities)	Sep-25	14%	15%	Better	28.20%	<5%	10%	24%
	RTT 52 Weeks	Sep-25	4977 (4.4%)	5629 (4.9%)	Better		3301 Mar-26	5781	2.60%
	RTT Elective care - >=65 Weeks	Sep-25	491 (0.43%)	693 (0.60%)	Better			573	0.17%
	RTT Elective care - 18 Week Performance	Sep-25	51.6%	50.80%	Better	44.5%	55%	51.5%	61%
	Safer Staffing - Average fill rate - registered nurses/ midwives (day shifts)	Sep-25	90.9%	91.6%	Better	85.8%	95%		
	Safer Staffing - Average fill rate - registered nurses/ midwives (night shifts)	Sep-25	94.4%	94.1%	Worse	88.7%	95%		
	Safer Staffing - Average fill rate - care staff (day shifts)	Sep-25	83.6%	84.3%	Better	84.8%	95%		
	Safer Staffing - Average fill rate - care staff (night shifts)	Sep-25	93.3%	89.6%	Worse	93.0%	95%		
	Care Hours Per Patient Day	Sep-25	8.23	8.20	Higher	7.3			
	Incidents/1000 beddays	Aug-25	57.50	62.52	Lower	52.30%			
	Falls	Sep-25	265	273	Lower	260			
	Pressure Ulcers	Sep-25	149	152	Lower	140			
	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	Jun-25	102.6	102.7	Better	103.6	100 (as expected range)		100
People	Training & development - Appraisals completed	Sep-25	87.8%	88.1%	Worse	84.30%	>90%		
	Training & development - STAM Weighted Average	Sep-25	92.7%	92.8%	Worse	90.50%	>90%		
	Workforce capacity - Vacancy Factor (Substantive contracted FTE) - monthly	Sep-25	9.2%	9.3%	Better	8.50%	10%		
	Workforce efficiency - Absence Sickness in month	Sep-25	4.8%	4.6%	Worse	5.00%	<4%		
Communities	Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good	Sep-25	90.0%	91.70%	Worse	89.80%	>=90%		
Future	Financial Stability - Variance from breakeven plan YTD	Sep-25	0.02	0.02	Same		£0		
	Bank and Agency Spend against planned trajectory	Sep-25	£-3.53M	-£3.25M	Worse		£0		
	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	Sep-25	32	44	Better		<27th		
One UHSX	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	Sep-25	6.2	6.4	Worse	6.3	>6.9		

Statistical Process Control

Statistical process control

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

SPC is a good technique to use when implementing change as it enables you to understand whether changes you are making are resulting in improvement — a key component of the Model for Improvement widely used within the NHS.

SPC is widely used in the NHS to understand whether change results in improvement. This tool provides an easy way for people to track the impact of improvement

To help you interpret the data a number of rules can be applied.

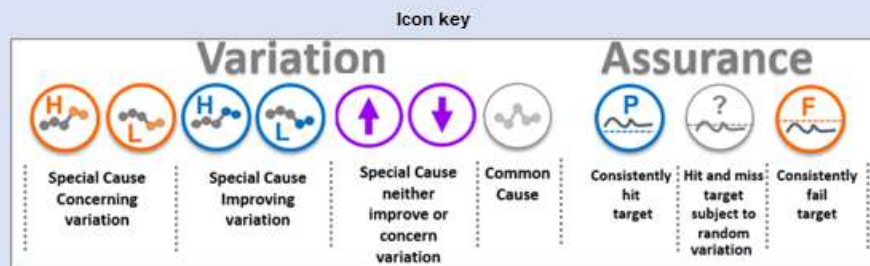
The rules (please note the rules are ordered to prioritised in the order trend, shift, 2 out of 3, single point)

- 1) Any single point outside the process limits.
- 2) A run of 6 / 7 points or more above or below the mean (a shift), or a run of 6/7 points or more all consecutively ascending or descending (a trend).
- 3) 2 out of 3 points outside either the upper or lower 2 sigma limit but not crossing the mean line.
- 4) If there is a large change in the moving range (greater than $3.27 \times \text{av moving range}$), this will be shown on the moving range chart only.

All these rules are aids to interpretation but still require intelligent examination of the data.

This tool highlights when a rule has been broken and highlights whether this is improvement or deterioration

If you change in your process and observe a persistent shift in your data, it may be appropriate to change the process limits. A process limit change can be added if the observed change is sustained for a longer period not just 7 points. You should try and find out the cause of the process change before recalculating the limits and annotate this on the chart. Be very cautious if you do not know what changed the process.



IPR SPC Summaries

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT < 18 Week Performance	Sep 25	51.6%	55.0%			48.7%	46.6%	50.7%
A&E < 4 hr Performance	Sep 25	68.9%	78.0%			70.9%	68.2%	73.6%
A&E 12 hr breaches	Sep 25	2826	2498			2688	1890	3485
Ambulance Handovers > 60 mins	Sep 25	2.6%	0.0%			3.8%	1.4%	6.3%
Cancer - 28 day faster diagnosis standard	Aug 25	72.5%	77.0%			73.2%	65.0%	81.4%
Cancer <62 Day performance	Aug 25	60.4%	75.0%			61.2%	51.4%	70.9%
RTT >52 Weeks	Sep 25	4977	3301			7921	6030	9812
Diagnostics - % <6 weeks	Sep 25	14.0%	5.0%			18.2%	13.1%	23.3%
RTT >65 weeks patients	Sep 25	491	0			1554	405	2703
L&D - Appraisals completed	Sep 25	87.8%	90.0%			84.6%	82.5%	86.7%
L&D - STAM Weighted Average	Sep 25	92.7%	90.0%			91.5%	90.4%	92.6%
Workforce - Vacancy Factor	Sep 25	9.2%	10.0%			9.0%	7.6%	10.4%
Workforce - In Month Sickness	Sep 25	4.8%	4.0%			4.8%	4.0%	5.7%
National staff engagement score	Sep 25	6.21	6.90			6.35	6.10	6.59
Summary Hospital-level Mortality Indicator (12M)	Sep 25	103.88	100.00			103.88	102.72	105.05
Patient experience - FFT	Sep 25	90.0%	90.0%			90.5%	88.6%	92.3%
Incident Rate /1000 Beddays	Aug 25	57.50	-			55.67	48.60	62.75
Patient Experience FFT A&E	Sep 25	79.9%	90.0%			82.4%	77.9%	87.0%
Safer Staffing: CHPPD	Sep 25	8.23	-			8.02	7.30	8.75
Falls	Sep 25	265	-			260	219	301
Pressure Ulcers	Sep 25	149	-			158	108	208

IPR SPC Summaries

		ASSURANCE				
					No Target	
VARIATION	 	L&D - STAM Weighted Average		RTT < 18 Week Performance Ambulance Handovers > 60 mins RTT >52 Weeks Diagnostics - % <6 weeks RTT >65 weeks patients L&D - Appraisals completed Workforce - In Month Sickness	Safer Staffing: CHPPD	
	 		A&E 12 hr breaches Cancer - 28 day faster diagnosis standard Patient experience - FFT	A&E < 4 hr Performance Cancer <62 Day performance National staff engagement score Patient Experience FFT A&E	Incident Rate /1000 Beddays Falls Pressure Ulcers	
	 	Summary Hospital-level Mortality Indicator (12M)	Workforce - Vacancy Factor			

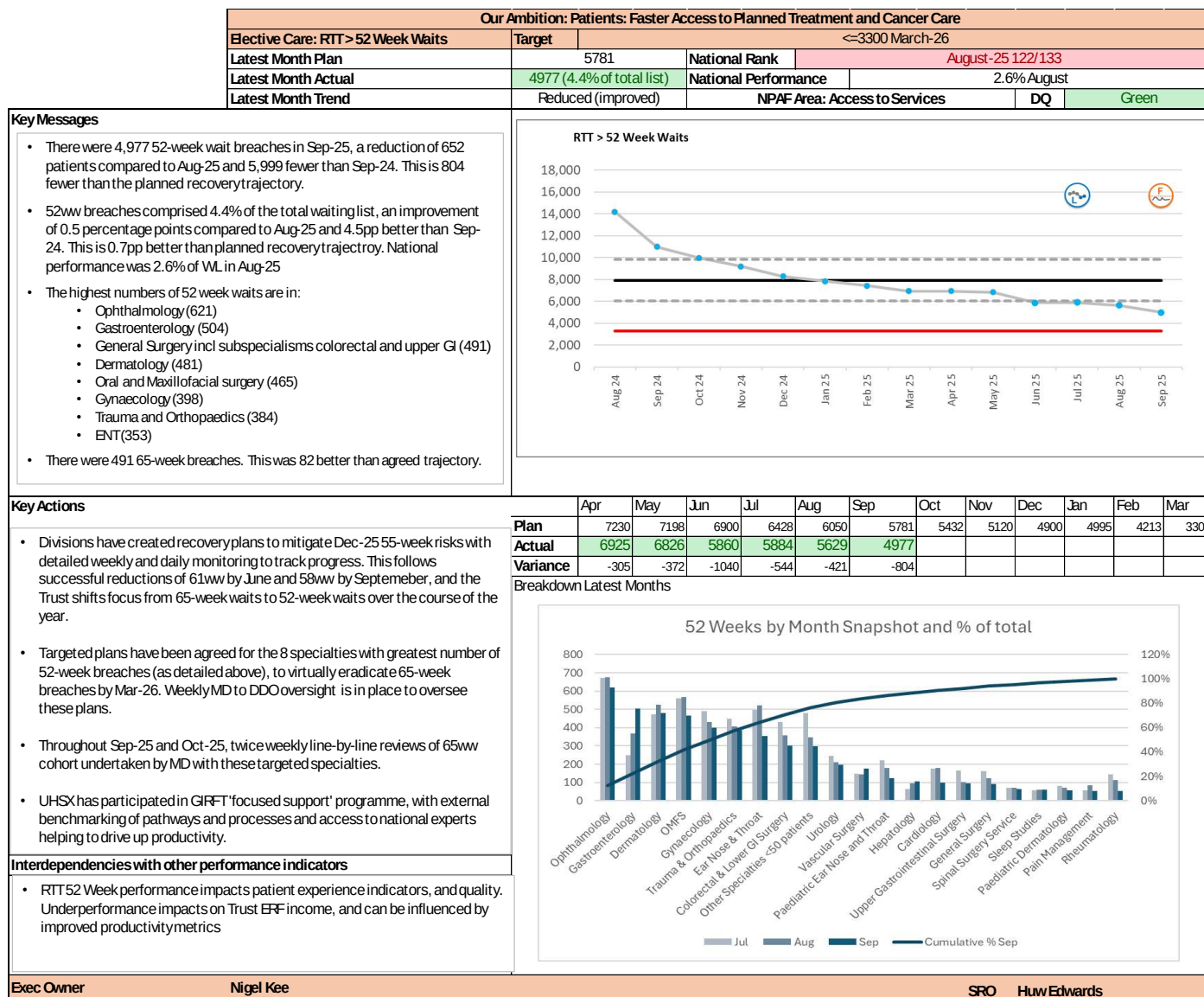
Patients



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Our Ambition: Patients: Faster Access to Planned Treatment and Cancer Care												
Elective Care: RTT <18 Week Performance				Target	55% by March-26							
Latest Month Plan				51.50%	National Rank		128/133					
Latest Month Actual				51.55%	National Performance		61.00%					
Latest Month Trend				Increased (improved)		NPAF Area: Access to Services		DQ	Green			
Key Messages												
- RTT <18 Week performance was 51.55% for UHSX Trust Sep-25 , an improvement of 0.8% from Aug-25, and a +7.1% improvement since Sep-24. It is 0.1% ahead of the Trust's improvement trajectory of 51.5% for Sep-25. National performance for Aug-25 was 61.0% - The waitinglist size decreased to 113,266 Sep-25 compared to 114,712 Aug-25 and 123,868 Sep-24 - The Trust aims to reduce the waiting list size to just below 102,000 by the end of Mar-26, by increasing productivity and activity by ~5% compared to 2024/5.												
Key Actions												
- Delivery of activity and productivity plans, to ensure enough patients are treated to reduce waiting list size and backlog over 18 weeks. Within this, the trust is focused on reducing waits for first appointment both to support this reduction but also to increases downstream time available for subsequent stages of the pathway. - Reducing backlog of routine referrals waiting longer than 7 days for triage and processing from ~3.3k to <=1k by Mar-26. - Expanding use of Netcall to increase clock stops: 12-weekly validation of inpatient WL (complete - Oct-25); creation of central list of standby patients to fill short-notice cancellations (complete - Oct-25); use of automatic text reminders for admitted appointments (including endoscopy) (from Dec-25) - Improving oversight of non-surgical specialties who can go further to help drive 18 week backlog clearance, through improved regular RTT oversight and governance. - Elective Co-ordination Centre to support transfers of patients for earlier treatment both between UHSX sites (to rebalance waits), and to external providers where agreed if deemed affordable												
Interdependencies with other performance indicators												
RTT performance impacts patient experience indicators, and quality. Underperformance impacts on Trust ERF income, and can be influenced by improved productivity metrics												
RTT < 18 Week Performance												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	50.2%	49.8%	50.7%	51.2%	51.1%	51.5%	52.3%	53.1%	53.0%	53.8%	54.4%	55.0%
Actual	50.3%	50.9%	51.3%	51.4%	50.8%	51.6%						
Variance	0.1%	1.1%	0.6%	0.2%	-0.3%	0.1%						
Breakdown Latest Month												
18 Week Backlog in descending order and % RTT Performance Sep-25												
18 Week Backlog % 18 Weeks												
Exec Owner												
Nigel Kee												
SRO												
Huw Edwards												

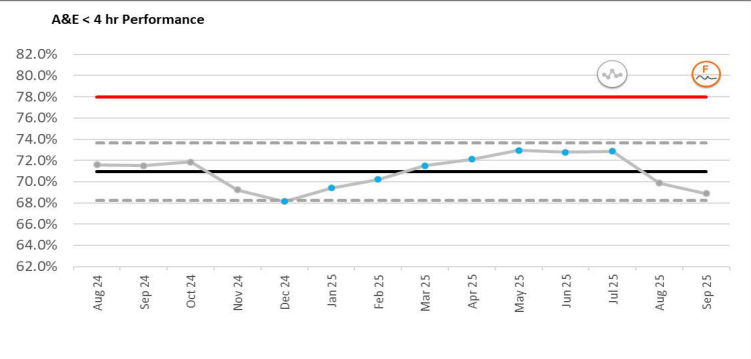


Exec Owner

Nigel Kee

SRO

Huw Edwards

Our Ambition: Patients: Better urgent and emergency care												
A&E<4Hour % Performance		Target	78%by March-26									
Latest Month Plan		74.60%	National Rank		99th of 121 Trusts (Aug-25)							
Latest Month Actual		68.90%	National Performance		75.00%							
Latest Month Trend		Reduced (worsened)	NPAF Area: Access to Services						DQ	Green		
Key Messages												
- A&E<4-hour performance was 68.89% in Sep-25. This is 0.98% lower than Aug-25, and 2.61% worse than Sep-24. National performance was 75.0% in August. It is below the Trust planned improvement trajectory of 74.6% for Sep-25. - All main sites saw a deterioration in performance from last month. RSCH fell by 0.6% from last month to 57.4% and was -3% from Sep-24. RACH fell to 91.86% from 94.76% in Aug-25 but improved by 2.2% from Sep-24. PRH fell to 64.1% from 68.4% in Jul-25 and by -11.3% from 75.4% in Sep-24. Worthing fell by 0.5% to 57.4% in Sep-25 from 57.9% in Aug-25 and by -4.8% from Sep-24 (62.2%). SRH also fell by 3% to 64.0% from 67.0% in Aug-25, and compared to 75.4% in Sep-24. - Patients in A&E for 12 hours or more increased to 2,823 in Sep-25 from 2,443 in Aug-25 (+15.6%) marginally lower than 2,878 Sep-24 (-1.9%). 60-minute handovers increased to 2.6% from 1.4% in Aug-25 and from 6.0% in Sep-24. 45 Minute handovers reduced to 7.3% from 8.8% last month and compared to 12.1% in Sep-24. - A&E attendances were 4.3% higher in Sep-25 compared to Sep-24 and 0.6% from Aug-25 (allowing for calendar days), with ambulance handovers being 3.7% higher between years, and walk ins being 4.5% higher. - There were 14 fewer 21-day patients on average in Sep-25 compared to Aug-25, and 9 fewer than 469 in Sep-24. DRD patients on average per day fell by 8 patients from last month to 352, and was 26 more than Sep-24 with 326.												
												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	71.2%	70.6%	73.2%	74.2%	74.8%	74.6%	76.1%	73.2%	71.9%	71.0%	74.0%	78.0%
Actual	72.1%	72.9%	72.8%	72.9%	69.9%	68.9%						
Variance	0.9%	2.3%	-0.4%	-1.3%	-4.9%	-5.8%						
Key Actions												
- Programme of work with designated UHSx SRO in place and working with the ICB re the model and provision of the UTC. National specification has been used as the basis for the local specification. Implementation plan by July 2025 - achieved. Ongoing productivity metrics now receiving focus in order to improve performance, increase speed, and ultimately reduce high spend intrinsic in the initial programme delivery. - Full review of UEC programme in terms of focus and governance. - Revised UEC Improvement programme has been agreed with 3 programme 'Buckets' 1) Front Door 2) Wards & Departments 3) Discharge. Each has an executive SRO. Delivery Leads for each discrete piece of work within the buckets have been identified, all lead names now agreed. - As of 14th July, SRO for the Programme is Nigel Kee - Capacity and configuration group established to support Hospital flow												
Interdependencies with other performance indicators												
Extended waits in A&E has a direct correlation with patient experience, safety and quality outcomes. More widely ED flow impacts staffing resource and financial costs.												
A&E and Emergency Flow												
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25						
UHS<4hr %	72.11%	72.94%	72.78%	72.88%	69.87%	68.89%						
RSCH	58.20%	60.21%	59.62%	59.18%	57.99%	57.44%						
PRH	67.60%	70.52%	69.48%	69.16%	68.44%	64.60%						
RACH	91.80%	92.43%	94.96%	95.07%	94.76%	91.87%						
Worthing	68.14%	67.09%	65.79%	66.29%	57.90%	57.38%						
SRH	63.02%	65.49%	66.51%	67.23%	66.99%	64.01%						
National	74.8%	75.4%	75.5%	76.4%	75.9%	75.0%						
A&E 12 hours in department	2,448	2,240	2,088	1,765	2,443	2,823						
A&E Attendances	36,483	38,342	37,228	38,746	37,446	36,455						
Time to Triage	17	17	18	18	16	17						
Time to Treatment	125	130	124	126	137	137						
Mean Waiting Time	302	294	288	272	306	345						
Ambulance Handovers	7,022	7,316	7,169	7,540	7,556	7,256						
Ambulance Handover <15 minutes	55.8%	59.0%	59.3%	64.0%	58.0%	55.8%						
Ambulance Handover >45 minutes	7.0%	6.2%	5.0%	2.6%	8.8%	7.3%						
Ambulance Handovers > 60 minutes	2.1%	2.0%	1.5%	0.6%	1.4%	2.6%						
>= 7 day LOS Patients	1,050	1,021	994	926	990	990						
>=21 day LOS Patients	476	460	432	397	447	433						
Ave. DRD per day	361	378	357	335	360	352						
Exec Owner		Nigel Kee				SRO David Coyle						



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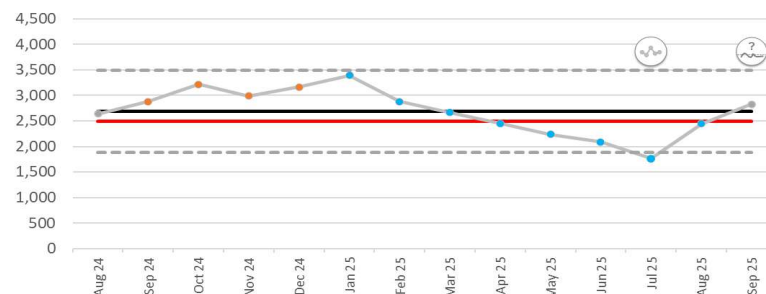
Excellent Care Everywhere

Our Ambition: Patients: Better urgent and emergency care					
A&E > 12 Hour waits	Target	A reduction in 2025/6 compared to 2024/5			
Latest Month Plan	2495	National Rank	66/119 week of 3rd October		
Latest Month Actual	2823 (7.74%)	National Performance	8.90%		
Latest Month Trend	Increased (worsened)	NPAF Area: Access to Services	DQ	Green	

Key Messages

- The Trust has improved materially in 2025/6 to date, relative to 2024/5 in terms of numbers of patients waiting in A&E for 12 hours or more.
- However, there was a deterioration in performance and delays in Aug-25 which was higher than the planned level of reduction for August.
- Of 2443 patients who waited over 12 hrs in A&E, prior to leaving the department, 1187 were at the Royal Sussex County due to extended flow constraints in month. This was 36.6% higher than in Jul-25 but 0.5% higher than Aug-24.
- Worthing site also had a challenging month with 587 over 12 hr waits, more than double that of July-25. This was 11% higher than in August.
- As A&E attendances were higher in Aug-25 than in Aug-24, comparison to the % of all attendances, shows an increase to 6.5% as a Trust in August, compared to 4.6% July-25 and 7.48% Aug-24

A&E 12 hr breaches



Key Actions

- Programme of work with designated UHSx SRO in place and working with the ICB re the model and provision of the UTC. National specification has been used as the basis for the local specification. Implementation plan by July 2025 - achieved
- Full review of UEC programme in terms of focus and governance.
- Revised UEC Improvement programme has been agreed with 3 programme 'Buckets' 1) Front Door 2) Wards & Departments 3) Discharge. Each has an executive SRO. Delivery Leads for each discrete piece of work within the buckets have been identified, all lead names now agreed.
- As of 14th July, SRO for the Programme is Nigel Kee
- Capacity and configuration group established to support Hospital flow
- RSCH Sprint re-implemented
- Mental Health delays in ED now being focussed on in a robust way.

Interdependencies with other performance indicators

Extended waits in A&E has a direct correlation with patient experience, safety and quality outcomes. More widely ED flow impacts staffing resource and financial costs.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	2849	2716	2556	2701	2179	2495	2732	2560	2753	2946	2574	2498
25/26	2448	2240	2088	1765	2443	2823						
Variance	-401	-476	-468	-936	264	328						

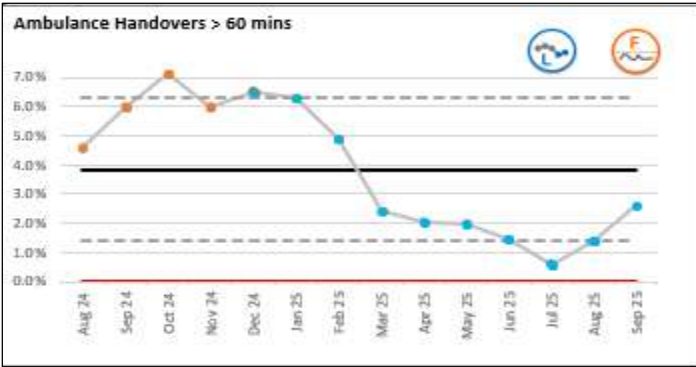
A&E >12 hours in Department:		2024/25						2025/26		Last Year		Last Month		
Site:		Jul-24	Aug-24	Sep-24	Jul-25	Aug-25	Sep-25	Var.	% Var.	Var.	% Var.	Var.	% Var.	
RSCH		1,223	1,181	1,178	869	1,187	1,143	-35	-3.0%	-44	-3.7%			
PRH		385	315	336	328	360	386	50	14.9%	26	7.2%			
RACH		0	1	1	1	3	5	4	400.0%	2	66.7%			
SRH		835	617	777	279	306	580	-197	-25.4%	274	89.5%			
WSH		497	527	586	288	587	709	123	21.0%	122	20.8%			
UH Sussex ALL		2,940	2,641	2,878	1,765	2,443	2,823	-55	-1.9%	380	15.6%			

As % of all Attendances		2024/25						2025/26		Last Year		Last Month		
Site:		Jul-24	Aug-24	Sep-24	Jul-25	Aug-25	Sep-25	Var.	% Var.	Var.	% Var.	Var.	% Var.	
RSCH		16.44%	16.50%	16.59%	10.63%	14.46%	14.93%		-2.0%		3.8%			
PRH		8.48%	7.19%	8.03%	6.69%	7.92%	8.68%		0.7%		1.2%			
RACH		0.00%	0.05%	0.04%	0.04%	0.16%	0.21%		0.1%		0.1%			
SRH		11.67%	8.71%	11.37%	3.79%	4.13%	8.27%		-4.6%		0.3%			
WSH		5.62%	6.23%	6.98%	3.16%	6.55%	8.23%		0.3%		3.4%			
UH Sussex ALL		7.89%	7.48%	8.24%	4.56%	6.52%	7.74%		-1.0%		2.0%			

Exec Owner Nigel Kee

SRO David Coyle

Our Ambition: Patients: Better urgent and emergency care											
Ambulance Handovers > 60 mins		Target	A reduction in 2025/6 compared to 2024/5								
24/25 Actual		4.60%	National Rank		Best Performing Region						
Latest Month Actual		1.40%	National Performance		5.8% National - 0.6% South East Coast						
Latest Month Trend		Increased (worsened)	NPAF Area: Access to Services						DQ	Amber	

- The Trust has seen significant improvement in extended ambulance handover delays in 2025/6 to date. - There was an increase to 105 >60 min handovers in Aug-2025 compared to 45 in July-25 but this remains favourable to Aug-24 which saw 321 over 60 min handover delays. - Of the 105 delays in August, 64 of these were at the Royal Sussex County, whilst 33 were at Worthing Hospital and 8 at Princess Royal Hospital. There were zero over 60 min handovers reported in SRH in Aug-25. - As a % of all handovers, August saw 1.4% of 7556 handovers over 60 mins, compared to 0.6% July-25, and 4.6% in Aug-24.											
											

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	590	478	333	408	321	422	515	434	470	460	315	169
25/26	144	145	104	45	105	189						
Variance	-446	-333	-229	-363	-216	-233						

Handovers:		2024/25			2025/26			Last Year	
Site		Jul-24	Aug-24	Sep-24	Jul-25	Aug-25	Sep-25	Var.	% Var.
RSCH		2,342	2,355	2,335	2,662	2,683	2,481	146	6.3%
PRH		757	775	768	826	822	850	82	10.7%
SRH		1,829	1,827	1,837	1,839	1,800	1,812	-25	-1.4%
WSH		2,027	2,053	2,054	2,213	2,251	2,113	59	2.9%
UH Sussex ALL		6,955	7,010	6,994	7,540	7,556	7,256	262	3.7%

>60 Minute Handovers:		2024/25			2025/26			Last Year	
Site		Jul-24	Aug-24	Sep-24	Jul-25	Aug-25	Sep-25	Var.	% Var.
RSCH		238	226	268	39	64	93	-175	-65.3%
PRH		11	2	14	2	8	25	11	78.6%
SRH		80	16	85	1	0	26	-59	-69.4%
WSH		79	77	55	3	33	45	-10	-18.2%
UH Sussex ALL		408	321	422	45	105	189	-233	-55.2%

% >60 Mins Handover		2024/25			2025/26			Last Year	
Site		Jul-24	Aug-24	Sep-24	Jul-25	Aug-25	Sep-25	Var.	% Var.
RSCH		10.2%	9.6%	11.5%	1.5%	2.4%	3.7%	-7.7%	
PRH		1.5%	0.3%	1.8%	0.2%	1.0%	2.9%	1.1%	
SRH		4.4%	0.9%	4.6%	0.1%	0.0%	1.4%	-3.2%	
WSH		3.9%	3.8%	2.7%	0.1%	1.5%	2.1%	-0.5%	
UH Sussex ALL		5.9%	4.6%	6.0%	0.6%	1.4%	2.6%	-3.4%	

Exec Owner

Nigel Kee

SRO

David Coyle

Key Actions

- Programme of work with designated UHSx SRO in place and working with the ICB re the model and provision of the UTC. National specification has been used as the basis for the local specification. Implementation plan by July 2025 - achieved
- Full review of UEC programme in terms of focus and governance.
- Revised UEC Improvement programme has been agreed with 3 programme 'Buckets' 1) Front Door 2) Wards & Departments 3) Discharge. Each has an executive SRO. Delivery Leads for each discrete piece of work within the buckets have been identified, all lead names now agreed.
- Newton consulting currently being onboarded who will be performing an initial diagnostic on pre-DRD processes within the Trust, here for 3 months.
- Capacity and Configuration group established to reconfigure bedstock in order to enable more intuitive and seamless Hospital flow and discharge.
- RSCH Corridor Care Sprint re-implemented.

Interdependencies with other performance indicators

- Poor discharge profiles create exit-block in ED. These extended have a direct correlation with patient experience, safety and quality outcomes, such as harm and mortality. More widely, ED flow impacts staffing resource and financial costs.

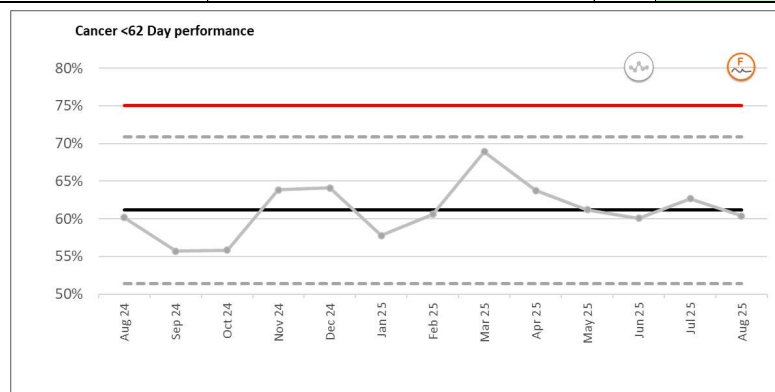


University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Faster Access to planned treatment and cancer care				
Cancer Care : 62 Day Performance	Target	75% by March-26		
Latest Month Plan	60.40%	National Rank	127 of 148 - August-25	
Latest Month Actual	60.40%	National Performance	69.11%	
Latest Month Trend	Reduced (Worse)	NPAF Area: Access to Services	DQ	Green

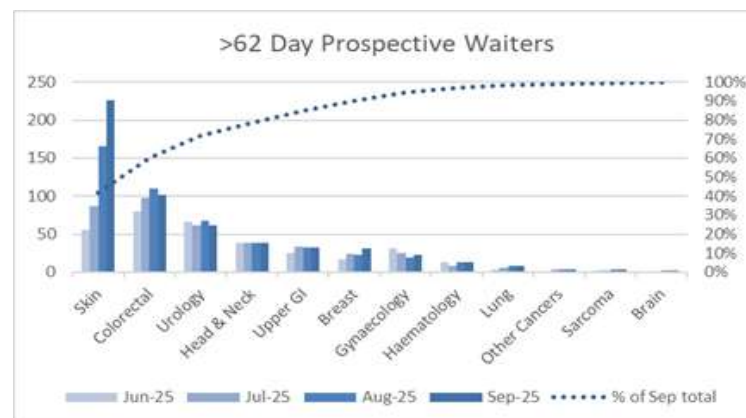
Key Messages

- Cancer 62 day cancer treatment targets were not met in Aug-25 with 60.4% starting treatment in under 62 days. This was a 2.3% deterioration from Jul-25, and a 0.2% improvement from Aug-24. It was lower than the National average of 69.1% for Jul-25 but in line with the Trust recovery trajectory plan for August (60.4%).
- There has been an increase in over 62 day patient backlog at the end September with 543 from 487 in July and a decrease in 104 day prospective waits in September to 88 patients from 91 in August. Most of the backlog growth is observed in Skin.
- The anatomical sites with most over 62 day patients at the end of Aug-25 were skin (226 patients, 61 more than Aug-25), colorectal (102 patients, 8 fewer than Aug-25) and urology (61 patients, 7 fewer than Aug-25). The total backlog is marginally under where it was in same period 2024. Some tumour sites e.g. gynae had 83 pts fewer in their backlog than the same period in 2024.
- Sept will be a more challenged month whilst skin backlog is recovered and to a lesser degree Breast – UHSx expect position to improve October to March 26



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	61.4%	61.5%	61.5%	61.2%	60.4%	65.7%	68.9%	69.7%	71.0%	67.8%	72.8%	75.2%
Actual	63.8%	61.2%	60.1%	62.7%	60.4%							
Variance	2.4%	-0.3%	-1.4%	1.5%	0.0%							

62 Day prospective waits by Month



Key Actions

- Weekly tumour site level driver meetings to target most challenged areas
- Pathway analyser work and KPI reporting to target delays
- Skin additional performance support as most challenged anatomical site
- Breast operative capacity constraints being tackled via work across sites and with IS support
- Focussed work re cancer diagnostics, particularly CT, pathology, lower GI imaging, and endoscopy

Interdependencies with other performance indicators

- Delays to cancer treatment can impact patient experience and outcomes

Exec Owner Nigel Kee

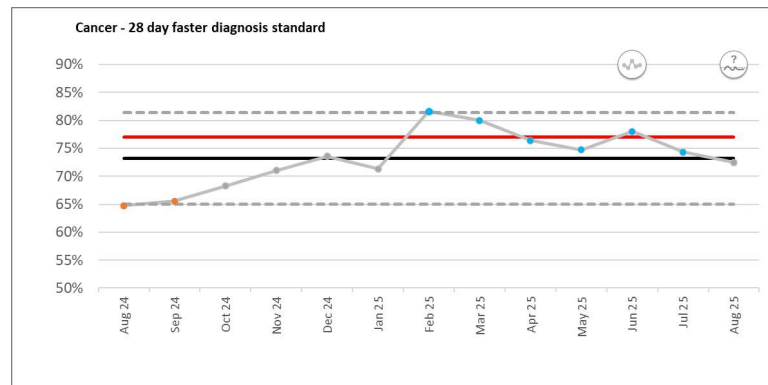
SRO Huw Edwards

Excellent Care Everywhere

Our Ambition: Patients: Faster Access to planned treatment and cancer care				
Cancer Care : <28 Day Faster Diagnosis Standard	Target	75% by March-26		
Latest Month Plan	76.70%	National Rank	103 of 140 - Aug-25	
Latest Month Actual	72.50%	National Performance	74.61%	
Latest Month Trend	Reduced (worsened)	NPAF Area: Access to Services	DQ	Green

Key Messages

- FDS fell to 72.5% Aug-25 from 74.3% in July, but was 7.8% higher than Aug-24, and just below the 75% target. The National average was 74.6%. Skin impacted the Trust aggregate position by 5% so had it not been for Skin pressures, FDS would be approx. 80%.
- The Trust has committed to hitting the 80% Faster diagnosis standard - ie 80% of patients diagnosed with or without cancer within 28 days, by March-26.



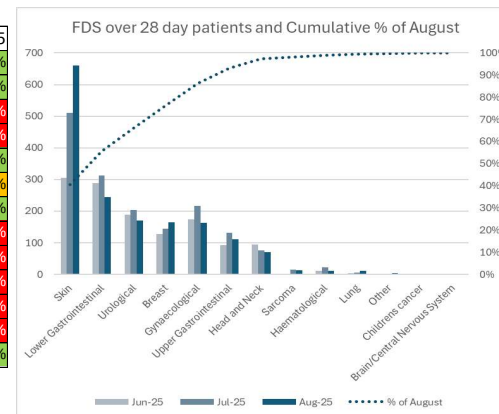
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	77.9%	78.0%	77.9%	76.3%	76.7%	78.7%	78.7%	79.6%	80.4%	78.6%	80.0%	80.0%
Actual	76.4%	74.7%	78.0%	74.3%	72.5%							
Variance	-1.5%	-3.2%	0.1%	-2.0%	-4.2%							

Key Actions

- Weekly tumour site level driver meetings to target most challenged areas
- Pathway analyser work and KPI reporting to target delays
- Skin additional performance support as most challenged anatomical site
- Focussed work re cancer diagnostics, particularly CT, pathology, lower GI imaging, and endoscopy

Faster Diagnosis Standard by Anatomical Site

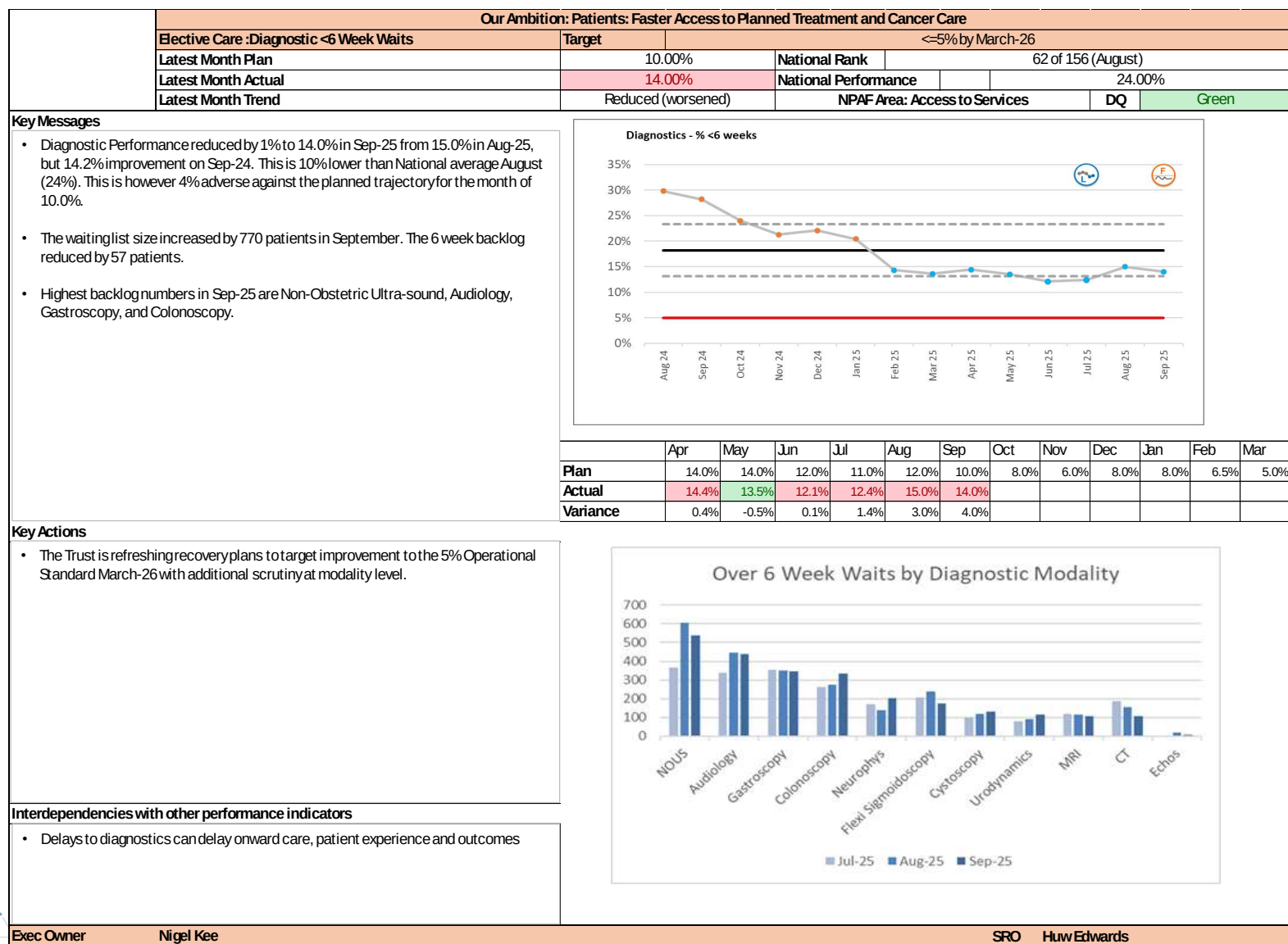
Site	Jun-25	Jul-25	Aug-25
Brain	100.0%	92.3%	95.5%
Breast	90.2%	89.9%	87.9%
Gynaecological	68.8%	64.2%	70.2%
Haematological	57.1%	29.0%	36.8%
Head and Neck	84.0%	87.1%	85.8%
Lower GI	72.6%	70.9%	75.1%
Lung	92.9%	90.0%	77.1%
Other	100.0%	75.0%	42.9%
Sarcoma	88.9%	80.0%	71.7%
Skin	78.2%	66.5%	58.5%
Upper GI	72.3%	71.0%	68.8%
Urological	61.2%	60.5%	59.5%
Childrens	77.8%	89.7%	89.5%



Interdependencies with other performance indicators

- Delays to cancer treatment can impact patient experience and outcomes

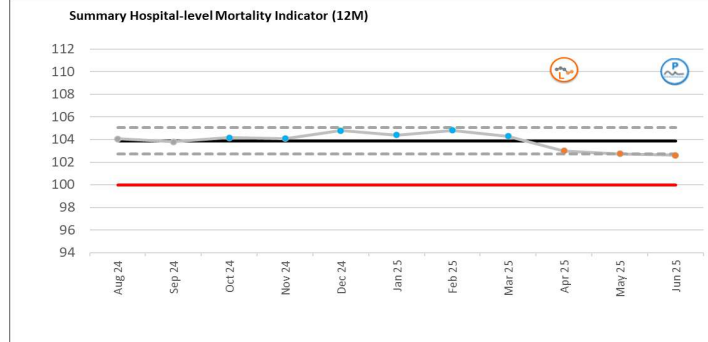
Exec Owner	Nigel Kee	SRO	Huw Edwards



Our Ambition: Patients: Fairness in access, experiences and outcomes					
Standardised Hospital Mortality Indicator	Target	In Expected Range			
24/25 Actual	103.60%	National Rank	In expected range		
25/26 Actual	102.60	National Performance	100		
Latest Month Trend	Reduced (worsened)	NPAF Area : Patient Experience	DQ	Green	

Key Messages

- The SHMI (Summary Hospital-level Mortality Indicator) is a measure used in to monitor mortality. The SHMI gives an indication of whether the number of deaths in a hospital is higher or lower than expected, based on the types of patients they treat. It does this by comparing the actual number of patients who die following hospital treatment (either during their stay or within 30 days of discharge) with the number expected to die. The expected number of deaths is calculated using a statistical model that predicts the number of deaths we would expect for a given group of patients, the case mix model used to calculate the expected number of deaths is based on the patients age, gender, primary diagnosis, comorbidities, admission method and socioeconomic factors (like deprivation index)
- The SHMI for UHSx is 104.91 (April 2024 - March 2025). This result is not an outlier using 95% over-dispersed funnel plot limits, but it is an outlier based on the stricter 95% Poisson method. The In-hospital SHMI is 106.89. The Out-of-Hospital SHMI is 100.69. The SHMI at PRH, RSCH, Worthing and St Richards are all within the expected confidence limits, this is despite the SHMI at RSCH 114.06



Rolling 12 months

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25 Actual	104.2	103.1	103.6	104.3	104.1	103.8	104.2	104.1	104.8	104.4	104.8	104.3
25/6 Actual	103.0	102.7	102.6									
Variance	-1.2	-0.4	-1.0									

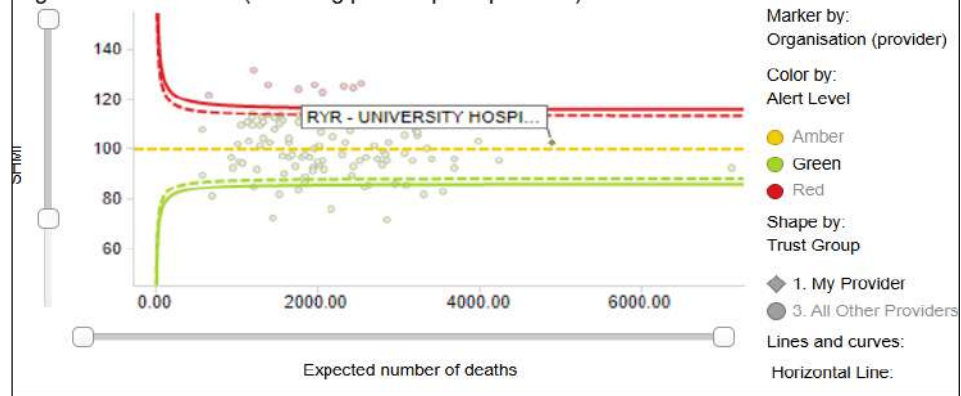
Key Actions

- Work has been undertaken with diagnostic outlier groups for head and neck cancer, melanomas of skin, pancreatic cancer and breast cancer to further outstand and investigate the cause of outlier status. As such the Learning from Deaths Team have updated the Learning from Deaths Policy (which is undergoing consultation and approval) to include the Standard Operating Procedure for investigating Outlier diagnostic groups
- In addition, a mortality improvement plan has been approved by the Mortality & Morbidity Surveillance Group, which includes actions to reduce outlier status being flagged as a result of erroneous coding.

Interdependencies with other performance indicators

- There are clear links re mortality and safety of care, patient and carer experience.

Figure 1b: Funnel Plot (Rebasing period up to April 2025)



Exec Owner	Prof Katie Urch	SRO	Dan Rennie-Hale

		Our Ambition: Patients: Fairness in access, experiences and outcomes													
Safer Staffing % Staffing against planned rota		Target		>95%											
Latest Month Plan				National Rank											
Latest Month Actual		Table below		National Performance											
Latest Month Trend		Variable per staff group/shift as below		NPAF Area: Patient Safety				DQ		Amber					
Key Messages															
- Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN, 2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). - Care Hours Per Patient Per Day (CHPPD) trust wide has seen a gradual increase from 7.1 in April 24 to 8.2 in September 25, please note there is a drop in CHPPD from 9.2 to 8.2 in August 25 this is a result of removing paediatrics and neonates from the CHPPD reporting to align with the national reporting. In addition, after benchmarking with other trusts ITU has been removed due to overinflating the CHPPD and masking lower levels of staffing in other areas. If ITU is included the CHPPD in August was 8.9 - In the model hospital data published in July 25 the trust has moved into mid quartile 4 for registered nurses and moved to quartile 2 for care staff. - The charts shows the fill rate % for Day and Night shifts for Registered Nurses/midwives and Health Care Assistants. Whilst there is some fluctuation, there has been a statistically significant improvement in RN day fill rates in June and July, and 6 consecutive points above mean for RN fill rates overnight - Day HCA fill rates are lowest with 83.6% cover , compensated in part by the RN cover, but the area of most focus in terms of actions to increase.															
Safer Staffing RN Day Safer Staffing RN Night Safer Staffing HCA Day Safer Staffing HCA Night															
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Registered Day		24/ 25	84.0%	82.2%	84.4%	83.7%	88.5%	85.8%	88.2%	90.6%	88.5%	89.5%	88.7%	89.6%	
		25/ 26	90.4%	90.7%	92.7%	92.5%	91.6%	90.9%							
Registered Night		24/ 25	87.5%	85.9%	85.8%	85.2%	92.0%	88.7%	91.7%	93.6%	90.6%	92.2%	91.7%	93.4%	
		25/ 26	93.1%	92.8%	93.5%	94.0%	94.1%	94.4%							
HCADay		24/ 25	81.9%	81.1%	82.4%	83.0%	85.0%	84.8%	83.3%	82.7%	83.1%	80.5%	79.1%	81.0%	
		25/ 26	83.0%	81.6%	81.2%	83.2%	84.3%	83.6%							
HCANight		24/ 25	89.5%	89.1%	89.5%	90.6%	90.4%	93.0%	91.6%	91.8%	91.2%	91.0%	91.3%	91.1%	
		25/ 26	91.9%	90.6%	88.9%	91.0%	89.6%	93.3%							
Care Hours/ Patient Day		24/ 25	7.1	7.3	7.4	7.4	7.7	7.3	7.5	7.6	7.6	7.7	7.6	7.8	
		25/ 26	8.0	9.0	8.9	9.2	8.20	8.23							
Key Actions															
- The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce with the skill and experience to deliver quality care. - The subgroups focusing on agency reduction, recruitment, retention, safe care, roster optimising and sickness management. The Deputy Chief Nurse (DCN) for Workforce along with the clinical workforce team undertook establishment reviews using the safer nursing care tool (SNCT) for all inpatient areas in the January 25 and will be repeated in November 25. Following the Establishment reviews 177 WTE HCA's were added to establish across the trust a combination of substantiating temporary workforce as part of budget setting and investment in ward areas where the team were under resourced mainly at St Richards hospital. - Recruitment to these posts is underway and as staff are onboarded there is a direct correlation with the gradual improvement in fill rate. Substantiating employ workforce will lead to a more consistent fill rate. - Recent changes to the Health and Care Visa which is a subtype of the skilled worker visa has increased the salary to 25k. The increased salary threshold for visa sponsorship has created challenge recruiting directly to band 3 posts with approx. 45% of applications requiring sponsorship. As a result, there has been extensive recruitment to band 2 HCA's who transition to band 3 at 6 months. This has resulted in challenge in the ward due to the higher leave skill restrictions in place for band 2 staff. Shorting the transition period is being reviewed to ease this pressure and support the ward teams transition staff in a timely manner - As part of the establishment restacking there is a commitment to exit agency in non-specialist areas and in this financial year there is an efficiency target of 40% agency reduction. Enhanced controls have been															
Interdependencies with other performance indicators															
Safer staffing has links to safe care for patients, staff experience, moral and fatigue, and financial cover															
Exec Owner		Dr. Maccie Davies													
		SRO: Annette Gerricke													

Our Ambition: Patients: Fairness in access, experiences and outcomes																																																																																																																			
Falls				Target	To reduce falls by 30%; 4.2, per 1,000 bed days																																																																																																														
2024/25					National Rank																																																																																																														
2025/6 latest month				265	National Performance																																																																																																														
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Key Messages																																																																																																																			
- Falls are a top contributor in terms of harms across UHSussex, and therefore key focussed work area to minimise them. - There has been a decrease in falls since March 2025, 285 to September, 265. 69.81% of falls (185 patients) in September 2025 reporting no harm. - Falls Rate per 1,000 bed days September 2025, 4.58. Average rolling year 4.46. Target 4.2. Overall, Trust data is tracking along the mean average and within the upper control limit, for both the number of falls and the number of falls per 1,000 bed days. - Moderate harm and above falls since April 2024 have not identified pattern or trend currently.																																																																																																																			
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- KPIs have been set for falls per 1000 beddays across UHSussex at 4.2 or less. - The harm free care and education team continue to work with sites and divisions to support quality improvement workstreams. - The divisions have been driving up improvement opportunities by focussing on the top themes such as completing falls and bedrail risk assessments and undertaking lying/standing blood pressures. This has enabled the identification of actual or potential issues earlier so that mitigations can be put in place. - Rate of falls will continue to be monitored via the weekly Harm Free Care Group, monthly QGSG and two monthly FSoC patient safety group.																																																																																																																			
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University Hospitals Sussex
NHS Foundation Trust

Excellent Care Everywhere

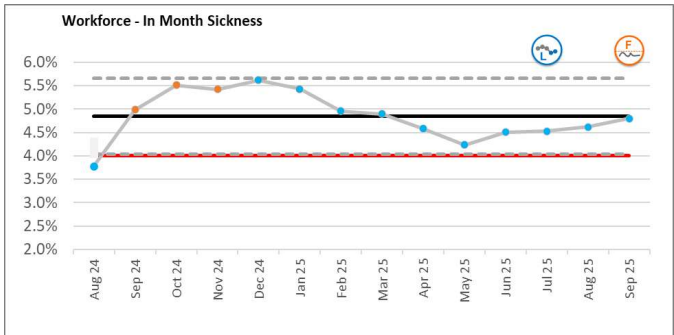
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Our People



Excellent
Care
Everywhere

We are compassionate. We are inclusive. We are respectful.

	Our Ambition: Our People																
	Sickness Absence Rates								Target		<4% sickness						
	24/ 25 Month Actual								3.80%		Regional Rank						
	25/ 26 Month Actual								4.60%		National Performance		4.7% (May-25)				
	Latest Month Trend								Increased (worsened)		NPAF Area: People and Workforce		DQ		Green		
Key Messages																	
- Sickness rates measure the percentage of staff absence due to illness and reflect staff health and wellbeing and workforce capacity. - Following decline in 2023-24, sickness absence increased in 2024-25, with the in-month Dec-24 figure at 5.6%. Since then there has been a steady reduction with the M6 (September) figure at 4.8%. For comparison UHSx is below the ICB position at 4.7% and slightly above the south-east region-wide position at 4.3%. - To date in 2025-26 several clinical Divisions have achieved consecutive months where they have met or been under the Trust target of 4%. The best sustained performance is Specialist Division which has achieved six consecutive months from March to August 2025 at under 4%. This reflects the strong divisional focus on sickness. - Areas such as HCAs have seen a reduction in absence of 3,436 FTE days in the comparative 6-month period but still remain the highest staff group for sickness with a 12-month rate of 9.5%. - Ancillary staff absence has increased in 2025-26 by an extra 1,785 days lost to asbsence when compared to 2024. However, when looking by locality St Richard's Hospital has achieved a reduction of 217 days.																	
																	
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar				
24/ 25		4.9%	4.9%	4.9%	5.4%	3.8%	5.0%	5.5%	5.4%	5.6%	5.4%	5.0%	4.9%				
25/ 26		4.6%	4.2%	4.5%	4.5%	4.6%	4.8%										
Variance		-0.4%	-0.6%	-0.4%	-0.8%	0.8%	-0.2%										
Key Actions																	
Nursing and Midwifery - workstream with a focus on 72 hotspot areas for sickness it continues to target. Systems - Managers are now being encouraged to use the facility in Healthroster to record completed return to work (RTW) interviews and this has seen recorded rates triple to nearly 45%. Governance - The focus is now on refreshing the divisional focus as we approach winter months and ensuring good basic sickness practices (e.g. return to work interviews after every absence) are embedded and maintaining strong governance. Mental Health Action Plan – MH Action plan has been produced and is currently in phase one of implementation. Medical Workforce - a workstream to improve the recording and management of doctors' absence is underway with a range of actions. Staff Group - tailored action plans in place for HCAs and Ancillary staff. Assurance - The People & Culture Assurance committee has had a 'deep-dive' and six monthly																	
Interdependencies with other performance indicators																	
Excessive sickness can impact operational performance and bank and agency spend, and staff morale and motivation																	
Exec Owner						David Grantham						SRO Helen Weatherill					

Our Ambition: Our People		Target		<10%			
Vacancy Factor				National Rank		Not available	
24/25 Month Actual		8.90%		National Performance		Not available	
25/26 Month Actual		9.30%		NPAF Area: People and Workforce		DQ Green	
Latest Month Trend		Reduced (improved)					

Key Messages

- The vacancy rate expresses, as a percentage of the Trust's overall budgeted establishment in month, the proportion of posts that are vacant. Vacant posts can impact service delivery, safety and temporary staffing costs.
- The Trust's budgeted establishment is 18,078 (increase of 768 from prior year). There are 16,423 wte staff in post (increase of 583 wte from prior year and an increase of 310 between Q1-Q2). The Trust currently has 1,656 wte vacancies, an increase of 186 wte in the past year resulting in a vacancy rate of 9.2% for M6.
- There has been a significant investment in substantive budgeted establishment (including the N&M workforce to reflect safer staffing tool outputs) and there are ongoing plans to fill these newly created posts and to keep vacancy levels with target.
- Vacancy rates by staff group shows higher rates within Clinical Support (14.4%), Healthcare Science (10.5%), Registered Nursing (10.0%) and AHPs (10.4%).
- If vacancies are looked at purely by wte, the highest vacancies are within Registered Nursing at 534 FTE, Clinical Support at 352 wte and Admin & Clerical at 291 wte.

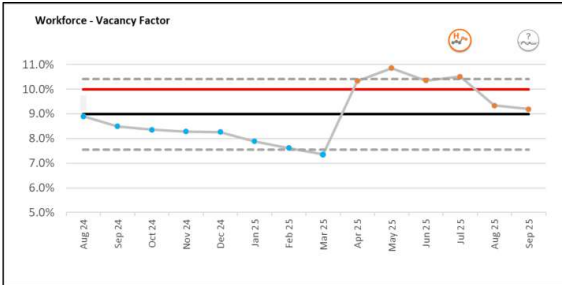
Key Actions

- 'Excellent care starts with you' employer brand strategy was approved by TMC in September and is being rolled out.
- Filming of staff for social media and online recruitment content in October.
- Attendance at the Health and Social Care Jobs Show at the Westfield Shopping Centre - interest in HCA, E&F and RN roles to be followed up.
- Recruitment newspaper (Sussex - 44 sites - 22,000 copies + 5,000 copies for hospital sites) - printing and distribution has commenced with a focus on EDI/values/local recruitment.
- Work is progressing to 'wrap' Trust vehicles with 'Excellent care starts with you' employer brand and recruitment advertising.
- Rolling programme of HCA and RN recruitment events.
- Retention activities such as career conversations, health and wellbeing and staff recognition under various People programmes.

Interdependencies with other performance indicators

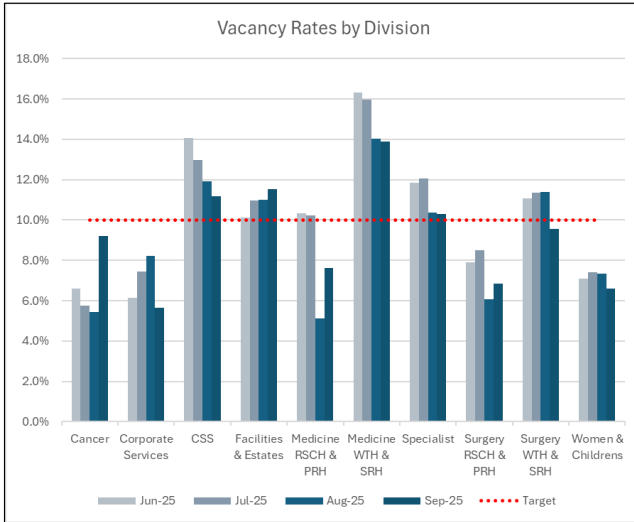
It is critical that the Trust has a sufficient core workforce to deliver patient care and minimise the use of agency or bank deployment unless necessary. High vacancy levels can impact negatively on quality, staff engagement and activity/performance.

Workforce - Vacancy Factor



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	8.3%	8.7%	8.7%	9.0%	8.9%	8.5%	8.4%	8.3%	8.3%	7.9%	7.6%	7.4%
25/26	10.3%	10.9%	10.4%	10.5%	9.3%	9.2%						
Variance	2.0%	2.2%	1.7%	1.5%	0.4%	0.7%						

Breakdown of Latest Month

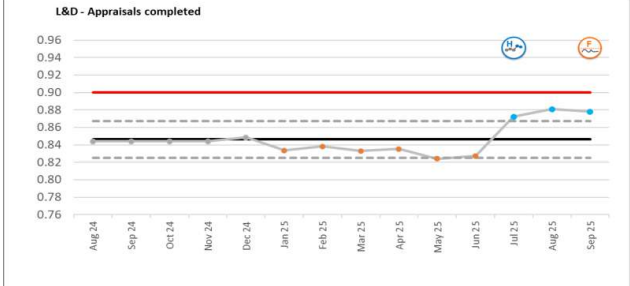
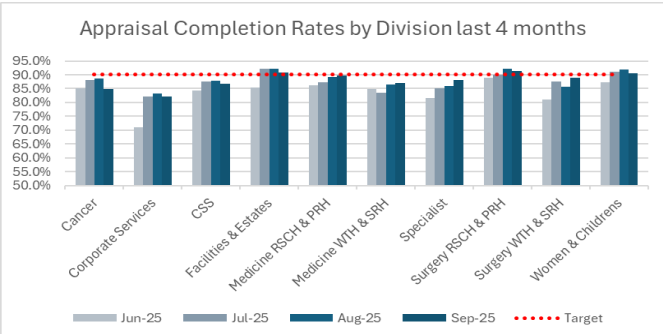


Division	Jun-25	Jul-25	Aug-25	Sep-25	Target
Cancer	6.5%	5.5%	5.0%	5.0%	10.0%
Corporate Services	6.0%	7.5%	5.5%	5.5%	10.0%
CSS	14.0%	12.5%	11.5%	11.5%	10.0%
Facilities & Estates	10.5%	10.5%	11.5%	11.5%	10.0%
Medicine RSCH & PRH	10.5%	10.5%	5.5%	5.5%	10.0%
Medicine WTH & SRH	16.5%	16.0%	14.0%	14.0%	10.0%
Specialist	12.0%	12.0%	10.5%	10.5%	10.0%
Surgery RSCH & PRH	8.0%	8.5%	6.5%	6.5%	10.0%
Surgery WTH & SRH	11.0%	11.0%	11.5%	11.5%	10.0%
Women & Childrens	7.0%	7.5%	7.0%	7.0%	10.0%

Exec Owner

David Grantham

SRO David Vincent

Our Ambition: Our People		Target		>90%			
Annual Appraisal % Compliance							
24/25 Month Actual		84.30%		National Rank			
25/26 Month Actual		87.80%		National Performance			
Latest Month Trend		Decreased(worsened)		NPAF Area: People and Workforce			
				DQ			
Key Messages				Green			
- The metric reports the proportion of eligible non-medical staff who have a Appraisal recorded as complete within the previous 12 months. - The Trust Non-Medical Appraisal rate maintained a level position in September 2025 at 87.1%. Although this remains slightly below the 90% target, compliance is notably higher than September 2024 (84.5%) and has continued a positive upward trajectory (at > 80.0%) throughout 2024/25. 10/17 Divisions improved or maintained (+/- 1%point) performance from August 2025. Three Divisions (F&E, CFO, Surgery (RSCH & PRH)) are above the 90%target, and three further Divisions are at 89-90% (W&C, CEO, Medicine (RSCH & PRH)). - By Staff Group, Healthcare Scientists (81.1%) and Add. Prof. Scientific & Technical (81.9%) remain the most challenged, and both have seen a fall of 3-4%points since August 2025. - By Division, lowest compliance is in non-clinical Divisions: CPO (78.6%), CMO (70.3%) Deputy CEO (61.4%), although absolute numbers of appraisees (and therefore impact on Trust compliance rate) is smaller.							
		Incl Medics					
		24/25					
		25/26					
		Variance					
		Non-medics					
		24/25					
		25/26					
		Variance					
Key Actions							
- Non-Medical Appraisal compliance continues to be a strong focus of meetings with Divisions on performance, and with support from HREPs to Divisional Management Teams. - Further work is being undertaken on data reporting (ie. to ensure staff with two Assignment Numbers are recorded as complete for both, as applicable). New Non-Medical Appraisal documentation is being piloted in Facilities and Cancer Division, ahead of transferring the process to Iris. An Iris-based system will reduce data re-entry and increase audit capability (eg. objectives), but will require a more structured process. - The NHSE 'Grip & Control' standards suggest a shorter 'appraisal season' aligned to Trust annual business and financial planning cycle –if implemented, this would involve a significant change, and potentially increased pace of completions. - The overall improvement in compliance during 2024/25 has been achieved in spite of significant operational pressures.							
Interdependencies with other performance indicators							
Appraisal is linked to staff satisfaction and development being an oportunity to recognise contribution and acheivements and any development needs. It does require time and focus and prioritising appraisal can be a challenge for managers and supervisors against operational and other immediate pressures.							
Exec Owner		David Grantham		SRO Nick Groves			

Communities



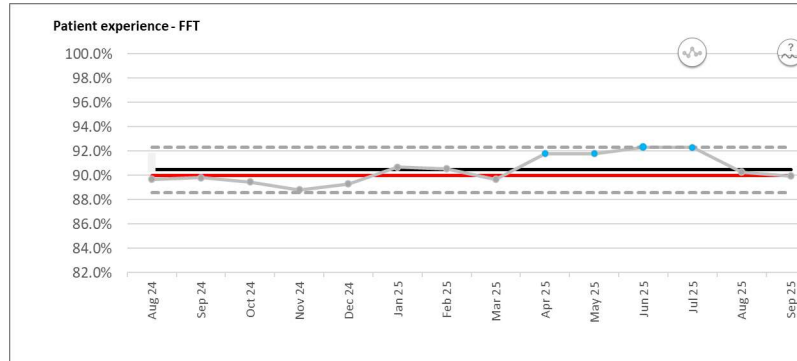
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Our Ambition: Communities				
Patient Experience: FFT	Target	>90%		
24/25 actual	89.8%	National Rank	24th of 117 A&E, 82nd of 119 Inpatients, 20th of 132 outpatients	
Latest Month Actual	90.0%	National Performance	91.6% (Aug-25)	
Latest Month Trend	Reduced (worsened)	NPAF Area: Patient Experience	DQ	Green
Key Messages				

- The Friends and Family Test (FFT) is a survey being distributed to ask patients to rate their care on a scale of very good (1) to very poor (5) and to give a reason for their score. The survey is grouped into four touchpoints – ED, maternity, inpatients and outpatients.
- Based on available FFT data, the significant majority of patients (over 90% at the end of Q2 2025/26) are satisfied that they have a good or very good experience of care, based on more than 30,000 responses.
- Patient reported experience of ED closely aligns to 4-hour performance
- The positive experience of care episodes identified through FFT is in contrast to trajectories for volumes of complaints and concerns, which are steeply upward. Triangulated data across complaints, PALS and other patient feedback identifies that the most prevalent causes of poor patient experience are delays to treatment, follow up, referral onward, results and tests, and the communication with the patient (including responsiveness by phone and email). Increases continue to be noted in complaints about the behaviour of doctors.



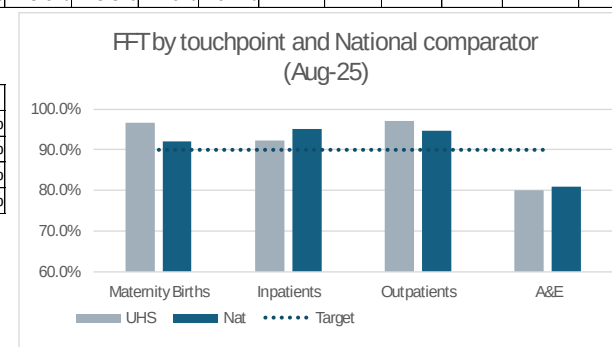
Key Actions

- Emergency department improvements and waits are integrated within the new strategy, and drivers such as 4-hour performance and RTT targets are integrated within the IPR. Patient reported experience via FFT will improve with reducing 4 hour and 12 hour waits, and ambulance handover times.
- To improve inpatient care, patient experience audits are being undertaken on the wards to identify concerns early for resolution as part of the fundamental standards of care programme. Changes to the visiting policy are supporting improved family engagement and has been evaluated.
- A communication skills programme for doctors is being developed, and improvements in waiting are included within delivery plans. Customer service training, building on the waiting standards, is being embedded within staff induction and training.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	88.9%	89.4%	88.8%	89.0%	89.7%	89.8%	89.5%	88.8%	89.3%	90.7%	90.5%	89.7%
25/26	91.8%	91.8%	92.3%	92.3%	91.7%	90.0%						
Variance	2.9%	2.4%	3.6%	3.3%	2.0%	0.1%						

Breakdown Latest Month

FFT Scores	UHS	Nat
Maternity Births	96.7%	92.0%
Inpatients	92.3%	95.0%
Outpatients	97.1%	94.6%
A&E	80.1%	80.9%



Interdependencies with other performance indicators

- ED performance correlates with patient reported experience via FFT
- Other key impacts relate to access times for elective care, completion of follow up actions and appointments, staff attitude, patient care and communication by/ accessibility of clinical staff.

Exec Owner	Dr. Maggie Davies	SRO	Nicole Chavaudra

Future



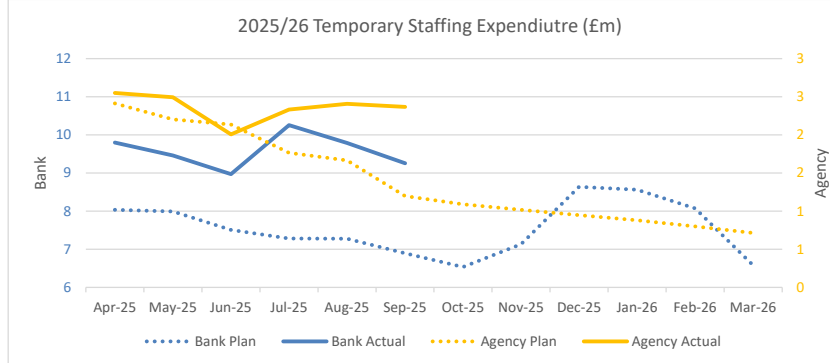
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		Our Ambition: Excellent Care for the Future																																																																																									
Financial Stability/variance from Breakeven Plan		Target		£0																																																																																							
25/26 Plan YTD (£m)		£15.18m deficit		National Rank																																																																																							
25/26 Actual YTD (£m)		£15.16m deficit		National Performance																																																																																							
Latest Month Trend		Decreased (improved)		NPAF: Finance and Productivity				DQ		Green																																																																																	
Key Messages																																																																																											
- The Trust submitted a revised breakeven financial plan for 2025/26; the YTD plan at M6 is for a £15.18 deficit. The actual deficit is £15.16m, which is £0.20m favourable to plan. - The plan to achieve the breakeven position includes the delivery of a £112.96m efficiency programme. This programme is phased; efficiencies increase as additional schemes are due to commence through the year. The YTD plan at M6 is for efficiency delivery of £31.35m. Actual delivery is £31.43m, £0.08m favourable to plan. The position includes non-recurrent slippage against agreed cost pressure funding. - The cash position is £2.42m which is on plan. - The capital expenditure plan is adjusted through the year to recognise additional capital funding that has been granted to the Trust. As at M6 the full-year plan totals £122.93 of which £60.05m is YTD. Actual capital expenditure YTD is £52.45m, £7.60m behind plan. This reflects timing differences and forecast outturn is in line with plan.		<table><tr><th rowspan="2">2025/26 M06 £m</th><th rowspan="2">Annual Plan</th><th colspan="3">YTD</th></tr><tr><th>Plan</th><th>Actual</th><th>Variance Fav/(Adv)</th></tr><tr><td>k&E (Surplus) / Deficit</td><td>0.00</td><td>15.18</td><td>15.16</td><td>0.02</td></tr><tr><td>Efficiency</td><td>112.96</td><td>31.35</td><td>31.43</td><td>0.08</td></tr><tr><td>Cash</td><td>2.42</td><td>2.42</td><td>2.42</td><td>0.00</td></tr><tr><td>Capital</td><td>122.93</td><td>60.05</td><td>52.45</td><td>7.60</td></tr></table> <table><tr><td>YTD as at</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td></tr><tr><td>Plan</td><td>4.94</td><td>9.78</td><td>13.10</td><td>14.28</td><td>14.98</td><td>15.18</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Actual</td><td>4.67</td><td>9.29</td><td>12.62</td><td>13.79</td><td>14.96</td><td>15.16</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Variance</td><td>0.27</td><td>0.49</td><td>0.48</td><td>0.49</td><td>0.02</td><td>0.02</td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										2025/26 M06 £m	Annual Plan	YTD			Plan	Actual	Variance Fav/(Adv)	k&E (Surplus) / Deficit	0.00	15.18	15.16	0.02	Efficiency	112.96	31.35	31.43	0.08	Cash	2.42	2.42	2.42	0.00	Capital	122.93	60.05	52.45	7.60	YTD as at	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Plan	4.94	9.78	13.10	14.28	14.98	15.18							Actual	4.67	9.29	12.62	13.79	14.96	15.16							Variance	0.27	0.49	0.48	0.49	0.02	0.02						
2025/26 M06 £m	Annual Plan	YTD																																																																																									
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Key Actions		- The financial plan requires a transission from monthly deficits to surpluses as the year progresses in order to deliver the final breakeven position. This is planned to be achieved through increased delivery of cost improvement plans. Delivery of schemes is montioered on an on-going basis with mitigations sought to offset any underdelivery. - A review of the NHSE grip and control checklist has been undertaken which will inform Executive Team consideration of further measures to implement to support reduction in the underlying expenditure run-rate. - There is an over-arching risk that the Trust will not deliver the financial plan as a result of a number of key contributors: delivery of the full efficiency target, cost of elective recovery within tariff and funded envelopes, 2024/25 exit run-rate above 2025/26 planning assumption and the risk of further industrial action with consequential impact on all aspects of performance, including ERF clawback. Regular monitoring and review of these issues is embedded in business partnering. Divisional Accountability Meetings are held at which divisional management teams meet with Trust Executives to review performance, including financial. Divisions whose performance is assessed to be of concern are subject to escalated oversight through regular Performance Review Group Meetings which drill into the causes of problems and support development of action plans to resolve them.																																																																																									
Interdependencies with other performance indicators		RIT performance: securing the variable ERF income that is assumed in the financial position requires relevant clinical activity to be undertaken and fully and appropriately recorded.																																																																																									
Exec Owner		Jonathan Reid																																																																																									
		SRO Naem Uddin																																																																																									

Our Ambition: Excellent Care for the Future				
Temporary Staffing Expenditure against Plan	Target	<£90.51M 25/6 Bank; £16.84M Agency		
25/26 Plan YTD (£m)	56.37	National Bank		
25/26 Actual YTD (£m)	71.69	National Performance		
Latest Month Trend	Decreased (improved)	NPAF: Finance and Productivity	DQ	Green
Key Messages				

- The 2025/26 national planning guidance included a requirement systems to reduce their temporary staffing expenditure; agency by a minimum of 30% and bank by a minimum of 10%. This system requirement flows into provider organisations planning for reductions in temporary staffing expenditure.
- The UHSussex 2025/26 plan is for 13.5% year-on-year reduction in bank staff expenditure from £104.6m in 2024/25 to £90.5m and a 49.1% reduction in agency staff expenditure from £33.1m to £16.8m. This means a total planned reduction in temporary staffing costs of 22.0%. NB The financial values given are for revenue expenditure only; temporary staff are also used in delivering some capital projects.
- The reductions in temporary staffing expenditure, particularly the premium agency costs, contribute to delivery of the Trust's efficiency programme and support delivery of high quality care.
- Planned monthly bank expenditure, while variable through the year, reflects a monthly reduction from £8.0m in M1 to £6.6m in M12.
- Actual bank expenditure to M6 is in excess of plan each month and by a cumulative total of £12.5m.
- Agency expenditure is planned to reduce on a monthly basis from £2.4m in M1 to £0.7m in M12.
- Actual agency expenditure to M6 is in excess of plan in months apart from M3 giving a cumulative total overspend of £2.8m.



£m	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	YTD	Annual Plan
Bank Plan	8.04	7.99	7.51	7.28	7.28	6.90	6.53	7.13	8.64	8.57	8.07	6.58	44.99	90.51
Bank Actual	9.80	9.46	8.97	10.25	9.79	9.26							57.53	
Variance	(1.76)	(1.47)	(1.46)	(2.97)	(2.51)	(2.36)							(12.54)	
Agency Plan	2.41	2.20	2.14	1.77	1.67	1.20	1.09	1.02	0.95	0.88	0.80	0.71	11.38	16.84
Agency Actual	2.55	2.49	2.01	2.33	2.41	2.37							14.16	
Variance	(0.14)	(0.29)	0.13	(0.57)	(0.74)	(1.17)							(2.78)	
Combined Plan	10.45	10.19	9.65	9.05	8.94	8.10	7.62	8.15	9.59	9.45	8.88	7.29	56.37	107.35
Combined Actual	12.35	11.96	10.98	12.59	12.20	11.62							71.69	
Variance	(1.90)	(1.76)	(1.33)	(3.54)	(3.25)	(3.53)							(15.32)	

Key Actions

- Electronic rostering of medical staff continues to be rolled out which will support the optimisation of the deployment of staff and provide greater visibility of issues such as sickness enabling appropriate management actions to be taken.
- Bank rates for medical staff have been held in 2025/26. Following Executive review new rates have been agreed for non-medical staff which will apply from 1st October 2025.
- Additional staff have been recruited into the HR team to support divisions appropriately address issues of long term sickness. Guidance has been issued to confirm the responsibilities for the management of resident doctors sickness.
- The use of enhanced medical remuneration package has been agreed in principle at FRDB; in practice the requirement and potential consequences are assessed on a case by case basis where the Chief People Officer ultimately signs off the enhanced package and these are limited to medical posts.
- Information on nursing agency usage is shared with managers on a weekly basis to highlight areas where investigation or further action is required.

Interdependencies with other performance indicators

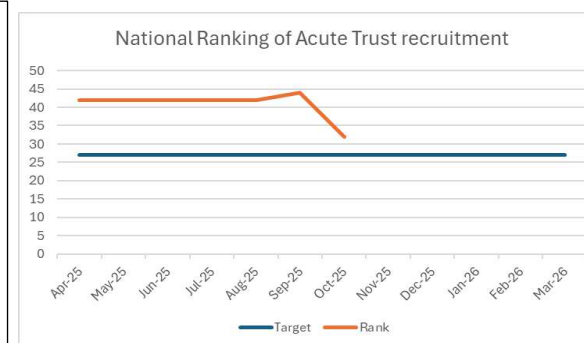
- Sickness absence and vacancy rates: levels of both drive the the need for temporary staff backfill

Exec Owner	Jonathan Reid	SRO	Naeem Uddin

Our Ambition: One UHSx				
Recruitment to studies national ranking	Target	27th or less		
24/25 Actual	55th	National Rank		
25/26 Actual	32nd	National Performance		
Latest Month Trend	Increased (improved)	NPAF Area: Access to Services	DQ	Green

Key Messages

- Research and Innovation drive continuous quality improvement in healthcare however a relatively small proportion of staff and patients participate in high quality research studies. Participating in research improves patients' satisfaction with clinical care and patients are missing out on this benefit. Participation in high quality research studies results in better treatments, as well as improved diagnosis, prevention, care and quality of life for our patients and their families.
- This chart shows the 12-month rolling Acute Trust ranking in terms of total recruitment to studies on the NIHR portfolio. The Trust currently stands at 32nd (October 25) putting it outside the top 20% of recruiting Acute Trusts over the past 12 months (a rank of 27 or above would put a trust in the top 20%). Our annual ranking for studies open has been consistently in the top 20% consistent for the last 3 years. However, our relative position for patient recruitment year on year is partially outside our control. The data is heavily skewed due to recruitment to large observational or screening studies that often recruit at a single site. The Trust performs better, standing at 27th when only looking at the number of interventional (treatment) study recruits which sits at 852 against a median of 954 for the top 28 Trusts.



Key Actions

Portfolio horizon scanning

Our delivery teams, working with Divisional Directors of Research and specialty leads, continually review available studies that offer potential benefit and are feasible to run across the Trust. In addition, our new NIHR Sussex Commercial Research Delivery Centre (CRDC), actively seeks commercial partnerships and provides a fast and efficient clinical trials delivery infrastructure working across clinical pathways and settings, enabling a hub and spoke model of commercial research delivery promoting research participation and inclusion. The Trust is developing research and innovation in line with the R&I Strategy. The UHS Future 2030 strategy reflects the strategic potential of R&I to drive transformations of services and care at UH Sussex.

Strategic development of R&I

The R&I delivery plan for the next five years focuses on:

Major Capital Project to develop clinical research facilities securing the re-provision of the Clinical Research Facility in the LMB and clinical research facilities at PRH and WH sites to a high quality and accreditable standard to deliver the Trust's R&I ambition.

Delivering the new NIHR Sussex Commercial Research Delivery Centre (CDRC), this will be a centre of excellence, offering additional commercial research delivery capacity to existing health and care organisations in Sussex.

RH workforce development and workforce model transformation of research-specialist workforce models of research delivery (hub and spoke, agile teams).

Streamlining study set up and delivery to ensure efficient delivery of clinical trials in line with DHSC performance expectations.

Developing embedded workforce research capacity including medical PAs for research, NMAHP advanced practitioner job planned research time and increased workforce research capability through training and placement opportunities.

Development of Joint Clinical Academic Departments establishing research-driven centres of excellence.

Development of our Research Leaders through the MyUHSussex Fellowship programme, NIHR and other external fellowship opportunities and increasing participation in NIHR Associate PI scheme.

Further development of the Health & Care Research Partnership supporting regional research growth and opportunity through shared research infrastructure, capacity building and collaboration with regional partner organisations.

Further development of Sussex Patient and Community Involvement and Engagement in Research – supporting the sustainability and development of the Sussex Research Engagement

Exec Owner	Prof Katie Urch	SRO	Martin Llewellyn

Major Projects Portfolio Overview

Portfolio Summary

During the last period 2 projects (SRH RAAC Remediation and Theatre Ventilation) were approved by the SMPC, have been added to the major projects portfolio (MPP) and launched. A property rationalisation and disposals programme board that will provide governance to the various Trust building acquisitions and disposals has been initiated and will be taken to SMPC committee for approval in November. Projects are broadly on track against agreed timelines and key milestones have been achieved: Approval by NHSE & NCAT of the Sussex Cancer Centre FBC moving it forward to JIC and HMT in the upcoming period; confirmation of a financially viable and low risk path to opening of the helideck, approvals of clinical models for the RSCH AFR and Stroke projects. The delay of handover and opening of RSCH AFR AMU due to water contamination is extremely disappointing, a decontamination plan is in place, and an AAR review will be performed so that lessons can be learnt for future MPs and wider Trust projects. SMPB is providing greater visibility of areas of challenge which will enable us to develop Trust wide rather than project focused improvements. Communication and planning around longer project timelines and mandated Trust protocols for specialised areas such as handover and water management are key examples that will be developed with Capital and Estates. Our financial profile is slightly off track, and it continues to be challenging to mobilise at a pace that matches actual capital spend to forecast, Finance are working to mitigate any potential negative impact, and this will be an increased project/portfolio focus going forward.

Portfolio Health				
Project/Programme	Time	Cost		Quality
		SR	EC	
Stages2&3	●	●	●	●
Helideck	●	●	●	●
EPR	●	●	●	●
Stroke reconfiguration	●	●	●	●
RSCH AFR	●	●	●	●
Clinical Research Facility	●	●	●	●
Southlands Theatres	●	●	●	●
SRH RAAC Remediation	TBC	TBC	TBC	●
Theatre Ventilation	TBC	●	TBC	●

Milestones Achieved in Previous Period

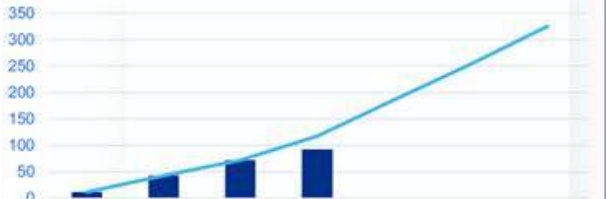


Stages of Development

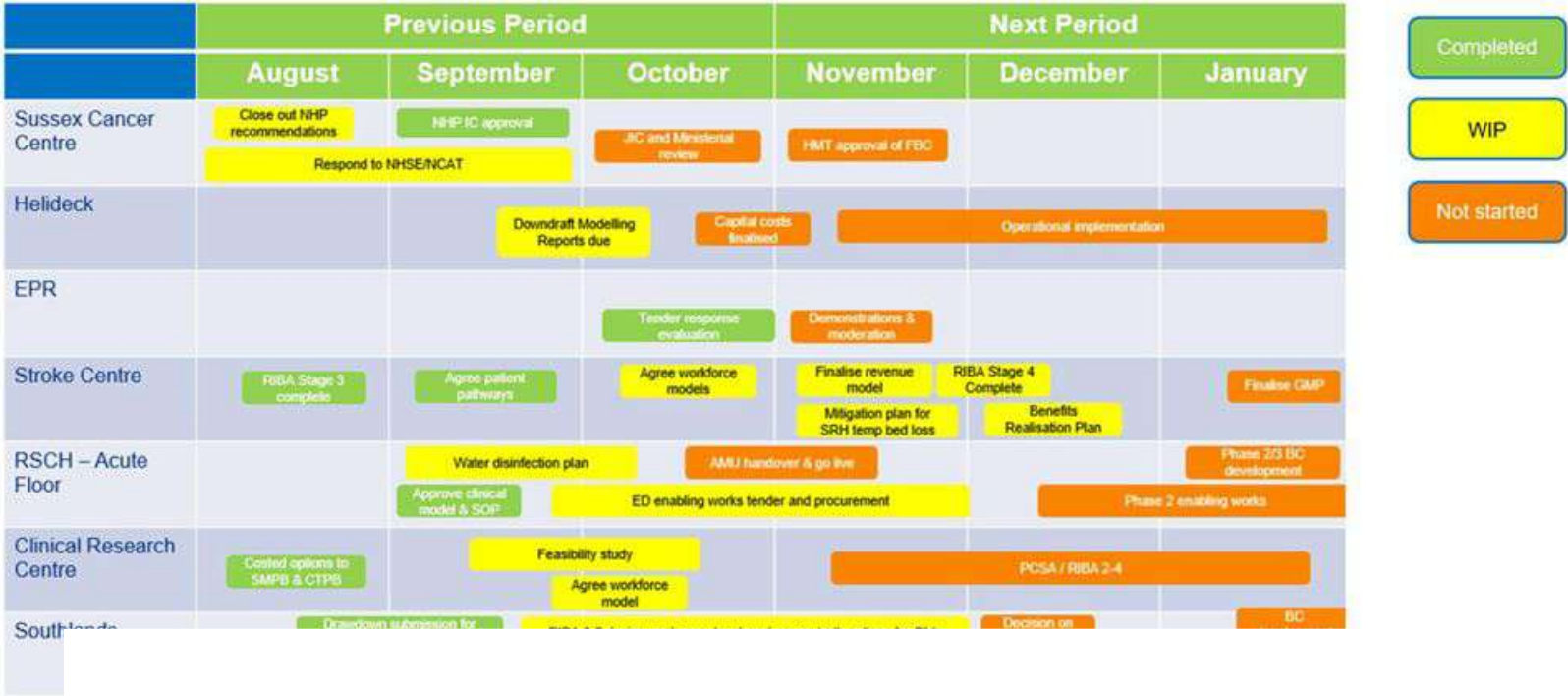
- Design/Approval
- Feasibility
- Procurement
- Construction



Major Projects Portfolio Spend vs Forecast (£'m)



Key Milestones in previous and next period



Key Milestones in previous and next period cont.



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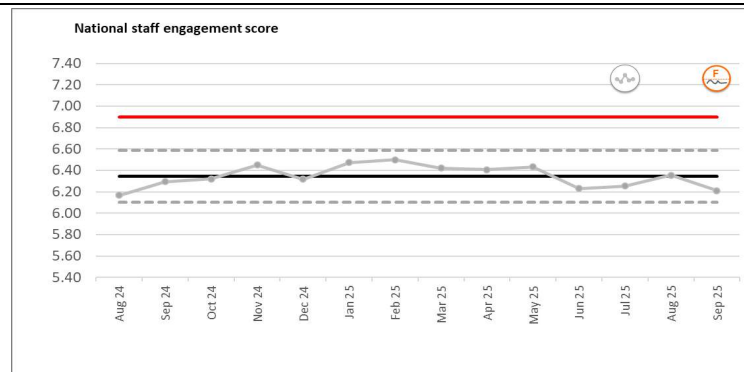
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University Hospitals Sussex
NHS Foundation Trust

Our Ambition: One UHSx						
Staff Engagement Scores	Target	>6.9				
24/25 Actual	6.29	National Rank				
25/26 Actual	6.21	National Performance	6.85 - Annual 2024 National NHS Staff Survey			
Latest Month Trend	Reduced (worsened)	NPAF Area: People and Workforce			DQ	Green
Key Messages						

- Staff engagement is measured nationally through the NHS annual Staff Survey and quarterly People Pulse survey, and locally through the monthly UHSussex Pulse Survey.
- The second quarter of the 2025-26 year has remained below the national average staff engagement score in the UHSussex monthly Pulse Survey, ending with a score of 6.21 (out of 10) in September 2025 (Q2 score range: 6.21 to 6.36). This is compared to our 6.29 score in September 2024. The Trust achieved the staff engagement target in the first quarter of 2024 but it has been consistently below 7.0 from July 2024 onwards.
- Our staff engagement score was 6.59 (out of 10) in the 2024 national NHS Staff Survey, compared to the national acute Trust average score of 6.84. Although our score has declined slightly since 2021, the gap to the national average has stayed consistent.
- UHSussex scored 5.49 (out of 10) in the most recent July 2025 national NHS People Pulse quarterly survey, compared to the 6.29 national average score.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	7.3	7.1	7.3	7.1	6.9	6.3	6.3	6.5	6.3	6.5	6.5	6.4
25/26	6.4	6.4	6.2	6.3	6.4	6.2						
Variance	-0.9	-0.7	-1.0	-0.8	-0.6	-0.1						

Breakdown Latest Month

Drilldown	25-Sep
Add Prof Scientific and Technical	6.55
Additional Clinical Services	5.49
Administrative and Clerical	4.99
Allied Health Professionals	6.23
Estates and Ancillary	5.81
Healthcare Scientists	5.54
Medical and Dental	6.22
Nursing and Midwifery Registered	6.39
Students	6.52

Key Actions

- The 2025-26 People Plan set out the projects and programmes being delivered across the People Directorate, aligned to the 7 national People Promise pillars to achieve optimum staff engagement.
- Following the launch of the Trust Strategy in October 2025, the improvement work in the People Plan has been mapped against the Ambitions and Priorities of the Trust Strategy to ensure it will support its delivery and progress milestones have been agreed.
- The Strategy sets out commitments to provide excellent care for our people and support colleagues to be their best, working together towards common goals, living our values and united for long-term success. Delivering these priorities is anticipated to improve UHSussex as an employer and increased staff engagement scores are anticipated as a result.

Interdependencies with other performance indicators

- When triangulating a low staff engagement score with other workforce metrics, it is common to see a correlation with high sickness absence and turnover rates. However, these rates are comparatively positive (4.8% and 6.2% respectively) and our stability rate is 90.6%.

Exec Owner David Grantham

SRO Helen Weatherill

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National Performance Assessment Framework and League Tables

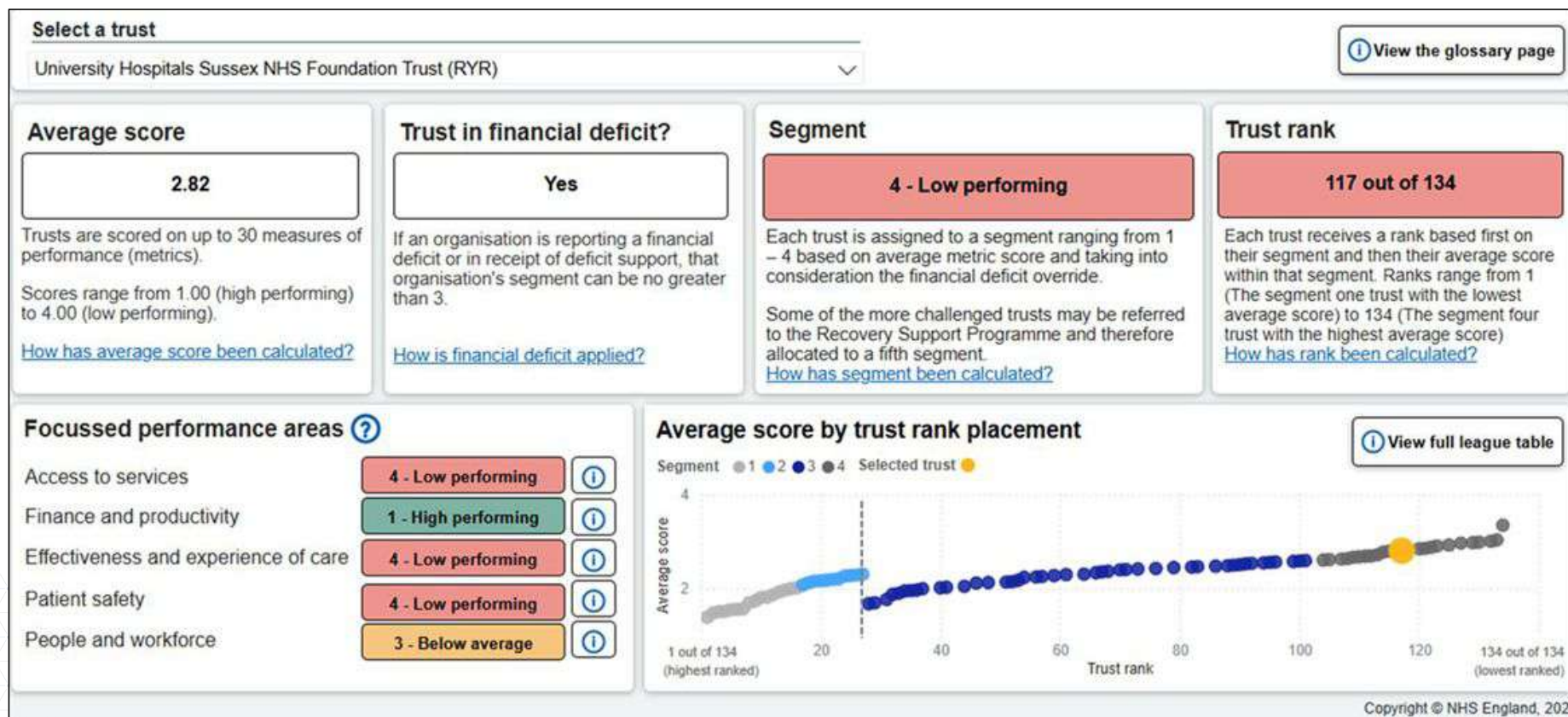
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We are compassionate. We are inclusive. We are respectful.

National Performance Assessment Framework and League Tables

- **Current segmentation**
- The Trust has been informed that it is placed within Segment 4 of the revised National Oversight Framework (NOF). The revised framework now contains five segments from best performing segment 1 to those requiring mandated support segment 5. The Trust has submitted its provider capability assessment which as with all providers will be used by NHS England to determine if any new Trusts need to move into segment 5 and into the national Trusts provider improvement programme.
- The Trust continues to engage with NHS England and the ICB through their formal oversight processes in respect of all aspects of our performance, which through these quarterly meetings provide assurance on the delivery of Trust's annual plan.
- **Drivers of the segmentation**
- During Q2 the Trust continued to focus on Emergency Care, Cancer and Planned Care delivery. The Trust remains within Tier 1 oversight for Planned Care performance having exited Tier 1 for cancer performance and remains in Tier 2 oversight for Emergency Care performance, where we are seeing enhanced performance oversight continue with NHS England. The Trust whilst continuing to make significant progress in reducing its overall RTT waiting list numbers and meeting its planned care performance plan did not achieve zero patients waiting over 65 weeks and in respect of emergency care performance the Trust has not made the performance gains it expected to within the quarter. The Trust, however, continues to reflect good cancer faster diagnostic performance.
- The Trust has met its financial plan for the first half of the year, which is a deficit meaning that the Trust cannot be placed into a segment above 3. The Trust in developing its 2025/26 plan recognised that there is a degree of risk in achieving its breakeven position by the year end. Oversight of the Trust's efficiency and productivity improvement plan is subject to regular review at the monthly Finance and Performance Assurance Committee alongside the regular meetings with the ICB.
- The Board Assurance Framework, as reported to the Board shows a predicted continued level of elevated strategic risk for the majority of its 11 strategic risks aligned to the Trust's Strategic Ambitions.
- **Implications of this segmentation**
- As the Trust is not in segment 5 of the revised framework it is not in receipt of mandated support, however the Trust has utilised its position within segment 4 to secure access to external advice and support specifically within the areas of UEC improvement and patient flow and with an extended review of the drivers of the Trust's financial deficit.
- **Actions being taken to move from segment 4**
- The Trust's developed Strategy sets out the Trust's ambitions over the next 5 years to 2030. As these ambitions are translated into the respective annual delivery plans these seek to move the Trust forward to provide excellent care everywhere and lift the Trust from segment 4. However, the Trust recognises it has much to do namely in the area of culture and the Trust remains with a small number of undertakings on its Licence with NHS England in respect of operational performance and finance and given the elevated degree of risk the Trust does not expect to exit segment 4 in the first part of 2026/27.
- The Board either directly or through its Patient and Quality, People and Culture and Finance and Performance Assurance Committees continues to exert oversight of the delivery of the Strategy aligned improvement plans established along with securing feedback from the routine NHS England oversight meetings and is supporting any areas that can be progressed more effectively.

National Performance Assessment Framework and League Tables





University Hospitals Sussex
NHS Foundation Trust

National Performance Assessment Framework and League Tables

• League Table Domain: Access to Services



University Hospitals Sussex
NHS Foundation Trust

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	Q1 2025/26	61.60	percent	3.53	98 out of 118	71.12	75
Access to services	Cancer care	Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	Q1 2025/26	76.39	percent	2.83	66 out of 118	76.88	80
Access to services	Elective care	Difference between planned and actual 18 week performance	Jun-25	0.64	percentage points	1.00	70 out of 131	0.99	0
Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Jun-25	51.30	percent	3.86	125 out of 131	60.72	
Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Jun-25	33.10	percent	3.80	73 out of 80	1.11	
Access to services	Elective care	Percentage of patients waiting over 52 weeks for elective treatment	Jun-25	5.18	percent	3.92	127 out of 131	2.40	1
Access to services	Urgent and emergency care	Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q1 2025	72.60	percent	2.89	77 out of 123	76.00	78
Access to services	Urgent and emergency care	Percentage of emergency department attendances spending over 12 hours in the department	Q1 2025/26	8.89	percent	2.55	64 out of 123	8.36	

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National Performance Assessment Framework and League Tables



• League Table Effectiveness, Patient Safety



Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Jun-25	1.70	days	3.78	117 out of 126	0.70	
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2023		score	2.00			
Effectiveness and experience	Patient experience	Summary Hospital Level Mortality Indicator	Apr 24 - Mar 25		score	2.00			
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.03	out of 10	3.75	123 out of 134	6.42	
Patient safety	Patient safety	Number of MRSA infections	Jul 24 - Jun 25	3.00	count	2.63	55 out of 134	3.00	0
Patient safety	Patient safety	Rate of C-Difficile infections	Jul 24 - Jun 25	1.34	rate	3.41	99 out of 134	1.22	1
Patient safety	Patient safety	Rate of E-Coli infections	Jul 24 - Jun 25	1.16	rate	2.79	66 out of 134	1.16	1



National Performance Assessment Framework and League Tables

- League Table Finance & productivity, People and Workforce**

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Finance and productivity	Finance	Combined finance	Q1 2025/26		score	2.00			
Finance and productivity	Finance	Planned surplus/deficit	2025/26	-1.62	percent	3.00	67 out of 134	-1.62	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 3 2025	0.12	percent	1.00	18 out of 134	0.00	
Finance and productivity	Productivity	Implied productivity level	To M12 2024/25 vs 2023/24	6.42	percent	1.34	16 out of 134	2.91	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	6.59	out of 10	3.55	114 out of 134	6.88	
People and workforce	Retention and culture	Sickness absence rate	Q4 2024-25	5.09	percent	2.18	63 out of 134	5.21	

Agenda Item:	11.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025
Report Title:	Maternity Assurance Reports				
Sponsoring Executive Director:	Maggie Davies, Chief Nursing Officer				
Author(s):	Emma Chambers, Director of Midwifery				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only	
	N/A	Yes	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement					
Summary of the report describing	Perinatal Quality Oversight Model (PQOM) monthly report August data)				
	<u>What:</u>				
	The Ockenden enquiry concluded that there needs to be more direct Board oversight of Maternity. A suggested dashboard was produced by NHSE which we have adapted for use at University Hospitals Sussex Trust and tested via Quality Board.				
	<u>So What:</u>				
What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i>	• There were no perinatal mortality cases in August. • There was one Maternity and Neonatal Safety Investigation (MNSI) referral (also required to be reported as a PSII), and two cases requiring Early Learning Review. • Perinatal mortality rates (stillbirths and neonatal deaths) remain below the latest available national rates (2023 data). • Brain injury (HIE) rates are being closely monitored via Rare Event charts and are currently in line with national rates. • Site specific outcome data stratified into Health inequality groups in Rare Event Chart format is now presented in the appendix. • Fetal monitoring training compliance is below expected levels at Brighton and Haywards Heath; improvement actions are underway with full compliance anticipated by the end of November. • None of our sites met compliance with timeliness of Hip Scan for babies who trigger the referral criteria. This was largely due to lack of scan appointment capacity and appears on the W&C and CSS Risk Registers. • Compliance with the Saving babies Lives (SBL) care bundle has reduced from 97% to 49% as assessed by the Local maternity and Neonatal System. This is due to a change in SBL version (now v3.2) with some new requirements, and the delay in merging and ratification of guidelines required by SBL. Urgent mitigations are in place to recover compliance before the next SBL assessment and CNST Maternity Incentive Scheme (MIS) submission in November. • The final report has been very recently received following the Insights visits by the regional perinatal team in August. There will be detailed sharing of findings in the November meeting to allow for analysis and action planning.				
So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i>					
What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s)being made)</i>					

The voice of the service user:

- Following a Bereavement Listening Event completed by the MNVP in the summer, a successful MDT co-production workshop took place on 10th October, this will lead to positive Development's within our Bereavement service.
- FFT rates remain above 90% on all sites.
- Complaint themes are analysed and required actions are monitored under the Service User Experience workstream of the Maternity and Neonatal Improvement Plan.

The Staff Voice:

- Staff Engagement scores remain below the Trust target at 5.6 vs 7, however, survey completion numbers are very low (35 staff). The Divisional leaders continue to offer various methods of staff support and engagement and are proactively encouraging completion of the Staff Survey to provide a more representative sample.
- The service is ready to fully engage in the national inquiry into maternity and neonatal services and be open to any recommendations made and is keeping both service users and staff up to date with progress of the investigation.

What Next:

- This report demonstrates that perinatal service teams continue to provide care resulting in stable outcome data and positive service user feedback.
- Focus on health inequality risks and staff wellbeing and culture continues.

ATAIN – reporting Q4 data

What:

In 2017, NHS England identified that over 20% of admissions of full-term babies into neonatal units (NNU) could have been avoided. By providing services and staffing models that keep birthing people and their babies together, we can reduce the harm caused by separation.

So What:

- For the total of Quarter 4, the benchmark of <5% of admission to the Special Care Baby Unit was met for the duration at WH (0.6%, 2.1% & 3.4%) and for SRH it did not meet the benchmark in February (2.3%, 6.2%, 3.4%). PRH and RSCH only met the benchmark in January for Quarter 4 (PRH 3.35%, 10.3%, 6.15%, RSCH 5.03%, 8.2%, 5.5%).
- The majority reason for admission this quarter across all four sites was again due to respiratory support.
- Overall, 91.4% (85) of admissions across all four sites were considered unavoidable with appropriate management with 8.6% (8) considered as potentially avoidable (national rate >20%).

What Next:

- ATAIN/Transitional Care Steering Group as a part of CNST working groups.
- The chair of the meeting has transitioned to the Neonatology leadership team (in place since May therefore not covering the Q4 period).

- The membership is currently in process of reviewing recent results across ATAIN and Transitional Care to agree an overarching action plan that will build in value to the current process for both audits.
- A managed action plan to be made available with the Q1 25/26.

Transitional Care – reporting Q4 data

What:

To provide assurance that the neonatal pathway into Transitional Care is fully implemented within the neonatal and maternity teams.

So What:

- Appropriate escalation for ongoing care was completed in the majority of cases. Individual case review and exploration of delayed escalation in 4 out of 101 cases has been completed.

What Next:

- Theme of the Month – started in July – focus on SBAR handovers.
- QI project focussing on neonatal Care and reducing admissions for hypoglycaemia.
- Review and align Neonatal guidance and how TC is done across the 4 sites.
- Improve data collection and more depth of knowledge about when processes aren't followed.
- Focus on daily reviews by medical teams.

Saving Babies Lives (SBL)

Both the Q4 2024/25 and Q1 2025/26 reports have been received, therefore, this summary includes only Q1 information.

What:

The NHS Long Term Plan reiterates the NHS's commitment to a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury and a reduction in preterm birth rate, from 8% to 6%, by 2025. Implementation of the care bundle has been included in NHS contracts and is a requirement of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. An audit plan has been developed to continually monitor and identify areas to improve the service and outcomes relating to the care bundle.

So What:

- Overall compliance has fallen in self-assessment of Q1 data compared to previous LMNS approved progress (97% to 96%). Await LMNS review and agreement with the self-assessment - review scheduled 24/09/2025.
- Element 1: Smoking cessation - Fully Implemented (100%)
- Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction not 100% due to the requirement to align Obstetric and Ultrasound guidance on scanning eligible patients – Partially Implemented (95%)
- Element 3: Fetal Growth Restriction - Fully Implemented (100%)
- Element 4: Fetal Monitoring - Fully Implemented (100%)

- Element 5: Reducing pre-term births need requirement fulfilled for nominated pre-term/perinatal optimisation lead Midwife, Neonatal Consultant, and Neonatal Nurse - Partially Implemented (96%) (down from 100% in Q4)
- Element 6: Management of diabetes in pregnancy – Await cross-trust guidance on the management of diabetic ketoacidosis which is currently being drafted by both Medicine divisions - Partially Implemented (83%)

What next:

- Element 2: A lead from USS has been appointed to address alignment of guidelines which will now progress quickly – assume gap analysis to be performed and then addressed
- Element 5: Recruitment is awaiting executive approval for Pre-Term Birth Midwife
- Element 6: Cross-site guidance now awaiting JOGGG approval and DKA guidance written by Endocrinology awaiting Trust ratification

Perinatal workforce report – Oct 2025 (6 monthly data)

What:

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

So What:

- Fill rates for maternity and neonatal services currently remain below recommended templates due to vacancy, sickness and parental leave.
- Recent recruitment campaigns in maternity including the second year of automatic on-boarding of student midwives (shortlisted Nursing Times Workforce Award) will result in an over recruited position at all sites from October. This position should significantly alleviate chronic short staffing experienced over several years, whilst not exceeding previous bank and agency spend.
- Neonatal services also anticipate a significantly improved staffing position, and a clear plan is in place to ensure a pipeline for Qualified in Speciality (QiS) training.
- The Midwifery Preceptorship Programme is robust and now well established. 98% of those who started in 2024 remain in post. UHSx has recently received the National Quality Mark for Preceptorship, a key component of being recognised as 'an employer of choice'.
- Whilst the balance of comments received from FFT are overwhelmingly positive, negative feedback frequently cites issues related to short staffing.
- Whilst turnover in perinatal services is low, in part owing to staff being settled in their local communities, engagement remains a challenge. Improved staffing should significantly improve this.

What Next:

- A Trust-wide decision regarding nursing and midwifery recruitment of students in practice placement is required to plan for the next cohort of newly qualified midwives.
- Perinatal workforce requirements are complex and can change rapidly. National recommendations have placed further pressure on services, by mandating various roles and requirements that are unfunded (specialist midwifery roles, increased scanning requirements etc.)
- The approved Clinical Operating Model is now almost fully recruited to, meaning an improved and more visible, permanent leadership structure for perinatal services.
- There remain teams with low morale as demonstrated by the Staff Survey and staff feedback, targeted work will be completed to understand the issues within these teams.
- Due to the improvements being made at every level as a result of the Maternity Improvement Plan and our commitment to the delivery of national drivers known to impact on patient safety, such as the Saving Babies Lives Care Bundle and the CNST Maternity Incentive Scheme, safety continues to improve as evidenced by our outcome data.

Maternity Vision and Roadmap 2025 – 2030

What:

The development of a maternity vision and roadmap is a requirement of exit from the Maternity Safety Support Programme.

The Vision was co-produced by service users and staff, and the roadmap to achieving the vision was developed by the maternity service multidisciplinary team.

So what:

- It is essential to have clear KPIs to drive improvement within maternity services. These have been developed in line with the NHSE Three Year Delivery Plan for Maternity and Neonatal Services.
- These KPIs are monitored via the Maternity and Neonatal Improvement Group and reported to Trust Board.

What next:

The vision and strategy for maternity services at our hospitals and within our communities is designed to create a safe, supportive, and personalised care environment for families. By focusing on quality and safety, workforce development, service user experience, innovation, and community partnerships, we aim to deliver outstanding maternity care that meets the highest standards of quality safety and personalised services that are responsive to service user needs as well as investment and development of our teams.

Perinatal Quality Oversight Model

What:

This report introduces the revised Perinatal Quality Oversight Model (PQOM), designed to ensure timely, effective oversight of maternity and neonatal services across the NHS. The PQOM sets out clear responsibilities at every level—Trust,

	ICB, regional, and national—to identify risk early, support improvement, and ensure accountability. This model replaces the 2020 Perinatal Quality Surveillance model. <u>So what:</u> The service has completed a gap analysis against the new model and will align ongoing reporting to meet the new requirements. <u>What next:</u> An action plan is in place to achieve the small number of changes required. All elements will be in place by the end of Q1 2026/27.					
Recommendation (linked to What Next section)	The Trust Board are asked to note the maternity assurance reports.					
Assurance / Scrutiny route already undertaken (please explain where matter previously considered, and assurance provided)	Directorate and Divisional Quality and safety meetings, QGSG (other than CNST paper) and Patient and Quality Committee.					
Link to Trust Strategy (note which theme)	Patients Yes / N/A	People Yes / N/A	Future Yes / N/A	Communities Yes / N/A	One UHSussex Yes / N/A	Culture Yes / N/A
Link to annual delivery plan						
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc						
Link to CQC domain	Safe Yes / N/A	Caring Yes / N/A	Effective Yes / N/A	Responsive Yes / N/A	Well-led Yes / N/A	Use of Resources Yes / N/A
Other impacts	Equality and Diversity (if yes has HEIA completed)		Environmental	Legal	External Registrations (if yes please indicate which)	
	Yes / N/A (Yes / No)		Yes / N/A	Yes / N/A	Yes / N/A	

Agenda Item:	12.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025
Report Title:	Board Assurance Framework report Q3				
Executive Sponsor	Michelle Arrowsmith – Chief Corporate Affairs Officer				
Author(s):	Glen Palethorpe – Company Secretary				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only	
	Yes	Yes	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement		NHS organisations are required to have effective risk management processes and are expected to have in place and effective Board Assurance Framework covering their Strategic risks			
Summary of the report describing What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i>	The Board at its meeting in June agreed the opening 11 Strategic Risks that make up the BAF, noting their alignment to the Trust's new strategic ambitions. Each strategic risk has an allocated Executive lead and oversight Committee. The respective lead Executives have updated the BAF in respect of their review of the assurances received in quarter 2 allowing them to provide a look back and look forward summary in support of their proposed quarter 3 scores. The Audit Committee in its meeting in October was assured over the continuing underpinning processes for the executive oversight and update of the BAF. Each allocated oversight Committee considered their element of the BAF agreed with the executives view that the reports and assurance received in quarter 2 did not support any change to the quarter 3 scores. The People and Culture Assurance Committee whilst agreeing there should be no reduction in the score for the culture risks at this time the culture improvement plan is starting to deliver but reflected that the level of improvement is unlikely to manifest in a risk reduction to a score of 12 by the year end and that a more realistic change would be to a score of 16.				
So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i>	The Board can take assurance over the underpinning BAF oversight processes. The Board is asked to note the recommendations of the respective committees that there should be no reduction in any of the strategic risk scores for quarter 3 except risk 7 where a reduction is recommended. The Board is also asked to note that the respective oversight committees have confidence that the target scores could be achieved by the year end with the exception of the cultural strategic risk.				
What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s) being made)</i>	The Board should note the continued confidence the Committees have that assurance over the planned actions will be provided over the next quarter to enable them to verify the planned risk score reductions with the exception of strategic risk 2.				

	The Board is asked to consider the comment provided by the People and Culture Committee that the reduction of the cultural risk despite the actions being taken will not see the risk move from its current score of 20 to a 12 but that a movement to 16 would be realistic and therefore the Board should seek adjustment to the BAF target score.					
Recommendation (linked to What Next section)	The Board should NOTE the assurance provided by the Audit Committee in respect of the underpinning processes for the oversight and maintenance of the BAF. The Board is asked AGREE the quarter 3 scores, noting the support for these scores by the relevant oversight committees, including a reduction in risk 7. The Board is asked to CONSIDER the comment provided by the People and Culture Committee that the reduction of the cultural risk despite the actions being taken will not see the risk move from its current score of 20 to a 12 but that a movement to 16 would be realistic and therefore the Board should seek adjustment to the BAF target score.					
Assurance / Scrutiny route already undertaken (please explain where matter previously considered, and assurance provided)	The Audit Committee considered the underpinning processes at its meeting in October Each of the respective oversight committees considered their element of the BAF at their meetings at the start of November.					
Link to Trust Strategy (note which theme)	Patient	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan	The BAF provides a mechanism to consider the strategic risks to the strategy achievement and thus the delivery of the annual delivery plan.					
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	This report covers all BAF risks					
Link to CQC domain	Patients	Caring	Effective	Responsive	Well-led	Use of Resources
	Yes	Yes	Yes	Yes	Yes	Yes
Other impacts	Equality and Diversity (if yes has HEIA completed)		Environmental	Legal	External Registrations (if yes please indicate which)	
	N/A		N/A	Yes	The Trust is expected to have an effective BAF aligned to its strategic risks	

2025/26 Board Assurance Framework Report

1 Introduction

1.1 At the Board in its meeting in June it agreed 11 Strategic Risks, as part of this Board review, it recognised that these strategic risks will be subject to a review by each of the allocated oversight Committees.

1.2 The BAF for 2025/26 has been aligned to the Trust's new strategy ambitions.

2 BAF Structure

2.1 The Trust revised the format of its BAF in 2024/25 to bring a focus to the actions taken and being taken in respect of each of its identified strategic risks. This revised first page for each strategic risk was valued by the NED Committee Chairs. The second page was also streamlined to bring a focus to the key controls and assurances rather than a long list of numerous elements, many of which the Board and its Committees would not wish to receive.

2.2 This format has broadly been retained for 2025/26 but with some notable changes; these being the strategic risks are linked to the 2030 strategic ambitions not the patient first domains; there has been the addition of inherent (uncontrolled risk score); and within the first page for each strategic risk a section shows the link to the strategy delivery plan milestones, recognising that these will be added too as the delivery plan is finalised.

2.3 A third page has been added for each Strategic Risk showing the underpinning aggregated (corporate) risks to allow for a better review of those risks with an impact of 5 in respect of how these are being controlled to make the risk less likely or where the likelihood of this risk occurring is high will allow the Committees to consider the impact these risks are having on the strategic risk score itself. This is a temporary step as work on the development of the supporting risk (corporate) risk register oversight and management processes concludes.

2.4 The BAF retains an explicit link to a Board Committee allocated for initial oversight, which will focus on the seeking of and then understanding of the assurances listed against the key controls. The BAF also retains a nominated executive lead for each risk.

2.5 The Board has commenced its review of its risk appetite statements and once concluded this will overlay the BAF allowing the Board and its Committee to focus their attention on those risks that are outside its defined tolerances.

2.6 The 2025/26 BAF retains risks around patient safety and quality of services, financial sustainability, workforce and culture, digital infrastructure and operational performance, but includes two new strategic risks, one linked to change capacity given how integral that is to the delivery of the strategic ambition of the Trust and the second linked to the Trust's non digital infrastructure and sees a separation of digital from research in terms on a risk for achieving our innovation and improvement ambitions.

3 BAF summary

3.1 Each Executive considered their respective segment of the BAF and provided a view as to the inherent score, the current score based on their knowledge of the controls in place and the assurances they are aware of, the target score to be achieved in the year and the longer-term goal score to be achieved by at least the end of 2030.

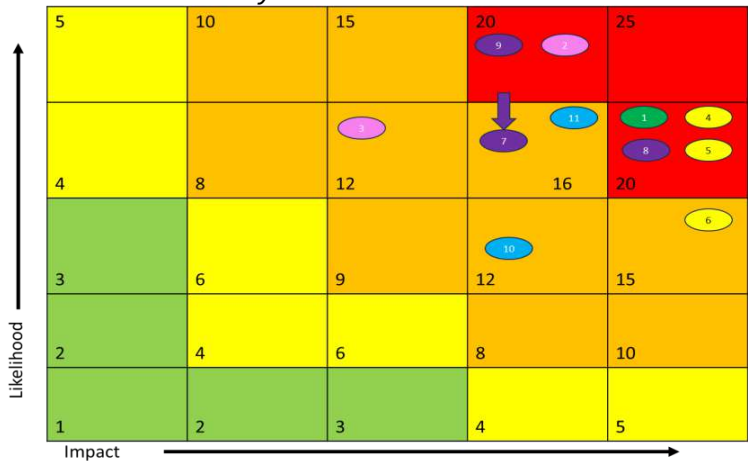
3.2 The Board at this meeting in September agreed that Strategic Risk 2 relating to culture should have its risk score adjusted to a score of 20 for quarter 1 and as there was no change in quarter 2 this higher score flowed through to that score.

3.3 The quarter 3 BAF sees one change to the scores for Quarter 3, this is to risk 7 relating to research where the development of a business cases and its support sets out the journey for a clinical research facility for the Trust, which sees this risk achieve its target score. The BAF continues to show two other risks which are deemed to be at their achievable score by the year end, one of these relating to the quality risk which is expected to remain as a significant risk, scoring 20 for the whole year and the workforce strategic risk where the controls are supporting the reduction to 12 and the assurances are indicating that this score can be maintained across the year.

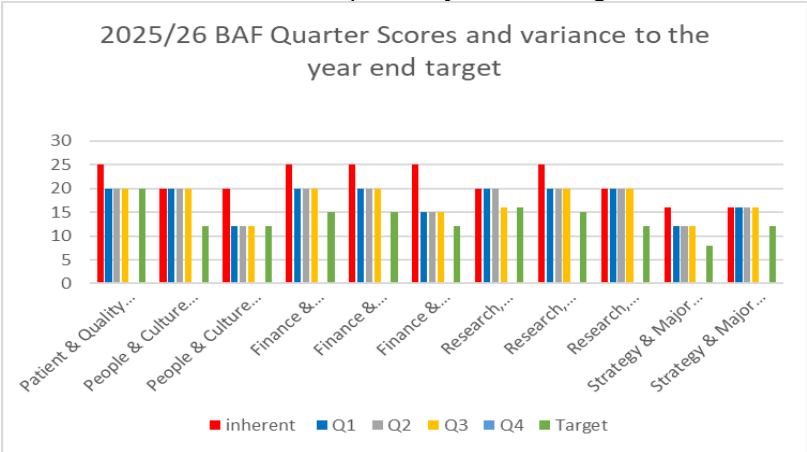
3.4 There are two risks where the current controlled score remains at the same level as the inherent score, these being for digital innovation which is scoring 20 and developing sufficient change resource which is scoring a 16.

3.5 The Executives do expect a reduction over the year for the 9 risks that are yet to be at their expected year end scores.

Strategic Risk Pictorial Summary



3.6 Below is a summary chart showing for the 11 Strategic Risks their quarter 1, 2 and 3 scores and the distance from their respective year-end target score.



3.7 The detailed BAF is attached at appendix 2.

4 BAF Quarter 3 Committee Review of the BAF

4.1 Each Committee met in November as planned and reviewed their allocated elements of the BAF and they each agreed with the Executive recommended score and made a recommendation to the Board to reconsider the target score achievable for risk 2 as the People and Culture Committee felt a score of 12 will not be met and as such a more realistic score would be 16 based on the lag between the actions being taken and the assurance being available to confirm that actions have had the impacted impact.

4.2 The Committee's each considered their allocated risks target score and remained confident that these excluding risk 2 as referred to above would be achieved by the year end.

4.3 Below is a summary of the respective Board Committee review of their allocated elements of the BAF.

4.3.1 Patient and Quality Assurance Committee

The Committee agreed that for the patient and quality strategic risk, the score should not change, recognising that whilst the actions are progressing the score would not change for the year. The Committee reflected that there continued to be an improvement in the assurances reported bring greater clarity to the gaps in assurance and the link to the actions to close these.

4.3.2 People and Culture Assurance Committee

The Committee agreed that the reports received and assurance these provided supported the workforce risk not changing from its target score for the year.

The Committee agreed that the reports it received and the detail within the BAF did not support a reduction in the strategic risk relating to Culture. The Committee discussed the cultural improvement plan and delivery actions and recommended that the Board reconsider the target score achievable for risk 2 as the Committee felt a score of 12 will not be met and as such a more realistic score would be 16 based on the lag between the actions being taken and the assurance being available to confirm that actions have had the impacted impact.

4.3.3 Research, Innovation and Digital Assurance Committee

The Committee agreed with the reduction in the research strategic risk 7, "We are unable to realise the benefits of transformation via research and innovation integration programs" as this was supported by the developing clinical research facility business case.

In respect of the two digital strategic risks the Committee agreed that the scores should not reduce.

4.3.4 Finance and Performance Assurance Committee

The Committee agreed that for each of the three risks it has assigned oversight for, that the reports received over quarter 2 supported that the risk scores should not reduce in quarter 3. The Committee reflected on the work to develop and then deliver the financial H2 plans and the performance improvement Urgent Emergency Care improvement plan and the planned assurance reporting over these to be provided across the months to the year end that will enable the Committee to validate the achievement of the expected

reduced risk scores. In respect of the strategic risk relating to the non digital infrastructure the agreed ventilation improvement programme investment will support a review of the risk score in quarter 4.

4.3.5 Strategy and Major Projects Assurance Committee

The Committee when it considered each of its two allocated risks agreed that the reports received over quarter 2 supported that the risk scores should not reduce in quarter 3. The Committee agreed that the actions taken in the first 2 quarters of the year whilst not yet reducing the risk score had improved the control environment which was reflected in the BAF. The Committee also agreed that the planned actions will enable it to validate a score reduction for each of these risks by the year end.

4.3.5 Audit Committee

The Audit Committee continued to receive a report providing assurance in respect of the underpinning processes for the oversight and update to the BAF. The Audit Committee also received a report in respect of the planned enhancements being developed to support a greater linkage of aggregated (corporate risks) to the individual strategic risks.

5 Conclusion

5.1 The Board should **NOTE** the assurance provided by the Audit Committee in respect of the underpinning processes for the oversight and maintenance of the BAF.

5.2 The Board is asked **AGREE** the quarter 3 scores, noting the support for these scores by the relevant oversight committees, including a reduction in risk 7.

5.3 The Board is asked to **CONSIDER** the comment provided by the People and Culture Committee that the reduction of the cultural risk despite the actions being taken will not see the risk move from its current score of 20 to a 12 but that a movement to 16 would be realistic and therefore the Board should seek adjustment to the BAF target score.

APPENDIX 1

BAF Summary

The table below shows by risk, their current score and their target risk score. The table as the year progresses will show the movement in risk between the current score for each quarter.
(No change, $\longleftrightarrow$ an increase in risk $\uparrow$ and $\downarrow$ a decrease in risk)

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores																		
	Inherent (uncontrolled)			2025/26 Q1			2025/26 Q2			2025/26 Q3			2025/26 Q4			2025/26 Target			
	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T	
Oversight provided by the Patient & Quality Assurance Committee																			
Risk 1 We are unable to maintain safe effective and compliant care.	5	5	25	5	4	20	5	4	20	5	4	20				5	4	20	
Assessed strength of control				Some weaknesses			Some weaknesses			Some weaknesses						no change expected			
Oversight provided by the People & Culture Assurance Committee																			
Risk 2 We do not develop a culture that supports the delivery of the Trust's mission of excellent care everywhere	5	4	20		4	5	20	*	4	5	20	*	4	5	20		3	4	12
Assessed strength of control				Some weaknesses			Some weaknesses			Some weaknesses									
Risk 3 We do not attract, develop and retain enough people with the right skills, values and behaviours to deliver our ambitions	5	4	20		3	4	12		3	4	12		3	4	12		3	4	12
Assessed strength of control				Some weaknesses			Some weaknesses			Some weaknesses						no change expected			
Oversight provided by the Finance and Performance Assurance Committee																			
Risk 4 We are unable to progress towards medium-term financial sustainability, driven by a failure to deliver the in-year financial plan and/or actions to return to a break-even run rate by M12 2026/27 along with national funding realignment away from Sussex ICB	5	5	25		5	4	20		5	4	20		5	4	20		5	3	15
Assessed strength of control				Some weaknesses			Some weaknesses			Some weaknesses									
Risk 5 We are unable to maintain the condition of our non digital infrastructure or support the required capital investments to deliver our strategic ambitions	5	5	25		5	4	20		5	4	20		5	4	20		5	3	15
Assessed strength of control				Some weaknesses			Some weaknesses			Some weaknesses									
Risk 6 We are unable to configure our services and sites to	5	5	25	5	3	15	5	3	15	5	3	15				4	3	12	

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores																	
	Inherent (uncontrolled)			2025/26 Q1			2025/26 Q2			2025/26 Q3			2025/26 Q4			2025/26 Target		
	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
enable us to deliver the Trust's annual performance plan leading to patients having a poor experience and increased safety risks due to extended waits for their treatment.																		
Assessed strength of control				Some weaknesses			Some weaknesses			Some weaknesses								
Oversight provided by the Research, Innovation & Digital Assurance Committee																		
Risk 7 We are unable to realise the benefits of transformation via research and innovation integration programs	4	5	20	4	5	20	4	5	20	4	5	20				4	4	16
Assessed strength of control				Some weaknesses			Some weaknesses			Some weaknesses								
Risk 8 Our digital immaturity in our infrastructure, skill and technology threaten our cyber security, operational and clinical performance.	5	5	25	5	4	20	5	4	20	5	4	20				5	3	15
Assessed strength of control				Some weaknesses			Some weaknesses			Some weaknesses								
Risk 9 We are unable to capitalise digital as a key driver for transformational improvement at the Trust.	4	5	20	4	5	20	4	5	20	4	5	20				4	3	12
Assessed strength of control				Some weaknesses			Some weaknesses			Some weaknesses								
Oversight provided by the Strategy & Major Projects Assurance Committee																		
Risk 10 We are unable to successfully develop and deliver our plans which configure our sites and services in a way that aligns with system partners and the ICS strategy	4	4	16	4	3	12	4	3	12	4	3	12				4	2	8
Assessed strength of control				Some weaknesses			Some weaknesses			Operating as intended								
Risk 11 We are unable to support, guide and deliver the level of change required to successfully deliver the strategy	4	4	16	4	4	16	4	4	16	4	4	16				4	3	12
Assessed strength of control				Some weaknesses			Some weaknesses			Some weaknesses								

Agenda Item:	13.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025	
Report Title:	Research, Innovation and Digital Assurance Committee Chair's Report					
Author(s):	Jackie Cassell – NED & Committee Chair					
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance		For Discussion	For Information only	
	N/A	Yes		Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality		Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A		N/A	N/A	
Regulatory Reporting Requirement						
Summary of the report describing						
What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i>		The report provides information over the business undertaken at the Research, Innovation and Digital Assurance Committee in November 2025. The Committee meeting was quorate and received its scheduled business.				
So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i>		The Board can take assurance from the oversight provided by this Committee over the domains of Research, Innovation and Digital specifically over the quality and safety of research studies undertaken over the prior year, the design of the digital resource prioritisation tool and the collaborative approach being taken to incorporate digital in the Trust's business continuity plans. The Board can also take confidence that through the work to develop the research delivery workstreams that the Committee will through that regular reporting be able to provide assurance on the delivery against the Trust research strategic ambitions.				
What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s) being made)</i>		The Board can receive the BAF with confidence knowing that the content and score for strategic risks 7, 8 and 9 have been scrutinised by the Research, Innovation and Digital Assurance Committee.				
Recommendation <i>(linked to What Next section)</i>		The Board is asked to NOTE - The Committee was quorate and considered all the expected reports in line with its schedule of business - The Committee's assurance over the digital and research and innovation domains - The Committee's recommendation that strategic risk 7 should be reduced from 20 to 16 (its target risk score) reflecting the mitigations towards establishing a fit for purpose clinical research facility, a key aspect of the risk. - The Committee's recommendation that the risk scores for risks 8 and 9 should remain unchanged from the quarter 2 score.				
Assurance / Scrutiny route already undertaken <i>(please explain where matter previously considered, and assurance provided)</i>						
Link to Trust Strategy <i>(note which theme)</i>	Patient	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes

Link to annual delivery plan	The Committee provides oversight of the delivery of the Trust's research, innovation and digital domains that are aligned to the Trust's Strategy which supports the delivery of the Trust's annual plan.					
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	The Committee has oversight of the key assurances referred to within the BAF for strategic risks 7, 8 and 9 and through their scrutiny of these recorded assurances consider and recommend to the Board their relevant current scores.					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	N/A	N/A	N/A	N/A	Yes	N/A
Other impacts	Equality and Diversity (if yes has HEIA completed)	Environmental		Legal	External Registrations (if yes please indicate which)	
	N/A	N/A		Yes	The Trust is required to maintain an effective system of governance, risk management and internal control (FT Code of Governance / FT Licence)	

Research, Innovation and Digital Assurance Committee Chair's Report

The Research, Innovation and Digital Assurance Committee met on the 5 November 2025 and was quorate with at least 2 NEDs and 2 Executives including the Chief Strategy Officer as the lead executive for the Committee being present. The Committee received all its planned business. In attendance were also the Chief Information Officer, the Clinical Director of Research & Innovation, and the Clinical Medical Officer from Kent Surrey and Sussex Health Innovation Network. For the Electronic Patient Record item, the Head of Programmes & Projects (IT) attended the meeting.

The key areas of focus for the Committee at its November meeting are listed below, noting the full breadth of the meeting's activity is included in a table at the end of this paper.

Research and Innovation

The Committee received its scheduled items to enable it to have oversight of research performance and assurance over the quality and governance of the research undertaken.

Research Delivery Plan for research and innovation

The Committee **received** the report providing information on the developed research workstreams which have been aligned to the Trust's strategy to enable effective oversight to be provided in respect of the delivery of the Trust's research ambitions. The Committee was provided with an update against these workstreams and **endorsed** this workstream structure which will enable the Committee to provide assurance to the Board on the Trust's delivery of the research ambitions. There had also been continued positive progress around researchers with support of the Trust Charity,

The importance of building research time into job planning to build capacity for research was acknowledged with more work to do to in particular to ensure job planning for research in non-medical professions.

The Committee **expressed** their thanks for the work undertaken and progress which enabled the report to be easy to read showing the clear alignment with the Trust Strategy.

The committee **received** a report on Quarterly performance against national standards and reflected national league tables. The Trust had made considerable progress but remains behind its target to reach the top 20. The Committee discussed the challenges the Trust's prospects in research had faced around the critical measure of study setup times in the context of changing targets and how these differed from other Trusts. The Committee heard about the team's engagement with national initiatives and other Trusts to identify improvements, and about recruitment taking place to make further progress from January 2026 in this fast-paced area with multidimensional challenges. The Committee was assured that the team is taking effective steps to improve this measure.

Clinical Research Development and the Commercial Research Development Centre

The Committee **noted** the work being undertaken to progress the development of a clinical research hub and spoke development with this project now being part of the Trust's major project portfolio. Workstreams around the estate and workforce were included in the update provided. The Committee also **noted** the opening of the Commercial Research Development Centre and the positive performance against all KPIs within the first six months of operation. The Committee heard how the collaborative work with partners and

the Trust's appetite for progress had inspired confidence from the NIHR and had opened opportunities for further investment funding. The Committee praised the success so far and thanked all those working behind it. Since the Clinical Research Facility development is so relevant to our business in supporting the wider Research domains, I will meet with the Chair of the Strategy & Major Projects Committee to discuss their oversight of Clinical Research Facility to support the co-ordinated and efficient assurance activity of both Committees.

Digital

The Committee **received** a number of reports providing information and assurance over the Trust's digital agenda.

Digital & Data Strategic Delivery Plan

The Committee **received** an update on the digital projects being undertaken across the Trust and **noted** the breadth of the projects being supported, particularly supporting operational efficiency. The Committee **received** an update on the Trust's digital priorities following publication of NHSE Medium-Term Planning Guidance and the Trust Strategy (October 2025). Patient Portal usage had grown by 250,000 interactions since May.

The Data Security and Protection Toolkit compliance continues to guide activity including cyber security. The Committee also examined the arrangements for Data Centre Resilience. I will meet with the Chair of the Audit Committee to discuss the oversight of actions given that the formal assurances around the toolkit submissions are scrutinised at Audit Committee while activities underlying this are relevant to our scope and oversight.

Digital Maturity

The Committee **received** a paper that outlined the Trusts current digital maturity against national standards which was relatively low, and had slightly improved since last year. Many elements of maturity will be through the Electronic Patient Record (EPR) implementation planned for 2027. The Committee **discussed** the approach to managing digital improvement in advance of EPR implementation. The Committee heard about the surveying in the Trust to gauge the level of staff confidence in digital technology, which had identified significant needs for training for which plans are in development.

Digital Business Continuity

Through the presentation of the report the Committee **discussed** the processes for enhancing the Trust's business continuity processes to incorporate digital system restoration and recovery. The Committee was **assured** that this process was being undertaken through collaboration with the operational divisions and IT. The Committee noted that the restoration and recovery risks were understood and noted the actions being undertaken to monitor the resilience of Trust's infrastructure.

AI developments

The Committee **received** an update on the progress made on setting up governance to lead and manage artificial intelligence use within the Trust, to take account of new developments in different areas building on work pioneered within Radiology. The Committee heard about a business case in development to fund the rollout of AI in the space of ambient voice

technology to clinical areas. Feedback from pilots had been positive and the staff conference had seen considerable interest and appetite for the opportunities AI can present. A paper to provide more detail on the framework for AI roll-out and the governance the plan would support will be **brought back** to a future meeting

Electronic Patient Record

The Committee **received** a high-level overview of the EPR procurement that is working to schedule to be delivered in 2027 and is overseen by the Strategy & Major Projects Committee. The Committee was **assured** by the accompanying current project rollout methodology in the successful and very clinically engaged scanning of records and images to the Electronic Document Management System which is enabling notes delivery, and will underpin the EPR's historic data.

BAF

The Committee **scrutinised** its allocated element of the Board Assurance Framework relating to strategic risks 7, 8 and 9. The Committee **considered** the review undertaken at the research, innovation and digital steering group strategic risk 7 'We are unable to realise the benefits of transformation via research and innovation integration programmes', should be reduced to a score of 16 that being its target score for the year. This reduction reflects a reduced risk due to development of a clinical research facility business case and its adoption as a Major Project. The Committee agreed that the recommended scores remaining at 20 for risk 8 and 9 were appropriate. The Committee discussed its approach to examining mitigations and focusing more strongly on these and their impact in future assurance reports.

Referrals to other Committees

The Committee agreed there were no matters from its November meeting it felt needed to be referred to another Committee for attention or action.

Appendix 1**COMMITTEE HIGHLIGHTS REPORT TO BOARD**

Meeting Details					
Meeting Date	5 November 2025	Chair	Jackie Cassell	Quorate	Yes
Declarations of Interest	No declarations were raised				
Items received at the Committee meeting					
Item	Presenter	Purpose of the paper	Action Taken		
Research, Innovation and Digital Steering Group Chair's report	Chief Strategy Officer	To provide context for the papers being considered at the meeting	The Committee noted this report and how the work of the steering committee supported the flow of performance and assurance reports to the Committee. There was particular discussion how the Health Innovation Network can support sustainably building internal capability to support innovation.		
Digital					
AI progress update	Chief Information Officer	To provide information on developments	The Committee noted the update which described the work being undertaken by the Trust as it assesses the opportunities AI can bring and the oversight governance arrangements that have been established with ongoing learning from pilot areas.		
Digital Business Continuity report	Chief Information Officer	To provide assurance over the Trust's processes	The Committee received the report and noted the work being undertaken in respect to enhancing the Trust's business continuity processes to include digital system recovery. The Committee noted that work was being undertaken collaboratively between the divisions and IT.		
Digital Workplan update	Head of Programmes & Projects (IT).	To provide assurance over the allocation of resources	The Committee received an update on the digital programme work across the breadth of projects being supported. The Committee noted the developed		

			prioritisation tool and strategy alignment.
Electronic Patient Record Programme and Electronic Document Management System Projects Reports	Chief Information Officer	To provide assurance over the Trust's processes	The Committee was updated on the process being followed for the procurement of the new EPR system, noting the Trust was at the supplier assessment stage. The Committee also noted the highly successful delivery of the EDMS activities across the Trust bringing a standardisation to the management of these records and a foundation to the new EPR and building confidence with clinician stakeholders.
Data Security and Protection Toolkit 2024/25	Chief Information Officer on behalf of Senior Information Risk Officer	To provide assurance over the process to achieve standards met	The Committee noted the Trust made its required submission supported by an improvement plan which had been accepted and approved by NHS E which sees the Trust as moving to standards met. The report had been received by the Audit Committee and delivery of actions to meet the improvement plan commitments by December 2025 were noted. The Chairs of RIDC and Audit Committee will meet to discuss the respective oversight at meetings.
Digital Maturity Assessment	Chief Information Officer	To note the outcome of the DMA and the improvement plan and governance proposals with a view to improvement against standards	The report was noted
Chief Information Officer Services Annual Report 2024/25	Chief Information Officer	To note	The Committee noted the process of the department through and service delivery through the year and approach to meeting the demand for Corporate IT services. The consolidated approach to a backlog of requests e.g. automation was discussed.
Research & Innovation			
Delivery plan for research and innovation for transforming research	Clinical Director of Research & Innovation	To provide information on the workstream activity since the last meeting	The Committee received the report describing the workstreams that have been established to meet the Trust's research ambitions.

Clinical research facility Commercial Research Development Centre milestone report	Clinical Director of Research & Innovation	To provide information on this initiative	The Committee noted the delivery against the established KPIs for the Commercial Research Development Centre in the first two quarters since opening. Strong Partnership working had multiple benefits and contributed to further investment potential. The Clinical Research Facility had progressed to a business case stage and had been added to the capital plan. This had led to a reduction in Strategic risk 7.
Charity research Programme annual report – Year 2 (of 3) review	Clinical Director of Research & Innovation	To Note success of the programme and ongoing commitment to partnership Also to Note potential next steps for developing the partnership beyond October 2026	The Committee noted the report that demonstrated tangible progress funded from trust donations and discussed opportunities to host a significant engagement event to capitalise on the positive progress.
Risk			
Research, Innovation and Digital key risk registers	Chief Medical Officer and Chief Strategy Officer	To enable the Committee to consider their allocated elements of the BAF	The Committee utilised this report when considering their allocated element of the Trust's BAF. In considering these reports the Committee noted the correlation between these risks and the reports received across the meeting.
Board Assurance Framework	Company Secretary	To review and recommend to the Board the scores for strategic risks 7, 8 and 9	The Committee considered the relevant segments of the BAF and alongside the reports received at the meeting agreed with the executives view of the risk scores. The Committee agreed risk 7 (research innovation) can be reduced with the positive progress on the clinical research facility as major contributor to realising research ambitions. The Committee agreed with the recommended scores for risk 8 and 9 (no change from the quarter 2 scores) with enhanced controls to come into effect only from quarter 4.

Agenda Item:	14.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025
Report Title:	Patient & Quality Assurance Committee Chair's Report				
Author(s):	Lucy Bloem, Non-Executive Director, Chair of Patient & Quality Assurance Committee				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only	
	Yes	Yes	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement					
Summary of the report describing What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i> So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i> What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s)being made)</i>		The report provides information over the business undertaken and the Patient and Quality Committee in September and November 2025.			
		The Committee meeting was quorate at each of these meetings and received its scheduled business. The Board can take assurance through the work of the Committee that focus is being provided to the areas of patient safety, quality of services and patient experience including the processes supporting the reporting of patient quality and safety KPIs. The Committee welcomed the continued development of statistical process control charts and the assurance that can be taken from their use.			
		The Committee in line with its Terms of Reference took the following actions - Considered and agreed to recommend to the Board: - The 2024/25 Infection Prevention and Control Annual Report			
		The Committee referred to Executive the requirement to bring to the January meeting of the Quality Committee, documented evidence of activity and assurance on actions arising from CQC inspections, and where the oversight has moved to business as usual where this is being monitored for assurance. This will ensure we have sufficient assurance over regulatory requirements.			
		The Committee noted information on the risks and plans to achievement of each element of Clinical Negligence Scheme for Trusts (CNST) year 7 in order to support the Board in determining the risk of any non-achievement.			
		The Committee noted progress on the development of Trust's Quality Impact Assessment process and how the development of this process would support and enhance the safety culture of the Trust.			
		The Board can receive the BAF with confidence that the content and score for strategic risk 1 has been scrutinised by the Patient and Quality Assurance Committee.			
		The Board can receive the 2024/25 Infection Prevention and Control Annual Report annual report for approval having confidence this has been considered and where appropriate adjusted for feedback provided.			
Recommendation <i>(linked to What Next section)</i>		The Board is asked to NOTE - The Committee was quorate and considered all the expected reports in line with its schedule of business; - The Committee's increasing assurance over the Trust's processes for patient quality and experience and pursuit of learning from reported incidents and complaints but recognises the challenges of embedding the learnings across UHSussex:			

	- The Committee's recommendation of the score for their allocated element of the BAF, strategic risk 1 for which the score remains at the target score of 20. The Board is asked to APPROVE, based on recommendation from the Committee - The 2024/25 Infection Prevention and Control Annual Report					
Assurance / Scrutiny route already undertaken						
Link to Trust Strategy (note which theme)	Patients	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	N/A	Yes	Yes	Yes
Link to annual delivery plan	No specific link					
Link to BAF	No specific link					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	Yes	Yes	Yes	Yes	Yes	Yes
Other impacts	Equality and Diversity (if yes has HEIA completed)		Environmental	Legal	External Registrations (if yes please indicate which)	
	N/A		N/A	N/A	N/A	

Patient and Quality Assurance Committee Chair's Report

The Patient and Quality Assurance Committee met in September and early November and was quorate at each meeting, with attendance by at least two NEDs and two Executives and the relevant directors. At each meeting the Committee received its planned business which included reports on Patient Safety and Duty of Candour, Maternity Reports, Clinical Outcomes including learning from deaths, Infection Prevention & Control, Patient Experience and quality scorecards including perinatal quality surveillance. The Committee also received reports from the Quality Governance Steering Group (QSGS) and reports from the Committee's reporting groups for information.

The key areas of focus for the Committee over the Quarter are listed below, noting the full breadth of the meeting's activity over the two meetings in the quarter is included in a table at the end of this paper.

Patient Safety

The Committee received a number of reports in respect of this domain over the quarter. In November the Committee received the 2025/26 Quarter 2 report in respect of incident reporting, duty of candour compliance and the fundamental standards of care process outcomes.

The Committee was **assured** over the underlying incident processes in respect of learning from each incident within the patient safety incident response framework. The Committee **noted** that the Patient Safety Incident Review Group continues to provide oversight of reported moderate and severe harms and through this oversight are engaging with the divisions in respect of increasing demands for mental health care within an emergency setting exacerbated by a local mental health facility closed to new admissions. The Committee noted the continued backlog in incidents, plans to address this but and acknowledged the Trust Operating Model would have implications for the Divisions clinical governance resource and the pace at which this could be addressed. Following my last report reflecting on Divisions recognising the risk of harms for patients outside of hospital waiting for an episode of care, analysis received indicated that top theme is delayed appointments (including follow-up appointments) and the this has increased since Q1. In addition there had been an increase in diagnostic testing incident reporting and incidents arising from contracted services were discussed.

Incident reporting had remained strong exceeding 60 per 1000 bed days showing the continuation of the Trust's drive for seeking opportunities for enhancing its learning culture, The Committee **noted** the reported rates place the Trust as average in the national reporting levels for the Trust that represented considerable improvement since 2021/22.

The Committee **noted** the reported Duty of Candour (DoC) compliance rate has increased across the quarter to 99% with the statutory components, the challenge is the timely sharing of investigation outcomes with families and driven overdue investigations.

The Committee discussed the reported never events in quarter 2 of 2025/26 and were informed that whilst there were no common issues within these, there is to be a more detailed review of these incidents to be reported to a future committee meeting. In response to learning from surgical past Never Events and a new Trust Safer Surgery policy a quality

improvement programme will commence in relation to the management and governance of National and Local standards for invasive procedures.

The Committee also **considered** the processes for learning from inquests and settled claims and was **assured** by the designed process in these areas but acknowledged a considerable resource challenge due to the increase in the number and complexity of inquests, including Jury inquests arising from deaths where the deceased was subject to a Mental Health Act section. The committee sought assurance that sufficient support of staff was in place.

The Committee **discussed** the outcomes of the Fundamental Standards of Care (FSoc) KPI quarterly report at its meeting in November, noting the significant increase in compliance of the audits. The Committee **noted** the insights that are being gained from FSoc audit outcomes to improve patient safety and experience. The Committee **discussed** over the forthcoming year the focus of this work needs to move to providing assurance over outcome now that the level of audit activity has increased to provide useful level of data. The connected SPC charts added further richness to the assurance provided by the full quarterly report.

Safeguarding

The Committee received the quarter 2 reports, recognising that significant improvement in compliance with the training targets in level 3 training e. The Committee noted upcoming consideration of the associated training need analysis. The Committee discussed the delayed discharge risks described in the report and the continued engagement with the local authorities and SPFT to work collaboratively to reduce these delays. The Chief Nurse advised that the Mental Health Quality and Strategy Group was being transitioned into a partnership working group with Sussex Police, SPFT and UHSx and the high level of risk around provision of mental health service provision for children and young people which was recognised in the recent CQC inspection

Infection Prevention and Control

The Committee **received** a report covering Infection Prevention and Control which containing the validated performance data across main infection types from Q1 2025-26 and the Annual Report for the year 2024-25. The report contained the full years data for these infection types with the Committee **discussing** the actions being taken for those that exceeded the expected trajectories, and also how these benchmark with other Trusts. The Committee also **noted** that the interventions previously discussed as committee had resulted in reduction of the levels of Surgical Site Infection (SSI) rates. The prioritised improvement plan for 2025/26 was discussed and the Estate & Facilities implications were acknowledged. The Committee was provided with an update on the actions in respect of the areas declared as non-compliant.

The Committee commends the Infection Prevention & Control Annual Report to the Board.

Maternity

The Committee at its November meeting **received** expected suite of maternity performance and assurance papers, including the Perinatal Quality Surveillance Reports & Dashboards; ATAIN & Transitional Care report, Perinatal Mortality Review tool assurance report,

Maternity Incident report, Claims Scorecard, Perinatal Workforce bi-annual report and Saving Babies Lives Report along with an updated report on the Trust CNST year 7 position.

In respect of the Trust's Perinatal Quality Surveillance (PQS) Reports & Dashboards for all four of its maternity units, which included the Ockenden data sets within the current dashboards. The Committee **noted** the Trust had maintained the NHSE ambition set in 2017 to reduce the stillbirth rate by 50% by 2025 with the aspiration of 2.5 per 1,000 births, with the service having exceeded this target by achieving 1.17 per 1000 births.

With regards to the maternity dashboards which covered the domains of; learning from incidents; training; and the voice of the service user, the Committee **noted** the significant progress made and recognised this had been driven by the delivery of the MSSP improvement Plan. Through this report and the PQS dashboard the Committee was **assured** over the division's continuing attention over the safety and experience of service users and babies. The committee discussed the homebirth service and the process to decide to suspend the service and the impact on service users.

The Committee **noted** through the ATAIN performance report the continued focus on learning from these admissions and the work being undertaken to continue to prevent wherever possible such avoidable admissions. The Trust, with 8.7% avoidable admissions compared favourably against a benchmark of 20% however there remain significant challenges in this area especially the provision of transitional care due to space/estate challenges especially in RSCH.

In Committee **received** the Maternity PSIRF Serious Incident Report for quarter 2 was **assured** the serious incidents had been investigated fully and lessons learnt across the Trust and this work was aligned to the Trust's patient safety incident response framework. The Committee noted the planned thematic reviews and the assurance over learning these will provide. It also noted the Q1 25/26 Maternity Claims Scorecard recognising that these cases updated on a rolling basis reflect some very historic cases given the nature of the statute of limitations, but the Committee took assurance from the triangulation of incidents, claims and complaints data from the period. The review underway of midwifery levels using Birthrate Plus system was noted.

The Committee **received** updates on progress towards the Trust's year 7 CNST Maternity Incentive Scheme submission and discussed the areas of risk. The key areas of risk escalated were training compliance of 90% given planned training clashes with doctor strike and Saving Babies Lives compliance in respect to documentation.

The Committee through an update from the Director of Midwifery was **assured** that the Trust was engaging with the national maternity inquiry and was reminded of the actions taken within the MSSP plan and through the delivery of the previous CQC recommendations.

The Committee **noted and discussed** the contents of the reports and agreed for these to be provided to the Board as part of the Maternity reports to the Board meeting in September.

Quality Assurance

Upon receipt of the Q2 Clinical Outcomes and Effectiveness report the Committee

reflected on the progress across the breadth of this area that had been achieved over the past two years and the amount of work to understand the status of each area and develop processes and action plans to address non-compliance. The Committee **noted** the reported position seeing the NICE Guidance review backlog had reduced significantly

The Committee **r** noted **limited assurance** in; clinical documentation where there is no sustained improvement and divisional trajectories are being developed; GIRFT where the limited compliance level remains static and whilst improvement plans have been developed many actions are overdue; Health Inequalities which requires PMO support. The remaining areas were noted as partial assurance.

Patient Experience

At the November Committee meeting the 2024/25 Quarter 2 Patient Experience Report was **received**. The Committee **noted** a further increase in complaints in Q2 to 531, the highest number received and alongside this that the highest number complaints had been able to be closed in the same quarter. It is also noted the upward trajectory of patient satisfaction with 92% of patients reporting a good or very good experience. The Committee **noted** the continued progress made in closing complaints. The Committee noted that triangulation of complaints, PALS and other patient feedback show that the main causes of poor patient experience are delays to treatment, follow up, referral onward, results and test and poor communications. This theme was further explored at the November meeting and the insights offered through a detailed piece of work in this area that will be presented to the Board.

The Committee **discussed** the actions being taken and supported by PALS to make improvements based on patient feedback along with how the Friends and Family Test feedback is used by divisions and corporately to drive change, in Q2 36,000 patients responded to a friends and family test survey, with the significant majority of patients (91%) reporting that they have a good or very good experience.

QSGS chairs report

The Committee at both its September and early November meetings **received** a report from the QSGS chair providing assurance over the work of that group and the focus that group brings over divisional patient safety, quality and patient experience. Specific focus was given to regulatory compliance and risks in areas across the Trust including Microbiology, Mortuary, Endoscopy.

Care Quality Commission (CQC) action plans

The Committee received an update on the action tracking process established to oversee the delivery of CQC actions.

The Committee discussed the process being applied to track the delivery of these actions and that a number of actions were now being tracked through business as usual processes overseen by other Board Committees and given the context of a number of expected reports and anticipated actions have made a referral to the Executive as above. The Committee noted the pressure the tracking of all these actions including those absorbed into the

business as usual process places on the central team but recognised that the target operating model for corporate services need to be able to provide a sustainable solution for compliance oversight.

Divisional Deep Dives

As part of the rolling programme of service engagement with the Committee, at the September meeting the Committee **received** a deep dive into the **Medicine Divisions' Emergency Department** successes, challenges, risks and opportunities.

The committee assured us on how the two Medicine divisions are working together through different mechanisms to share learnings across our UEC/UTC/SDEC and sites (in context of CQC visit to RSCH ED and actions taken post this. The Committee was able to **note** that both divisions had established clear and defined governance structures for all four EDs (RSCH, PRH, WH, SRH) under their respective Chiefs of Service and cooperated through regular cross-site meetings are held involving Matrons, Senior Nurse Leaders, and Clinical Leads to ensure consistency in standards and escalation protocols. Peer reviews and headline feedback sessions are conducted using CQC-aligned scrutiny, now inclusive of pharmacists and medical staff. The Committee heard about shared procedures and pathways and how Fundamental Standards of Care (FSOC) Audits had been developed and engaged with positively and used as a catalyst improvement work, especially at RSCH, particularly in areas of falls risk mitigation and mental health documentation

50 senior medical leaders had been engaged with a training programme fostering accountability and cross-site collaboration. Divisions are working to elimination of care in non-clinical space. Enhanced monitoring had strengthened accountability and included daily metric tracking of time to triage, and consultant review monitored at individual clinician level. The Committee heard about the positive effect of the Navigation Hub: Collaboration with SECAMB, with efforts to secure sustained ICB funding following the analysis that showed the effect on presentations. The committee noted the detailed analysis of August performance and the actions following lessons learned. This was all underpinned by the work being done to develop the right culture and developing working relationships across the sites alongside investments in the estate to improve our departments.

The Divisions were invited to **come back** in March 2026 to update on action progress while written assurance is sought to confirm the consistency of arrangements across each site ED.

Risk registers

The Committee **noted** the correlation between the highly scored patient quality, safety and experience risks and the reports and discussions had at the meeting and utilised these when it considered the allocated segment of the BAF. The BAF had been accompanied with a thematic grouping of Division risks together with the main controls and details of actions to enhance those. While there had been continued improvement in the timely review of risks and risk information completeness, the Committee further discussed the work that is needed to bring greater clarity of the most significant risks facing the Trust and the risk management work on developing the corporate risk register.

Board Assurance Framework

The Committee scrutinised its allocated element of the Board Assurance Framework relating to strategic risk 1, this being *we are unable to maintain safe effective and compliant care*.

Following the review of the BAF itself and the reports received at the Committee in early November they agreed with the recommendation that despite the improved understanding of the respective challenges and developed action plans given the time these actions will take to provide robust assurance that no change should be made from the quarter 2 score of 20 noting that this score is the target score for the whole year.

Referrals to other Committees

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

Appendix 1**COMMITTEE HIGHLIGHTS REPORT TO BOARD****Meeting Details**

Meeting Date 30 September 2025 **Chair** Lucy Bloem **Quorate** Yes

Declarations of Interest No declarations were raised

Items received at the Committee meeting

Focus, Operation and Priorities of the Committee			
QGSG reports	Presenter Chief Medical Officer/ Dep. Chief Medical Officer	Purpose For information	Outcome /Action taken Noted and assurance taken over the work of QGSG
Quality Dashboard (excl Maternity) Safety, Mortality Effectiveness, Experience,	Presenter Chief Medical Officer	Purpose For information	Outcome /Action taken Noted
Deep Dive: Emergency Departments	Presenter Medicine Division RSCH/PRH and Medicine Division SWS Divisions Chiefs and Nurse leaders	Purpose For assurance	Outcome /Action taken Noted and assurance taken Action to receive written assurance of processes implemented across <u>all</u> ED sites (aligned governance structures / procedures / pathways) & planned action to ensure patient safety and care within non-clinical space
Quality Impact Assessments (Efficiency Programme Update)	Presenter Chief Medical Officer	Purpose For information	Outcome /Action taken Noted. The Committee requested confirmation of target date for to complete and implement new policy
Patient Safety			
Infection Prevention and Control Q1 2025/26 and Director of Infection Prevention and Control Annual Report 2024/25	Presenter Director Infection, Prevention & Control	Purpose For assurance	Outcome /Action taken Notes. Action to provide assurance of lessons learned from the previous years' handwashing, environmental & commode audits. Also to investigate and refine intracavity device decontamination. The Committee commends the Director of Infection Prevention and Control Annual Report 2024/25 for approval by the Board.
Safeguarding Annual Report 2024/25	Presenter Director Infection, Prevention & Control	Purpose For assurance	Outcome /Action taken The Committee ratified the report and noted progress.

Quality Assurance Report Including Clinical Outcomes & Effectiveness Group Reports Q1 2025/26 report including Mortality & Learning from Deaths Q1 2024/25 report	Presenter Chief Medical Officer/ Director of Clinical Outcomes & Effectiveness	Purpose For assurance	Outcome /Action taken Noted and assurance taken over the processes for improving the Trust compliance. Also assurance taken over the review and learning from deaths. Action to provide an update on fractured neck of femur outcomes in light of clinical transformation improvement
Facilities & Estates- update reports including: an update on the progress of the Estate Improvement Plan, Ventilation Action Plan, Medical Devices Management Review (Final Report), Medical Equipment Action Plan, Fire Enforcement Action Plan, and the Estate Condition Report	Presenter Director of Estates and Facilities / Chief Finance Officer	Purpose For information	Outcome/Action taken Noted the update on work taking place and apparent progress towards an assurance report in the form required by the Committee. Action to present an updated Fire strategy. Also formalised structure of Estates Reporting through H&S to be presented
Clinical Outcomes & Effectiveness and Health Inequalities quarter 1 report	Presenter Director of Clinical Outcomes and Effectiveness	Purpose For Assurance	Outcome /Action taken Noted and assured over the compliance processes
Maternity Assurance Update, Vision and Roadmap	Presenter Chief Nurse / Director of Maternity	Purpose To approve	Outcome /Action taken Noted the assurance update and endorsed the strategic focus on service safety, quality improvement, reduce inequality, workforce sustainability and user experience.
Perinatal Quality Oversight Model	Presenter Chief Nurse / Director of Midwifery	Purpose For information	Outcome /Action taken Noted
Risk			
Trust Risk Register relating to Patient & Quality Summary of changes only, between Quarterly meetings	Presenter Chief Medical Officer / Chief Nurse	Purpose For information	Outcome /Action taken Noted the register changes

Meeting Details

Meeting Date 4 November 2025 **Chair** Lucy Bloem **Quorate** Yes
Declarations of Interest No declarations were raised

Items received at the Committee meeting

Patient Safety			
Quarter 2 Patient Safety Incident & Duty of Candor report	Presenter Director of Patient Safety	Purpose For assurance	Outcome /Action taken Noted and assured over the investigation and learning processes
Medico-legal report to September 2025	Presenter Director of Patient Safety	Purpose For assurance	Outcome /Action taken Noted the learning processes
Fundamental Standards of Care Quarter 1 report	Presenter Deputy Chief Nurse (Quality)	Purpose For assurance	Outcome /Action taken Noted and assured of the audit processes
Clinical Outcomes & Effectiveness & Health Inequalities Quarter 2 report	Presenter Director of Patient Experience for Director of Clinical Outcomes and Effectiveness	Purpose For Assurance	Outcome /Action taken Noted and assured over the compliance processes
Mortality & Learning from Deaths quarter 2 report	Presenter Director of Patient Experience for Director of Clinical Outcomes and Effectiveness	Purpose For Assurance	Outcome /Action taken Noted the process for review, investigation and learning
Safeguarding quarter 2 report	Presenter Associate Director of Safeguarding	Purpose For Assurance	Outcome /Action taken Noted the activity update.
Infection Prevention and Control report to September 2025	Presenter Director of Infection Prevention and Control	Purpose For assurance	Outcome /Action taken Noted the activity update.
Patient Experience			
Patient Experience Assurance Report Quarter 2 report 2025/26	Presenter Director Patient Experience & Engagement	Purpose For assurance	Outcome /Action taken Noted and assured over the learning processes
Annual Inpatient Survey 2024	Presenter Director Patient Experience & Engagement	Purpose For information	Outcome /Action taken Noted
Maternity			
National Maternity Inquiry Update	Presenter Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted
Maternity Governance Framework	Presenter Director or Midwifery / Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted

Perinatal Quality Surveillance Report and Dashboards to August 2025	Presenter Director or Midwifery / Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted and assured over the performance
ATAIN/Transitional Care Q4 2024/25	Presenter Director of Midwifery/ Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted and assured over the review of these cases
Maternity Claims Scorecard Q1 2024/25	Presenter Director of Midwifery	Purpose For information	Outcome /Action taken Noted
Perinatal Mortality Review Tool (PMRT) Q4 2024/25 (part 2)	Presenter Director of Midwifery/ Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted and assured over the performance
Perinatal Workforce Apr-Sept 2025	Presenter Director of Midwifery/ Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted
Maternity PSIRF Q2 2025/26	Presenter Chief Nurse/ Director of Midwifery/ Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted and assured over the process for review, investigation and learning
Saving Babies Lives Q4 2024/25 and Saving Babies Lives Q1 2025/26	Presenter CNO/ Director of Midwifery/ Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted and assured over the performance
CNST Maternity Incentive Scheme Year 7 – update	Presenter Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted the current position
Reporting Group			
QGSG Chair's assurance report, including quality scorecards, divisional summary reports and quality domain summary reports: Pharmacy & Medicines Governance; Mortuary Quarterly Review	Presenter Chief Medical Officer	Purpose For assurance	Outcome /Action taken Noted
CQC action tracking			
CQC Update / Action Plans	Presenter Chief Nurse/ Director of Patient Safety & Learning	Purpose For information	Outcome /Action taken Noted and assured over the process for tracking actions
Risk			
Patient and Quality Risk Report	Presenter Chief Nurse/ Chief Medical Officer	Purpose For information	Outcome /Action taken The Committee noted these
Board Assurance Framework	Presenter Chief Nurse/ Chief Medical Officer	Purpose For information	Outcome /Action taken The Committee reviewed its allocated segments and agreed with and recommended the proposed score for risk 1 to the Board

Agenda Item:	15.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025
Report Title:	People & Culture Committee Chair's Report				
Author(s):	Paul Layzell – NED & Committee Chair				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For Discussion	For Information only	
	Yes	Yes	N/A	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement					
Summary of the report describing What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i> So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i> What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s)being made)</i>	<i>The report provides information over the business undertaken and the People and Culture Committee in November 2025.</i>				
	<i>The Committee meeting was quorate at each of these meetings and received its scheduled business and had a good discussion on the Trust's cultural improvement programme.</i>				
	<i>The Board can take assurance through the work of the Committee that focus is being provided to the areas of culture and workforce including the processes supporting the reporting of workforce KPIs. The Committee agreed to provide feedback on the People scorecard to enable this to be iteratively improved for 2026/27.</i>				
	<i>The Committee took the following actions:-</i> <i>Reviewed the half yearly safer staffing analysis and approved its placement on the Trust's website. With high level summary of this data provided within the routine integrated board report to Board.</i> <i>Endorsed the proposal to deliver the next three-year health and wellbeing delivery plan.</i> <i>The approval of the Education Placement Providers Self-Assessment Return to be made to NHS England.</i> <i>Referred the delivery judgements to the CQC Improvement Group for them to determine if these actions can be closed given the embedded oversight within routine reporting.</i>				
	<i>The Board should note that based on the discussion at the prior meeting, time is being created at the February committee meeting to receive a high-level view of the long-term workforce plan in order to understand plans to mitigate risks identified to future recruitment and retention of staff.</i>				
<i>The Board can receive the BAF with confidence that the content and score for strategic risks 2 and 3 have been scrutinised by the People and Culture Assurance Committee.</i>					
<i>The Board can also be assured that the publicised safer staffing report has been scrutinised by the Committee prior to its publication.</i>					

Recommendation (linked to What Next section)	The Board is asked to NOTE - the Committee met and received the expected assurance reports - the Committee's actions especially in respect of the agreement to the submission of the education placement providers self-assessment to NHS E - the Committee's recommendation of the scores for their allocated elements of the BAF, strategic risks 2 and 3, noting that the Committee recommended no change to these risks for the forthcoming quarter. - the Committee's recommendation to adjust the target score for strategic risk 2 to 16.					
Assurance / Scrutiny route already undertaken (please explain where matter previously considered, and assurance provided)	A number of items presented to the Committee had been considered by the Committees reporting groups.					
Link to Trust Strategy (note which theme)	Patients	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan	The People and Culture Committee provide oversight of the Trust's delivery of many aspects that link to the delivery of the Trust's annual plan, not least those covered by the people promises, workforce wellbeing actions and those linked to staff training and development					
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	The Committee has oversight for the allocated people related strategic risks, risks 2 and 3					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	Yes	N/A	N/A	N/A	Yes	N/A
Other impacts	Equality and Diversity (if yes has HEIA completed)		Environmental	Legal	External Registrations (if yes please indicate which)	
	N/A		N/A	Yes	The Trust is required to maintain an effective council of governors (FT Code of Governance / FT Licence)	

People and Culture Committee Chair's Report

The People and Culture Committee met on 4 November 2025. The Committee was quorate at both meetings as was attended by at least two Non-Executive Directors and two Executives Directors. In attendance at these meetings were the respective report presenters including the Director of Workforce Planning & Deployment, Director of Human Resources, Director for Integrated Education, and the Associate Director of Leadership, Culture and Development, Director of Medical Education and for the item on Safer Staffing the Deputy Chief Nurse.

At its meeting the Committee received its planned items including a report on the delivery of the people plan, the cultural programme delivery plan, health and wellbeing action update, the guardian of safe working quarterly report, consultant job planning update, an update on the workforce harmonisation work programme, safer staffing half yearly review and integration education reporting which include the education placement providers self-assessments and the GMC national trainee/trainer survey results and actions. The Committee also received the People Risk paper and the BAF for the Committee's oversight of their allocated strategic risks.

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

People Performance Overview Report.

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

The Committee **agreed** to create time in its February meeting to consider the developing longer-term workforce plan to allow a conversation on future staffing challenges.

Culture Programme

The Committee **received** a summary presentation on the continuing progress with the cultural improvement programme and **noted** the various initiatives progressed and planned over the areas of

- Values and Behaviours,
- Reward and Recognition,
- Leadership and Management,
- Organisational Development Infrastructure

The Committee **discussed** the next steps and the challenges that the range of change management programmes underway this year bring to the cultural improvement programme. It also considered the ongoing resourcing challenge within the people function that increase risk to the delivery of the work

The Committee **thanked** the former Chief OD Officer for their dedication and leadership in this area.

Workforce Harmonization Programme

The Committee **received** an update on the programme of workforce harmonisation and recognised the extensive work already undertaken. The next challenge was dealing with multiple on call arrangements. Options had been identified, and trade unions consulted and further work detailed work had been requested by the Trust Management Committee. The Committee agreed that this work programme aligns to the delivery of the people strategic people ambition.

2025/26 People Plan update

The Committee **received** its scheduled report providing an update on the 15 improvement projects showing how these align to each of the 7 people promises within the agreed 2025/26 people plan. The Committee was **assured** over the alignment of the people delivery plan with the developed strategy delivery plan and that future reporting would be brought through that reporting structure.

10 – point plan improving resident doctors working lives

The Committee **received** the Trust's assessment against a mandated 10 point plan to improve resident doctors working lives and was assured over the progress made to achieve compliance, including extension of the Committee's membership to a resident doctor representative. The Committee was **assured** over the delivery plan oversight and **agreed** to extend the Committee membership to include a resident doctor representative.

Safer Staffing Report

The Committee **received** the six-monthly safer staffing update and discussed the paper and the outcome of the latest review and noted the positive impact of increasing the care hour per patient day through the substantiation of a number of nursing and health care assistants posts into the 2025/26 budgets. The Committee discussed the report and noted that the update shows wards have been shown to be safely staffed, noting that at times of peak demands this has been maintained through the use of addition staff provided through the bank or agencies

The Committee was **assured** that the annual review will be undertaken in line with the national guidelines and **agreed** for this report to placed on the trust's website.

Integrated Education reports

The Committee **received** the Education Placement Providers Self-Assessment and **agreed** for this to be submitted to NHS England.

The Committee also received the results of the GMC national trainee and trainer surveys. The Committee discussed these and was **assured** that the actions plan to address the issues raised by trainees and trainers was to be overseen by the healthcare education group. The Committee reflected on the actions taken including those in relation to the Trust's cultural improvement plan and their alignment to the reduction in the overall number of concerns raised.

Guardian of Safe Working Hours report

The Committee **noted** the report from the Guardian of Safe Working Hours report and the **assurance** the report provided over the continued effectiveness of the underpinning reporting processes and that prompt actions were taken in respect of matters raised.

Risk report and Board Assurance Framework

The Committee **noted** the correlation between the highly scored workforce and cultural risk themes and discussions held at the meeting. The Committee also referred to these themes when it considered the allocated segments of the BAF.

The Committee scrutinised its allocated element of the Board Assurance Framework relating to strategic risks 2 and 3 these being *we do not develop a culture that supports the delivery of the Trust's mission of excellent care everywhere* **and** *we do not attract, develop and retain enough people with the right skills, values and behaviours to deliver our ambitions*.

Following the review of the BAF itself the reports received, the Committee **agreed** with the recommendation to make no change from the 2 scores for both these risks. The Committee reflected that risk 2 was likely to reduce by the year end but not to the initial target score of 12. The Committee suggested that the Board should move the 25/26 target score to 16 as a realistic score to be achieved, as whilst there is degree of work being undertaken there remains a degree of changes which it felt will see that the initial reduction to 12 will not be made by 31 March 2026

Referrals to other Committees

The Committee having considered the reports it received at its meeting **agreed** there were no matters it needed to refer to any other Committees and scheduled time at its January meeting for the items referred to the Committee by other Board Committees.

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	4 November 2025	Chair	Paul Layzell	Quorate	Yes
Declarations of Interest	No declarations were raised				
Items received at the Committee meeting					
People Performance Overview including People Scorecard	Presenter Chief People Officer	Purpose For discussion and assurance	Outcome /Action taken The Committee utilised the overview to bring focus to the key elements of the papers being presented at the meeting. The Committee noted the continuing slight improvement in performance reported across the various workforce KPIs noting that vacancy rates have been re set with the staffing out turn increase. The Committee noted this update and recognising the linkage between this update and the BAF strategic risks and how the level of change programmes being delivered within the Trust bring a degree of challenge to the cultural improvement programme.		
CQC allocated actions oversight assurance register	Presenter Chief People Officer	Purpose For discussion and assurance over delivery	Outcome The Committee agreed the level of assurance of progress was reasonably stated, recognising that the oversight of many of these is provided through the workforce scorecard but where there was a need for specific actions it recorded how these had been taken and where this was reported. The Committee agreed to refer the delivery judgements		

			to the CQC Improvement Group for them to determine if these actions can be closed given the embedded oversight within routine reporting.
Updates from work with system partners	Presenter Chief People Officer	Purpose For discussion and assurance	Outcome The Committee noted the verbal update in respect of the collaboration with the ICB and other NHS partners. The Committee also received an update on the engagement being undertaken with our Local Authorities and skills resourcing. The Committee discussed the training level and the Trust's improved utilisation of this levy.
Culture Programme Update	Presenter Culture and OD consultant / Interim Assistant Director of Leadership & Management	Purpose For information	Outcome /Action taken The Committee received a summary presentation on the continuing progress with the cultural improvement programme. The Committee noted the various initiatives progressed and planned over the areas of - Values and Behaviours, - Reward and Recognition, - Leadership and Management, - Organisational Development Infrastructure The Committee discussed the next steps and the challenges that the various wider ranging change management programmes are underway this year. The Committee discussed the ongoing resourcing challenge within the people function that risk the ongoing delivery of this programme

			The Committee thanked the former Chief OD Officer for their dedication and leadership in this area.
Effectiveness of Internal Communications – update	Presenter Director of Communications	Purpose For information	Outcome /Action taken The Committee received the update on the delivery against the agreed recommendations from April 2025. The Committee noted the progress made and the actions to be taken in respect of those that remain in progress. The meeting discussed the scope for using enhanced technology to support staff to navigate to where answers to routine information can be found.
Health and Wellbeing update Including – assessment against the NHS H&W framework, the Trust's delivery plan and the VPR quarterly report	Presenter Associate Director, Leadership, OD & Engagement	Purpose For information	Outcome /Action taken The Committee received a series of reports covering the Trust's work to support staff health and wellbeing and noted the progress made over the current three year delivery plan. The Committee through the report was assured over the progress made and the linkage of this work to the staff survey results. The Committee noted the planned improvements that should arise from the new occupational health delivery model. The meeting discussed how technology could assist in raising manager awareness of the various staff support available.

			The Committee endorsed the proposal to work on the next three year delivery plan.
Job Planning	Presenter Chief Medical Officer	Purpose For assurance	Outcome The Committee received over the delivery of the consultant job planning work programme and was assured that the programme would deliver over 85% of consultants and SAS doctors having an agreed and signed job plan by the year end
2025/26 People Plan update	Presenter Director of workforce	Purpose For discussion and assurance	Outcome The Committee received its scheduled report providing an update on the 15 improvement projects showing how these align to each of the 7 people promises within the agreed 2025/26 people plan. The Committee noted that this item is also covered within the Strategy and Major Projects Committee through the strategic delivery plan. The Committee was assured over the mapping of this work to the three people ambitions and noted that future reporting of the people delivery plan will be through strategic delivery plan.
Workforce harmonisation programme update	Presenter Director of workforce	Purpose For discussion and assurance	Outcome The Committee received the report showing the progress being made across the various harmonisation workstreams. The Committee noted the work and was assured as to the programmes alignment to the Trust's people ambition to supporting the delivery of equitable terms and conditions for all, noting that the next stage of work in

			respect of on call arrangements was complex.
Employee relations report 6 monthly update	Presenter Director of workforce	Purpose For assurance	Outcome The Committee received the report and noted the improvement in case recording and the relatively stable level of cases over the first six months of the year. The Committee noted the reduction in formal action required and that work remained to be completed to reduce the length of time to progress cases. The Committee discussed the options that may be available to support more timely investigation conclusions. The committee noted within the report information on the continuing work to support timely return of staff from periods of sickness.
10-point plan improving resident doctors	Presenter Director of HR and Director of Medical Education	Purpose For assurance	Outcome The Committee received the report and update on the delivery of the 10 point plan. The Committee noted the progress from the initial self-assessment through the delivery of the action plan and was assured over the oversight of the action plan delivery. The Committee agreed to extend its membership to include a resident doctor representative as recommended by the 10-point plan.
Guardian of safe working hours Q2 report	Presenter Chief People Officer	Purpose For assurance	Outcome /Action taken The Committee received the report and noted the Guardian's assurance over the established processes for

			exception reporting. The Committee noted that the report provided assurance over the action being taken in respect of issues raised.
Integrated Education Update including education placement providers self-assessment	Presenter Director of Integrated Education	Purpose To note	Outcome /Action taken The Committee noted the report which included the required self-assessment. The Committee discussed the assessment and recognised this for timing reasons this declaration came to the Committee as the parent for the healthcare education development group who's meeting did not align with the required submission timetable. The meeting discussed the judgements and approved the self-assessment submission.
GMC national trainee / trainer survey	Presenter Trust Director of Medical Education	Purpose To note	Outcome /Action taken The Committee noted the report which provides feedback on the trainee and trainer survey. The survey is designed to provide an assessment of the post graduate medical education quality. The Committee noted that progress had been made in several specialities since the prior year survey and demonstrated the positive impact of targeted interventions however, there remains work to be done to address persistent cultural issues where action is linked back to the cultural improvement plans.
Nursing Safer Staffing six monthly report	Presenter Deputy Chief Nurse	Purpose To review	Outcome /Action taken The Committee received the six-month update on the

			application of the National Quality Board safer staffing tool. The Committee noted the improving care hours per patient day (CHPPD) reflecting the establishing of additional posts within the 2025/26 budgets.
Committee reporting group reports	Presenter Taken for information without wider discussion	Purpose For information	Outcome /Action taken The Committee received these and noted their correlation to the Chief People's oversight report
People Risks update	Presenter Chief People Officer	Purpose To note	Outcome /Action taken The Committee noted the report and recognised that work is to be undertaken to review the recording and management of risks within the organisation. The Committee reflected on thematic analysis of the recorded risks with a workforce implication when considering the workforce strategic risk.
Board Assurance Framework	Presenter Company Secretary	Purpose To review and recommend to the Board	Outcome /Action taken The Committee reviewed its allocated segments and agreed with and recommended score for both the culture risk (risk 2) workforce risk (risk 3) scores. The Committee discussed the scores and felt these were reasonable recognising that for risk 2 this score should reduce by the year end. The Committee also discussed the target score of 12 and felt this would not be achieved and that a target of 16 would be more realistic.

Agenda Item:	16.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025
Report Title:	Finance & Performance Assurance Committee Chair's Report				
Author(s):	Philip Hogan, Chair Finance & Performance Assurance Committee				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only	
	No	Yes	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement					
Summary of the report describing		The report provides information over the business undertaken at the Finance and Performance Assurance Committee across the meetings in September and early November 2025 covering month 5 and month 6 year to date outcomes and forecasts for the full year. The Committee was quorate at each meeting and received its scheduled business.			
What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i>		The Committee in accordance with its Terms of Reference approved two investment decisions in September and one in November. These concerned • Pharmacy Invest-to-Save initiatives for SACT and medicines optimisation. • Radiotherapy Linac Replacement enabling works pending the new Cancer Centre. • Stroke reconfiguration enabling works at SRH.			
So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i>		The Committee also approved the drawdown of £4.8m cash from a NHSE fund to support Trusts with the finest working capital margins. A further proposal to approve use of Capital funds from NHSE (fully funded) for 2025/26 to develop temporary theatre capacity to undertake ventilation upgrade in existing PRH & SRH theatres was considered and is commended to the Board. The Board can take assurance from the oversight being provided by this Committee to the areas of financial and operational performance and the plans to address any risks to the achievement of the Trust annual delivery plan. The Board can also take assurance that the Committee has oversight of the Trust cash management actions. The Board can also take assurance that the Committee will secure assurance that the Trust's green plan will be adjusted to match the revised national guidance.			
What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s) being made)</i>		The Board can receive the Trust's integrated performance report relating to operational and financial performance with confidence that the Committee has discussed the plans to address the risks in achieving the Trust's annual delivery plan and support the CFO's recommendation to enhance the current control environment and actions resulting from the recent "Sprint" review which will be presented to the Board on 13 th November 2025. The Board can receive the BAF with confidence that the content and score for strategic risks 4, 5 and 6 have been scrutinised and the current and target assessment score remain unchanged.			
Recommendation <i>(linked to What Next section)</i>		The Board is asked to NOTE - The Committee was quorate and considered all the expected reports in line with its schedule of business.			

	- The Committee's assurance over the Trust's current plans and controls for the delivery of its annual financial and operational plan. - The Committee's recommendation of the scores for their allocated elements of the BAF, strategic risks 4, 5 and 6. The Committee commends the Board APPROVE the investment case to spend up to £13.5 million to develop temporary theatre capacity to enable the refurbishment and upgrade of theatre capacity at SRH and PRH. The Committee asks that the re-submission of the winter plan assurance statement is DELEGATED to the Committee.					
Assurance / Scrutiny route already undertaken						
Link to Trust Strategy (note which theme)	Patients	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan	<i>The Committee provides oversight of the delivery of the Trust's annual financial and operational plan delivery</i>					
Link to BAF	<i>The Committee has oversight of the key assurances referred to within the BAF for strategic risks 4, 5 and 6 and through their scrutiny of these recorded assurances consider and recommend to the Board their relevant current scores.</i>					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	Yes	Not directly	Not directly	Not directly	Yes	Yes
Other impacts	Equality and Diversity (if yes has HEIA completed)	Environmental		Legal	External Registrations (if yes please indicate which)	
	N/A	N/A		Yes	The Trust is required to maintain an effective system of governance, risk management and internal control (FT Code of Governance / FT Licence)	

Finance and Performance Assurance Committee Chair's Report

The Finance and Performance Assurance Committee met in September and early November 2025 and was quorate at each meeting with at least two NEDs and two Executives present including the Chief Operating Officer and Chief Financial Officer present at each meeting. The Committee at each meeting received its scheduled items of business.

The key areas of focus for the Committee are listed below, noting the full breadth of the meeting's activity over the quarter is included in a table at the end of this paper.

Quarter 2 2025/26 Financial Performance Report

At each meeting, the FPC received a report from the Chief Financial Officer on the financial position against the Trust's Break-Even financial plan. The report showed that the Trust had month on month and year to date met its submitted plan. Delivery of this position has required the use of non-recurrent mitigations and the Committee examined the extent and implications of these.

The Committee discussed the Trust financial report and **noted** the following:

Whilst the Trust had achieved its overall financial plan up to month 6 there were areas of individual variance and operating divisions had been collectively adverse to plan in month 6. Particular risks to the underlying run rate are workforce overspend and efficiency shortfalls.

The Committee noted a rapid piece of focused work (the "Sprint") led by the Chief Finance Officer to determine the actions required to deliver its year-end performance commitments including the financial position. The exercise aligns activity, finance, and workforce plans and a core working group will continue to provide central oversight. An ERF income risk arising from planned activity not having been delivered in full in August is being addressed through the sprint with the identification of plans to ensure the planned level of ERF is earned, both through improved capture and appropriate valuation of activity and improved productivity, within the expenditure envelope.

At the September meeting the Committee **noted** the work undertaken for each clinical and corporate division focussed on their forecasts to the year end and discussed the further grip and control measures that may need to be applied in line with the principles set out with the Board. Effectiveness of the non-pay controls with discretionary non-pay spend had remained below pre-control level. Temporary staffing remains above plan and overall pay expenditure exceeds financial plan. While a planned shift from temporary to substantive staff continues, the Committee heard future budget manager framing is clear on the agency reduction imperative. Enhanced grip and control metrics have been aligned with NHSI&E frameworks. An audit report will be **brought back** to further assure their consistency.

The Committee further **discussed** the impact the Trust's current deficit position was having on its cash position. The Committee recognised that the short-term cash management actions were effective and following the previous request to the Operational Director of Finance welcomed the medium to longer term cash forecasting in the report. The Committee acknowledged the close monitoring applied and were informed of further mitigation actions that could be considered to ensure critical supplies are not interrupted. Payment to suppliers within 30 days remained below standard and work continued to support small, local or critical suppliers. The Committee **requested** scenario testing and sensitivity analyses for Board visibility.

The Committee **endorsed** an application for revenue support from NHS England for the full amount allowable in the form of one-off working (public dividend) capital cash support.

The planning process for 2026/27 is likely to require December and February submissions and the Board will be invited to consider **delegating** submission approval to the Committee.

Efficiency and Productivity

The Committee **received** the scheduled efficiency and productivity reports at each of its meetings in the quarter. At month 6 the Committee noted that some £102m of the revised £113m plan had been assured as having robust plans to deliver and these schemes were progressing into their delivery phase. However, some Division plans remain partial, and the Committee heard about extensive work taking place with 3 divisions with particular risks.

The plan itself was marginally behind planned delivery at month 6 and the Committee recognised the significant delivery expectation in the latter half of the year for which corporate schemes had yet to be assured and some risks had crystallised including slippage on medical rate card changes.

The Committee **discussed** this risk and were informed of possible mitigations that are being considered. The Committee discussed its concern as to the Trust's capacity to deal with the larger schemes in the latter quarter along with the ambitious capital and transformation programme for the year. The Committee was **assured** of the process and diligence being applied to the review of the efficiency programme both centrally and divisionally and that external review had confirmed the accuracy of reporting.

The Committee supported the continued focus on divisional accountability and welcomed the alignment of coding recovery plans with financial delivery.

The Committee **received** an initial paper of the scale of the challenge the Trust will face in 2026/27 and subsequent years heard how Divisions had engaged in a credible approach to identifying potential improvement schemes that might help meet the scale of challenge faced. Clinic productivity continues to be highlighted as an area of significant opportunity. The Committee **noted** the good and early progress made in the planning thinking, acknowledged the outline planning timetable, the sparse and somewhat conflicting instructions emerging from the ICB, Region and NHSE, and agreed the planning process should continue and focus on what is within the Trust's own control and understand and adapt to any additional requests or demands as they emerge.

The Committee **noted** considerations for the range, ambition and difficulty of options that will be offered for Board Workshop evaluation in due course.

Capital

The Committee **noted** that the Trust was at month 6 behind its capital plan but the Committee heard this is a timing issue and that the full year plan is expected to deliver within the original budget.

The Committee were informed that internal audit is undertaking support work in respect of challenging cost increases in Capital projects.

Investment decisions

The Committee in line with its delegated authority **approved**:

- Pharmacy Invest-to-Save initiatives for SACT and medicines optimisation. These are expected to unlock savings and improve cancer treatment resilience.
- Radiotherapy Linac Replacement funds were approved for temporary installation at RSCH, enabling future replacement at Eastbourne ensuring resilience pending the opening of the new Cancer Centre.
- Stroke reconfiguration enabling works at SRH. The Committee approved expenditure for works necessary to facilitate the reconfiguration of Stroke services.

The Committee also **commended to the Board**, a proposal to approve fully NHSE funded ventilation works with temporary theatre to enable critical infrastructure to be replaced. The Committee noted positive clinical engagement and enabling of coordinated servicing. The Committee examined the governance arrangements followed and endorsed the modular principle of changes and recognised that these offer the opportunity to consider the options for a sustainable delivery model in designing future theatre needs after 2030.

Quarter 2 2025/26 Operational Performance

Each meeting the Committee **received** a detailed report on the Operational performance of the Trust including the constitutional standards set by NHSE. The Committee discussed the Trust operational performance report in detail and **noted**:

- Urgent and Emergency Care (UEC) has improved marginally with some variability over time depending upon demand in each location and a dip in performance in August. Overall, the Trust remains lower than national average and behind our planned trajectory to meet the 78% 4-hour target by the end of the year.
 - The Committee took **reassurance** that the recent opening of SDECs, reinvigoration of local teams, enhanced governance and external scrutiny and support and a renewed focus on flow and discharge is expected to deliver the planned year end performance and the Committee will receive an assurance report at the month 7 meeting at the end of November.
 - The trust has improved significantly in ambulance hand overs and has made progress on reducing patients in non-clinical areas (ICorridor care).
- Referral to treatment performance saw further improvement by month 6 to 51.5% which is below the national performance level but was marginally ahead of the Trust's improvement trajectory. The Committee **noted** significant progress in reducing the cohort of patients at risk of waiting over 65 weeks and **discussed** the plans the Trust has in place to address this recognising some complexity in treatment coordination for the longest waiting patients. The Committee received reassurance that the zero 65 week target was on track to be delivered.
- Cancer performance remains broadly on track but saw a deterioration in quarter 2 missing the 62-day target with a performance of 60.4% but this was in line with the recovery trajectory. The faster diagnostic standard performance was 72.5% at month 5, just below the 75% target and 74.6% national performance.
- The Trust's diagnostic performance this was ahead of trajectory and sees the Trust within the top quartile of national performance and **noted** that on this run rate the Trust is on track to achieve the 5% target by the year end.

The Committee **recognised** further Industrial Action is anticipated later in November 2025 which poses a further risk to activity trajectory noting that despite plans to continue elective care as far as possible the last industrial action did negatively impact on operational performance once when rearranged leave was taken, the trajectory has since recovered.

Winter Planning

The Committee received an updated and finalised Winter Plan 2025/26, which addressed the feedback from the September meeting. The plan now reflects: Trust-wide bed gap mitigation with site-specific actions at RSCH, Worthing, PRH, and SRH, Escalation areas identified and operational cadence established and IPC and vaccination programmes in place, with enhanced respiratory testing and PPE protocols. Risks remain around system-dependent mitigations and workforce pressures: The Committee asks the

Board to accept its assurance that the Trust has a robust winter plan, noting the importance of continued monitoring and system collaboration.

The Board is asked to **delegate** approval of the submission of an updated Winter Plan Assurance Statement to NHSE, to the Committee.

Environmental Sustainability Report

The Committee **received** a report on the Trust delivery against its developed green plan noting that there has been national guidance issued that will see the plan revised to move its focus to climate adaptation rather than a drive for de-carbonisation.

The Committee **noted** the current performance and key risks to achieving 2025/26 targets. The Committee also **endorsed** the proposed Green Plan refresh approach.

Risk and the Board Assurance Framework

The Committee **reflected** on the reports received and the key operational and financial risks, in particular those from the Sprint work described above and utilised this information when scrutinising their allocated elements of the Board Assurance Framework relating to strategic risks 4, 5 and 6, these being:

- risk 4 - *We are unable to progress towards medium-term financial sustainability, driven by a failure to deliver the in-year financial plan and/or actions to return to a break-even run rate by M12 2026/27 along with national funding realignment away from Sussex ICB,*
- risk 5 - *We are unable to maintain the condition of our non-digital infrastructure or support the required capital investments to deliver our strategic ambitions and*
- risk 6 - *We are unable to configure our services and sites to enable us to deliver the Trust's annual performance plan leading to patients having a poor experience and increased safety risks due to extended waits for their treatment.*

Through the information recorded in the BAF, the reports received at the early November meeting the Committee **agreed** their prospective quarter 3 scores should not reduce from those recorded at quarter 2.

Referrals to other Committees

The Committee agreed there were no matters from its meetings it felt needed to be referred to another Committee for attention or action.

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	25 September 2025	Chair	Philip Hogan	Quorate	Yes
Meeting Date	6 November 2025	Chair	Philip Hogan	Quorate	Yes
Declarations of Interest	No declarations were raised				
Items received at the Committee meeting					
<u>2025/26 Quarter 2 Financial Performance Report</u> - monthly position - cash reporting - grip and control reports	Sep	Nov (4 th)	Presenter Chief Finance Officer / Director of Operational Finance (Jun)	Purpose For assurance	Outcome /Action taken Noted M6 position and delivery that was in line with the submitted plan. Noted Sprint work in readiness for H2 to ensure Activity/Finance plan alignment and to address associated risks
<u>2025/26 Quarter 2 Efficiency & Productivity Reporting</u> - monthly position and assurance process	Sep	Nov (4 th)	Presenter Chief Finance Officer / Efficiency Director	Purpose To inform the committee on the update on the 2025/26 plan delivery	Outcome /Action taken Noted the Trust position and the work to manage the inherent risk in the latter quarter of the plan
<u>Pharm@Sea Summary Update</u>	Sep		Presenter Chief Finance Officer / Commercial Director Pharm@Sea Chair	Purpose To note the report on the Trust’s current Wholly Owned Subsidiary	Outcome /Action taken The Committee Noted the summary update and discussed areas of opportunity
<u>Wholly Owned Subsidiary</u>		Nov (4 th)	Presenter Chief Finance Officer / Commercial Director	Purpose To note progress with developing a proposal that will be considered by the Trust Board	Outcome /Action taken The Committee Noted the update

<u>Capital Investment Progress Report</u> Update on Capital Plan for 2025/26 delivery and the development of the longer term five year plan	Sep	Nov (4 th)	Presenter Director of Capital Planning	Purpose To update on the implementation of the 2025/26 capital plan & set out actual position at Q2 end.	Outcome /Action taken Noted the delivery of the was slightly behind the plan in quarter 2 but that this was not a cause for concern.
<u>Financial Consultancy Proposals</u> - Drivers of Deficit Review - Workforce Variation and Cost Review		Nov (4 th)	Presenter Chief Finance Officer	Purpose To inform the committee on the work engaged following ICS scoping that will report back for consideration	Outcome /Action taken The committee received the draft statement of works for both reviews
Commercial Progress Report Q2 2025/26 including Procurement Update	Sep	Nov (4 th)	Presenter Commercial Director	Purpose To Note	Outcome /Action taken Noted activity undertaken by the commercial directorate
Quarter 3 Environmental Sustainability Report		Nov (4 th)	Presenter Chief Finance Officer	Purpose To Note	Outcome /Action taken Noted the activity being undertaken and the move to a focus on climate adaptations
Operational Performance Reporting ▪ Performance Scorecard ▪ Constitutional Standards Performance Report	Sep	Nov (4 th)	Presenters Director of Performance and BI / Chief Operating Officer	Purpose For information	Outcome /Action taken Noted progress in elective recovery, diagnostics, and cancer pathways. The level of improvement in urgent & emergency care remains insufficient.
ICS System Update	Sep	Nov (4 th)	Presenter Chief Finance Officer/ Chair of Committee	Purpose For information	Outcome /Action taken Noted the work being undertaken within the ICS.
<u>Investment Decisions & Contract Recommendations</u> - Ventilations Works Options Paper		Nov (4 th)	Presenter Chief Finance Officer / Capital Director	Purpose To Agree and recommend for Board approval	Outcome /Action taken The Committee commends to Board approval of NHSE capital funding allocation from NHSE's Estates Safety Fund & NHSE Constitutional Standards Fund to build temporary theatres to enable ventilation works at SRH and PRH over the next 4 years.

<u>Investment Decisions & Contract Recommendations</u> - Pharmacy – Invest To Save initiatives	Sep		Presenter Chief Pharmacist	Purpose To Approve proposals and To Note phased approach to the workforce expansion. Also to Note that medicines related benefits will be reported by the PMO as Cost Improvement.	Outcome /Action taken The Committee approved appointment to the workforce outlined across the three programme areas (SACT, COVID, & Meds Optimisation). and approved the proposal to repatriate outsourced activity and scale inhouse services in line with strategic priorities.
<u>Investment Decisions & Contract Recommendations</u> - Sussex Cancer Centre Radiotherapy Linac Replacement	Sep		Presenter Chief of Service and Divisional Operations Director (Cancer Division)	Purpose To Approve	Outcome /Action taken The Committee approved the capital funding to enable the temporary Linac installation in the existing RSCH Cancer Centre.
<u>Investment Decisions & Contract Recommendations</u> - Use of Funds for refurbishment of staff areas on former RSCH Waves/Subway site	Sep		Presenter Chief Finance Officer	Purpose To Note	Outcome /Action taken The Committee noted the works approved by the Capital Investment Group to facilitate the relocation of resident teams from a site to be disposed of
<u>Investment Decisions & Contract Recommendations</u> - Enabling works at SRH for Stroke Reconfiguration.		Nov (4 th)	Presenter Chief Finance Officer / Capital Director	Purpose To Approve	Outcome /Action taken The Committee approved overall costs of enabling works and in-principal contract award for early enabling works in advance of GMP and FBC. The Committee approved the required conditions for contract award to fulfil in advance
<u>Winter Planning</u> Review of Winter Plan. Noted Draft Assurance Statement submitted in September 2025 that was not assured of capacity mitigation	Sep	Nov (4 th)	Presenter Chief Operating Officer / Deputy Chief Operating Officer	Purpose For discussion and assurance of presence of plan that mitigates capacity risks through Winter	Outcome /Action taken The Committee discussed the plan and will seek to confirm assurance to the Board Subject to further off-line discussion

<u>CQC allocated actions oversight assurance</u>		Nov (4th)	Presenter Chief Finance Officer /	Purpose For discussion and assurance over delivery	Outcome The Committee did not note the report but is aware that the Board will be informed of a referral to the Executive for clearer cross-referencing reports providing the evidence of oversight for actions moved to business as usual.
<u>Risk and Board Assurance Framework</u>		Nov (4th)	Presenter Chief Finance Officer / Company Secretary	Purpose To agree whether risks at the end of Q2 are fairly stated.	Outcome /Action taken The Committee reviewed their allocated elements and agreed with the Executives' recommendation there are no changes for Q3 from the Q2 scores.

Agenda Item:	17.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025
Report Title:	Strategy and Major Projects Assurance Committee Chair's Report				
Author(s):	Paul Layzell – NED & Committee Chair				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For Discussion	For Information only	
	N/A	Yes	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement					
Summary of the report describing		<i>The report provides information over the business undertaken at the Strategy and Assurance Committee in November 2025.</i>			
What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i>		<i>The Committee meeting was quorate at this meeting and received its scheduled business, including the requested item on the acute floor reconfiguration.</i>			
So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i>		<i>The Board can take assurance from the oversight provided by this Committee over the developing Strategy Delivery Plan.</i> <i>The Board can be assured over the progress of the majority of the major projects within the major projects portfolio. For those flagged by the Strategy and Major Projects Programme Board as having some degree of delivery risk the Committee discussed these and received a more detailed report on the acute floor reconfiguration and the actions taken in respect of lessons learnt from the prior phases to be applied to the final stage.</i>			
What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s)being made)</i>		<i>The Board can take assurance through the work of the Committee that focus is being provided to the areas of strategy delivery development and oversight on the major projects portfolio delivery.</i> <i>The Board can also receive the BAF with confidence that the content and score for strategic risks 10 and 11 have been scrutinised by the Strategy and Major Projects Assurance Committee who agreed with the Executives' recommendations to make no change for quarter 3.</i>			
Recommendation <i>(linked to What Next section)</i>		The Board is asked to NOTE - The Committee was quorate and considered all the expected reports in line with its schedule of business - The Committee's review of the Strategy Delivery plan - The Committee's recommendation of the scores for their allocated elements of the BAF, strategic risks 10 and 11. - The review of the Committee's terms of reference determined there was no need to recommend any changes.			
Assurance / Scrutiny route already					

undertaken (<i>please explain where matter previously considered, and assurance provided</i>)						
Link to Trust Strategy (note which theme)	Patient	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan	<i>The Committee provides oversight of the delivery of the Trust's major projects aligned to the Trust's Strategy which support the delivery of the Trust's annual plan.</i>					
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	<i>The Committee has oversight of the key assurances referred to within the BAF for strategic risks 10 and 11 and through their scrutiny of these recorded assurances consider and recommend to the Board their relevant current scores.</i>					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	N/A	N/A	N/A	N/A	Yes	N/A
Other impacts	Equality and Diversity (if yes has HEIA completed)		Environmental	Legal	External Registrations (if yes please indicate which)	
	N/A		N/A	Yes	<i>The Trust is required to maintain an effective system of governance, risk management and internal control (FT Code of Governance / FT Licence)</i>	

Strategy and Major Projects Assurance Committee Chair's Report

The Strategy and Major Projects Assurance Committee met on the 6 November 2025 and was quorate with at least five NEDs and six Executives being present including the Chief Strategy Officer the lead executive for the Committee. The Committee received all its planned business. In attendance were also the Director of Strategy, Director of Capital, Director of Facilities and Estates, Director of Strategic Finance, Director of HR Operations and Company Secretary.

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

Although the committee is still in its first year of operation, it noted the step-up in reporting on the Strategy and Major Projects and thanked the team bringing the work together.

Engaging Partners, Staff and Patients

In fulfilling its terms of reference, the Committee had asked for and **received** a report on the approach to engaging partners, staff and patients, all of whom played important roles in securing the success of major projects. The Committee was **assured** over the broad approach and asked that engagement was regarded as a continuous process through the lifetime of a project and that it should feature in all project reports.

Trust Strategy Delivery Plan

The Committee **received** the developing Strategy Delivery Plan showing for each Strategic Ambition the key deliverables and it was assured over the breadth of engagement in producing the content of the plan.

The Committee **discussed** the format of the document and **provided feedback** to aid its continued development. The Committee asked for greater focus on a forward outlook for each project through the inclusion of more programme outcome measures to complement the process measure already included, and an extended narrative on actions planned for the next period. It asked that future actions are risk assessed and for the principal risks to be highlighted.

The Committee **endorsed** the work being undertaken to align the delivery plan with the Trust's developing 2026/27 annual plan.

The Committee **noted** and welcomed the plan to produce periodic short reports showing the delivery against the annual strategic delivery plan and endorsed the use of various medium such as short videos to support great staff and stakeholder engagement.

The Committee **agreed** that the delivery plan and its content and milestone tracking will provide a sound base for future updates to the Board.

Major Projects

The Committee **received** reports on the overall major project portfolio, reports on the RSCH Acute Floor Reconfiguration project and the Helideck and a report describing the major project governance processes.

The Committee **noted** that the feedback from the last meeting on the format and content of the major project portfolio report has been incorporated into the report at this meeting. The Committee discussed and approved an additional major project in respect of estates rationalisation agreeing that it met all the criteria to be a major project.

The Committee **discussed** the report on the Acute Floor Reconfiguration (AFR) noting that this had been flagged within the portfolio report as a project at risk. The Committee **agreed** the actions proposed by the executive to conduct a look back review of the project and the work being undertaken on the scoping and costing of the last stage of the project. The revised project plan for the remaining stages will be presented to the next meeting.

The Committee **discussed** the value of receiving information on the identification and dissemination of lesson learnt as projects progresses complementing the final benefits realisation reporting especially as many of these projects will have multi-year delivery timescales.

The Committee **received** the major project governance document and was **assured** that the development and application of this framework and processes will reduce some of the challenges experienced by the Trust in delivery previous major projects. The Committee also **noted** the developing support programme to be given to project SROs.

The Committee welcomed the recent confirmation of funding for the new Cancer Centre and congratulated the team on achieving this significant milestone.

Board Assurance Framework

The Committee **scrutinised** its allocated element of the Board Assurance Framework relating to strategic risks 10 and 11, these being risk 10 *We are unable to successfully develop and deliver our plans which configure our sites and services in a way that aligns with system partners and the ICS strategy* and risk 11 *We are unable to support, guide and deliver the level of change required to successfully deliver the strategy*.

Through the information recorded in the BAF, the reports received at the November meeting the Committee **agreed** that there should be no changes for quarter 3 to the scores from those agreed at Board for quarter 2. The Committee also considered the reports it will receive over the next quarter and agreed that they should provide the assurance that would see a movement in the risks through the roll out of dedicated major project SRO training and the reporting of the strategy delivery plan outcome delivery milestones.

Review of Terms of Reference

The Committee recognising that this was its first year of operation undertook a **review** of its business against the terms of reference and agreed that the reports and cycle of business was enabling it to discharge its terms of reference and therefore **agreed** that there was no need for any changes to be recommended to the Board.

Referrals to other Committees

The Committee agreed there were no matters from its November meeting it felt needed to be referred to another Committee for attention or action.

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	6 November 2025	Chair	Paul Layzell	Quorate	Yes
Declarations of Interest	No declarations were raised				
Items received at the Committee meeting					
Item	Presenter	Purpose of the paper	Action Taken		
Trust Strategy Delivery Plan	Chief Strategy Officer and Director of Strategy	To discuss and provide feedback	The Committee received the developing strategy delivery plan. The Committee discussed the format of the document and provided feedback to aid its development. The Committee endorsed the work being undertaken to align the delivery plan with the Trust’s developing 2026/27 annual plan. The Committee agreed that the delivery plan and its content and milestone tracking will provide a sound base for future updates to the Board.		
Update on strategy launch, communications and engagement	Director of Strategy	To note	The Committee received information on the work that supported the launch of the strategy and the continuing engagement work. The Committee noted the positive feedback from the staff and trade unions on the level of engagement in the strategy development and the launch and engagement work.		
Model for engaging partners and patients in change	Chief Strategy Officer	To note and provide assurance over the process	The Committee received a paper that shows the process by which partners and patients are engaged within change programmes.		
Major Project Portfolio Overview report	Director of Strategy	To note and agree the addition of another major project	The Committee noted the update which summarises for the portfolio as a whole and for each project their position, the interdependencies between projects and the key project delivery risks.		

			The Committee discussed the projects and the progress being made. The Committee consider the request for an additional major project to be accepted and agreed the estate rationalisation met the criteria to be a major project.
Acute Floor Reconfiguration update	Chief Operating Officer	To discuss t	The Committee discussed the learning from the challenges to the delivery of this project, noting the strategic imperative of this project for patients and staff. The Committee agreed the actions proposed by the executive in respect of the look back review of the project, the work being undertaken in respect of the scoping and costing for the last stage of the project and agreed that the remediation actions would be reported back to the Committee. The Committee noted that Internal Audit are undertaking a review over project management across large scale capital programmes and will report by the end of the calendar year.
Helipad Update	Director of Facilities and Estates	To note progress	The Committee received report on this project and noted the work in train and the work to operationalise this project subject to the external stakeholders' review including the CAA and the air ambulance service. The Committee discussed the further internal stakeholder engagement to be delivered prior to the operationalisation of the helipad.
Summary of Major Projects' Governance arrangements	Director of Strategy	To note	The Committee received a report explaining the project governance arrangements being applied at the Trust. The Committee was assured that these arrangements address much of the learning from reports to early meetings as to why projects are off track.

			The Committee noted the support being provided to SROs to lead major projects.
System Developments	Chief Strategy Officer	To note the wider context the Trust operates in	The Committee noted this update and was assured that the Trust is continuing to engage with the system partners.
Board Assurance Framework	Company Secretary	To review and recommend to the Board the scores for strategic risks 10 and 11	The Committee considered the relevant segments of the BAF and alongside the reports received at the meeting agreed with the executives view of the risk scores. The Committee also considered the assurance planned for the next quarter and agreed that it would sufficient to enable judgements to be made over the quarter 4 scores.
Strategy and Major Projects Programme Board Chair's report	Chief Strategy Officer	For information only	The Committee noted the update
Summary of Clinical Transformation Programme Board outputs	Chief Strategy Officer	For information only	The Committee noted the update
Review of the Terms of Reference	Chair	To review and determine if there is a need for any changes	The Committee reflected that the meeting is discharging its ToR.

Agenda Item:	18.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025
Report Title:	Audit Committee Chair's Report				
Author(s):	Mike Driver – NED & Committee Chair				
Purpose of the report: (indicate as appropriate)	For Decision	For Assurance	For Discussion	For Information only	
	N/A	Yes	Yes	N/A	
Reason for not being taken in public (indicate as appropriate)	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement					
Summary of the report describing		The report provides information over the business undertaken at the Audit Committee on 14 October 2025.			
What (summary of current position / issue & why it matters and evidence to support that position etc)		The Committee meeting was quorate and received its scheduled business covering internal audit, counter fraud, and external audit along with the underpinning BAF and risk management processes.			
		The Committee also received reports detailing the Trust's management oversight for the use of single tender waivers and the mitigations for any losses or special payments			
So What (provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)		The Board can take assurance from the oversight provided by this Committee over the systems and processes supporting the Trust's Board Assurance Framework including the plan to enhance the risk management process as the Trust matures it's understanding and use of risk within its business.			
		The Board can also take assurance that internal audit activity is risk based and is directed at areas where anticipated improvement recommendation would be of greatest value and that where such recommendations are made that executive oversight of their delivery is broadly in place.			
What Next (summary of intended action and benefits supporting the choices and recommendation(s)being made)		The Committee agreed that there was value in undertaking a complementary and additive deep dive of specific BAF risks at future meetings. These will focus on the effectiveness of controls and the adequacy of the mitigations and assurances being relied upon when determining the risk outlook and scores. With that in mind the Audit Committee agreed to undertake a deep dive of strategic risk 1, which relates to patient quality and safety at the next Audit Committee meeting in February 2026.			
Recommendation (linked to What Next section)		The Board is asked to NOTE that: - The Committee was quorate and considered all the expected reports in line with its schedule of business. - The Committee's assurance over continuation of the underlying BAF processes.			

	- The Committee's endorsement of the planned risk management improvements being led by the newly appointed Chief Corporate Affairs Officer. - The Committee did not have any specific escalations to make to the Board					
Assurance / Scrutiny route already undertaken (please explain where matter previously considered, and assurance provided)	The BAF had been scrutinised by the Executive Team.					
Link to Trust Strategy (note which theme)	Care	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan	The Audit Committee provides oversight of the Trust's systems of risk management and internal control which underpin the delivery of the Trust's annual plan.					
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	The Committee has oversight of the application of the BAF process with each allocated Board Committee having responsibility for the scrutiny of the recorded assurances supporting the determined current quarterly scores.					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	N/A	N/A	N/A	N/A	Yes	N/A
Other impacts	Equality and Diversity (if yes has HEIA completed)	Environmental		Legal	External Registrations (if yes please indicate which)	
	N/A	N/A		Yes	The Trust is required to maintain an effective system of governance, risk management and internal control (FT Code of Governance / FT Licence)	

Audit Committee Chair's Report

The Audit Committee met on the 14 October and was quorate. It received all its planned business. In attendance were the Chief Financial Officer, the Chief Corporate Affairs Officer, the Trust's Operational Finance Director, Deputy Director of Finance – Operational Finance, and Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members. The Chief Information Officer and Head of Information Governance and Data Protection Officer attended for the Data Security and Protection Toolkit report and the Trust's Chief Procurement Officer attended for the relevant report on tender waivers compliance along with the LCFS benchmarking paper on tender waivers.

The key areas of focus for the Committee at its October meeting are listed below, noting the full breadth of the meeting's activity is included in a table at the end of this paper.

Risk Management and BAF reports

The Committee considered, reviewed and discussed the underlying processes for the maintenance of the Trust's BAF and as a result were assured over these processes. The Committee noted the work planned to bring a greater focus on risk mitigation arrangements and on the work planned to develop the Trust's risk appetite statements. The Committee discussed the value a conducting complementary and additive deep dives at future meetings. These would focus on the effectiveness of the controls and the adequacy of the assurances being relied upon when determining the risk outlook and scores. With that in mind the Audit Committee agreed to undertake an initial deep dive of strategic risk 1, which relates to patient quality and safety at its next meeting in February 2026.

The Committee endorsed the risk management policy compliance report noting that it assurance over the clinical and corporate divisional processes for registering risks and reviewing them on a timely basis. The Committee did note, however, the need for consistent training to be provided to risk owners, managers and staff.

The Committee reflected that whilst commendable work had been undertaken to improve compliance with the established processes, with the increased confidence in the basics there was a now a need to undertake work to separate the recording of issues to allow true risk recording to take place alongside supporting a wider cultural change to focus on utilising data over the effectiveness of the identified controls to ensure the risk scores better represent the real as opposed to perceived risks.

The Committee supported the work being undertaken to strengthen the Trust's risk management processes and endorsed the need for this to be undertaken at some pace and valued the work being overseen by the newly appointed Chief Corporate Affairs Officer.

Internal Audit activity

The Committee received a report on the Internal Audit work undertaken in the quarter and noted that where the Trust has proactively used internal audit to support with clear recommendations in areas of anticipated weakness those recommendations were supported by clear actions, implementation dates and owners. In this quarter this included reports on medical gases and clinical policy management where both reports received moderate assurance for the design of controls but limited assurance regarding the application of those controls. The Committee also noted the positive opinion for the Trust's central health and safety systems and the supportive recommendations as the Trust revises its improvement systems.

The Committee noted a significant number of outstanding Internal Audit recommendations but took confidence from the update from the Chief Financial Officer that the missing responses had now been provided. The Committee also noted the need it to maintain some oversight of the recommendations made by other 3rd Line assurance bodies such as the CQC.

Data Security Protection Toolkit

The Committee considered the report confirming that whilst the assessment criteria had changed significantly for this year, 2025/26, the Trust has established a process of seeking, validating and learning from the assurances being obtained against the established standards. The Committee was informed that the Trust has already delivered 65% of its planned actions that formed its improvement plan. The remaining actions are on track to be delivered ahead of the December 2025 deadline.

The Committee noted it would receive further updates in respect of the 2025/26 submission at future meetings.

Local Counter Fraud activity

The Committee considered the Local Counter Fraud progress report for Quarter 2 of 2025/26 in relation to their work undertaken in respect of reported concerns. The Committee was also updated in response to the actions taken in respect of any reported concerns. Through this report and the update provided by the Trust's Local Counter Fraud Specialists the Committee noted there were no significant fraud risks that the Trust needed to be actioned urgently. The Committee noted the work undertaken to support staff training especially in respect to budget holders.

The Committee received the LCFS benchmarking report in respect of the number of tender waivers. The report which showed that the Trust was using fewer tender waivers than many of the other NHS Trust's it had been benchmarked against. The report provided assurance that the Trust's processes support staff to utilise the routine procurement routes open to them.

Referrals to other Committees

The Committee did not make any formal referrals to any other Committee as it was provided with confidence from the Chief Financial Officer that the recommendations relating to medical gases would be tracked through the Estates Improvement Group reporting to the Patient and Quality Assurance Committee and from the Chief Medical Officer that the routine reporting from the Director of Clinical Outcomes and Effectiveness the actions to improve clinical policy management would be again reported to the Patient and Quality Assurance Committee.

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	14 October 2025	Chair	Mike Driver	Quorate	Yes
Declarations of Interest	No declarations were raised				
Items received at the Committee meeting					
Item	Presenter	Purpose of the paper	Action Taken		
Board Assurance Framework	Company Secretary	For assurance over the application of the Trust's process	The Committee considered, reviewed and discussed the underlying processes for the maintenance of the Trust's BAF and as a result were assured over the continuation. The Committee discussed and endorsed the actions to determine the Trust's risk appetite statements which would support the future review of the BAF. The Committee agreed that at its future meetings it would undertake a complementary and additive deep dive into strategic risks.		
Risk Management Policy Compliance report	Company Secretary	For assurance over the application of the Trust's process	The Committee received the risk management policy compliance report provided. The Committee discussed the improvement that has been made within the divisions in reviewing the highly scored risks. The Committee endorsed the work being undertaken to strengthen the risk management processes within the divisions and the establishment of a functioning corporate risk register. The Committee noted the work being led by the newly appointed Chief Corporate Affairs Officer to reinvigorate the Risk Oversight Group to enable that executive group to bring a focus to the effectiveness of the risk mitigations.		

Internal Audit Reports - Activity Progress Report - Recommendation Follow Up Report - Annual Internal Audit Activity Benchmarking Report.	BDO (Internal Auditors)	For assurance over respective areas of internal control	The Committee noted the work undertaken in the quarter and that internal audit had concluded work in areas where management anticipated they could add value through focused improvement recommendations. The Committee noted the positive opinion in respect of the central health and safety systems and processes along with advisory recommendations made in respect of the Trust's improvement systems as they are undergoing a revision. The Committee noted the negative assurance opinions in respect of the application of the systems of internal control within the areas of Medicines Management and Clinical Polices management. The Committee was assured by the Chief Medical Officer that the findings are being addressed, and oversight of their delivery would fall to herself overseen by the Patient and Quality Assurance Committee. The Committee received an update on the progress made by management in delivering the agreed improvement recommendations. The Committee noted the increase in those recommendations where no update had been provided by management. The Committee received the Internal Audit Annual Report benchmarking report which given the breadth of the audit activity showed that the Trust had continued to use Internal Audit proactively to review areas of concern to support the Trust's drive for improvement
Counter Fraud Reports - Activity Progress Report - Tender Waiver Benchmarking Report	RSM (LCFS)	For assurance over respective areas of internal control and for information on the Trust's fraud profile	The Committee noted the work undertaken by the counter fraud team, that there were no elevated fraud risks from the work in the first quarter of the year. The Committee noted the proactive work undertaken especially in relation

			especially in respect of the e-learning module launch which mandated for all new budget holders which will then be incorporated into current budget holder refresher training for 2026 onwards. The Committee in receiving the LCFS benchmarking report in respect of tender waivers secured confidence in the Trust's procurement processes as the report showed a lower level of waivers at the Trust when compared with others and that this continues the trend set by the Trust over the past few years to reduce their use.
External Audit Update - Progress report	GT (External Audit)	To note status of the External Audit work	The Committee noted that the 2025/26 external audit work is at a very early stage, with the audit planning to be concluded in January to then be followed by the interim audit ahead of the year end. The Committee received confirmation that both external audit and the Trust's finance teams were resources to deliver a successful year end audit.
Losses, Special Payments	Assistant Deputy Director of Finance - Operational Finance	To note the report and the assurance it provides over the application of the Trust's processes.	The Committee noted that a detailed review which had been undertaken over aged debt to determine the realistic collectability for these debts and secured information over those processes applied and recognised the proportionality of the work undertaken. The Committee took assurance from the continued comparably low value of losses and special payments.
Tender Waiver Report	Chief Procurement Officer	To note the report and the assurance it provides over the application of the Trust's processes.	The Committee noted the continuing relatively low level of these across the year and in the quarter and through discussion with the Chief Procurement Officer the Committee was assured over the processes being applied to support the review of Waivers. The Committee also reflected on the Counter Fraud benchmarking which supported the Committee's confidence over the

			Trust's comparably lower levels of these than undertaken at other NHS organisations.
Data Security Protection Toolkit programme update	Chief Information Officer and Information Governance Manager / Data Protection Officer	To note the progress made and receive an update on the Trusts processes	The Committee was updated on the Trust's process for the submission of the Toolkit declaration for 2025/26 and the actions being to deliver the 2024/25 submitted improvement plan. The Committee noted the update from the Data Protection Officer that the work in relation of asset management improvements would be completed by the end of November and that the work in relation to corporate records management would be substantially completed by the end of December.
Health and Safety Committee Chairs Report	Company Secretary	Provision of information on the activity of this Committee and that Committee's view of the Trust's Health and Safety risks.	The Committee noted that the gap in assurance in respect of a number of estates risks was provided by a report from the Estates Improvement Group direct to the Patient and Quality Assurance Committee. The Committee noted that as reported by Internal Audit that the medical gases risk would be adjusted for the next Committee meeting with assurances being provided through that improvement plan.
External Auditor Appointment	Assistant Deputy Director of Finance - Operational Finance	For noting the successful conclusion of the appointment process.	The Committee received an update on outcome of the process to appoint an external audit provider from 2026/27 year onwards.

Agenda Item:	19.	Meeting:	Trust Board in Public	Meeting Date:	13 November 2025
Report Title:	Company Secretary Report				
Author(s):	Glen Palethorpe – Company Secretary				
Purpose of the report: (indicate as appropriate)	For Decision	For Assurance	For discussion	For Information only	
	N/A	N/A	N/A	Yes	
Reason for not being taken in public (indicate as appropriate)	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement		The Trust is required to hold an annual meeting each year to present its annual report and accounts and for these documents to be adopted by the Council of Governors			
Summary of the report describing What (summary of current position / issue & why it matters and evidence to support that position etc)		The following is a summary update of matters not covered elsewhere within the Board pack. 2024/25 Annual Meeting As in prior years we have held our AGM and formal Council of Governors meeting consecutively on the same day. For the 2024/25 year we held these on the 30 September 2025. We took the decision for the 2024/25 Annual Meeting to hold this virtually having regard to the travel challenges posed by selecting a physical venue within West Sussex or Brighton and Hove given the wide geographic area we serve including East Sussex, given the nature of services provided through the Royal Sussex County Hospital campus. This change saw an increase in attendance supporting our desire to make this meeting as accessible as possible We had some 45 members of the public attend the meeting virtually along with our Governors and Board members, the previous year we had 36 members of the public register to attend but on the day, we had a few cancel, thus making the actual attendance at little lower. Given a national change to the MS Teams platform, we used a different instance of this to our normal Board meetings which meant we had to request members of the public register to attend but based on the numbers who registered and attended we not believe this prevented anyone from attending who wished to attend. In the prior year we had asked people to indicate if they wished to attend so that we could be sure there were the appropriate number of seats available and we did not find we have many, there were just a very small number less than half a dozen, who attended on the day without letting us know, so this step for formally registering to receive a link to the meeting was not entirely new. Undertaking this virtually was also a cost effective way to hold the meeting as within the Trust buildings we have few rooms that would accommodate the actual level of attendance of over 75 when including our external audit presenters. We recorded the meeting for those who were not able to attend and that is available along with the annual report and accounts on our website and has had some 20 views since the meeting.			

So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i>	<i>We will take our internal learning from our delivery of the on-line Annual Meeting into the planning for next year’s meeting.</i>					
What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s)being made)</i>	<i>Once the national year end timetable is set, we will confirm the date of our Annual Meeting for 2025/26.</i>					
Recommendation <i>(linked to What Next section)</i>	<i>The Board is asked to NOTE</i> <i>- The relative success of holding the Trust’s Annual Meeting online and that lessons from the session will be taken forward to the planning for next year’s Annual Meeting.</i>					
Assurance / Scrutiny route already undertaken <i>(please explain where matter previously considered, and assurance provided)</i>	<i>Not applicable</i>					
Link to Trust Strategy <i>(note which theme)</i>	Patients Yes	People Yes	Future Yes	Communities Yes	One UHSussex Yes	Culture Yes
Link to annual delivery plan	<i>The Board determine the Trust’s Strategy and thus the annual delivery plan</i>					
Link to BAF <i>(explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)</i>	<i>Not directly</i>					
Link to CQC domain	Safe N/A	Caring N/A	Effective N/A	Responsive N/A	Well-led Yes	Use of Resources N/A
Other impacts	Equality and Diversity (if yes has HEIA completed)	Environmental		Legal	External Registrations (if yes please indicate which)	
	N/A	N/A		Yes	<i>The Trust is required to hold an Annual Meeting to present its annual report and accounts</i>	

Trust Board in Public 13 November 2025

APPENDICES



University Hospitals Sussex
NHS Foundation Trust

Perinatal Quality Oversight Model (PQOM)

Trust wide summary report

August Data 2025

Purpose and background

Purpose

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

Background

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

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

Introduction

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

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

Contents

1. Escalations and Celebrations
2. Risk register updates
3. Domains
 - a) Deaths and Harm
 - b) Leadership and Training
 - c) Voice of the User
 - d) Team feedback
4. Quality Improvement
 - Monthly Maternity Incentive Scheme CNST update
 - Bi-monthly Maternity Safety Support Programme (MSSP) and Maternity and Neonatal Improvement Plan (MNIP) update
 - Quarterly Saving Babies Lives (SBL) report (separate paper)
 - Quarterly Perinatal Mortality Review Tool (PMRT) report (separate paper)
 - Quarterly Avoiding Term Admissions into Neonatal units (ATAIN) quarterly report (separate paper)

1. Escalations and celebrations

Escalations for October meeting

- ▶ None of our sites met compliance with timeliness of Hip Scan for babies who trigger the referral criteria. This was largely due to lack of scan appointment capacity and appears on the W&C and CSS Risk Registers.
- ▶ Compliance with the Saving babies Lives (SBL) care bundle has reduced from 97% to 49% as assessed by the Local maternity and Neonatal System. This is due to a change in SBL version (now v3.2) with some new requirements, and the delay in merging and ratification of guidelines required by SBL. Urgent mitigations are in place to recover compliance before the next SBL assessment and CNST Maternity Incentive Scheme (MIS) submission in November.
- ▶ The final report has been very recently received following the Insights visits by the regional perinatal team in August. There will be detailed sharing of findings in the November meeting to allow for analysis and action planning.

Celebrations for October meeting

- ▶ Due to the flexibility of the Maternity and Neonatal Voices Partnership (MNVP) service user group, compliance with Safety Action 7 of the CNST MIS has been achieved.
- ▶ Following a Bereavement Listening Event completed by the MNVP in the summer, a hugely successful MDT co-production workshop took place on 10th October, this will lead to positive Development's within our Bereavement service.

2. Risk register updates

New risks:

The following risks were added during August with a score of 16 and above:

None

There following risks were closed during August with a score of 16 and above:

None

Domains

3a) Deaths and Harm

- ▶ Perinatal Mortality cases for August 2025

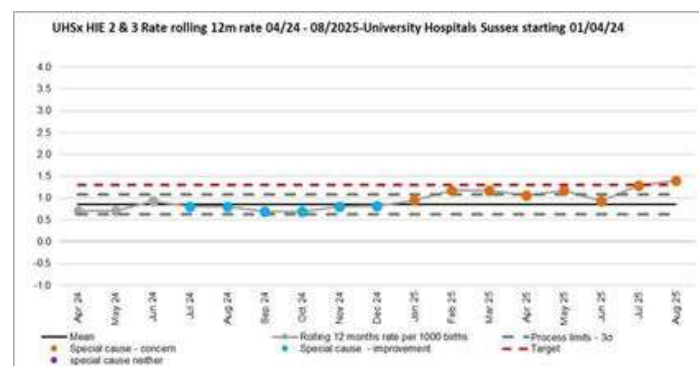
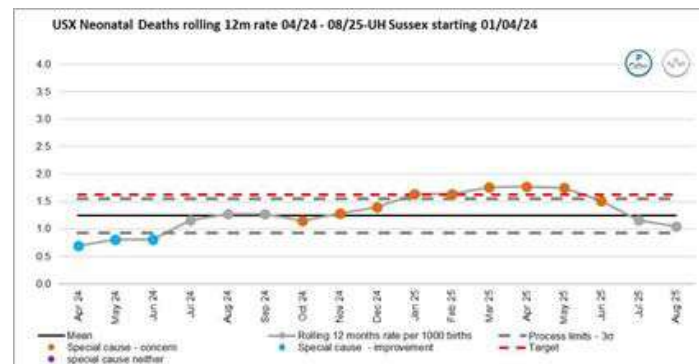
Nil

- ▶ Perinatal Morbidity cases for August 2025

- ▶ SRH: MNSI Referral and associated PSII for Dashboard: Neonatal Cooling.
- ▶ SRH: ELR: Massive Obstetric Haemorrhage 4.7litres. Admission to High Dependency Unit
- ▶ WH: ELR: Post Partum Haemorrhage, 3rd degree tear, missing swab

3a) Deaths and Harm

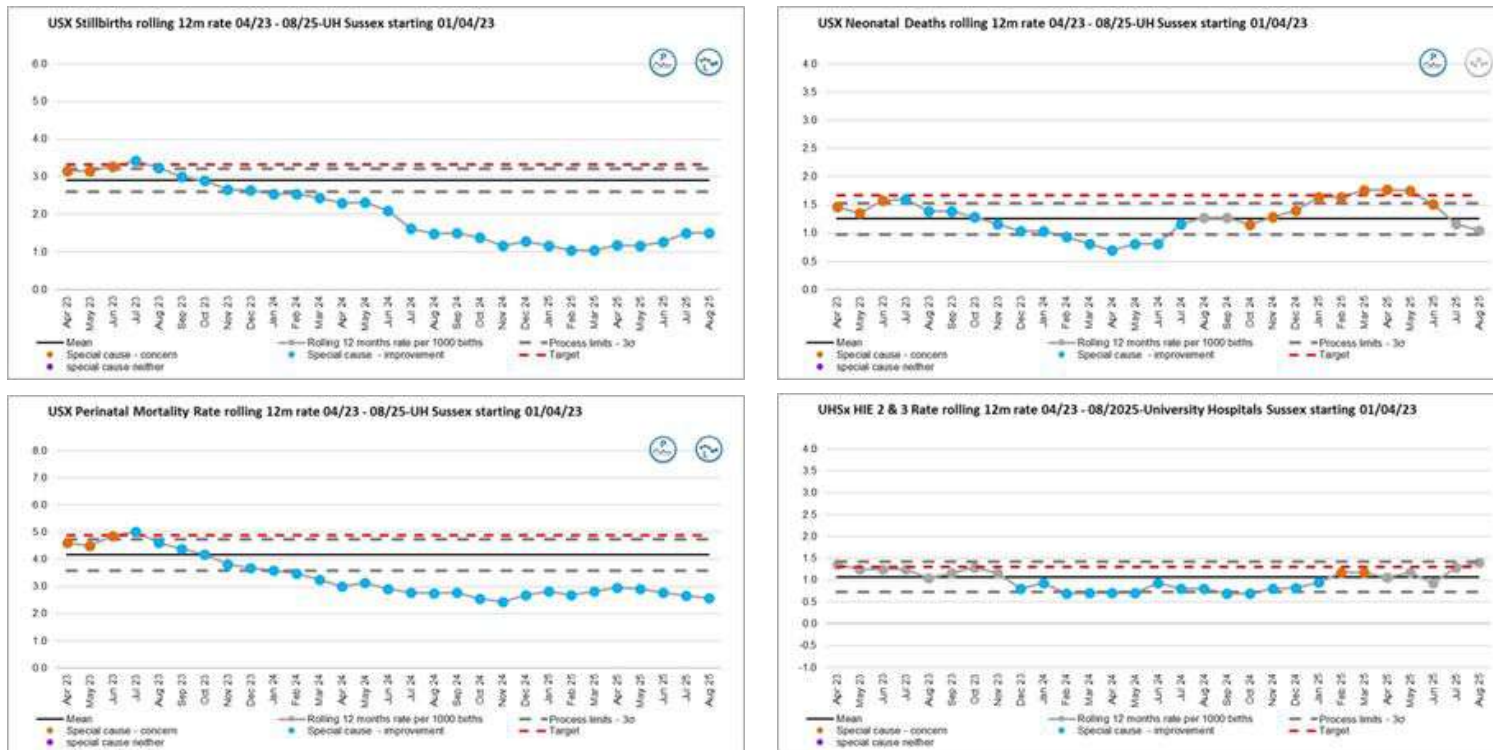
Perinatal Mortality Statistical Process Control (SPC) charts



Outcomes over a 17-month period using 24/25 data as a baseline.

Analysis – The Board can take assurance that perinatal mortality and stillbirth rates remain stable. Thematic reviews of HIE (brain injury) and neonatal deaths have been completed and previously reported to Trust Board. Close monitoring will continue.

Perinatal Mortality Statistical Process Control (SPC) charts over longer period to demonstrate trends



Due to the small numbers involved, site specific Rare Event SPC charts are now included in appendix 1, to allow for monitoring of mortality and morbidity outcomes.

Update once LMNS scorecard in - August data demonstrates no significant deterioration in any measure for perinatal mortality.

Outcomes over a 29-month period using 23/24 data as a baseline.

Health inequalities

- ▶ Statistical Process Control (SPC) charts for key indicators stratified to Global Majority groups and most deprived groups are compiled by the Local maternity and Neonatal System (LMNS) for individual sites. These charts are now included in appendix 2.

Analysis of August data:

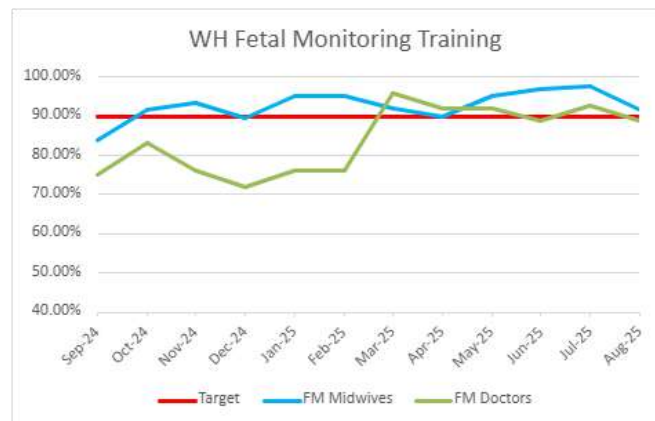
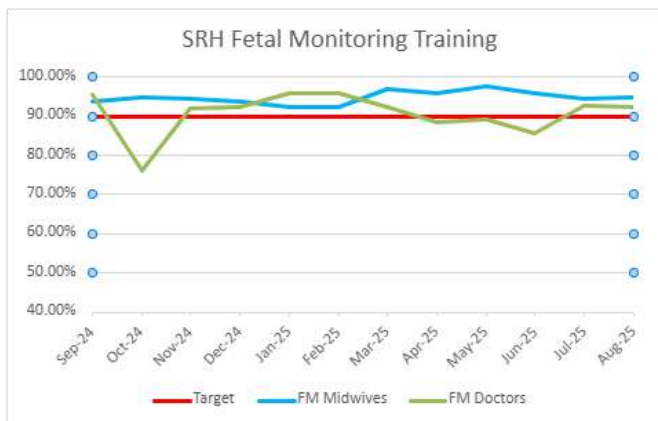
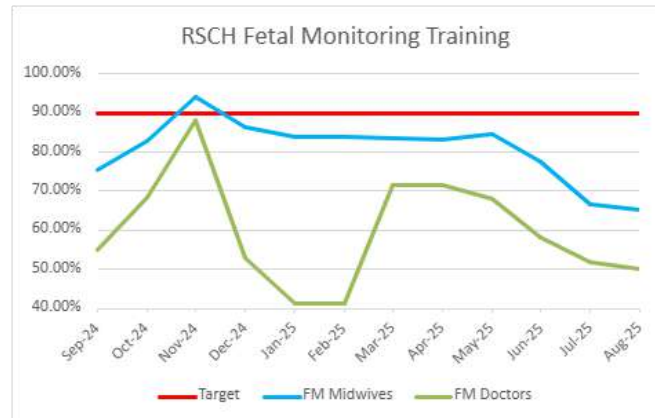
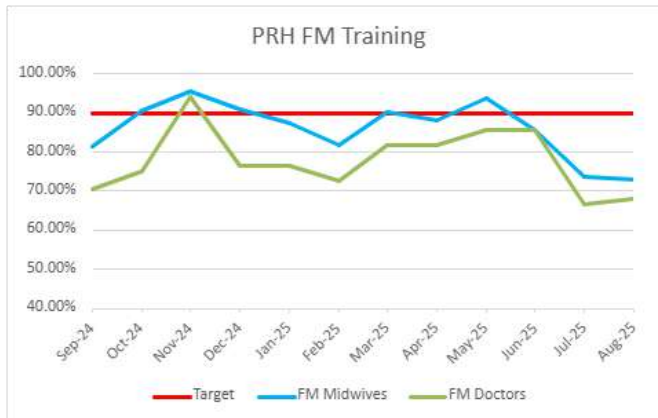
No concerning change, is noted in all measures apart from the cases below.

'Significant deterioration' (please note small numbers) identified in the following, classed as significant deterioration due to number commonly zero:

PRH Haywards Heath:

- ▶ Smoking at Booking – one case out of 12 births to women from a Global Majority background.
- ▶ Smoking at Delivery – one case out of 12 births to women from a Global Majority background. This was the same service user for both cases.

3b) Leadership and training: Fetal Monitoring



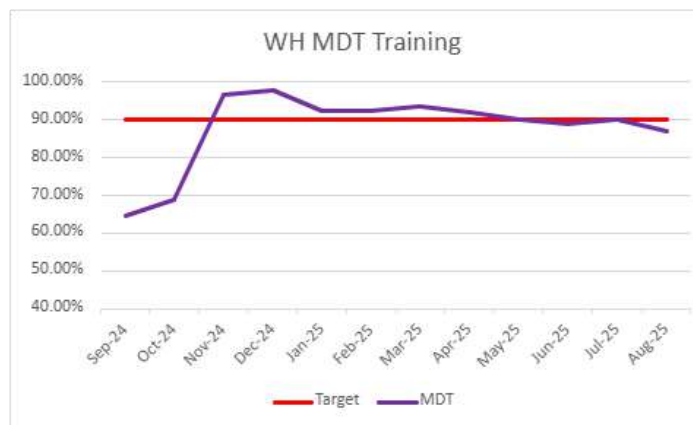
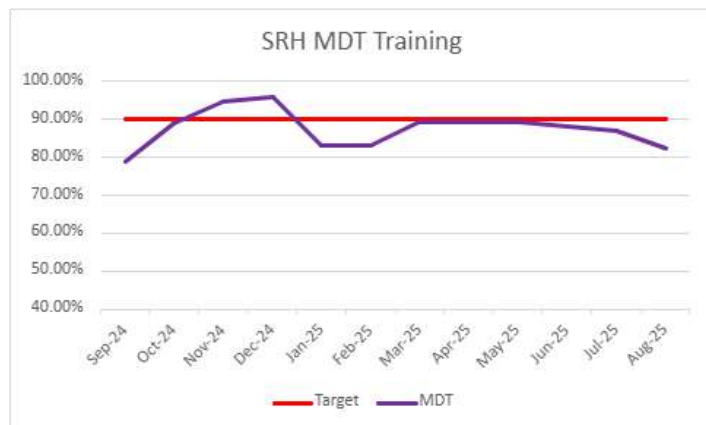
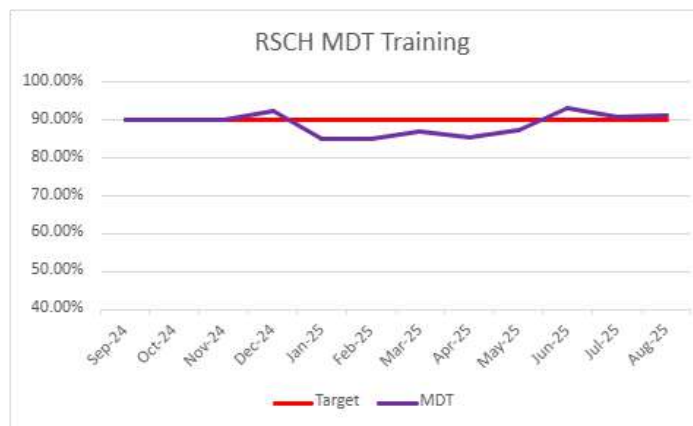
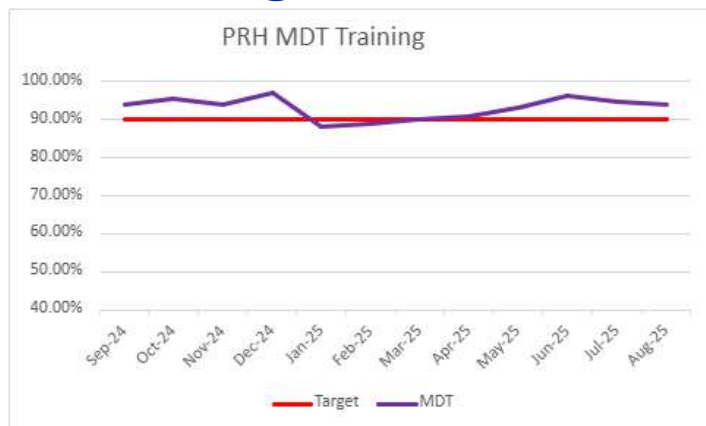
Fetal Monitoring Training stats reported in graphs and on PQS Dashboard are completion of elearning and study day attendance. CNST compliance is study day only.

Fetal Monitoring (FM) training compliance for medical staff at all sites is below 90% with RSCH remaining the greatest cause for concern. Site leaders and the obstetric clinical director are focused on improvement.

Midwifery compliance has also reduced due to returners from long term sickness and maternity leave, these staff members are booked in to September/ October sessions.

Adherence to educational requirements for maternity staff is essential to maintain safety and meet compliance with the CNST maternity Incentive Scheme – 90% compliance must be achieved for all staff groups in all training.

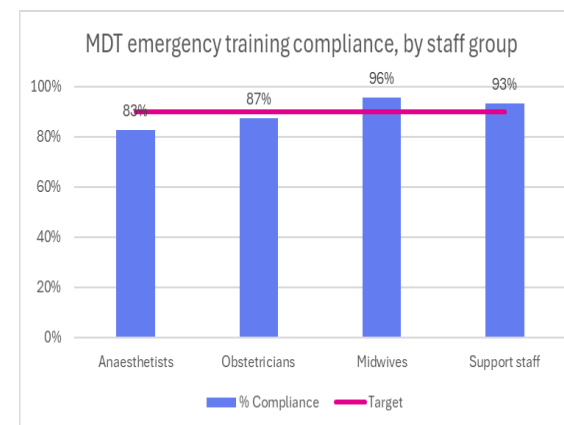
3b) Leadership and training: Multidisciplinary Training



Charts to left display all staff groups combined compliance,

CNST Safety Action 8 requires submission of each staff groups' compliance rates (bar chart below):

Obstetric and Anaesthetic compliance has improved by ~10% but still remains below target, work ongoing to ensure everyone is booked and attends their training before Nov 25 deadline.



3c) Voice of the user

Voice of the user	Princess Royal, Haywards Heath	Royal Sussex County Hospital, Brighton	St Richards Hospital, Chichester	Worthing Hospital, Worthing
FFT (% and response rate)	92.86%	100%	93.02%	96.55%
Complaints	3	4	2	0
Legal Claims	0	0	0	0
MNVP concerns	0	0	1	1

Challenges remain with capturing FFT data at RSCH & PRH, because of an IT problem that affects mining the data regarding live births from BadgerNet. A fix is being tested and an improved rate of SMS distribution and subsequent response rate is expected

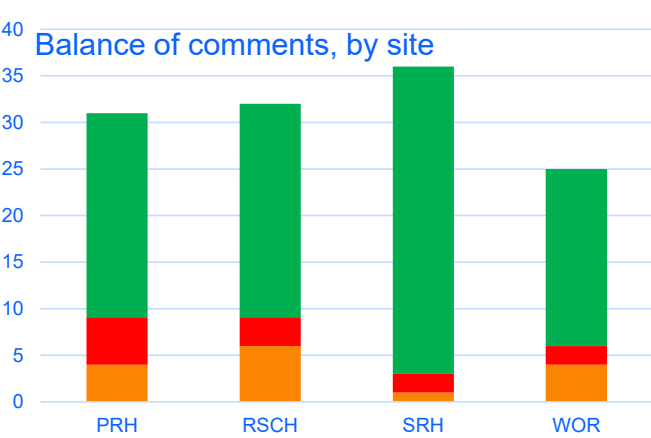
PRH FFT rate has dropped below 90% but may be related to new response rate issues:

- PRH 92.86% with 8.33% response rate (previously ~19%)
- RSCH 100% with 5.34% response rate
- WH 93.02% with 21.72% response rate
- SRH 96.55% with 18.01% response rate

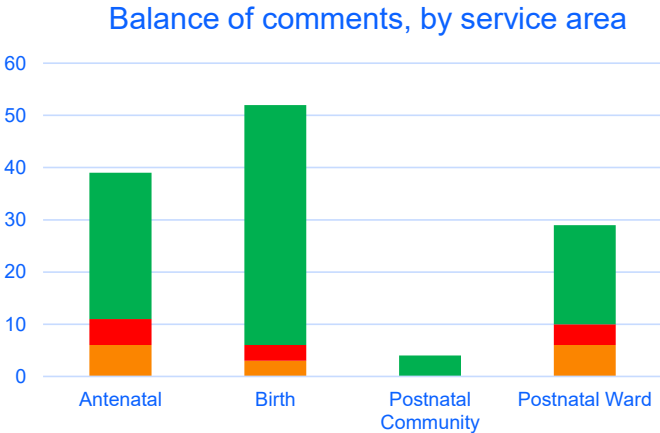
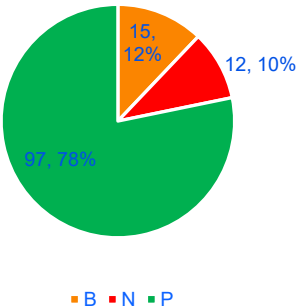
Of the 12 complaints received (2 occurred at a non-UHSussex site with care received during home birth therefore do not appear on the site-based chart above), 5 identified problems in clinical care and 4 in communication with staff but for different reasons and different stages of pregnancy.

The actions generated from service user feedback in any form will be progressed and monitored under the Maternity and Neonatal Improvement Group.

Top three positive and negative themes



Balance of comments, by positive negative and both



✓ **Top 3 Positive Themes (from a total of 122 comments)**

Exceptional Staff Attitude and Support

- The overwhelming majority of feedback highlights how staff at all levels from midwives and consultants to receptionists and support workers were consistently kind, supportive, professional, and compassionate.

Feeling Safe, Informed and Empowered

- Patients often expressed appreciation for the way their care plans, concerns, and choices were acknowledged.
- There was a strong theme of feeling safe and empowered through clear communication and shared decision-making, even when complications arose.

Continuity and Quality of Care Throughout the Journey

- Many comments praised the seamless care across different stages: antenatal, labour, delivery and postnatal.
- Patients felt there was genuine continuity, particularly when they were seen by the same midwives or care team.
- They often described their experience as holistic and well-coordinated, which contributed to a strong sense of trust and satisfaction.

⚠ **Top 3 Negative Themes (from a total of 17 comments)**

Staffing Shortages and Delays

- A recurring issue was long wait times for care, inductions, discharges, or even basic attention.
- Three patients reported feeling ignored or overlooked, often due to staff being overstretched.
- In some cases, patients were left in discomfort or distress without support, particularly during triage or overnight stays.

Environmental Comfort and Facilities

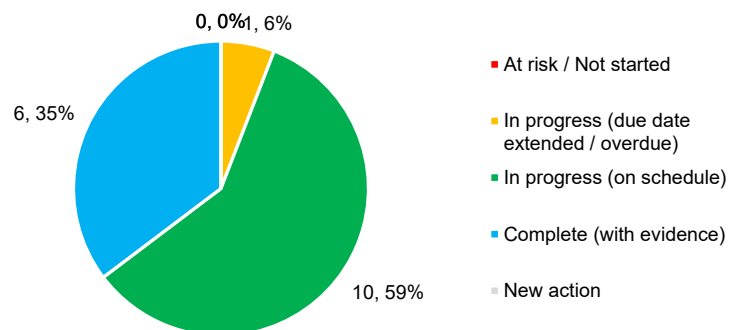
- Several comments criticised the physical environment of the wards.
- Common complaints included overcrowded and noisy shared rooms, lack of cooling (especially in summer), and uncomfortable furniture.

Communication and Attentiveness failures by some staff

- While most staff were praised, there were a five incidents of poor communication or attitude from individual staff members.
- Some of these five patients felt disrespected or not believed, especially when reporting pain or concerns.
- Privacy breaches and inconsistent messages, particularly around breastfeeding or medical plans, which led to distress and confusion.

MatNeo Improvement Plan – Service User Experience workstream

Experience progress - number and %



- ▶ Working group meets monthly, chaired by Head of Midwifery and MNVP strategic lead
- ▶ The group reports into the Maternity and Neonatal Improvement Group, chaired by the Chief Nurse and attended by NHSE, LMNS, MSSP, CQC, MNVP and others
- ▶ Actions developed from FFT and MNVP themes and annual CQC patient survey feedback, including:
 - ▶ Improving discharge processes
 - ▶ Improving availability of information at antenatal check ups via antenatal clinic Baby TV
 - ▶ Increasing use of SBAR in handovers so staff know the women's history before providing care
- ▶ The recent MNVP summit actions are being incorporated with many changes already in place.

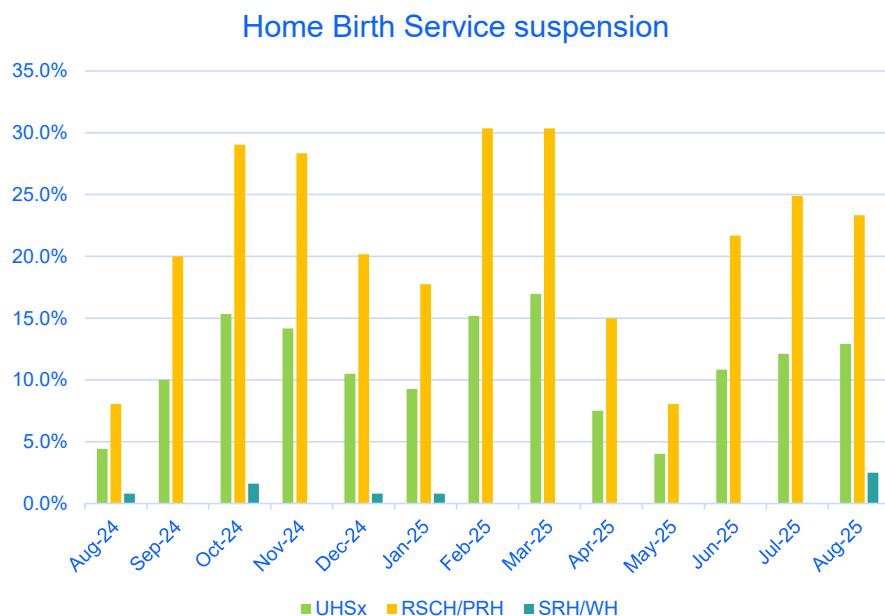
Escalations:

- Potential delay in required audits for Baby Friendly Initiative (infant feeding) due to reduction in bank usage – potential to use specialist midwives to support.

Celebrations:

- Self-administration pilot to begin at RSCH and learning used to roll out across sites
- Beginning to analyse patient experience data based on ethnicity to identify themes
- New code will enable all service users who have birthed to receive FFT SMS

Homebirth suspensions



- August continues to see a higher suspension rate due to significant sickness and annual leave within the home birth team with gaps in the rota not being able to be covered by bank.
- This meant that sadly 16 shifts were cancelled (26% suspended); however, this translated to 5 women/people out of 38 (4.2%) having to give birth outside of their preferred birth location. This is the highest the homebirth rate seen since the data began being collect and is viewed to be a positive outcome.
- Decision made for consultation to commence to gain core community midwifery teams to be on-call for homebirths to support a more robust system of 3rd and 4th on-call.
- Continuity of care team continue to be on-call for homebirths
- Rotation of passionate core/community midwives taking bank shifts to continue to cover high levels of sickness within the Homebirth team
- Recruitment day successful in recruiting 2 WTE to the team, due to start in December 2025.

3d) Team feedback



Position

- The **Division** has seen a reduction in Staff Engagement and Staff Voice that Counts scores in July and August.
- The number of participants remains low however, the findings are concerning.

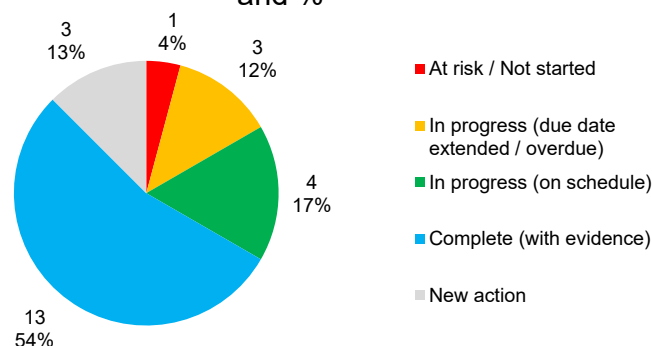
- Divisional and Directorate staff survey posters capturing actions taken in response to 2024 results.
- Action plans have been created for each Directorate area and progress is monitored monthly.

Actions

- Leadership Programme being delivered by the Organisational Development Team will take place during November and December.
- The Division plans to circulate a questionnaire to all staff understand the increase in staff having reported they have experience discrimination – currently in draft
- Listening events being held across Directorates
- Significant encouragement for staff to complete the current annual Staff Survey.

3d) Perinatal Leadership and Culture update

Leadership and Culture progress - number and %



- ▶ This working group is formed of perinatal staff from across sites and professions and chaired by the Director of Midwifery.
- ▶ Actions are developed based of themes from the MSSP deep dive and SCORE survey results.
- ▶ The group is working to improve:
 - ▶ Strategy and local leadership
 - ▶ Professional Midwifery Advocate offer
 - ▶ Staff support and psychological safety
 - ▶ Cross site orientation and mobility
 - ▶ Communication and appraisal processes
- ▶ A new 'cultural safety' working group is under development in response to staff survey feedback and will supersede this group once actions have been closed.

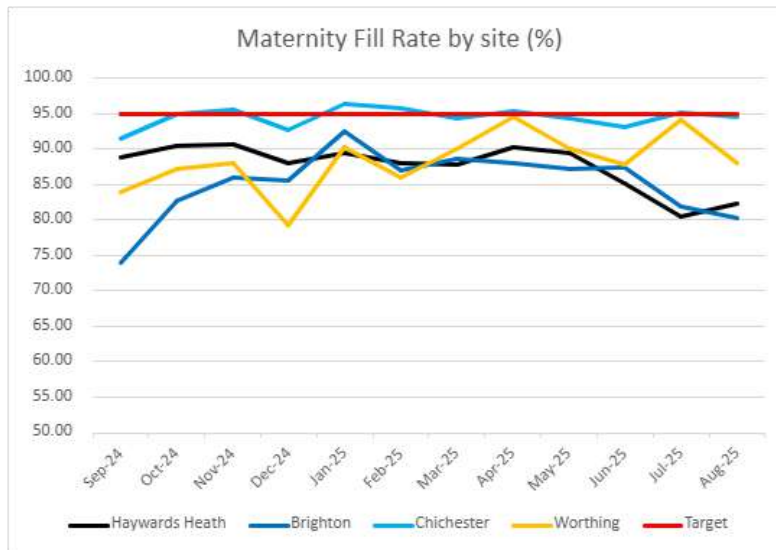
Escalations:

- Swipe access and access to IT currently prohibits rotational posts and mutual aid in times of escalation
- $\frac{3}{4}$ of Quad and CNO unable to attend Restorative culture training programme due to CQC visit in September

Celebrations:

- Restorative culture training programme complete
- Increasing number of Culture Coaches within the perinatal service trained and supported by NHSE.

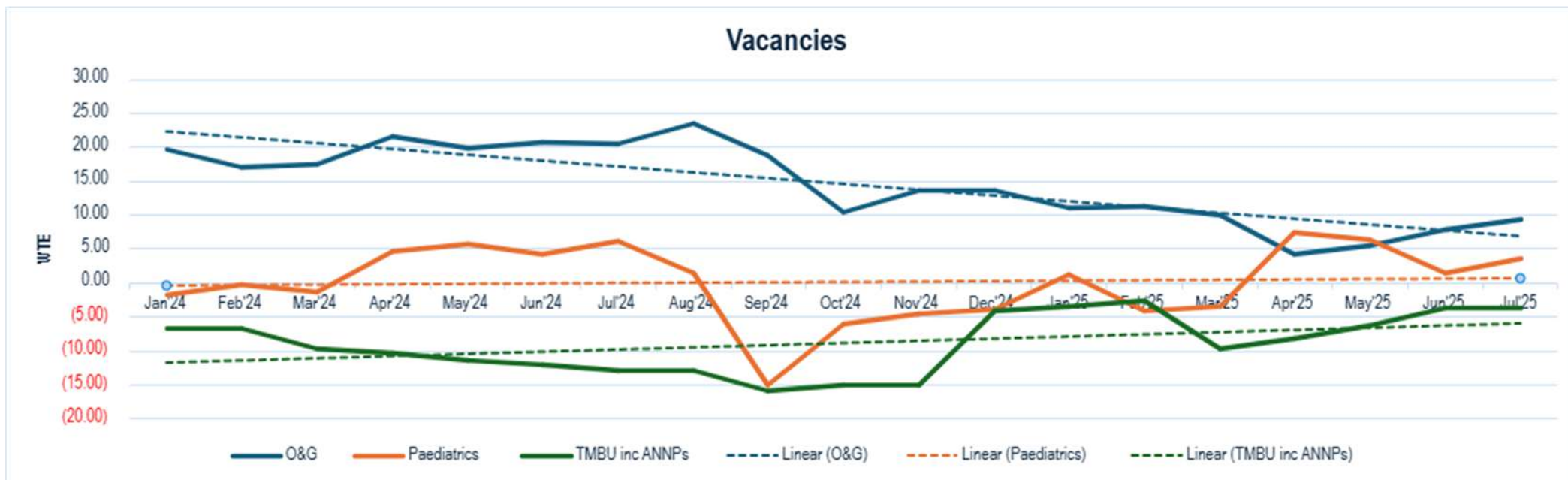
Perinatal workforce - midwifery



Workforce	Princess Royal, Haywards Heath		Royal Sussex County Hospital, Brighton		St Richards Hospital, Chichester		Worthing Hospital, Worthing	
Midwifery B5/6/7 core vacancy	-9.32%	↓	-9.25%	↓	5.41%	↑	-3.43%	↓
Midwifery sickness	7.90%	↔	5.40%	↔	5.40%	↓	8.70%	↑
Parental leave	3.70%	↑	7.00%	↔	6.70%	↓	2.60%	↑
Actual vs planned staffing	82.35%	↑	80.30%	↑	94.57%	↓	88.01%	↓

- Increased sickness and maximum annual leave has impacted fill rates over the summer, particularly in Brighton and Haywards Heath. Mitigations have been in place as much as possible, and the maternity escalation policy has been activated when needed to manage risk. Despite this, some shifts have been very challenging for teams. Pastoral and leadership support is in place.

Perinatal workforce - medical



Obstetric narrative: Three substantive consultant posts appointed with a view to starting in January 2026 at the PRH and RSCH sites. Additional obstetric consultant support at RSCH, initially on a fixed term basis, is being explored.

Neonatology: Recent work has aligned demand for required staff to undertake the workload. We are actively recruiting to identified vacancies and are nearly at full establishment.

Perinatal workforce – Neonatal Nursing

		RN	Non-RN	TOTAL
Beeding WH	Planned	180	62	284
Beeding WH	Actual	142	52	194
	%	76%	84%	78%

		RN	Non-RN	TOTAL
SRH SCBU	Planned	186	62	248
SRH SCBU	Actual	160	22	182
	%	86%	36%	73%

		RN	Non-RN	TOTAL
PRH SCBU	Planned	120	60	180
PRH SCBU	Actual	124	5	139
	%	112%	8%	77%

		RN (QIS)	RN (Non-QIS)	Non-RN	TOTAL
TMBU	Planned	558	434	62	1054
TMBU	Actual	357	465	46	868
	%	64%	107%	74%	82%

Active recruitment efforts are ongoing across four sites. Some staff have increased their hours, leading to a reduction to 19% overall for August which is an improvement from the 21% in July.

Band 6 QIS coverage at TMBU remains static at 42% with ~7–8 WTEs beginning the QIS course in September, this is projected to increase to 51%.

The overall staffing trajectory plan remains on track the overall neonatal staffing vacancy is expected to reduce to 5-7% by January 2026.

Actual verses Planned

SRH

There are 5WTE Non-RN staff in SRH. During August there was pregnancy related sickness and annual leave. These shifts were not covered by Bank as managed with substantive cover.

PRH

A range of sickness, leave, and one staff member on apprenticeship training. These shifts were not covered by Bank as managed with substantive cover.

TMBU refusals

NICU Planned Vs Actual	Surgical Babies	Extreme Prem 22Wks-29wks	Refused - Staffing	Refused - Maternity refusal	Refused - TMBU Full	Refused from Worthing	Out of Network	Refused Unknown	Refused Other	Total number of babies refused
Refusals IN Utero	0	5	1	1	5	0	3	0	1	8/14
Refusals Ex Utero	0	0	1	0	0	0	0	0	0	1/9

July 32 referrals (15 IUT/17EUT, 5 being surgical)
August 23 referrals (14 IUT/9 EUT, 5 being surgical)

Referrals Accepted August

IUT 43% (27% in July)
EUT 90% (18% in July)
EUT (surgical) 100% (0% in July)
August saw less referrals compared to the previous month and an improved acceptance rate.



Quality Improvement

CNST, MSSP, MNIP

Maternity Safety Support Programme

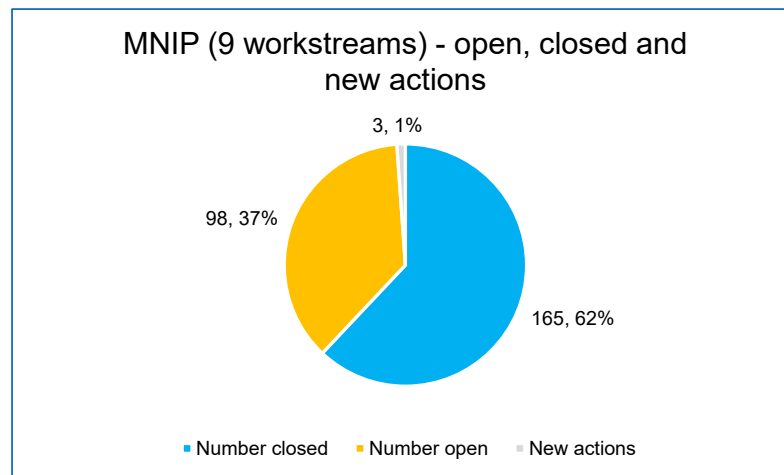
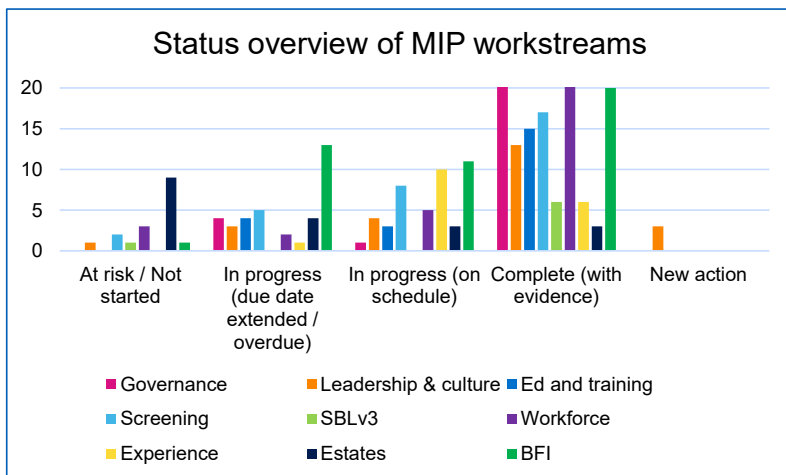
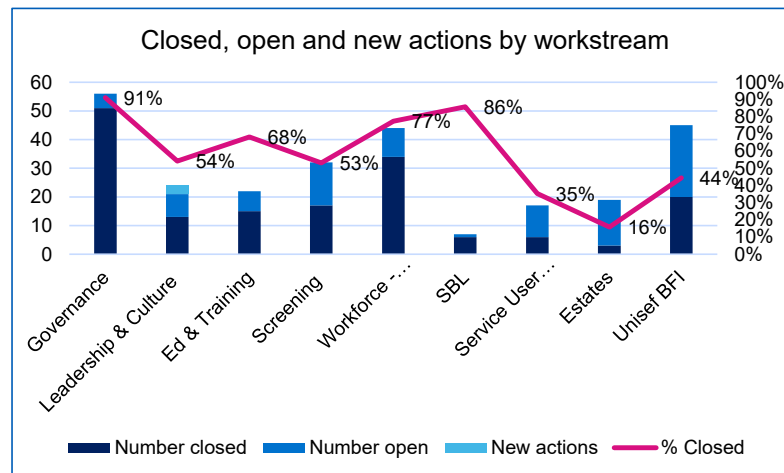
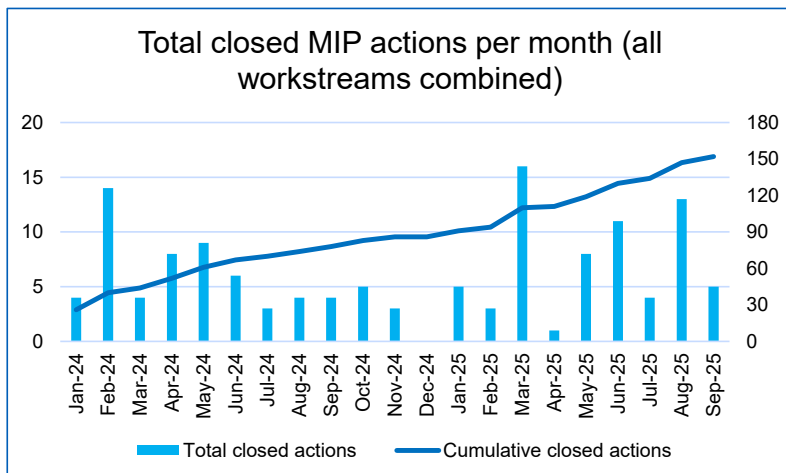
Maternity and Neonatal Improvement Plan (Bi-monthly)

Maternity Safety Support Programme (MSSP)

- ▶ The MSSP 'exit' meeting planned for 5th August 2025 had been delayed following the announcement by the Secretary of State (SoS).
- ▶ A deep dive of evidence and assurance of embedding of closed actions was completed on 14th July, with evidence commended by the MSSP Maternity Improvement Advisor.
- ▶ All exit criteria has been met, with recent ratification of:
 - ▶ The Maternity Vision: [UHSx Maternity vision & strategy v1.0 \(2025-2030\) FINAL.docx](#)
 - ▶ The Maternity Governance Framework
 - ▶ Planned caesarean lists at Brighton



Progress overview across MNIP



Key successes / challenges:

- Neonatal governance framework ready for divisional ratification.
 - Work for teams to align processes underway
- LMNS review of open and closed Ockenden actions assured current position (94% complete)
- Estates workstream is challenging to progress – work underway to transfer ownership to Director of Estates working party and Corporate Estates Improvement Group

CNST Maternity Incentive Scheme (MIS) overview

Will be updated via MNIP

Conclusion and recommendations

- ▶ This report demonstrates that perinatal service teams continue to provide care resulting in stable outcome data and positive service user feedback.
- ▶ Focus on health inequality risks and staff wellbeing and culture continues.
- ▶ The service is ready to fully engage in the national inquiry into maternity and neonatal services and be open to any recommendations made.

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



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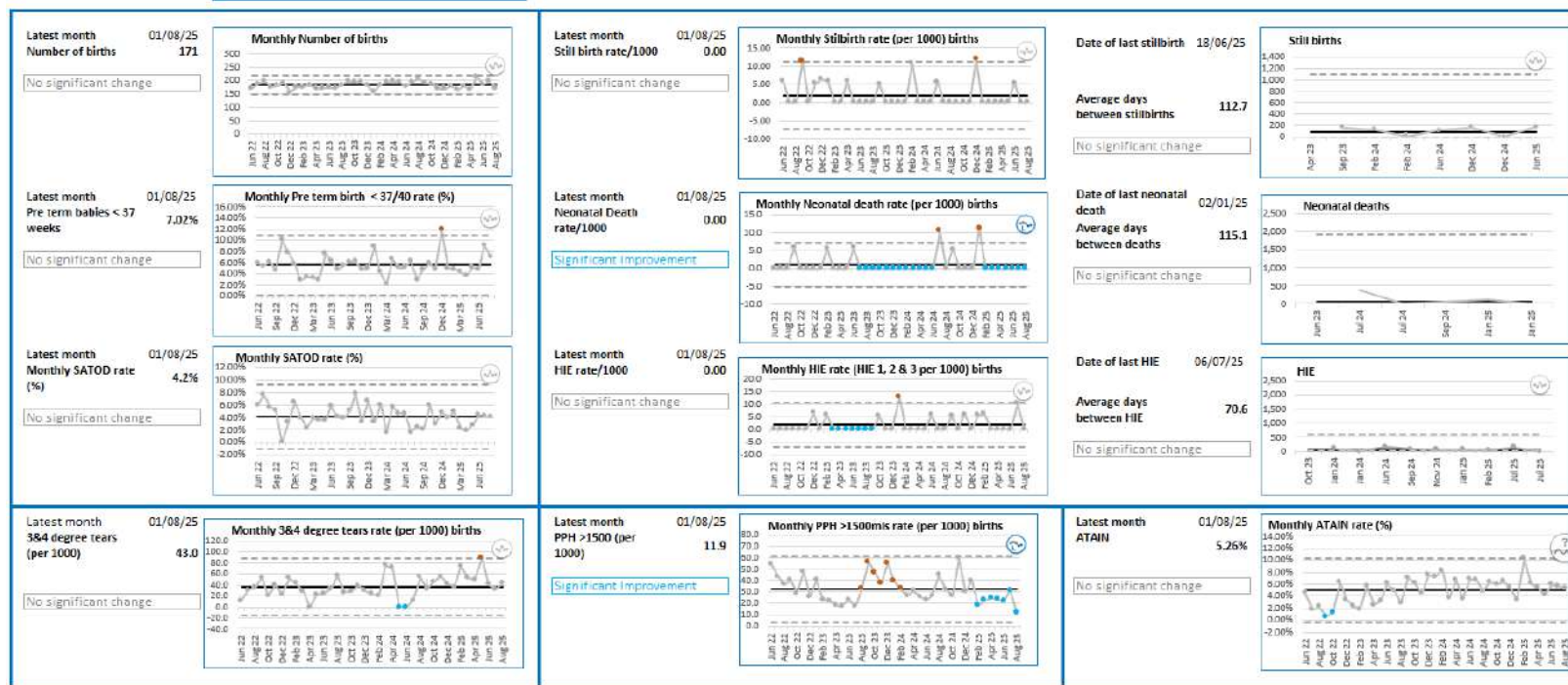
Appendix 1

Morbidity and Mortality Outcome Data

August 2025

Haywards Heath

Maternity overview PRH



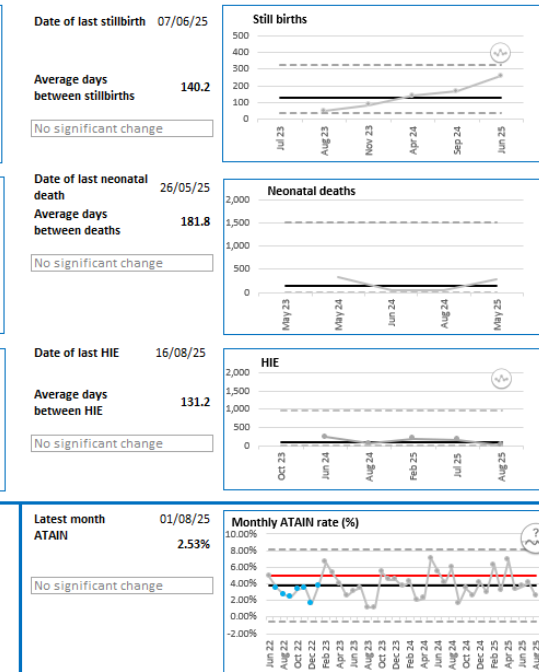
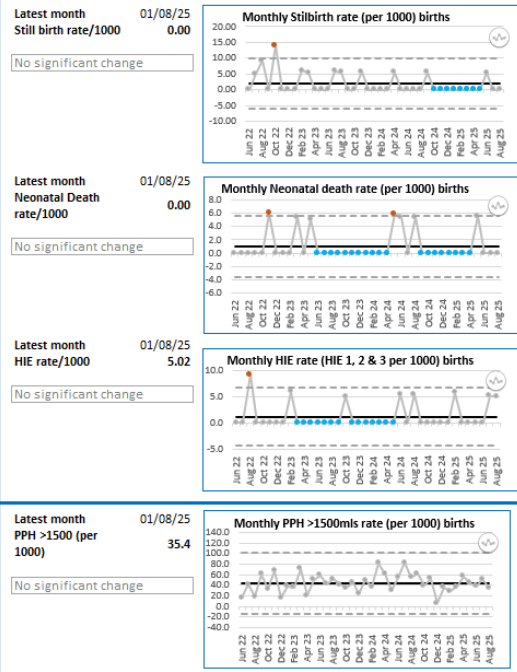
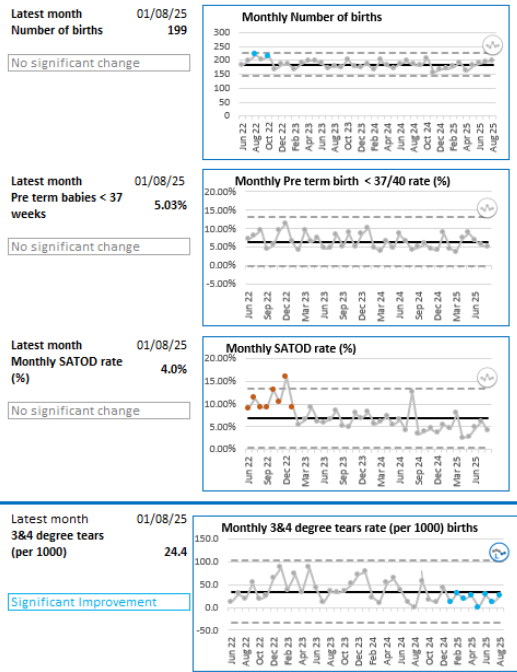
Brighton

Maternity overview **RSCH**



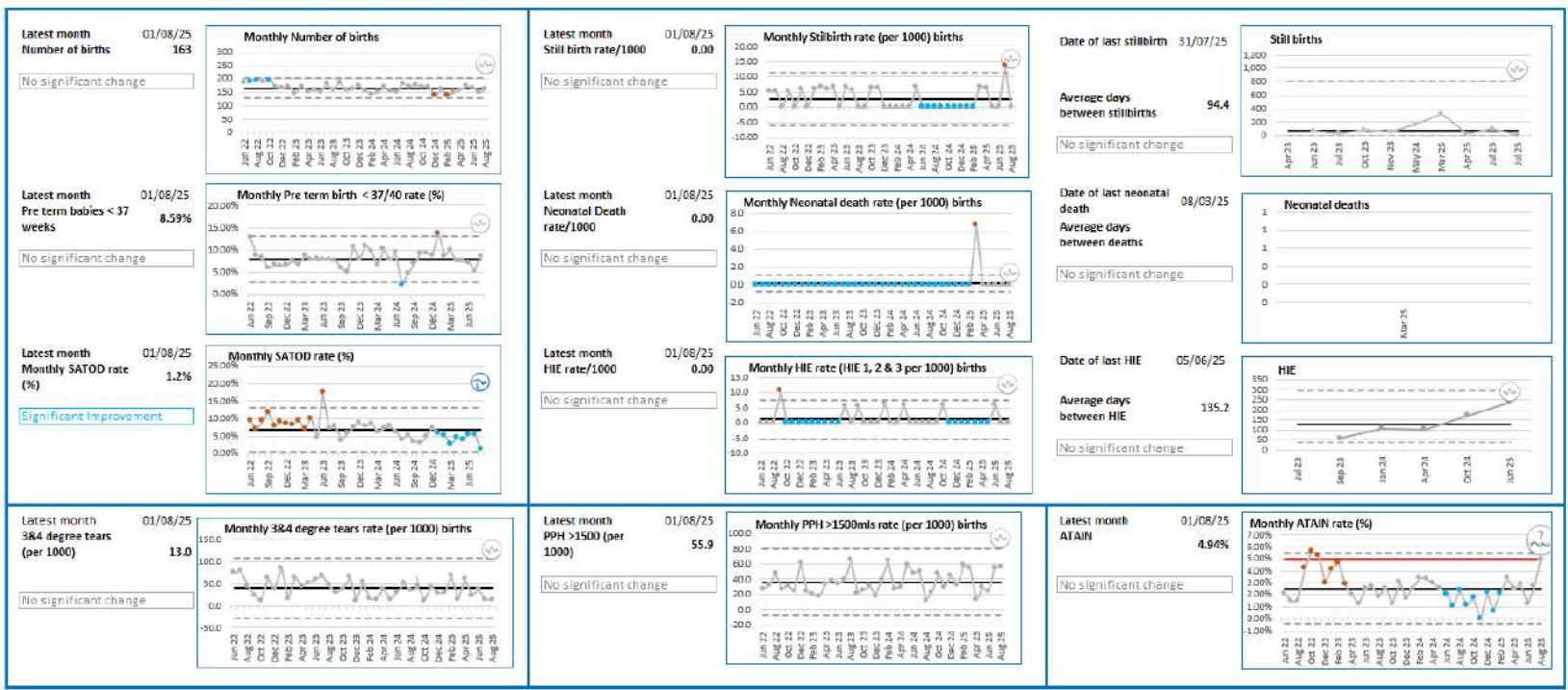
Chichester

Maternity overview **SRH**



Worthing

Maternity overview **WH**





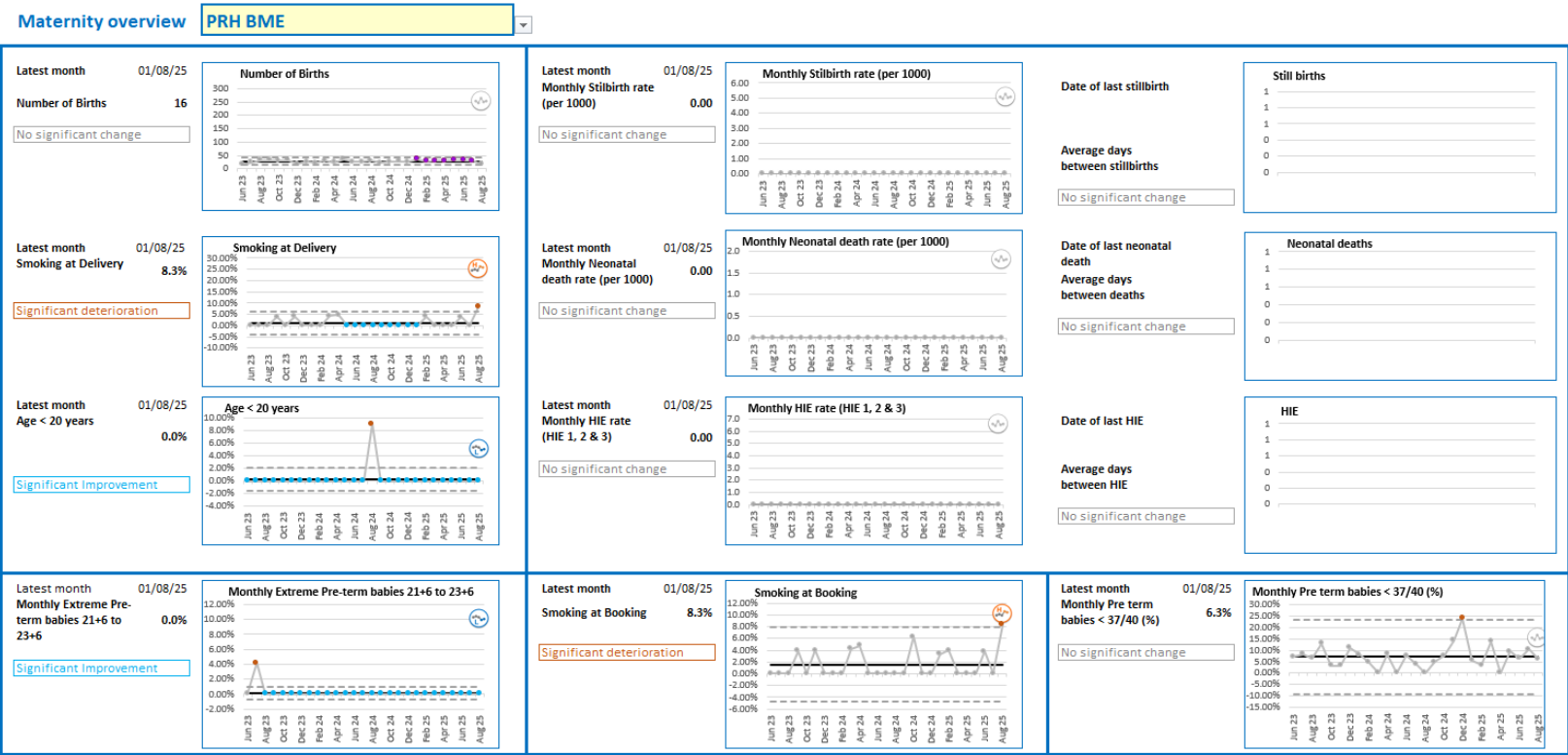
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Appendix 2

Health Inequalities Segmented Data

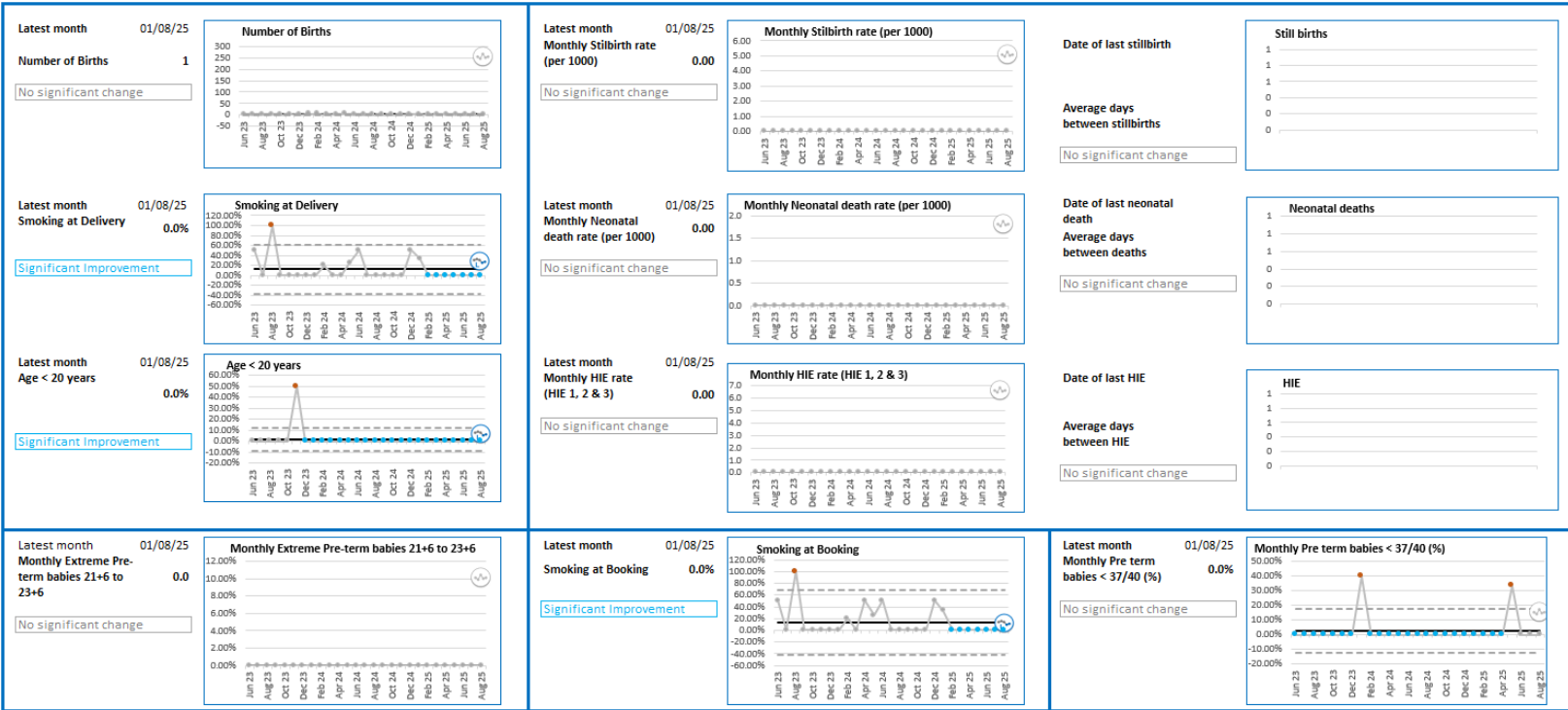
August 2025

Haywards Heath – Global Majority



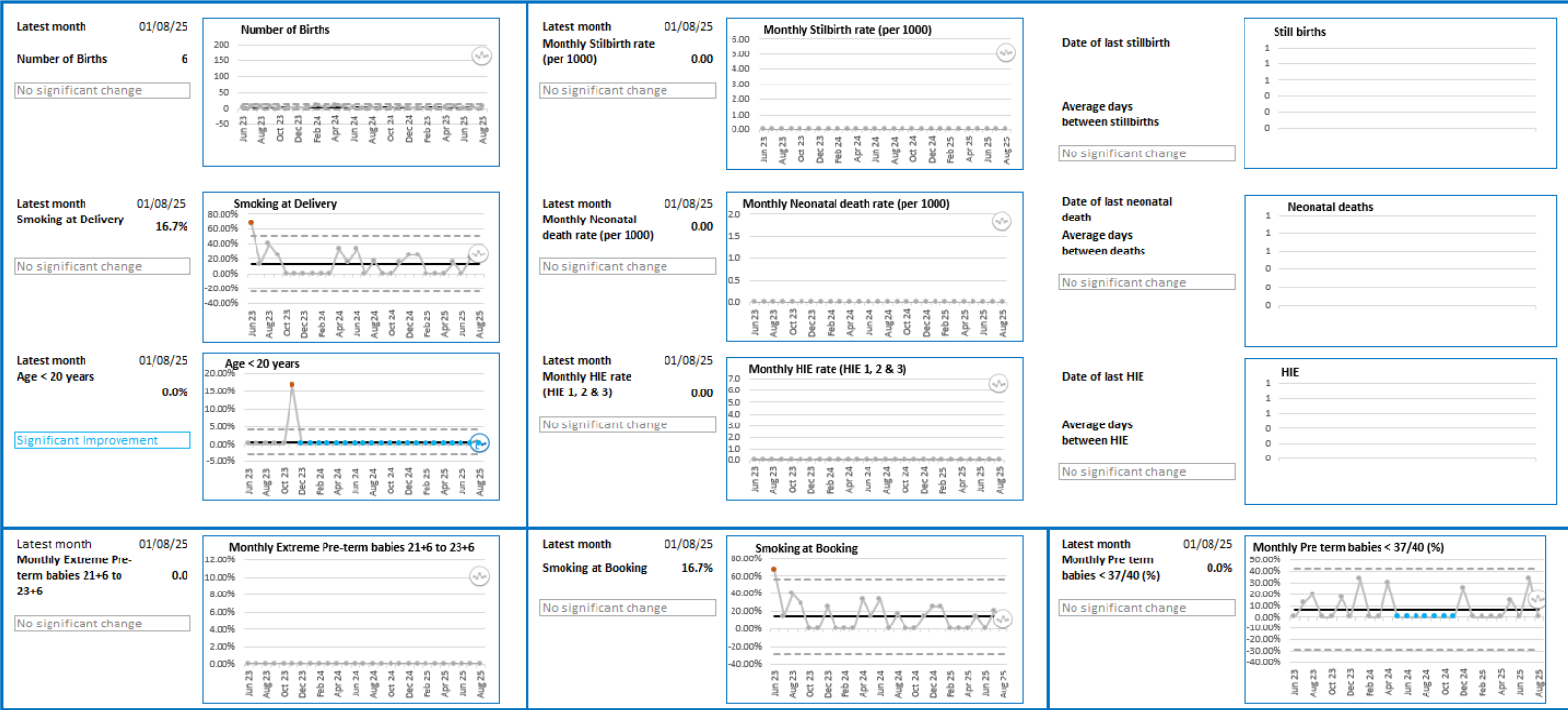
Haywards Heath – 10% most deprived

Maternity overview PRH 10% most deprived



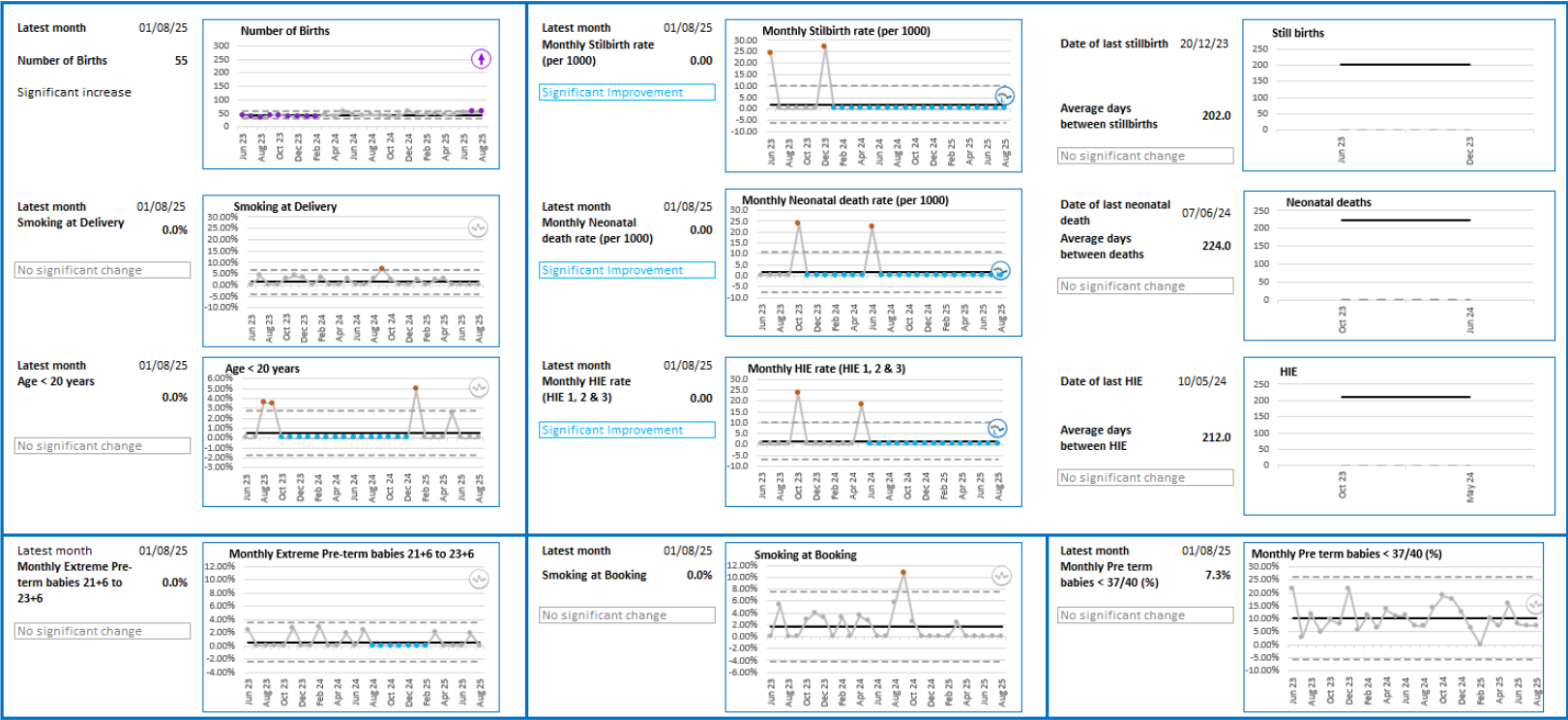
Haywards Heath – 20% most deprived

Maternity overview **PRH 20% most deprived**



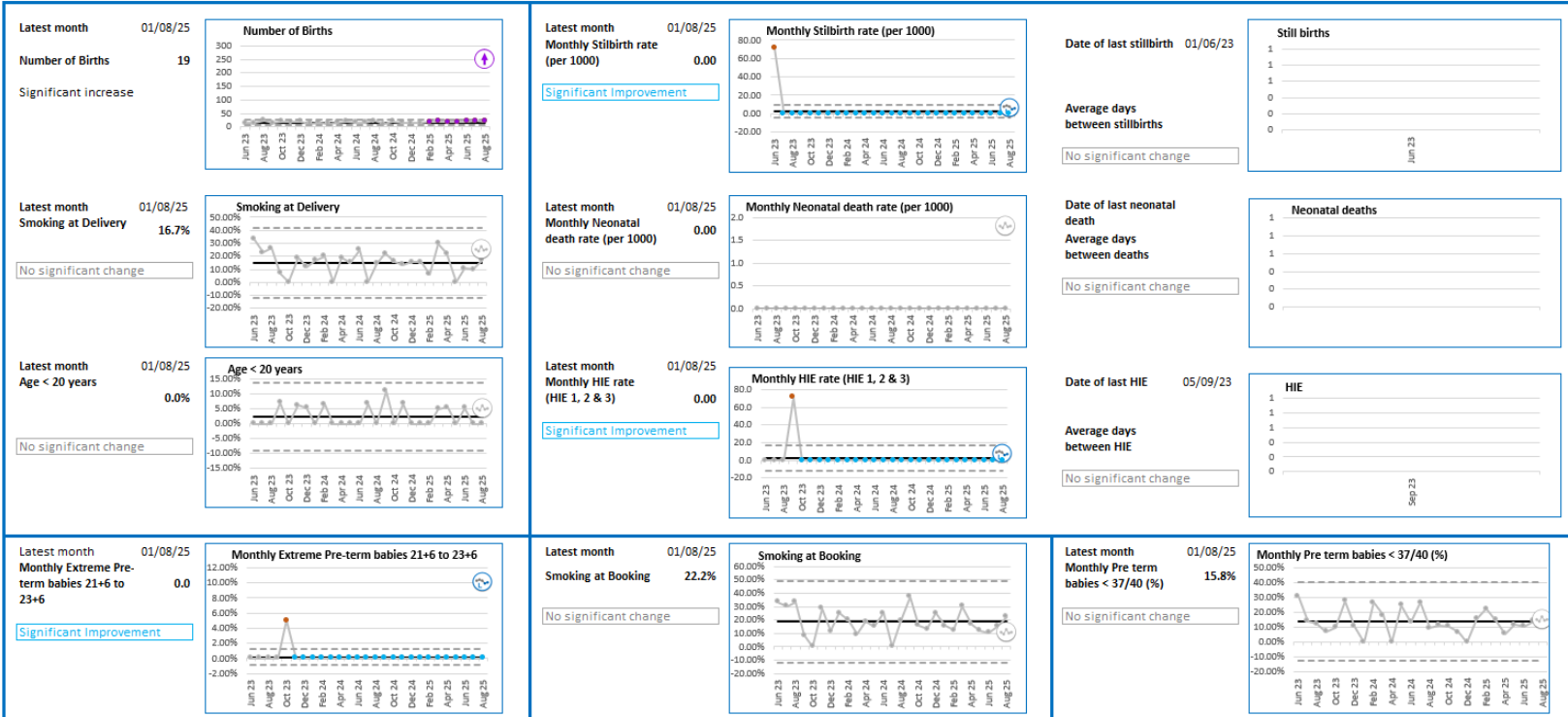
Brighton – Global Majority

Maternity overview RSCH BME



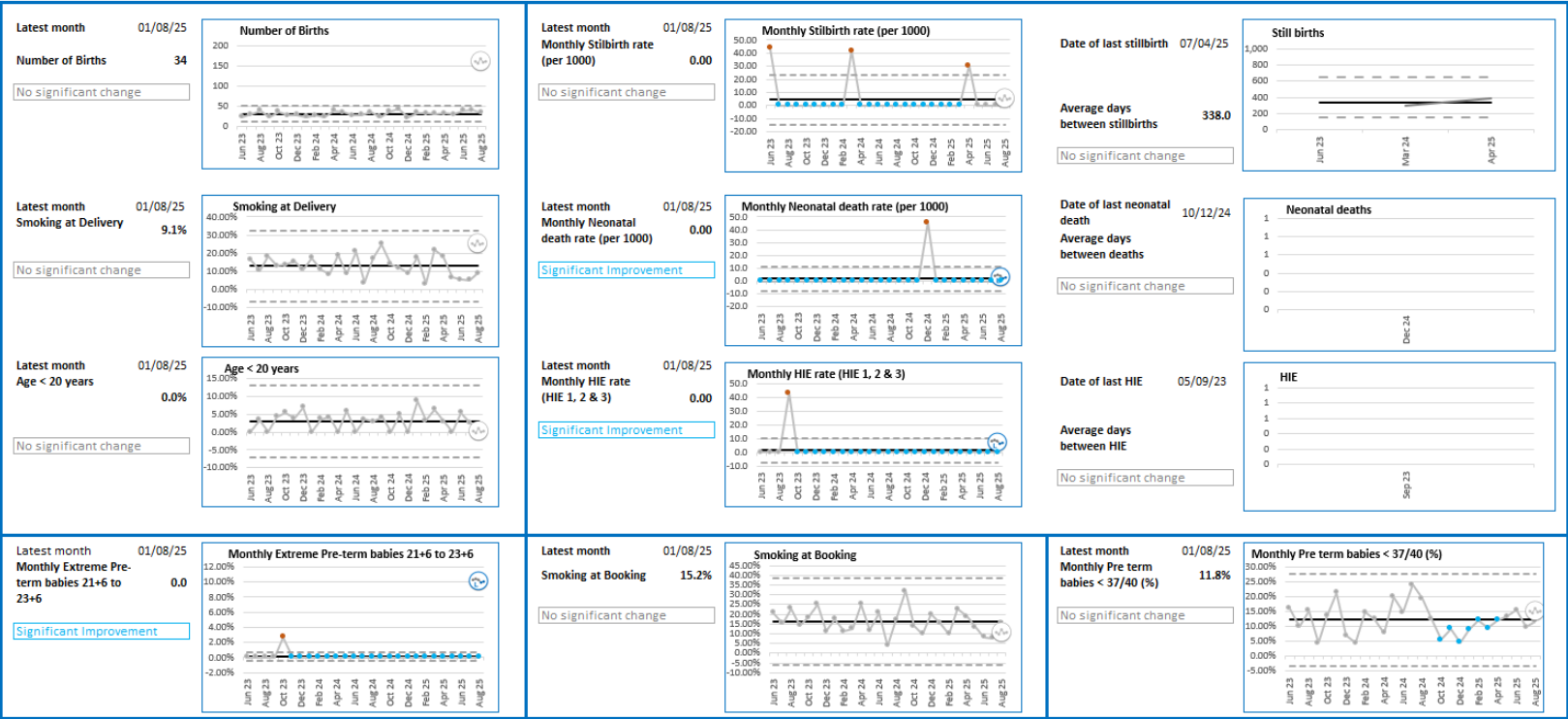
Brighton – 10% most deprived

Maternity overview **RSCH 10% most deprived**



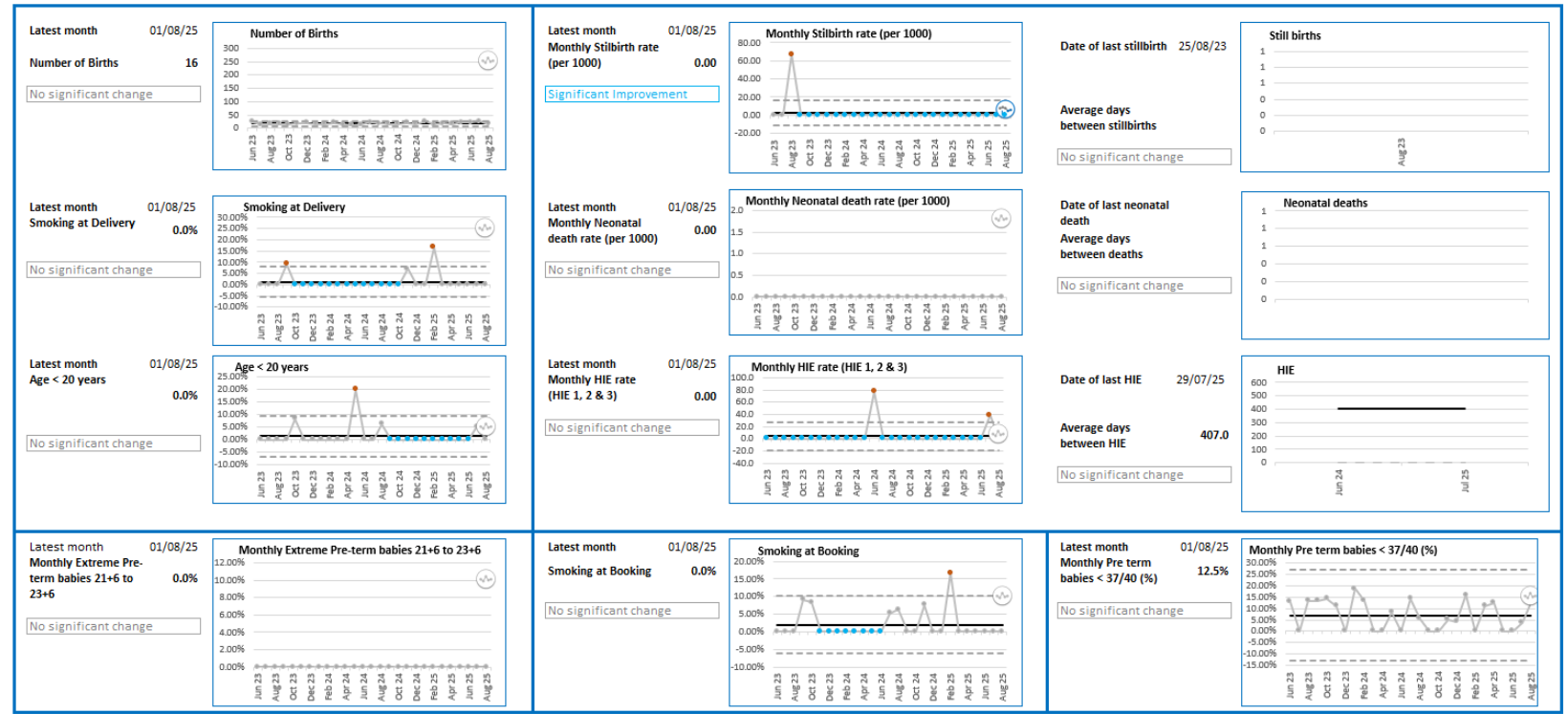
Brighton 20% most deprived

Maternity overview RSCH 20% most deprived

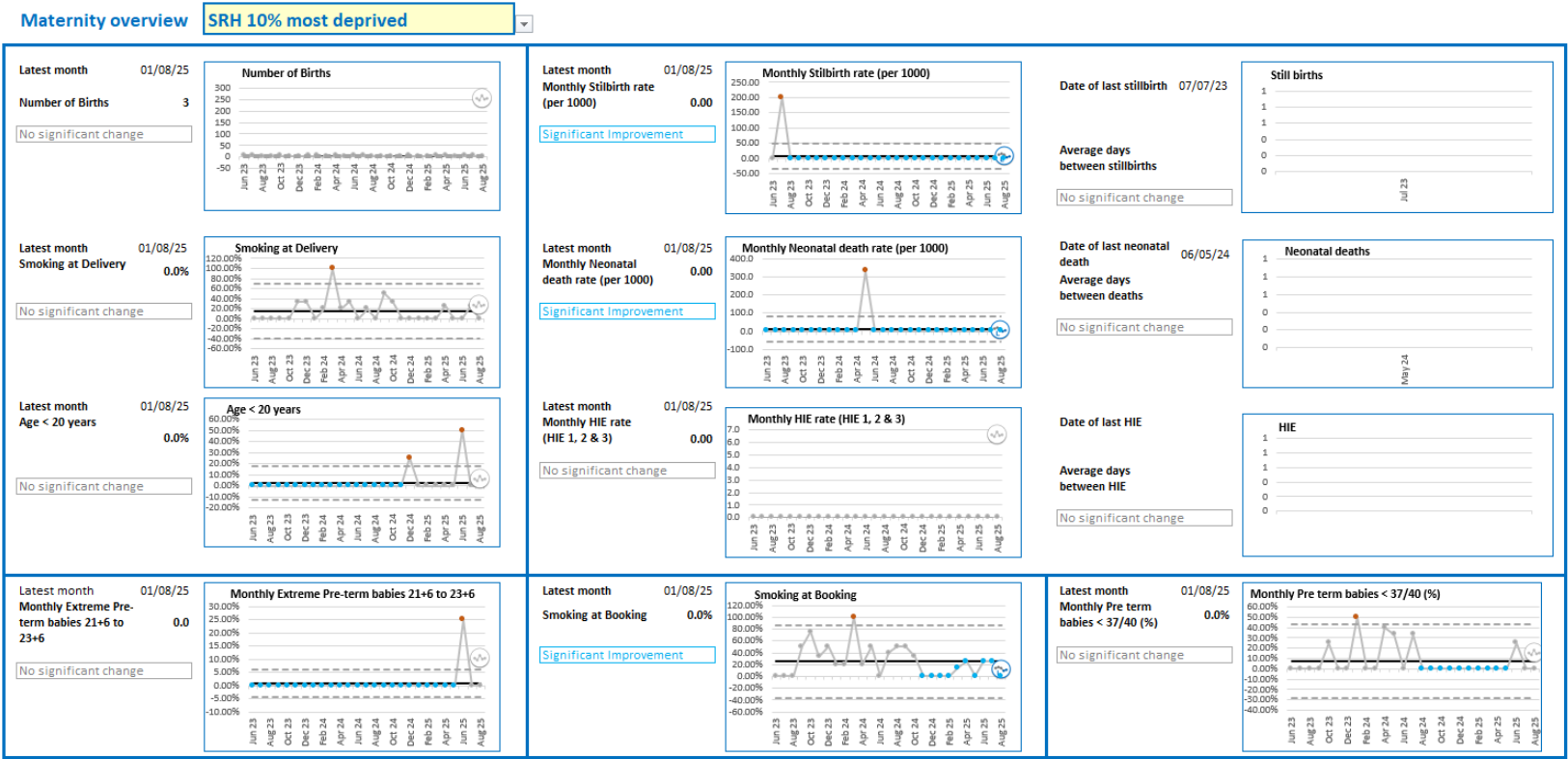


Chichester – Global Majority

Maternity overview **SRH BME**

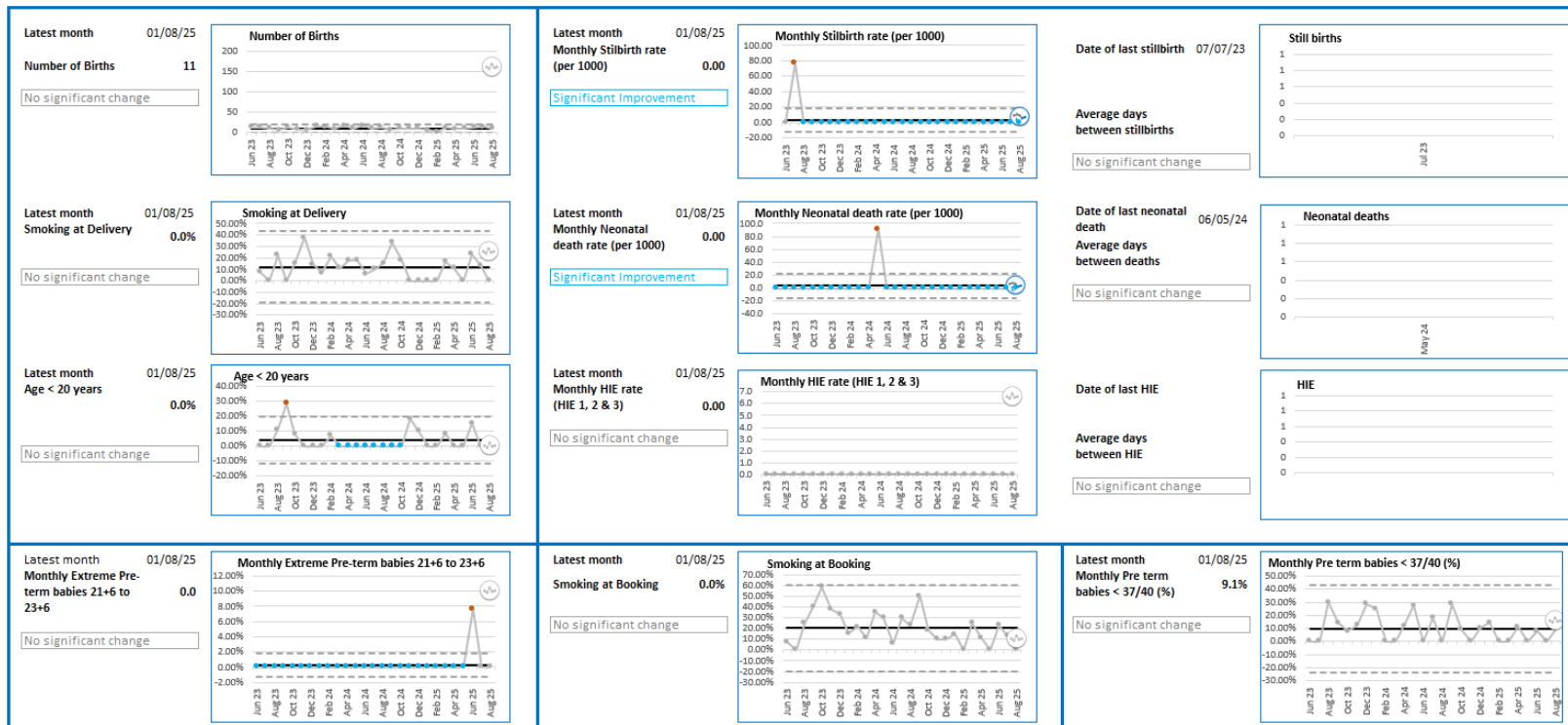


Chichester – 10% most deprived



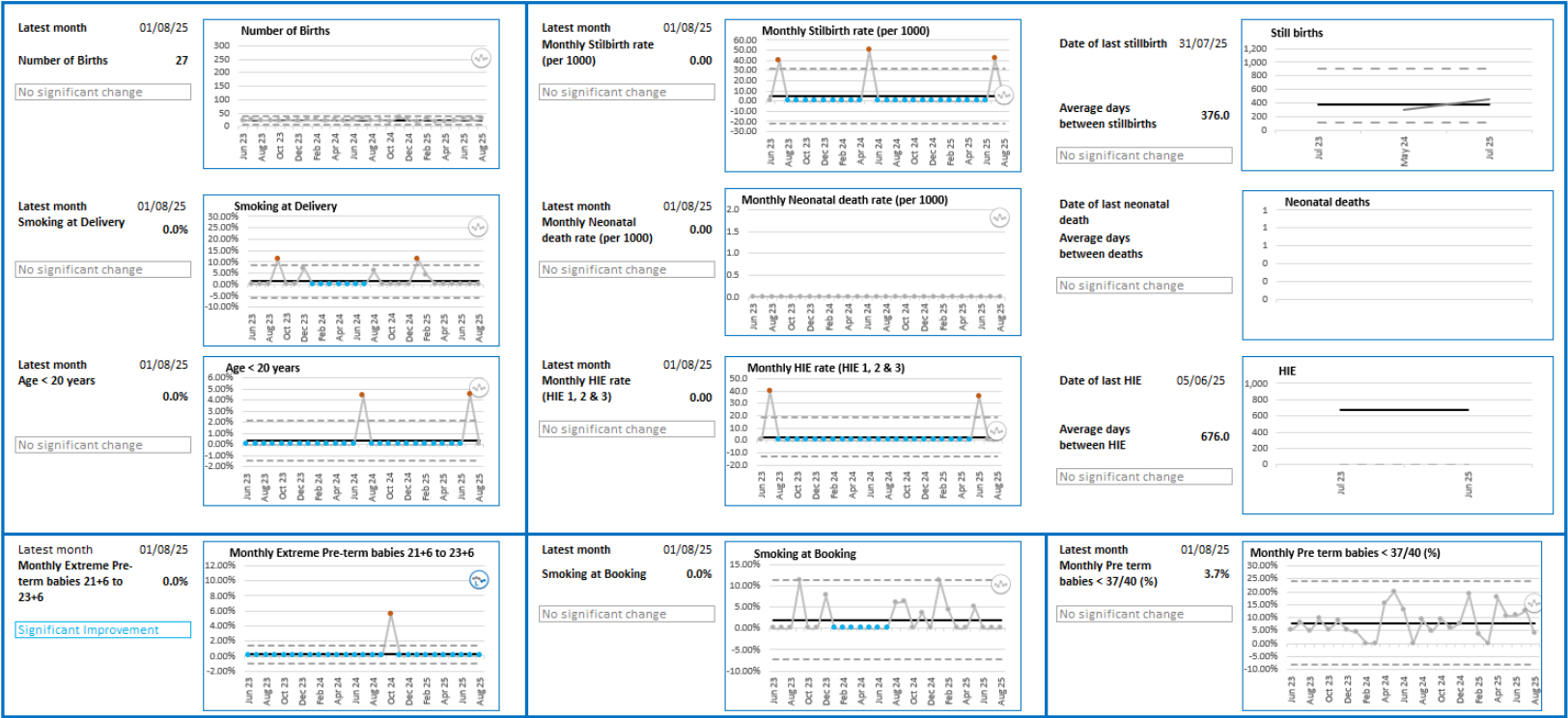
Chichester – 20% most deprived

Maternity overview **SRH 20% most deprived**



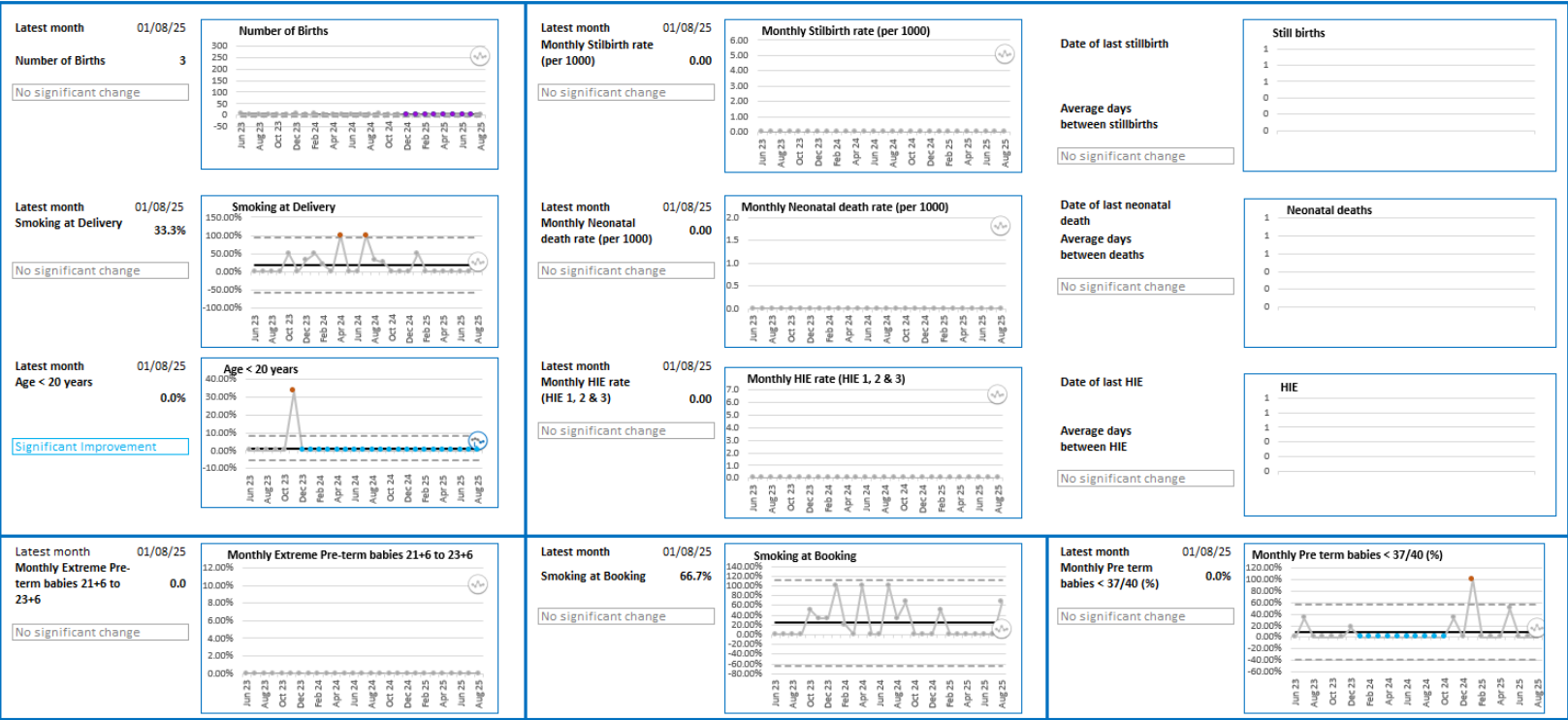
Worthing – Global Majority

Maternity overview WH BME

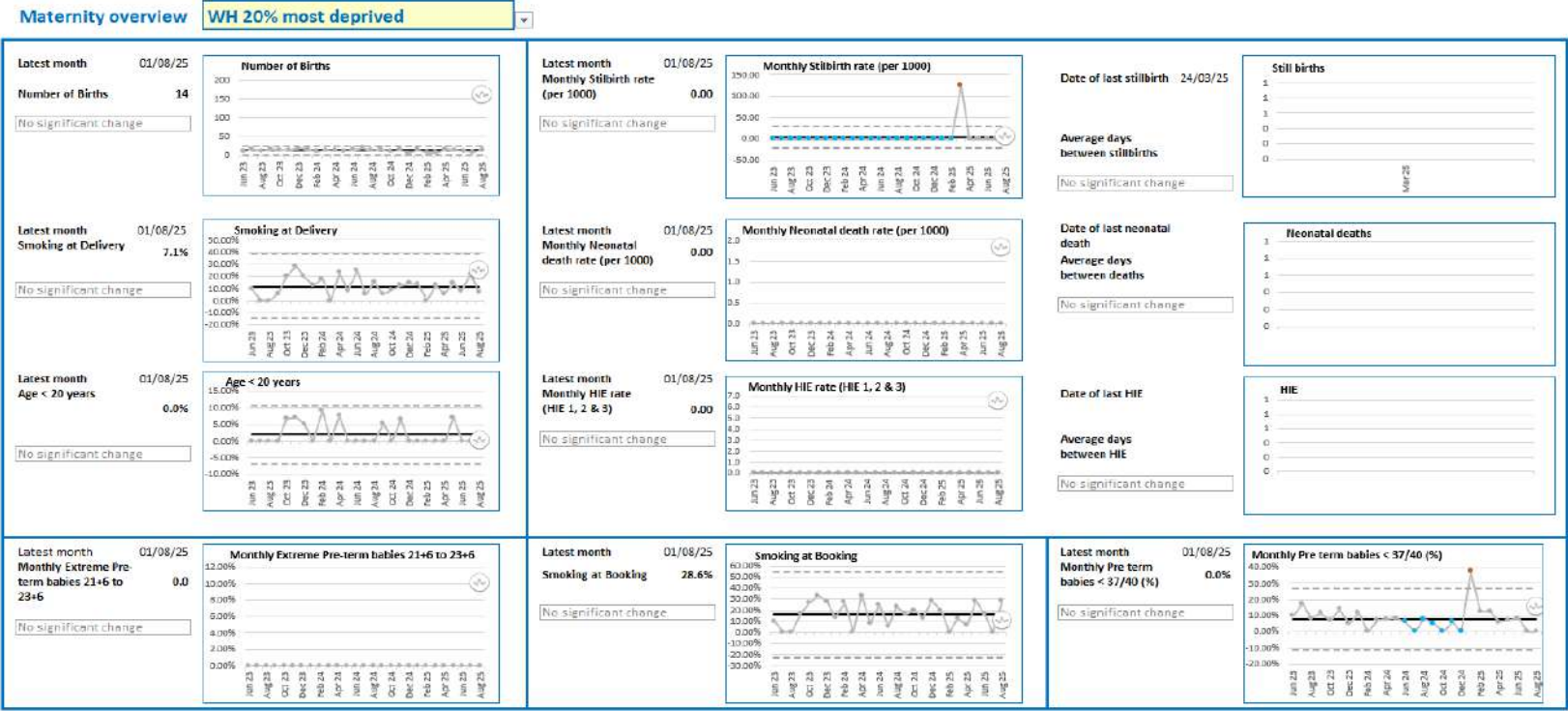


Worthing – 10% most deprived

Maternity overview **WH 10% most deprived**



Worthing – 20% most deprived





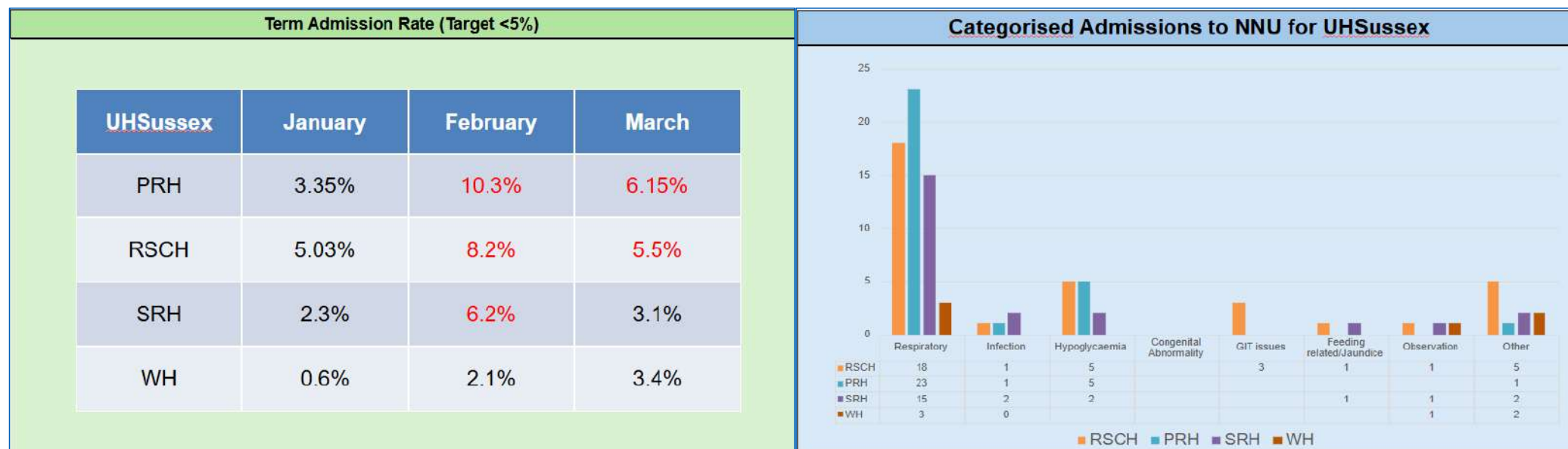
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ATAIN Q4 25/26 Executive Summary

QGSG/PQC
August 2025

Summary of findings

- ▶ Higher than expected rates of term admission in February (PRH/RSCH/SRH) and March (PRH/RSCH)
- ▶ The most prevalent issue initiating admission across all sites was Respiratory



Summary of findings

- ▶ For the total of Quarter 4, the benchmark of <5% of admission to the Special Care Baby Unit was met for the duration at WH (0.6%, 2.1% & 3.4%) and for SRH it did not meet the benchmark in February (2.3%, 6.2%, 3.4%). PRH and RSCH only met the benchmark in January for Quarter 4 (PRH 3.35%, 10.3%, 6.15%, RSCH 5.03%, 8.2%, 5.5%).
- ▶ There were 34 admissions to NNU from RSCH, 30 admissions from PRH, 22 admissions from SRH and 9 admissions from WH which is a total of **93** term admissions to the SCBU/NUU.
- ▶ The majority reason for admission this quarter across all four sites was again due to **respiratory support**.
- ▶ Overall, **91.4%** (85) of admissions across all four sites were considered **unavoidable** with appropriate management with **8.6%** (8) considered as **potentially avoidable**.

Recommendations/Actions

- ▶ There is an ATAIN/Transitional Care Steering Group as a part of CNST working groups
- ▶ The chair of the meeting has transitioned to the Neonatology leadership team (in place since May therefore not covering the Q4 period). The membership is currently in process of reviewing recent results across ATAIN and Transitional Care to agree an overarching action plan that will build in value to the current process for both audits.
- ▶ Next meeting of working group is 05/09/2025 and revised and managed action plan to be made available with the Q1 25/26 report in October 2025.



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Saving Babies Lives (SBL) Q4 Executive Summary

QGSG/PQC
August 2025

Element Summary Outcomes

97% implemented overall

1. Reducing smoking in pregnancy – 100% implemented
2. Risk assessment and surveillance for fetal growth – 95% implemented
3. Raising awareness of reduced fetal movements – 100% implemented
4. Effective fetal monitoring in labour – 100% implemented
5. Reducing preterm birth – 83% implemented
6. Management of pre-existing diabetes in pregnancy – 97% implemented

Identified barriers to 100% implementation

Element 2 – Risk assessment & surveillance of Fetal Growth Restriction

- ▶ Alignment of guidance for scanning eligible patients across CSS and W&C divisions
- ▶ Improve risk assessment completion to correctly identify and refer eligible patients

Element 6 – Management of pre-existing diabetes in pregnancy

- ▶ Joint trust guidance for the management of diabetic ketoacidosis is required
 - ▶ Currently being produced by Medicine East & West

Element 5 – Reducing pre-term birth

- ▶ Nominate leads for pre-term/perinatal optimisation across:
 - ▶ Midwifery – approval of post and recruitment required
 - ▶ Neonatal consultant
 - ▶ Neonatal nursing

Further discussion

- ▶ Due to a change in leadership and to ensure this piece of work is being produced by those people who can influence performance/quality improvements, in Q2 25/26 some Element leadership will change:
 - ▶ Element 2: Fetal Well-being Team and Antenatal/Community Matron will jointly lead considering the emphasis on initial booking and regular risk assessments
 - ▶ Element 5: Inpatient Matrons will lead considering the emphasis on optimising care for service users experiencing premature birth

UHSx Action Plan

Element	Element description	Intervention reference	Action	Lead	Timeline
2	Fetal growth restriction	2.7	Uterine Artery Doppler audit required from obstetrics lead at WH/SRH	Fetal Wellbeing Consultant Obstetrician Lead	All actions are progressing with identified leads to provide updates on timelines in Q1 25/26 (September 2025)
		Outcome indicator 2a	Risk assessment Quality	Community Leads / ANC leads / Digital leads	
		Digital BP	Further planning needed to embed digital BP recording	HoM/Transformation	
		2.14	Low Papp-A process variation across the two legacies	New 8a Screening lead	
3	Reduced fetal movements	3.2	MAU/ANC to document when an ultrasound is performed following RFM to support reporting	Transformation Lead MAU/Triage leads/ANC	
		3.2	cCTC documentation – needs greater awareness	MAU/Trage	
4	Fetal monitoring in labour	4.3	Agree content and create a visual aid to have attached to CTG machine to support holistic review documentation	FWB MW	
		4.3	Add column to hand overboard to say when CTG fresh eyes due to support timely review at PRH and RSCH	FWB MW	
		4.3	Message of the Week relating to epidural and FM during siting. Variance identified - WH and SRH will do a pre-epidural CTG RSCH and PRH do not	FWB MW	
5	Pre-term birth	5e 5f	Optimal cord management	Transformation Lead, I/P matrons, Neonatal cons	



LMNS Assurance Meeting Action Plan

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

UHSussex SBL Quarterly Assurance Meeting

Q1 25/26 Data
September 2025

Executive Summary

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6	Assessment 7	Assessment 8	Assessment 9
Review Quarter	Q2 23/24	Q3 23/24	Q3 23/24	Q4 23/24	Q4 23/24	Q1 24/25	Q2	Q3	Q4	Q1
Assurance Review Date	12/09/23	06/10/23	06/11/23	01/12/23	11/03/24	11/06/24	20/09/24	02/11/24	25/06/25	24/09/25
Element 1	10%	60%	70%	100%	100%	100%	100%	100%	100	100%
Element 2	65%	70%	70%	75%	95%	100%	100%	100%	95	95%
Element 3	0%	0%	0%	100%	100%	100%	100%	100%	100	100%
Element 4	20%	40%	80%	80%	100%	100%	100%	100%	100	100%
Element 5	0%	63%	81%	81%	96%	100%	100%	100%	100	96%
Element 6	0%	83%	100%	100%	100%	100%	100%	100%	83	83%
TOTAL	21%	63%	76%	86%	97%	100%	100%	100%	97	96%

For a comprehensive review of progress within each element of SBLv3.2, please refer to each individual quarterly report:

- ▶ [SBL element 1 report - Q1.pptx](#)
- ▶ [SBL element 2 report - Q1.pptx](#)
- ▶ [SBL element 3 report - Q1.pptx](#)
- ▶ [SBL element 4 report - Q1.pptx](#)
- ▶ [SBL element 5 report Q1 25 26.pptx](#)
- ▶ [SBL element 6 report Q1 2526.pptx](#)

Celebrations and escalations

Celebrations

- ▶ Although some falling performance is noted in individual elements, most metrics remain at Ambition or even above Stretch with slow progress being made against remaining areas of needed development to get the trust up to 100% compliance from its current position
- ▶ Monthly meetings are more effective and maintain quoracy
- ▶ Appropriate clinicians now leading on the Element workstreams
- ▶ Vision of improvements is more unified
- ▶ Process improvements have led to deeper interrogation of data and leading peripheral improvement in clinical practice
- ▶ Standardised audit practice is now being observed.

Escalations

- ▶ Compliance has fallen in self-assessment of Q1 data compared to previous LMNS approved compliance (97% to 96%). Await LMNS review of data for determination on true compliance - review scheduled 24/09/2025.
- ▶ Element 2 – removal of auditing all SGA babies. Current auditing of all 3rd centile babies exceeds SBL expectations and provides all the information needed to improve processes.
- ▶ Recruitment for Pre-Term Birth Midwife awaits finance approval

Individual Element Data and Summary of Q1

Element 1 – Reducing Smoking in Pregnancy Outcomes

Indicators	% Ambition	% Stretch Ambition	Q1 25/26 %	Q4 24/25 %	Progress
1ai. Carbon Monoxide (CO) level at booking	90	95	93.3	94.5	-1.2
1aii. CO level at 36 weeks (36/40)	80	95	86.1	87.9	-1.8
1aiii. % with smoking status recorded at booking	80	95	99.8	100	-0.2
1aiv. % with smoking status recorded at 36/40	80	95	62.5	61.5	1.0
1b. % who have opt-out recorded at booking	90	95	94.3	96.5	-2.2
1c. % referred for tobacco dep treatment who set a quit date	50	60	56.4	55.4	1
1d. % smokers at booking who are CO verified non-smokers at 36/40	25	N/A	MIS 31 TDT 38	28.7	9.3
1e. % referred who set quit date and have non-smoking CO verified quite at 4 weeks	50	60	MIS 38 TDT 55	29.4	25.6
1.2. % where CO is recorded at all antenatal appts.	Maintain	N/A	72.8	70.8	2
1.3. % where smoking status is recorded at all antenatal appts.	Maintain	N/A	86.4	81.8	4.6

Element 1 Quality Improvement

Work underway

- ▶ Improving CO monitoring and reading in ANC, MAU and LW
- ▶ Improving the monitoring of missing 36-week smoking status
- ▶ Updating NRT guideline
- ▶ NICE guideline gap analysis
- ▶ Data to now be sourced from TDT as better accuracy compared to MIS – data point comparison represented on previous slide

What next

- ▶ Explore whether CO monitors would improve overall monitoring and potential funding streams

Element 2 – Fetal Growth Outcomes

Outcome Indicator	% Ambition	% Stretch Ambition	PRH Q1	RSCH Q1	WH Q1	SRH Q1	UHSx Q1 25/26	UHSx Q4 24/25	Progress
Additional Measure: % booked who had risk assessment for aspirin	80	90	98.7	97.5	99.4	99	98.6	99.10	-0.2
Additional Measure: % Vit D recommended at booking	80	90	52	47	41.4	37.8	44.9	44	1.2
2a. % where a risk assessment is completed by 14/40	80	90	100	99.8	100	100	100	99.9	0.1
2b. % where SGA fetus is detected antenatally	N/A	N/A	3	7	5.7	5.6	5.4	5.3	0.1
2d. % born under 3rd centile >37+6	Maintain	N/A	85.7	50	50	66.7	71	57.10	13.9
2e. % born above 3rd centile <39+0 and IOL/LSCS for suspected SGA	0	0	0	0.2	0.2	0	0	0.14	Static

Element 2 Quality Improvement

Work underway

- ▶ Working with consultants to align Low PAPP-A pathways
- ▶ Exploring WHO vs Intergrowth risk assessments to avoid duplication
- ▶ Obstetric lead sonographer now in RSCH/PRH and interim cover WH/SRH.
 - Undertaking gap analysis between obstetric and sonography guidelines to develop merged version
- ▶ Improving community training on FGR risk assessments
- ▶ Mapping FGR risk pathways

What next

- ▶ Aligning DATIX triggers for undetected FGR
- ▶ Deep dive into themes from exception reporting to be reported to Q&S

Element 3 – Reduced fetal movement (RFM) Outcomes

Indicator	%Ambition	% Stretch Ambition	RSCH	PRH	WH	SRH	UHSx Q1 25/26	UHSx Q4 24/25	Progress
3a. % who attend with RFM and have a cCTG	Maintain	N/A	89	97	97.4	97.5	95.12	93.3	1.82
3b. % who attend with recurrent RFM who had an USS the next working day	N/A	N/A	33	27	86.6	66.6	53.3	9	44.3
3c. % of still births and neonatal deaths with RFM as contributory factor	Data available in October								
3d. % induction when RFM is the only indication before 39/40	<5	N/A	3.5	2.1	1.8	0	2.02	1.65	-0.37

Element 3 Quality Improvement

Work underway

- ▶ Improving audit for Q2 to identify the true eligible population, to understand % of people who didn't get scan (recurrent RFM)

What next

- ▶ Explore USS referral failsafes with MAU and community leads
- ▶ Explore options to work towards 7-day scanning service to meet needs of service users and requirements of SBL.

Element 4 – Fetal monitoring during labour Outcomes

Indicator	% Ambition	% Stretch Ambition	RSCH	PRH	WH	SRH	UHX Q1 25/26	UHSx Q4 24/25	Progress
4a. % staff trained on CTG interpretation, intermittent auscultation, human factors, and situational awareness	80	90	93	96	93.03	99.2	95.45	86.5	9.95
4b. % staff successfully completed mand. Annual competency assessment	80	90	73	78	96.25	99.3	87.17	89.6	-2.43
4.2 % have structured risk assessment at the start of labour	N/A	N/A	100	100	86.25	86.25	93	45.5	47.5
4.3/4.4 % fresh eyes review hourly for CTG or 4 hourly for IA	N/A	N/A	1.9	6.4	28	18.3	13.5	12.6	0.9

Element 4 Quality Improvement

Work underway

- ▶ FM guideline out for comment with JOGGG
- ▶ Data quality issues on Badgernet leading to 4.2 needing to be audited manually therefore now Badgernet champions and documentation support from FWB midwives

What next

- ▶ Develop visual aids for 'fresh eyes' reviews

Element 5 – Reducing preterm birth and optimising perinatal care Outcomes

Indicator	% Ambition	% Stretch Ambition	Q1 26/26	Q4 24/25	Progress
5a. % singletons <27/40 or <28/40 if multiples with an EFW of under 800g born with NICU	70	85	100	85.7	14.3
5b. % born <34/40 receiving full dose of antenatal corticosteroids within 1 week before birth	40	55	69.2	55.3	14.0
5c. % born <30/40 who receive magnesium sulphate within 24 hours prior to birth	80	90	70	84.6	-14.6
5d. % born <34/40 who have their umbilical cord clamped at or after one minute of birth	50	N/A	89	92	-2.8
5e. % born <34/40 who have a first temp which is both between 36.5-37.5C and measured within one hour of birth	65	N/A	100	68	32.0
5f. % born <34/40 who receive their own mother's milk in the first 2 days of life	Maintain	N/A	84	42	41.8
5ji. % singleton born 16/40-23+6/40	Maintain	N/A	0.73	0.05	0.68
5jii. % singleton born 24/40-36+6/40	Maintain	N/A	5.67	5.97	-0.30

Element 5 Quality Improvement

Work underway

- ▶ 'Meet the neighbours' events
- ▶ Exploring options for trans vaginal scanning
- ▶ Updating pre-term birth guidelines
- ▶ JD out for approval for preterm birth lead midwife – expected decision in Sept

What next

- ▶ QI plan development on appointment of preterm birth lead midwife

Element 6 – Managing diabetes in pregnancy Outcomes

Indicator	% Ambition	% Stretch Ambition	RSCH & PRH	WH	SRH	UHSx Q1 25/26	UHSx Q4 24/25	Progress
6g. T1 & T2 diabetic women/people with HbA1c measure at start of 3rd trimester	80	95	80	85.7	85.7	84.2	87.5	-3.2

Element 6 Quality Improvement

Work underway

- ▶ Review of diabetes clinic service provision complete via specialist demand and capacity review – meeting planned for discussion and planning
- ▶ Cross site guideline developed and awaiting review at JOGGG
- ▶ DKA guideline out for ratification

What next

- ▶ Continuing to develop diabetes service provision



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Perinatal Workforce Report October 2025



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Background

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

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

The Maternity Incentive Scheme Year 6 declaration evidenced workforce planning to the required standard. A Birth Rate Plus (BR+) assessment is currently underway, expected to report in January 2026, assessing the midwifery and maternity support worker workforce. Current staffing models for maternity reflect the previous BR+ recommendations from 2023 which The Trust Board accepted and the service is funded to the recommended establishment.



Maternity

Since September 2024, UHSx maternity has had two WTE 8a Recruitment & Retention Matrons in post, with initial 12 month contracts extended to March 2026 to also support Neonatal Services.

Vacancy data for midwives, nurses and support workers is now well understood, with short and long-term workforce strategies in place. Cross-site recruitment events are now well established and close to being fully embedded, an initiative shortlisted for the Nursing Times Workforce Awards. Workforce establishment tools for both maternity and neonatal teams now provide real-time data, reducing vacancy length and enabling proactive planning.

All student midwives at UHSx have been offered substantive hours at their first-choice site for the second year running. This will over-recruit against establishments but remains within hours previously covered by bank and agency. This initiative has also been shortlisted for the Nursing Times Workforce Awards. Agency use is expected to cease by November 2025, with significant bank reductions.

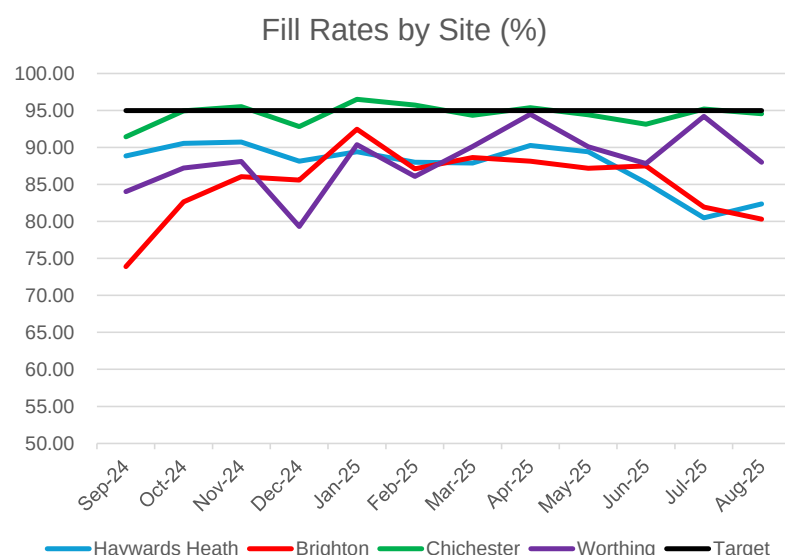
Given national and local improvements in maternity staffing, UHSx is no longer pursuing international recruitment. T Level students are now in their second maternity placements, strengthening future pipelines.

A new Birthrate Plus review, using prospective methodology, began in August 2025 and will conclude in January 2026, ensuring accurate, site-specific workforce templates.



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Current position - Midwifery

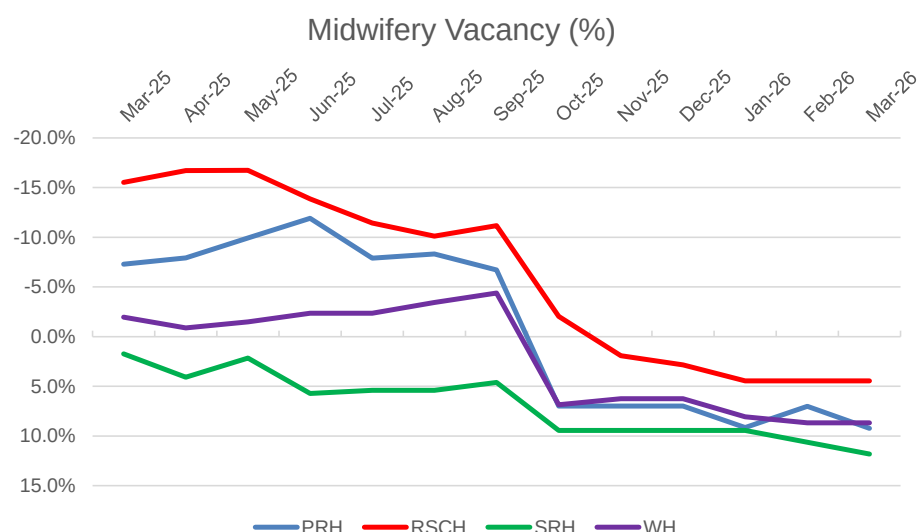


- **Staffing Overview:**
- **Haywards Heath (PRH):** Staffing was challenging over summer due to short-term sickness, compounded by a small NQM intake in October 2024 progressing to B6 roles in summer, leaving B5 posts vacant until October 2025.
- **Brighton (RSCH):** Significant improvement since summer 2024 with a mix of internal and external NQM recruits, and ongoing external recruitment for B6 roles. Agency use has decreased and is expected to end by November 2025. Redeployment of specialist staff over the summer saved approximately £16,000 by covering 418 clinical hours that would otherwise have required Agency staff.
- **Chichester (SRH):** Staffing remains stable.
- **Worthing (WH):** Improvements continue, though short-term sickness affects stability.
- A noticeable staffing improvement is expected across all sites in November 2025 when preceptees move to B6 roles and the new cohort of NQM completes their orientations.
- Midwifery shift leaders are familiar with the maternity escalation policy, and short-term support from redeployed staff is often available but not reflected in fill rate data. Plans are in place for specialist midwives to regularly contribute some of their hours to clinical work, reducing bank use and enhancing clinical expertise and acumen.
- **One-to-one care** during established labour is consistently provided, though occasionally midwives are redeployed from other services, like the postnatal ward or home birth service, to achieve this.



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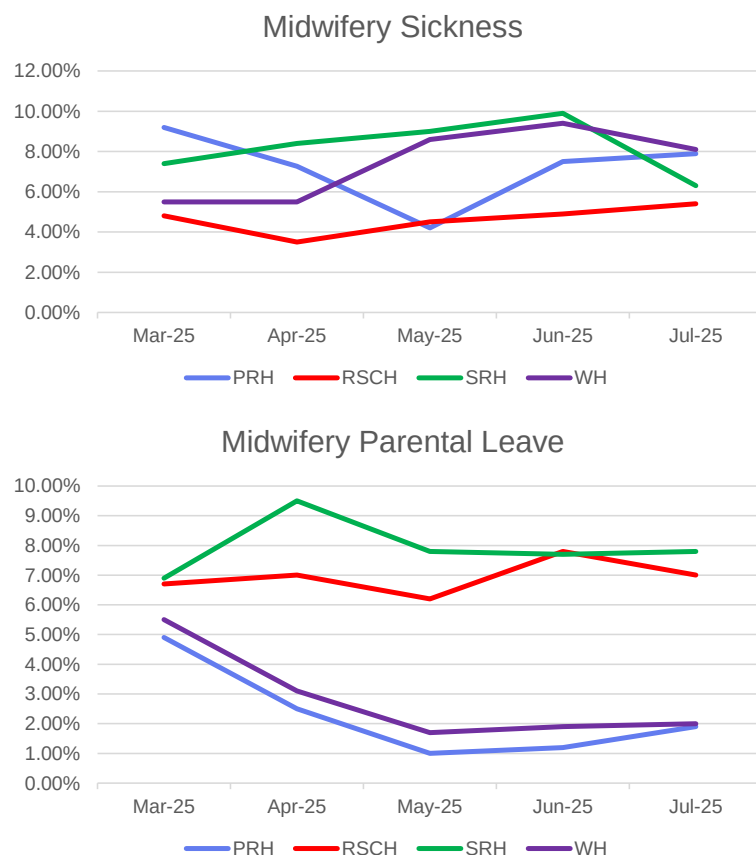
Midwifery Vacancy



- **Midwifery Vacancy:**
- All sites will be over recruited to midwives from October 2025 based on current templates PRH (7%), RSCH (1.9%), SRH (9.4%), WH (6.9%). This is due to a Trust wide initiative for Nursing & Midwifery to automatically on-board students who have trained in our units. This work has been shortlisted for the Nursing Times Workforce Awards 2025.
- The over recruitment does not exceed monthly bank and agency spend. Agency is anticipated to cease completely in Nov 2025 with a significant reduction in Bank use.
- Turnover is generally low and all staff who leave are offered an exit interview with R&R Matrons. Movement within the directorate is more common as staff move cost codes e.g. hospital to community.
- Work is underway to ensure appropriate future forecasting of anticipated retirement to ensure recruitment campaigns anticipate future fluctuations.
- PRH: Several staff moved from hospital to community-based roles May/June, increasing vacancy >10% briefly.
- RSCH: Vacancy has continued to improve steadily following external campaigns. Vacancy at RSCH remains the most fragile, however, a wait list of staff, who have successfully interviewed is now in place as mitigation.
- SRH: Whilst over recruited by 9%, maternity leave is high (next slide) therefore fill rates remain stable.
- WH: Stable

Perinatal workforce report October 2025

Midwifery sickness and parental leave



Sickness

- PRH – whilst an improvement was seen in Q1, sickness at PRH has increased over the summer, significantly affecting fill rates.
- RSCH - has improved significantly from a peak of 11% in Nov 24 supported by maternity leaders who line manage staff completing the Trust Management Skills Training: Health, Wellbeing and Absence to ensure Management of sickness is robust and in line with policy, supported by the HR team.
- SRH – an improved trend at the start of Q2.
- WH - remains high, significantly effecting fill rates.
- Various support and wellbeing offers are in place across the Division, including Listening Events, regular updates via newsletters and video messages, and increased visibility of leaders.

Parental Leave:

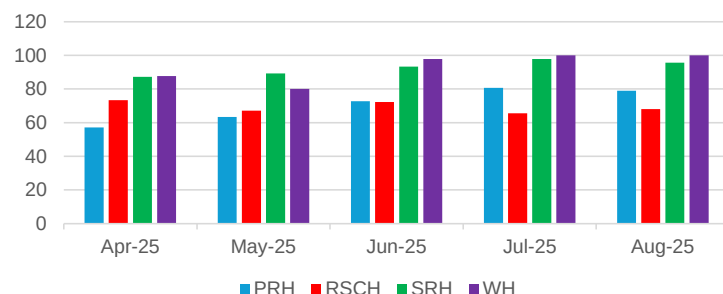
- Parental leave remains high at RSCH & SRH but has significantly reduced at PRH and WH. This will be mitigated in the over recruitment from October 2025.
- Parental leave represents a unique challenge in a service with an almost exclusively female workforce. The removal of the bursary for student midwives has resulted in a younger newly qualified midwifery workforce and higher maternity leave rates as a result.

Acuity - Maternity

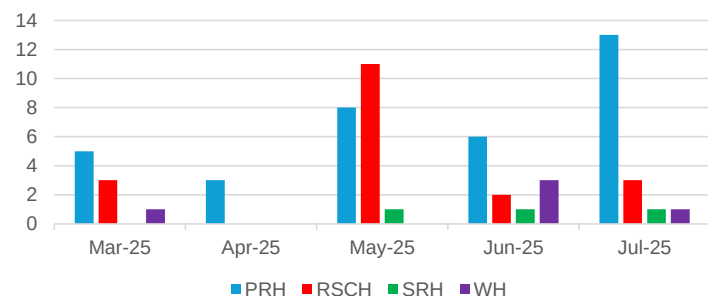


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BR+ Acuity Tool Compliance (%) Target = 85%



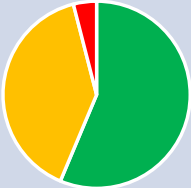
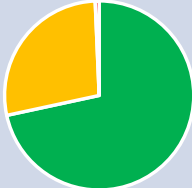
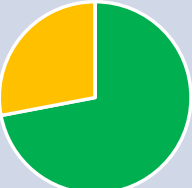
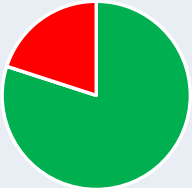
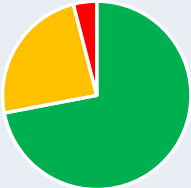
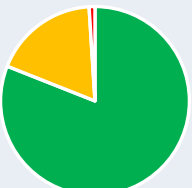
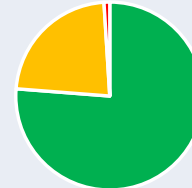
Capacity/Escalation - Internal Divert Events



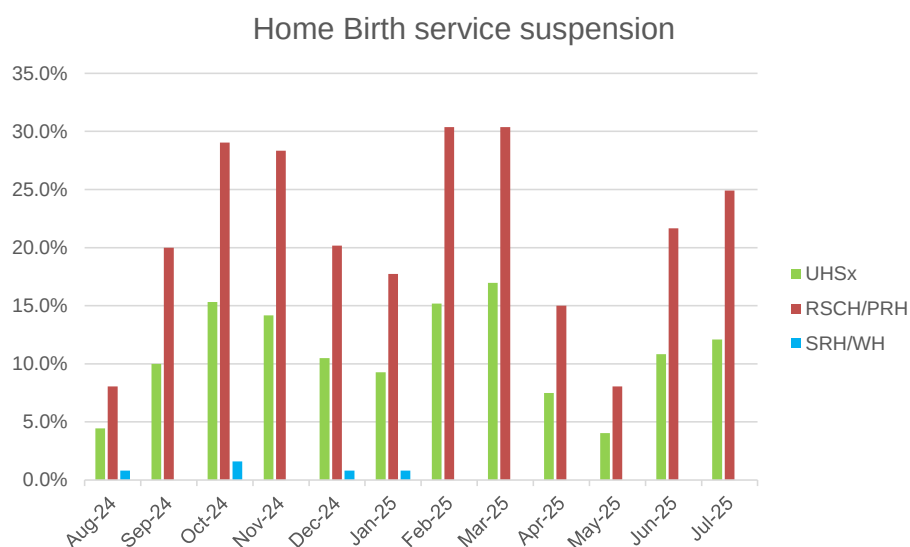
- The **BR+ Acuity tool** tracks compliance with supernumerary status for labour ward coordinators (LWC), one-to-one care during labour, and addresses staffing shortfalls.
- The target for tool completion is 85%, achieved at SRH & WH but not at PRH & RSCH. Mitigations are in place to address this gap.
- Labour ward coordinators must be supernumerary and not provide 1:1 care during labour. 'Red Flag' incidents related to coordinator status are captured in acuity reports and are shared in divisional and Maternity Safety Champion meetings. The service meets CNST Maternity Incentive Scheme requirements for year 6 and is on track for year 7.
- While there is no national midwife-to-birth ratio benchmark, UHSx's staffing is based on a 2023 BR+ assessment. The current ratio is 1:22, a decline from 1:21 in April 2024. The new report is anticipated early 2026.
- Acuity is measured every 4 hours the BR+ tool, considering case complexity and staffing. Activity in maternity can vary, with peaks and troughs; the escalation policy ensures service support when staffing does not meet acuity needs.
- In addition, twice daily Safety Huddles led by the Matrons review staffing versus acuity. This information is shared daily across sites with senior leadership. On some occasions women/birthing people need to be diverted to an alternative site within the Trust at times of escalation.

Quarterly acuity (midwife : activity)


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	Brighton	Haywards Heath	Worthing	Chichester
Q1 2025 *This data does not include midwives redeployed from other areas for periods of time to mitigate.	Q1 RSCH BR + Acuity RAG Status (%)  Meets acuity Up to 2 MW's short 2 or more MW's short	Q1 PRH BR+ Acuity RAG Status (%)  Meets acuity Up to 2 MW's short 2 or more MW's short	Q1 WH BR+ Acuity RAG Status (%)  Meets acuity Up to 2 MW's short 2 or more MW's short	Q1 SRH BR+ Acuity RAG Status (%)  Meets acuity Up to 2 MW's short 2 or more MW's short
July 25 *This data does not include midwives redeployed from other areas for periods of time to mitigate.	July 25 PRH BR + Acuity RAG Status (%)  Meets acuity Up to 2 MW's short 2 or more MW's short	July 25 RSCH BR+ Acuity RAG Status (%)  Meets acuity Up to 2 MW's short 2 or more MW's short	July 25 WH BR+ Acuity RAG Status (%)  Meets acuity Up to 2 MW's short 2 or more MW's short	July 25 SRH BR+ Acuity RAG Status (%)  Meets acuity Up to 2 MW's short 2 or more MW's short

Home Birth Service

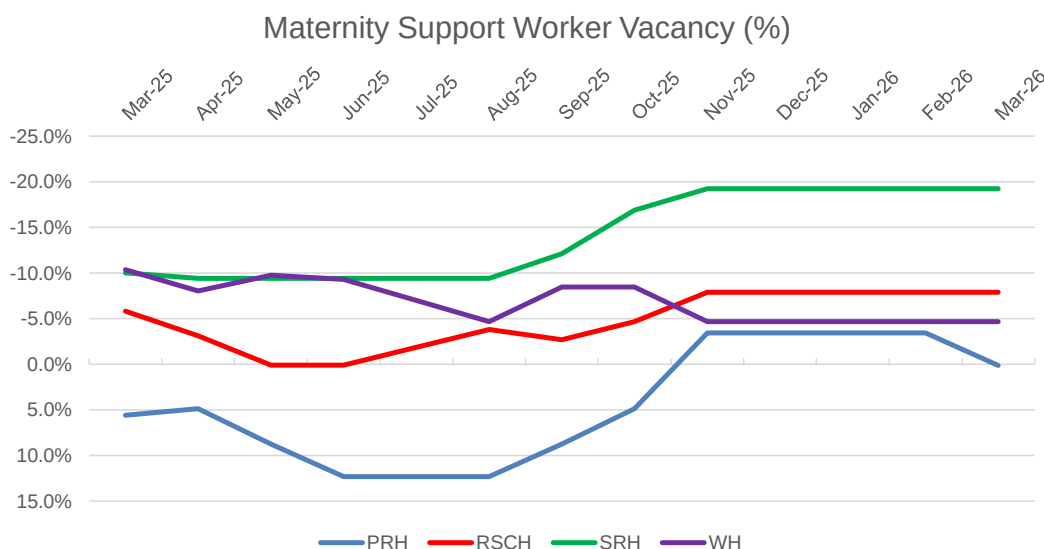


- Homebirth service suspensions remain low at SRH/WH.
- At PRH and RSCH, the homebirth model changed in May 2024, initially reducing suspensions, but rates rose again over the past year, peaking at 30% in Feb–Mar 2025.
- Unprecedented staffing pressures from vacancies, sickness, and parental leave were partly mitigated by redeploying continuity midwives over the summer, but suspensions remained high, drawing negative national media attention.
- Fifteen shifts (24%) were suspended, affecting 2 of 13 women (8%)—an improvement on 25% in June.
- Burnout contributes to vacancies and sickness, and strained relationships with leadership are being addressed through a Restorative Culture programme.
- A new hybrid model is proposed, with a core team (10 WTE) supported by the wider community for out-of-hours cover. Used successfully in other Trusts, it is expected to reduce suspensions and improve staff wellbeing. Formal consultation begins October 2025, with implementation in early 2026.
- Recruitment has improved, with 1 WTE starting in October and 2 WTE in December 2025.

Maternity Support Workers and Nursery Nurses



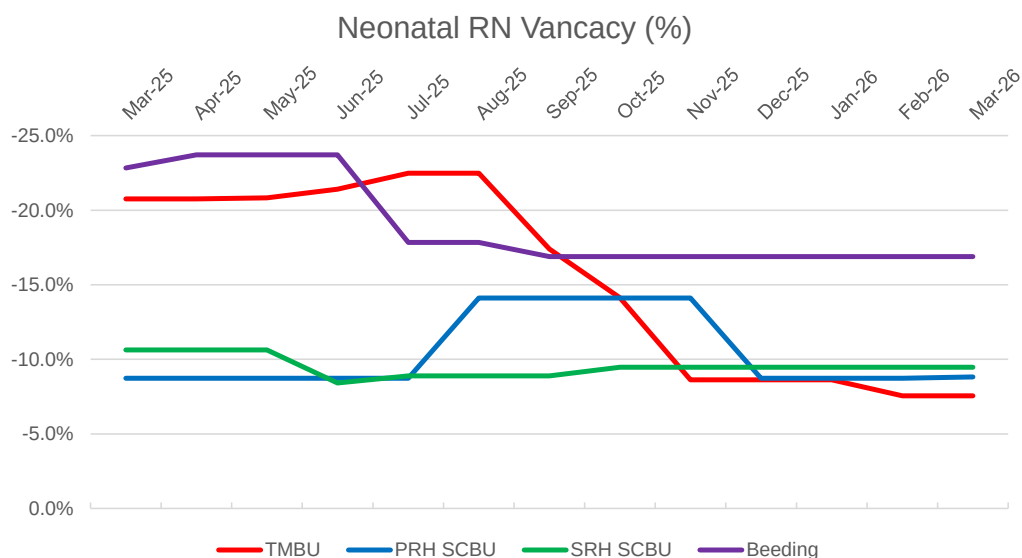
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- MSWs and NNs are vital to maternity care, supporting both service users and the midwifery team. Retention is challenging due to competing roles with similar pay but fewer responsibilities and unsocial hours, with turnover higher than midwifery. Many staff leave to start midwifery training, reflecting the role as a pathway into the profession.
- R&R Matrons run regular cross-site recruitment events, anticipating attrition (e.g. September university intakes). Suitable candidates not immediately placed are held on a 3-month waiting list. Recent campaigns have attracted international recruits, increasing team diversity, but since April 2025 Band 3 roles are no longer eligible for sponsorship.
- The Band 3 MSW job description is under review to align with HCA roles in nursing, alongside development of a Band 2 pathway to broaden domestic recruitment. This has caused a delay in recruiting in the early Autumn, but these posts are expected to be filled imminently.
- SRH: A significant number of MSWs left this September to pursue further education. Recruitment event planned Nov 25.
- PRH: A reduction in MSW & NN budget resulted in an over recruited position which as now resolved.
- Midwifery apprenticeships remain a priority, though progress depends on government funding for backfill.



Neonatal nursing – current position



- Active recruitment efforts are ongoing across four sites. Some staff have increased their hours, leading to a reduction to 19% overall for August which is an improvement from the 21% in July.
- Band 6 QIS coverage at TMBU remains static at 42% with ~7–8 WTEs beginning the QIS course in September, this is projected to increase to 51%.
- The overall staffing trajectory plan remains on track the overall neonatal staffing vacancy is expected to reduce to significantly by January 2026.
- **Actual verses Planned**
- **SRH**
- There are 5WTE Non-RN staff in SRH. During August there was pregnancy related sickness and annual leave. These shifts were not covered by Bank as managed with substantive cover.
- **PRH**
- A range of sickness, leave, and one staff member on apprenticeship training. These shifts were not covered by Bank as managed with substantive cover.



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Neonatal – Planned Vs Actual

NICU Planned Vs Actual	Surgical Babies	Extreme Prem 22Wks-29wks	Refused Staffing	Refused - Maternity refusal	Refused - TMBU Full	Refused from Worthing	Out of Network	Refused Un known	Refused Other	Total number of babies refused
Refusals IN Utero (IUT)	0	8	0	0	11	2	2	0	0	11
Refusals Ex Utero (EUT)	4	0	2	0	11	2	2	0	1	14

May: 30 referrals 18 refused

June: 35 referrals (15 IUT/20 EUT) & 27 refused

July: 32 referrals (15 IUT/17EUT, 5 being surgical)

Refusals were due to the unit being full with intensive care (ITU) and high dependency care (HDU) babies due to high demand, there was not an issue with transferring lower dependency babies out of the unit. Cot demand is reviewed by the neonatal network annually.

Only two of the refusals were due to neonatal staffing.

Referrals Accepted July

IUT 27% compared to 25% in June

EUT (all) 18% compared to 70% in June

EUT (surgical) 0% compared to 75% in June

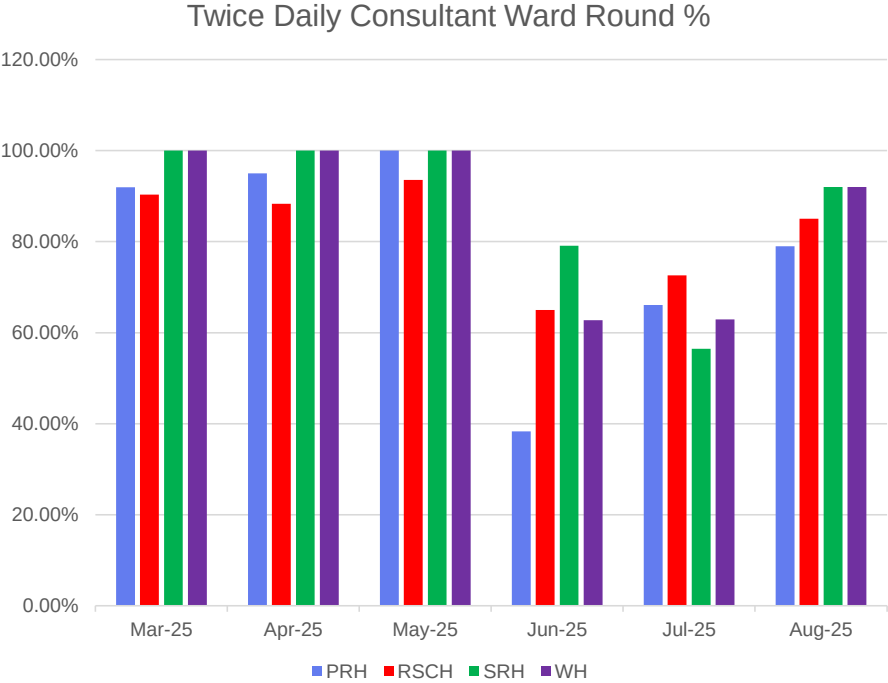
The occupancy and acuity at TMBU in July was higher than usual. 89 % monthly cot occupancy which is higher than June at 80%. When broken down further this was 83% occupancy in ITU, 100% occupancy in HDU and 85% occupancy in SCBU.

Perinatal workforce - Medical



- **Obstetric:** Three substantive consultant posts were appointed in mid-September for the PRH and RSCH sites. These are currently fixed term appointments.
- **Neonatology narrative:** Recent work has aligned demand to required staff to undertake the workload. We are actively recruiting to identified vacancies and are nearly at full establishment.

Twice Daily Consultant Obstetric Ward Round Compliance



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



Service User Voice



*Challenges remain in capturing FFT feedback – cot cards with a QR code are successful at SRH & WH with plans to roll out at PRH & RSCH

Top 3 Positive Themes

Exceptional Staff Attitude and Support

- Repeated praise for midwives, nurses, and doctors being *kind, caring, supportive, and professional*.
- Many comments mention staff going “above and beyond,” being “reassuring,” and making patients feel “safe” and “heard.”

Positive Birth Experiences (Including Home and Water Births)

- Home birth and water birth services were described as *calm, empowering, and beautiful*.
- Service users appreciated being supported in their birth choices and feeling in control.

Continuity and Quality of Care

- Many service users felt well cared for throughout antenatal, birth, and postnatal stages.
- Specific mentions of feeling “listened to,” “informed,” and “looked after” by consistent staff members.

Top 3 Negative Themes

Staffing Shortages and Delays

- Several comments noted *long waits for pain relief, delayed discharge, and lack of attention* due to understaffing.
- Some service users felt like a burden or were left without adequate support during critical moments.

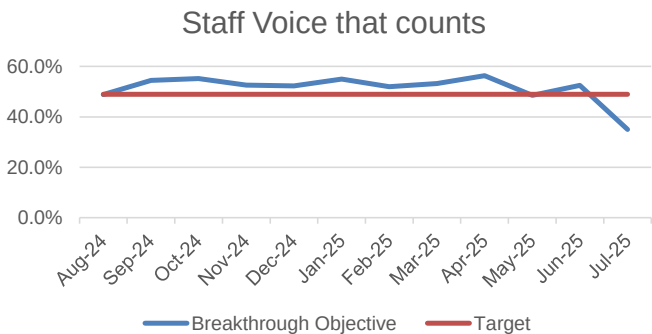
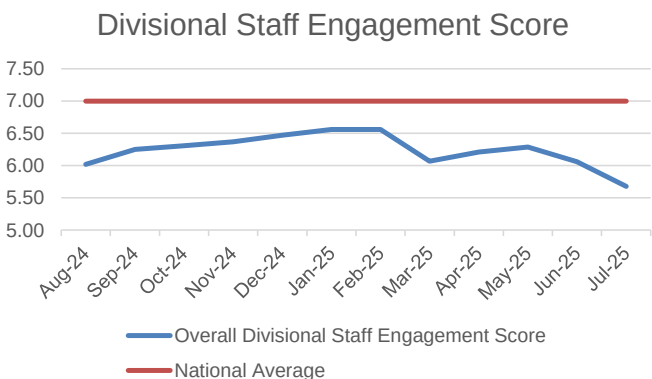
Inconsistent or Poor Communication

- Reports of *conflicting advice, missed appointments, and lack of follow-up* (e.g., no midwife visit post-discharge).
- Some service users felt *confused or uninformed* due to poor communication between departments or staff.

Lack of Continuity and Administrative Issues

- Frustration with *seeing multiple midwives, duplicate appointments, and disjointed care* between locations (e.g., Worthing vs. Brighton).
- A few service users mentioned *errors in booking* (e.g., missed C-section scheduling) and *impersonal care*.

Divisional staff engagement scores



Position

- The **Division** has seen a reduction in Staff Engagement and Staff Voice that Counts scores in July.
- The number of participants remains low (20) however, the findings are concerning.
- Divisional and Directorate staff survey posters capturing actions taken in response to 2024 results.
- Action plans have been created for each Directorate area and progress is monitored monthly.

Actions

- Leadership Programme being delivered by the Organisational Development Team will take place during November and December.
- The Division plans to circulate a questionnaire to all staff understand the increase in staff having reported they have experience discrimination – currently in draft
- Listening events being held across Directorates





Analysis

- Fill rates for maternity and neonatal services currently remain below recommended templates due to vacancy, sickness and parental leave.
- Recent recruitment campaigns in maternity including the second year of automatic on-boarding of student midwives (shortlisted Nursing Times Workforce Award) will result in an over recruited position at all sites. This position should significantly alleviate chronic short staffing experienced over several years, whilst not exceeding previous bank and agency spend.
- Neonatal services also anticipate a significantly improved staffing position, and a clear plan is in place to ensure a pipeline for QiS training.
- A Trust-wide decision regarding nursing and midwifery recruitment of students in practice placement is required to plan for the next cohort of newly qualified midwives.
- The Midwifery Preceptorship Programme is robust and now well established. 98% of those who started in 2024 remain in post. UHSx has recently received the National Quality Mark for Preceptorship, a key component of being recognised as 'an employer of choice'.
- Whilst the balance of comments received from FFT are overwhelmingly positive, negative feedback frequently cites issues related to short staffing e.g. *long waits for pain relief, delayed discharge, and lack of attention* due to understaffing.
- Whilst turnover in perinatal services is low, in part owing to staff being settled in their local communities, engagement remains a challenge. Improved staffing should significantly improve this. Directorate wide strategies to support engagement also include:
 - Professional Midwifery Advocate (PMA) Lead in post aligning and reinvigorating service across sites including restorative clinical supervision, supporting quality improvement and career conversations.
 - Restorative Culture Programme completed by the Senior Leadership Team with plans to cascade to teams.
 - Listening events bi-monthly plus bespoke events for teams under pressure.
 - Site by Site 'Retention Weeks' lead my R&R Matrons
 - Increased visibility of the clinical and Divisional leadership team, completing clinical shifts.
 - Joint obstetric consultant meetings to share learning and support.
 - Non-executive Maternity Safety Champion visits to clinical areas within maternity and neonates to listen to staff and offer support.
 - Recruitment and Retention Matrons remain in post until March 26
 - Significant communications offer to keep teams updated
 - Improve Well App – shortlisted for Nursing Times Workforce Award

Conclusion

- Perinatal workforce requirements are complex and can change rapidly. National recommendations have placed further pressure on services, by mandating various roles and requirements that are unfunded (specialist midwifery roles, increased scanning requirements etc.)
- The approved Clinical Operating Model is now almost fully recruited to, meaning an improved and more visible, permanent leadership structure for perinatal services.
- Improvements have been seen in the overall staffing position in all Perinatal services. The focused work of the Recruitment and Retention matrons has expedited this progress.
- There remain teams with low morale as demonstrated by the Staff Survey and staff feedback, targeted work will be completed to understand the issues within these teams.
- Due to the improvements being made at every level as a result of the Maternity Improvement Plan and our commitment to the delivery of national drivers known to impact on patient safety, such as the Saving Babies Lives Care Bundle and the CNST Maternity Incentive Scheme, safety continues to improve as evidenced by our outcome data.
- Positive service user experience Friends and Family feedback data continues to trend above national rates.
- Finally, this paper highlights additional scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been triangulated to provide further assurance. Perinatal services should experience significant improvement to staffing and fill rates in the next quarter. With a clear and robust escalation policy in place and twice daily oversight of the maternity and neonatal units, acuity verses staffing being monitored, early interventions can be taken to maintain safety and activate deployment of staff to ensure care needs are maintained and safety remains the priority for the service.





University Hospitals Sussex NHS Foundation Trust Maternity vision & roadmap

2025-2030

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Introduction – about our service

University Hospitals Sussex NHS Foundation Trust provides care to the population of a wide geographical area.

We have obstetric led maternity units at St. Richard's hospital, Chichester, Worthing Hospital, Princess Royal hospital, Haywards Heath and the Royal Sussex County hospital, Brighton.

We have a midwife led-alongside birthing unit at Chichester. A home birth service is also provided by all our community teams across the four sites.

The Worthing and Chichester Special Care Baby Units have paediatric consultants on call out of hours. Haywards Heath unit has a Special Care Baby Unit with a neonatal consultant on call out of hours. The Brighton service provides care to women and people whose baby may require care at the tertiary level 3 neonatal intensive care unit, accepting babies from other sites within the Trust and from other Trusts if required. Brighton also provides a neonatal surgical service serving Kent, Surrey and Sussex.

Several different specialties totalling around 1,000 colleagues contribute to providing maternity care, including midwives, obstetricians, neonatologists, maternity support workers, neonatal and general nurses, nursery nurses, anaesthetists, administrators, and housekeeping teams.

Approximately 9,000 babies are born within the service each year, making this one of the largest services in England.



The maternity service has been on a difficult journey over the last 3 years. Nationally, scrutiny of maternity services and resulting quality improvement work has been immense, this has been replicated locally. This is all within the context of the legacy impact of the Covid pandemic and a national midwifery and neonatal nursing workforce crisis.

In September 2021, our maternity services were inspected by the Care Quality Commission (CQC). The rating received were:

- ▶ Chichester, Haywards Heath and Worthing – **Requires Improvement**
- ▶ Royal Sussex County – **Inadequate**

As a result, we entered the Maternity Safety Support Programme (MSSP) in February 2022.

An informal CQC visit in April 2022 showed improvements being made. All CQC 'warning notice', 'must do' and 'should do' actions have been completed.

The Worthing and Brighton sites had a comprehensive CQC inspection in February 2025, at the time of writing ratings from this inspection had not been received.

A robust Maternity Improvement Plan is in place and monitored via the bi-monthly Maternity Improvement Group. This is a live and iterative plan, where all improvement work is captured, meaning there is senior oversight and significant focus and support.

We are on track to move into the sustainability phase of the programme mid-2025, and to exit the programme late-2025.

Our vision

Key words were extracted from feedback received from our service users, via the Friends and Family test, Maternity and Neonatal Voices Partnership (MNVP) quarterly survey, and MNVP '15 steps' walkarounds.

Key words were also obtained from feedback from members of the clinical team via the annual Staff Survey, SCORE survey, ImproveWell, feedback to Recruitment and Retention midwives and following the Culture Event held in June 2024.

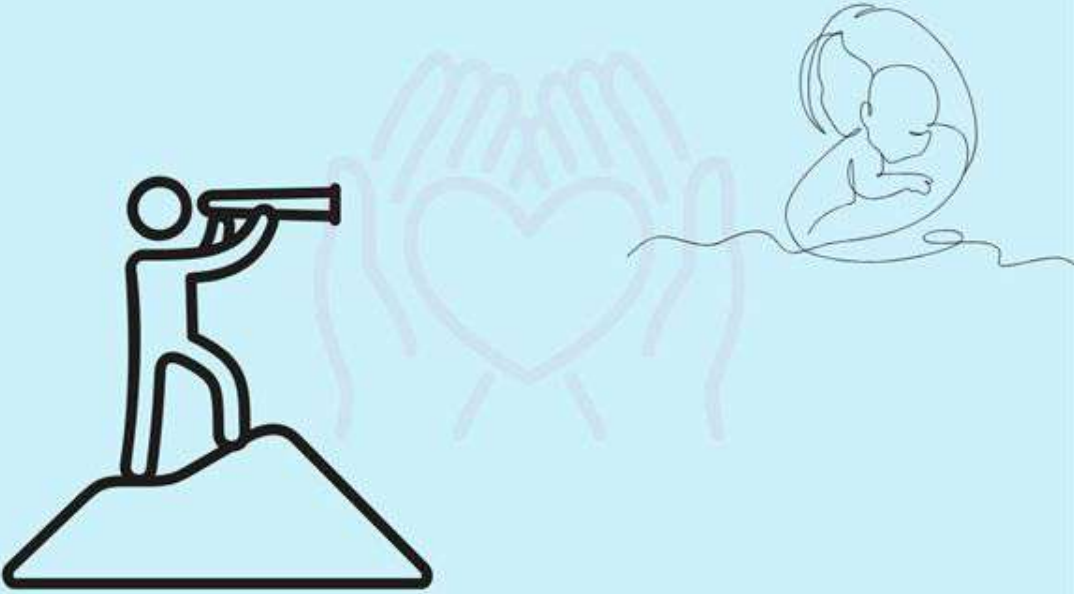
The words we collated from all these measures were presented back to service users and the teams and each group were asked to vote on what they felt were the most important words to include within our vision....



**University
Hospitals Sussex**
NHS Foundation Trust

UHSussex Maternity Services

Our vision is to be a leading provider of
maternity care, where supportive,
compassionate care and kind communication
create a safe, empowering and personalised
experience for all families.



The roadmap towards our vision

Our goals are aligned with the NHS Three Year Delivery Plan for Maternity and Neonatal Services (2023)¹ and the University Hospitals Sussex Maternity Improvement Plan.

Highest Standards of Safety and Quality of Care



Sadly, we know that mortality and morbidity within maternity care will never be eliminated completely, however, our improvement work is focused on reducing avoidable harm by ensuring systems and processes and facilities support our teams to provide the highest standards of safe quality care across our perinatal service.

How will we measure this:

Perinatal mortality rate (PMR, stillbirth and neonatal death rates combined)

Maintain a PMR rate below national rates for equivalent services. Monitor via Statistical Process Control (SPC) charts to allow early identification of changing rates and early action in response.

Complete required reporting and robust reviews of all cases of mortality via the Perinatal Mortality Review Tool process and Child Death Overview Panel process when applicable.

Hypoxic Ischemic Encephalopathy (HIE or brain injury)

Maintain a HIE rate lower than national rates for equivalent services. Monitor via Statistical Process Control charts to allow early identification of changing rates and early action in response.

Reducing avoidable harm

- Report and review cases of harm via the DATIX incident reporting system.
- Maintain DATIX reporting rates in line with national targets.

¹ [NHS England » Three year delivery plan for maternity and neonatal services](#)

- Capture incident data within clinical dashboards to allow for early identification of trends.
- Fully engage in the Patient Safety Incident Response Framework (PSIRF) plan and as per our Maternity Governance Framework to allow for thematic analysis and appropriate response.
- Monitor rates of clinical incidents such as massive obstetric haemorrhage, via SPC charts to identify concerning trends early and explore actions.

Legal claims and complaints

Monitor complaint and legal claim numbers and benchmark against historic data/identified themes. Continue to conduct thematic analyses and take appropriate action/response. Triangulate against complaints and incident data to ensure the improvement work has the correct focus.

Maternity and Neonatal Safety Investigation (MNSI) referrals and Patient Safety Incident Investigations (PSII)

Monitor MNSI and PSII numbers and benchmark against historic data/identified themes alongside the national picture. Continue to conduct thematic analyses and take appropriate action/response. Share findings of reports and learning with system partners.

Reducing Health Inequalities

Black women and people are 4 times more likely and Asian women and people are 2 times more likely to die during pregnancy or up to six weeks after birth. Women and people living in the most deprived areas are twice as likely to die than those living in the least deprived areas². Babies born to mothers who are from deprived or ethnically diverse groups are more likely to be stillborn or die in the neonatal period³.



Targeted and focused improvement interventions are required to reduce the risk of health inequalities.

² [MBRRACE-UK Maternal Report 2023 - Infographics.pdf](#)

³ [State of the nation report | MBRRACE-UK](#)

This will be achieved by:

Stratifying outcome data for groups at risk of health inequalities. Monitor using SPC charts to allow early identification of changing rates and early action in response. This will be shared following the Perinatal Quality Surveillance Model.

Targeting improvement interventions for those most at risk of health inequalities, for instance Continuity of Carer, asylum seeker specialist services has been shown amongst the evidence base as an opportunity to improve outcomes. Monitor percentage of women and people from these groups cared for by these services via SPC charts and alongside key outcome data.

Work with system partners and service user groups to better understand the needs of service users from diverse groups and co-produce improvements and tailored services.

Workforce Development

The maternity workforce locally and nationally has been significantly impacted by staff shortages, burnout and high turnover since the pandemic. Locally, the high cost of living and working environment concerns also impact recruitment and retention. There has been a significant focus on staff wellbeing and recruitment and retention over the last 3 years, resulting in a reduction in midwifery vacancy from 22% in 2022 to <5% in 2025, full recruitment to maternity support worker and nursery nurse posts, and a stable obstetric workforce.

- Maintain a <5% vacancy for all staff groups.
- Maintain a turnover rate lower 12% for all staff groups.
- Maintain a >90% appraisal rate for all staff groups.
- Maintain a staff engagement score equal to or higher than Trust target rate (7.0) via the People Scorecard.

This will be achieved by:

- Providing accessible wellbeing support to our teams.
- Providing time for professional and leadership development, talent management and succession planning.
- Focusing on equality, diversity and inclusion workstreams to support staff from underrepresented groups to progress and meet their aspirations.
- Encouraging participation in cultural improvement work.
- Using the workforce lived experience to further support co-production of services.
- Work with estate and strategy teams to improve the working environment to enhance staff experience.



Enhancing Service User Experience

Most complaints and negative feedback centre on issues with communication. It is also known that gaps in staffing and the pressure this causes, impacts effective communication.

Women and people are continuing to become more and more informed and are aware of their options during pregnancy and birth, and they deserve clear and evidence-based information to allow them to make informed choices.



This will be achieved by:

- Co-production of maternity and neonatal quality improvements with the MNVP and neonatal networks.
- Workforce and leadership capacity improvements.
- Health inequalities data sharing and information.
- Information available in various languages and accessible formats.
- Restorative Culture training.
- Building relationships with stakeholders such as doulas and antenatal educators.
- Regular thematic review of complaints, FFT responses, plaudits, legal claims.
- Estate improvements.

Increasing Innovation and Technology



The digital landscape within healthcare is changing rapidly. Maternity services must keep pace with this to allow for innovation of services and accessible evidence-based information to ensure services are tailored to the needs of the population that it serves.

Research & development across perinatal services continues to evolve and is an invaluable mechanism to support safe and

effective services. It also creates opportunities for the workforce as well as ensuring service users remain at the heart of co-produced services.

This will be achieved by:

- Understanding the current position across perinatal services regarding technology and Research & Development.
- Aligning the perinatal digital strategy with the local and national digital strategy supporting data informed services.
- Increasing recruits to research studies year on year.
- Utilising income from studies to promote innovation and improvement within the perinatal service.
- Continue driving and monitoring perinatal improvements via the maternity improvement plan and maternity improvement group to champion and safeguard perinatal services.

Community and Partnership

It is essential to work within the local and regional healthcare systems to ensure accurate benchmarking, shared learning and innovation of services.

This will be achieved by:

- Multidisciplinary engagement in the Local Maternity and Neonatal System (LMNS), and across regional and national workstreams.
- Engagement with local service user groups.
- Ensuring patient and public involvement and engagement is front and centre of Research and Innovation.



Ensuring the efficient use of resources

The NHS nationally, and the Trust locally are under severe financial pressure. In line with all Trust services, the maternity service must ensure that our budget is used efficiently while maintaining the quality and safety of services.

This will be achieved by:

- Close scrutiny of budgets and expenditure at all levels.
- Regular reviews of service provision to ensure the best use of available resources.
- Consideration of innovation to improve service efficiency alongside quality and safety.

Conclusion

The vision and strategy for maternity services at our hospitals and within our communities is designed to create a safe, supportive, and personalised care environment for families. By focusing on quality and safety, workforce development, service user experience, innovation, and community partnerships, we aim to deliver outstanding maternity care that meets the highest standards of quality safety and personalised services that are responsive to service user needs as well as investment and development of our teams.

Clinical Protocol, SOP & Pathway [ID] governance and approval

Owner	Clinical Director
Author/further information	Give name of Post and dept etc.
Protocol, SOP, Pathway Version	Please list version & delete document type as required Protocol, SOP, Pathway Version
Related policies	List relevant policies
Related documents	List related guidelines
Standards	List standards that the protocol must meet (NHSLA, NICE other professional body etc)
Superseded documents	List any previous protocols which this replaces
Review due	3 years from ratification date

Approval

Add departmental governance group	Date approved:	DD.MM.YYYY
Add divisional governance group or appropriate other	Date approved:	DD.MM.YYYY

Consultation

Add relevant Trust-wide governance group (see table below)	Date approved:	DD.MM.YYYY
Add other specialist teams or groups as appropriate	Date approved:	DD.MM.YYYY

Ratification

Clinical Document Approval Group	Date approved:	

Protocol, SOP, Pathway version control log

Version	Date	Author(s)	Comment
1.0			[Briefly state changes if updated, or if reviewed and no changes state this and date]

Director of Infection Prevention and Control Annual Report April 2024- March 2025



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DRAFT

1. Executive Summary

University Hospitals Sussex NHS Foundation Trust (UH Sussex) continues to meet its statutory obligations under the Health and Social Care Act 2008 (the Hygiene Code). The Trust’s annual Infection Prevention and Control (IPC) Board Assurance Framework assessment confirms broad compliance, with 41 of 54 standards fully achieved, 11 partially compliant, and only two non-compliant (fit testing). Plans are in place to address these areas, supported by recruitment and oversight through the Trust IPC Committee (TIPC), and Quality Governance Steering Group (QSGS), achieving full compliance in 2025/26.

All improvement actions identified following the 2023 Care Quality Commission (CQC) inspection have been delivered and are now embedded as part of “business as usual.” The Trust is fully compliant with the National Infection Prevention and Control Manual (NIPCM).

1.1 Performance and Surveillance

- Infection rates per 100,000 bed days remain comparable or better than regional Trusts for most metrics, despite absolute numbers being high due to size and activity. Power BI dashboards have enhanced monitoring and divisional analysis.
- Mandatory surveillance trajectories were not fully met, but benchmarked well against other organisations. There was particular learning around line-associated infections and antimicrobial stewardship.

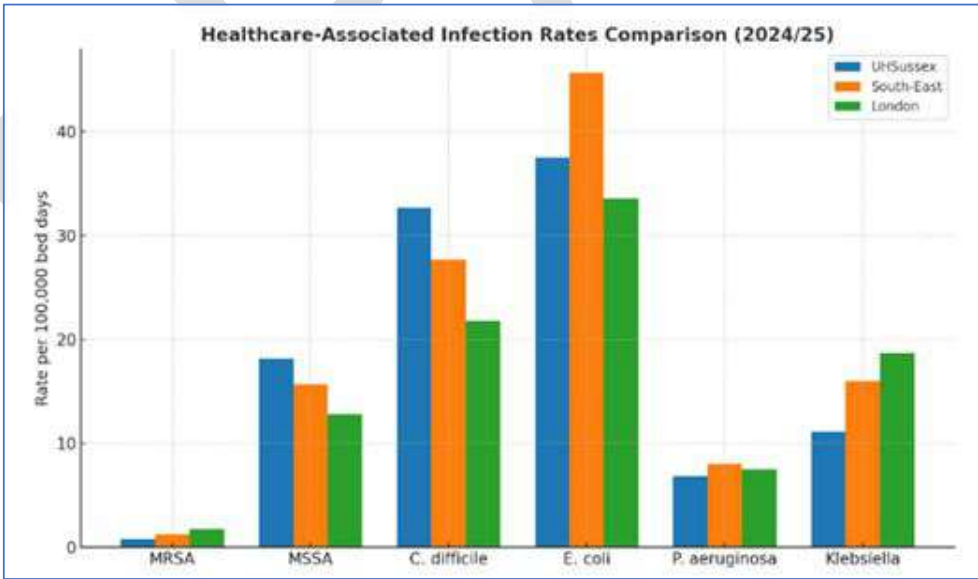


Table 1, UH Sussex Mandatory surveillance data benchmark per 100,000 bed days.

- Trust-wide programmes have been launched to strengthen vascular access device management, commode cleaning standards, and antimicrobial prescribing practices.
- Outbreak management was robust across the year, including respiratory viruses (influenza, COVID-19, RSV), and norovirus. A significant case of pan-resistant *Acinetobacter baumannii* with *Candidoyzma auris*, was safely contained.

1.2 Governance and Assurance

- Estates and Facilities, including water, and ventilation safety remain critical areas of focus. The Trust has progressed a 10-year ventilation replacement plan, strengthened the Water Safety Group, and influenced national design guidance to reduce risks associated with waterborne pathogens.
- Surgical site infection (SSI) surveillance is in place across cardiac, orthopaedic and breast surgery, with improvements seen in SSI rates.
- Decontamination services continue to be strengthened with central oversight, audits, and incident investigation.
- Antimicrobial stewardship has seen gradual improvement, although national consumption targets remain challenging due to workforce pressures in pharmacy and microbiology.

1.3 Workforce, Education, and Research

- IPC training compliance remains high at 92.3%, with strong engagement through IPC Link Champions and participation in national campaigns such as “Gloves Off.”
- Fit testing capacity is being expanded through dedicated recruitment.
- Staff vaccination uptake was lower than desired (31% influenza, 26% COVID-19), contributing to staff absence during outbreaks.
- Recruitment of a dedicated fit testing team is underway.
- The IPC team continues to grow as a research-active department, with contributions to national guidelines, national and international networks, and sustainability-focused projects such as safe reuse of medical equipment.

1.4 Priorities for 2025/26

- **Achieve full compliance:** Ensure full compliance with the IPC Board Assurance Framework, including antimicrobial stewardship and provision of a fit testing service at all main Trust sites.
- **Strengthen surveillance:** Expand surgical site surveillance (including additional categories), improve line-associated bloodstream infection prevention, and increase IPC reviews and visits across all Trust sites.
- **Embed audit and accountability:** Deliver robust audit feedback, ensure divisional accountability, and integrate PSIRF methodology into infection investigations for efficient capture and learning.
- **Assure environmental safety:** Support Facilities and Estates to maintain water and ventilation standards across the Trust.
- **Grow engagement:** Expand the IPC Link Champion programme and clinical engagement across all departments and sites.
- **Broaden research and innovation:** Enhance research skills and initiatives within IPC, promote sustainability projects (including hydration and mouth care), and increase regional and national impact through conferences and collaborations.

1.5 List of Abbreviations used in the document

No.	Abbreviation	Full Text	No.	Abbreviation	Full Text
1	3Ts	Teaching Tertiary and Trauma	34	IPOG	Infection Prevention Operational Group
2	AMP	Anti-microbial pharmacist	35	IV	Intravenous
3	BAF	Board Assurance Framework	36	<i>K. pneumoniae</i> , <i>K. oxytoca</i> , <i>Klebsiella</i> spp.	<i>Klebsiella pneumoniae</i> , <i>Klebsiella oxytoca</i> and <i>Klebsiella</i> species
4	BSI	Blood stream infection (bacteraemia)	37	LIMS	Laboratory information management system
5	CAG	Clinical Advisory Group	38	LMB	Louisa Martindale building
6	cDIPC	Corporate Director Infection Prevention Control	39	MDRO	Multi drug resistant organisms
7	CDT	<i>Clostridioides difficile</i> toxin	40	MPV	MPox virus (previously Monkeypox)
8	CEO	Chief Executive Officer	41	MRSA	Meticillin Resistant <i>Staphylococcus aureus</i>
9	CMO	Chief Medical Officer	42	MSM	Men who have Sex with Men
10	CNO	Chief Nursing Officer	43	MSSA	Meticillin Sensitive <i>Staphylococcus aureus</i>
11	COCA	Community-onset community-associated	44	NHSE	National Health Service England
12	COHA	Community-onset healthcare-associated	45	PLACE	Patient Led Assessment of the Care Environment
13	COIA	Community-onset indeterminate-associated	46	PPE	Personal protective equipment
14	COVID-19	Coronavirus disease of 2019	47	PRH	Princess Royal Hospital
15	CPA	Clinical Pathology Accreditation	48	PSIRF	Patient Safety Incident Response Framework
16	CPE	Carbapenemase-producing Enterobacterales	49	QGSG	Quality Governance Steering Group
17	CQC	Care Quality Commission	50	QSIP	Quality Safety Improvement Programme

18	CSSD	Central sterile services departments	51	RACH	Royal Alexandra County Hospital
19	DCS	Data Capture System	52	RSCH	Royal Sussex County Hospital
20	DDD	Defined Daily Dose	53	SCFT	Sussex Community Foundation Trust
21	DIPC	Director of Infection Prevention Control	54	SRH	St Richards Hospital
22	EDU	Endoscopy decontamination units	55	SRO	Senior Responsible Officer
23	EPRR	Emergency preparedness resilience and response	56	SSD	Sterile Service Department
24	EUCAST	European Committee on Antimicrobial Susceptibility Testing	57	SSI	Surgical Site Infection
25	FFP	Filtering Face Piece	58	SSISS	Surgical Site Infection Surveillance Scheme
26	HCAI	Healthcare-associated Infection	59	STAM	Statutory and mandatory training
27	HOHA	Hospital-onset healthcare-associated	60	THR	Total hip replacement
28	HPV	Hydrogen Peroxide Vapour	61	TIPC	Trust Infection Prevention Committee
29	HTM	Health Technical Memorandum	62	TKR	Total Knee replacement
30	ICB	Integrated Care Board	63	UHSussex	University Hospitals Sussex NHS Foundation Trust
31	iGAS	Invasive Group A Streptococcus	64	UKHSA	UK Health Security Agency
32	IPC	Infection Prevention & control	65	VIP	Visual infusion phlebitis
33	IPCT	Infection Prevention & control Team	66	WGS	Whole-genome sequencing
			67	WH	Worthing Hospital
			68	WSP	Water Safety Plan

2. Introduction

Welcome to the annual Director of Infection Prevention and Control (DIPC) report for University Hospitals Sussex (UHSussex) for the year 2024-25. UHSussex serves a community of 1.9 million people and employs nearly 20,000 staff across seven main hospital sites and several smaller locations.

2.1 What This Report Covers

This report summarises our infection prevention and control (IPC) and antimicrobial stewardship efforts from April 1, 2024, to March 31, 2025. It includes all UHSussex sites.

- Royal Sussex County Hospital (RSCH)
- Royal Alexandra Children's Hospital (RACH)
- Sussex Eye Hospital (SEH)
- Princess Royal Hospital (PRH, Haywards Heath)
- Worthing Hospital (WH)
- Southlands Hospital (SH, Shoreham)
- St Richard's Hospital (SRH, Chichester)

Additionally, it covers services at Crawley & Worthing Sexual Health Service, Brighton General Hospital, Hove Polyclinic, Newhaven Hospital, and Park Centre for Breast Care. We also have IPC service contracts with three hospices in West Sussex.

2.2 Compliance and Assurance

We are pleased to report that UHSussex meets requirements of the CQC under the Health and Social Care Act 2008 regulations (the Hygiene Code). Our IPC Board Assurance Framework assessment confirms our broad compliance with these regulations. We are fully compliant in 4 domains, partially compliant in 6 domains with 1 area of concern which is not compliant in some parts of the trust (table 2 below) related to backlog estates maintenance of critical ventilation. The trust is sighted on areas where we need to make improvement. Any areas of concern identified by the CQC in August 2023 have been addressed. We are compliant with the National Infection Prevention and Control Manual (NIPCM).

2.3 Our Commitment to Safety

This report is based on the Hygiene Code framework and outlines our IPC arrangements. It highlights the projects and initiatives we have implemented over the past year to protect our patients from healthcare-associated infections (HCAIs). This ensures that our patients, staff,

and the public can trust that we are meeting our obligations for patient safety and clinical governance.

3. Organisation and Governance of IPC Service

Criteria 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of the service users and any risks that their environment and other users may pose to them.

3.1 Governance framework

Every Trust must have a Director of Infection Prevention and Control (DIPC). At UHSussex, the Chief Nurse, Maggie Davies, is the Executive DIPC, with Pat Cattini as the Corporate Director handling daily responsibilities, and Sharon Reed as the operational lead nurse and Deputy DIPC.

The Trust's Infection Prevention and Control Committee (TIPC) oversees all IPC activities and meets quarterly. The TIPC receives assurance reports from the water Safety Group, Ventilation Safety Group, Decontamination Group, Antimicrobial Pharmacy, Surgical Site Surveillance, Estates and Facilities, Capital development and Property, and Occupational Health.

TIPC reports to the Quality Governance Steering Group (QGSG), which then reports to the Patient and Quality Committee, a sub-committee of the Executive Board.

Monthly IPC Operational Group (IPOG) meetings, chaired by the Deputy DIPC, monitor progress on the IPC work plan. These meetings help address operational issues and escalate them to TIPC if needed. IPOG reports contribute to the quarterly TIPC report, summarizing IPC activities.

The statutory DIPC Annual Report and the Board Assurance Framework (IPC-BAF) are presented through TIPC.

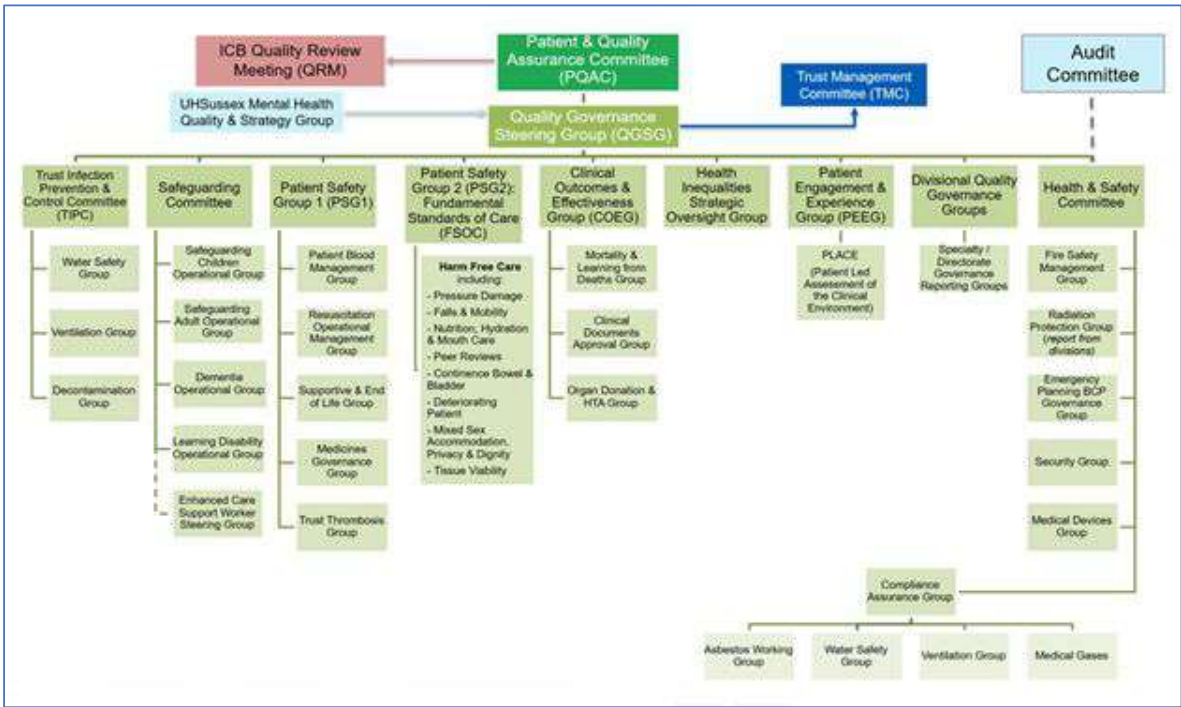


Table 2 Trust Governance structure

3.2 Infection Prevention and Control Team (IPCT)

Infection prevention is part of every role at UHSussex. The Infection Prevention and Control Team (IPCT) provides expert guidance and supports staff in maintaining high IPC standards. They ensure guidelines, policies, and protocols are up-to-date and effectively implemented to reduce HCAI. The IPCT focuses on educating staff, promoting proper antimicrobial use, advising on personal protective equipment (PPE), and managing infection outbreaks.

The IPCT works closely with site and clinical teams to ensure safe patient placement and risk reduction. They are supported by Consultant Microbiologists and Virologists, and a part-time Infection Prevention and Control Doctor (ICD) Dr James Price (4 PA's).

The team is structured to recruit and develop practitioners at various levels, ensuring sustainability and succession planning. Team members receive ongoing training and attend relevant conferences to stay current. The IPCT has a presence on each of the four main sites, providing consistent advice across the organisation.

To address antimicrobial resistance, the IPCT works with the Trust's Antimicrobial Pharmacists to promote safe antimicrobial use. The clinical lead Antimicrobial Pharmacist is Joanne Munns.

IPC also work closely with the Estates and Facilities teams on environmental hygiene, decontamination, new builds, refurbishments, ventilation, and water safety.

3.3 Key roles and responsibilities

The IPCT is responsible for all aspects of infection control across all staff groups. This includes managing outbreaks, alert organism management, environmental management, antimicrobial stewardship, education, and epidemiology. Their duties include:

- Providing expert advice to staff, patients, and visitors.
- Participating in surveillance, investigation, and management of HCAI and infectious diseases.
- Ensuring compliance with current legislation and guidance.
- Advising the Trust board on IPC legislation and compliance.
- Planning and implementing strategies to reduce HCAI, including mandatory training.
- Ensuring policies and procedures are in place for safe and effective care, such as hand hygiene.

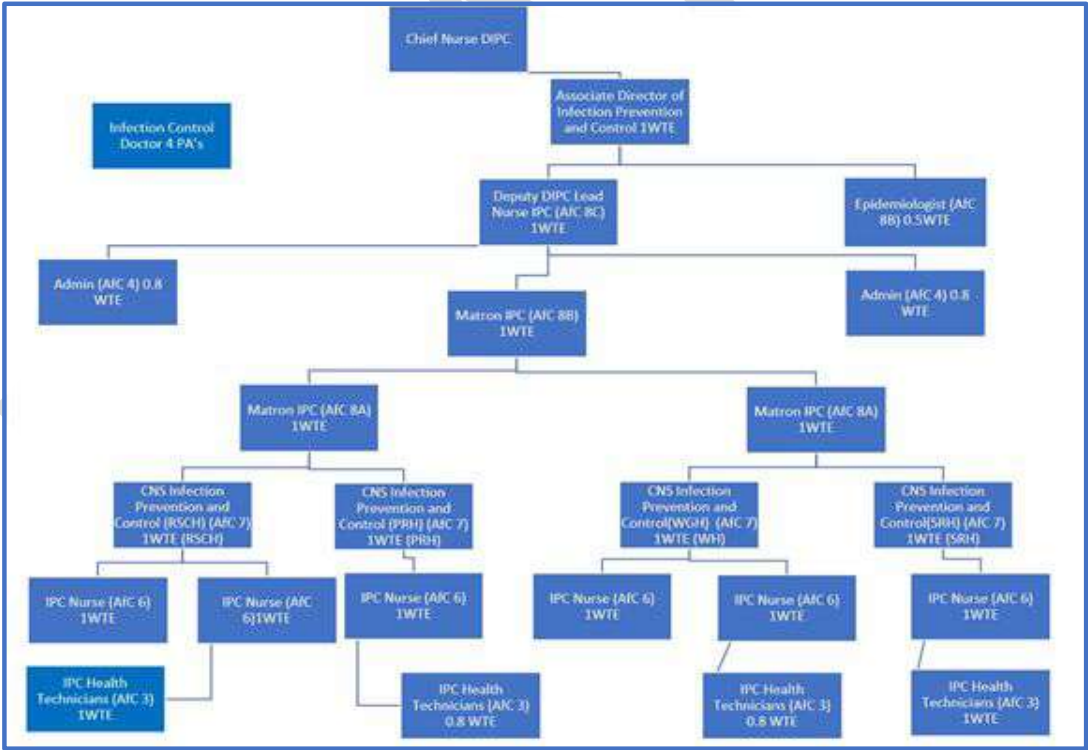


Table 3 Infection Prevention and Control Team structure at UHSussex

3.4 TIPC membership

The TIPC has a broad membership with representation from divisions and our partner organisations (see Appendix 1). TIPC terms of reference are reviewed and agreed annually.

3.5 IPC Board Assurance Framework (BAF)

The IPC BAF is updated annually to assure the Trust Board that IPC arrangements align with the National Infection Prevention and Control Manual (NIPCM) and the Health and Social Care Act 2008 (Hygiene Code).

Hygiene Code Criteria	Description	See Report Section	BAF Section
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of the service users and any risks that their environment and other users may pose to them.	3	1
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	6	2
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.	7	3
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.	5 & 8	4
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.	4 & 9	5
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	10	6
7	The provision or ability to secure adequate isolation facilities.	11	7
8	The ability to secure adequate access to laboratory support as appropriate.	12	8
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help prevent and control infections.	13	9
10	That they have a system or process in place to manage staff health and wellbeing, and organisation obligation to manage infection, prevention and control.	14	10

Table 4 Health and Social Care Act 2008: Code of Practice on the prevention and control of infection (Hygiene Code).

The BAF includes 54 key lines of enquiry over the 10 domains of the Hygiene Code. The annual BAF assessment found that six domains are fully compliant and four partially compliant. Of the 54 elements, the trust is fully compliant against 41, partially compliant against 11 and non-compliant against 2.

The two areas of non-compliance are around fit testing (criteria 6), however there is a plan in place and recruitment will begin shortly. The work plan will go to TIPC to provide delivery oversight. This will enable the Trust to be compliant in this area next year.

The areas of partial compliance are around antimicrobial stewardship (criteria 3) and OH support (criteria 10). This is due to the shortages of pharmacists and lack of access to data to identify trends. Funding allocated for a pharmacist recruitment drive in 2025 will bring further support.

The framework report acts as a gap analysis and allows us to prioritise areas for improvement going forward. Incomplete domains and elements are escalated through the QGSG for risk oversight. Key areas for improvement and actions are documented and a summary with associated actions is documented in Table 5a.



Table 5 Summary 2024 BAF assessment of each section of the Hygiene Code (see table 2)

3.6 Risk assessment

The IPC risk register is updated at least quarterly. Two significant risks (score over 12) are detailed on the IPC risk register: inadequate staff FFP3 respirator fit testing and failures in critical ventilation across UHSussex. These risks are also identified in the BAF with associated mitigations.

Risk Identified	Actions
Imperfect ventilation strategy and delivery	Physical mitigations are in place in non-critically ventilated areas (HEPA filtered air scrubbers, open windows/natural ventilation). Trust wide plans for improvement of critical ventilation have been drawn up. Significant remedial work will be undertaken over the next 10 years.
Lack of planned preventative maintenance in some areas inhibiting environmental cleaning	Estates working with IPC and hospital leadership teams to effect repairs in prioritised areas. An Estates Improvement Group has been set up for next year and strategic plans are in place for significant capital investment to improve the Estate.
Need to improve waste handling	Local audits are showing some non-compliance with incorrect segregation at source. There is a limited team offering waste support and education across the Trust.
Non-compliance with segregation of laundry at source	Issues with segregation of laundry at ward level leading to excess red bag laundry is being addressed by direct intervention from IPC team.
Limited antimicrobial stewardship service across UHSussex	Development of ward specialist pharmacists to support within clinical areas and business plans for increasing pharmacy workforce. Need to improve EPMA and digitisation of pathology to understand prescribing data, trends and antimicrobial resistance patterns.
Sub-optimal fit-testing for staff	Effort to prioritise high risk staff for fit testing. Recruitment underway for substantive fit testers with aim this will be green next year.
Occupational Health service provision at UHSussex sites	Planning for enhanced availability and service for screening; staff vaccination support. Plans in place for UHSussex to consider a single trust wide service.

Table 6 Themes identified in 2025 BAF assessment

3.7 CQC Action Plan

Following the CQC inspection in August 2023, the trust completed the required actions which include aspects of infection prevention and control. There were 7 identified areas for improvement. Evidence of compliance was collated and monitored by the CQC steering group. This work needs is now 'business as usual' and thus monitored through TIPC on a quarterly basis.

Regulation 12: Safe Care and Treatment - IPC Audit, monitoring and ventilation	Target completion action owner	Trust Target Completion	RAG
1.Update annual audit programme for coming year and publish in the annual report.	31/03/2024	N/A	Completed
2. IPC healthcare assistants to work on wards 2 hours a week to develop consistent audit practice.	30/04/2024	30/09/2024	Completed
3. Introduce IPC champions to provide a conduit between IPC and clinical departments.	31/03/2024	30/09/2024	Completed
4.Introduce divisional IPC 'Deep Dives' to pull together data for each division to be shared at Governance meetings.	31/12/2024	31/12/2024	Completed
5. Continue to refine SSI data collection and expand service offer.	31/12/2024	31/12/2024	Completed
6. Formalise IPOG audit reporting template for all divisions with training.	31/03/2024	N/A	Completed
7. Second annual IPC Team away day April 24	09/04/2024	30/09/2024	Completed

Table 7 IPC CQC actions

4. Healthcare-associated Infection surveillance Mandatory Reporting

Criteria 5: There is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

All Trusts in England must submit monthly data on key healthcare-associated infections to the UK Health Security Agency (UKHSA) Data Collection Scheme (DCS).

4.1 Key Infection Categories:

- **Hospital Onset Healthcare Associated (HOHA):** Infections detected in the hospital two or more days after admission.
- **Community Onset Healthcare Associated (COHA):** Infections occurring in the community or within two days of admission, if the patient was an inpatient in the reporting Trust within the previous four weeks.
- **Community Onset Indeterminate Association (COIA)**
- **Community Onset Community Associated (COCA)**

HOHA and COHA cases are considered attributable to the Trust.

4.2 Performance Summary:

- The UH Sussex infection rates for all five mandatory surveillance metrics exceeded national thresholds (where available).
- When compared to other Trusts in the South-East, our infection rates per 100,000 bed days are comparable to or better than those of other hospitals.
- This highlights the importance of measuring infection rates rather than absolute numbers to understand our performance in infection prevention and control (IPC) over the past year.
- IPC implemented Microsoft Power BI tools to optimise mandatory national infection surveillance reporting, including risk factor collation and analysis. IPC have undertaken a Divisional level analysis, looking at trends in key reportable healthcare-associated infections, summary on which is provided alongside each 'key organism'.

Mandatory reportable infections	Q1	Q2	Q3	Q4	Year to date cases	UKHSA Q1 threshold 25/26	UKHSA Annual threshold F25/26
Meticillin-resistant <i>Staphylococcus aureus</i> (MRSA) BSI	1	-	-	-	1	0	0
Meticillin-sensitive <i>Staphylococcus aureus</i> (MSSA) BSI	18	-	-	-	18	No threshold	No threshold
<i>Escherichia coli</i> (<i>E.coli</i>) BSI	55	-	-	-	55	43	208
<i>Klebsiella species</i> BSI	18	-	-	-	18	12	67
<i>Pseudomonas aeruginosa</i> (<i>P.aeruginosa</i>) BSI	15	-	-	-	15	6	36
<i>Clostridioides difficile</i> (<i>C.difficile</i>) infection	45	-	-	-	45	30	152

Table 8: Summary of mandatory reportable healthcare-associated infections at UHSussex by quarter. Results are RAG rated against national quarterly threshold (red = above threshold, orange = meets threshold, green = below threshold, grey = no national threshold provided). Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission. Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks. DCS = UKHSA data capture system. YTD = year to date. Key: NA = no national ceiling available, MSSA = Meticillin resistant *S. aureus*, MRSA = Meticillin resistant *S. aureus*.

4.3 Healthcare-associated *Staphylococcus aureus* (MSSA and MRSA) bloodstream Infections

Healthcare-associated *S. aureus* bloodstream infections, including both Meticillin-sensitive (MSSA) and Meticillin-resistant (MRSA) strains, are significant due to their high morbidity and mortality rates, especially in vulnerable patients. These infections often result from invasive procedures and prolonged hospital stays. MRSA is particularly challenging due to its resistance to many first-line antibiotics. While MSSA can be treated with a broader range of antibiotics, prompt and effective management is crucial to prevent severe complications. Both MSSA and MRSA infections underscore the need for stringent IPC measures to prevent transmission and outbreaks. Early detection and targeted antimicrobial therapy are essential for improving patient outcomes and reducing the healthcare burden.

4.4 MRSA

- **Reported Cases:** In 2024/25, there were five healthcare-associated MRSA BSI HOHA and/or COHA), against a UKHSA ceiling of zero cases (Figure 1).
- **Infection Rates:** The cross-Trust rate was 0.78 per 100,000 bed days, a decrease from 1.08 per 100,000 bed days in FY 23/24 and lower compared to a South-East rate of 1.23 and the London rate of 1.73 (figure 2).
- **Hospital-Onset Cases:** Four out of the five cases (80%) were hospital-onset.
- **Investigations and Actions:** Risk factor analysis noted 19% of all MRSA BSI's during a 10-month period attributable to vascular access devices or line-associated, with Medicine and Surgery Divisions sharing the majority of case incidence, which is expected owing to them being the largest Divisions.
 - As part of the after-action review (AAR), which is within the PSIRF methodology, for all MRSA BSIs, we identified the following themes, 1) Delay of prescribing suppression therapy, 2) Suppression therapy not administered correctly (diluted rather than using neat), and 3) lack of IV-line care and phlebitis awareness.
 - In response, we reviewed our suppression therapy guidance, focused on optimising approaches around intra-venous placement times and worked with the antimicrobial stewardship group to harmonise suppression therapy. Specifically, consideration being given to IPC being able to prescribe

suppression therapy under a Patient Group Directive (PGD). Further work needed to ensure governance supports this method.

- IPC’s annual programme of work will include line-associated BSI surveillance as a top priority for FY 2025/26.

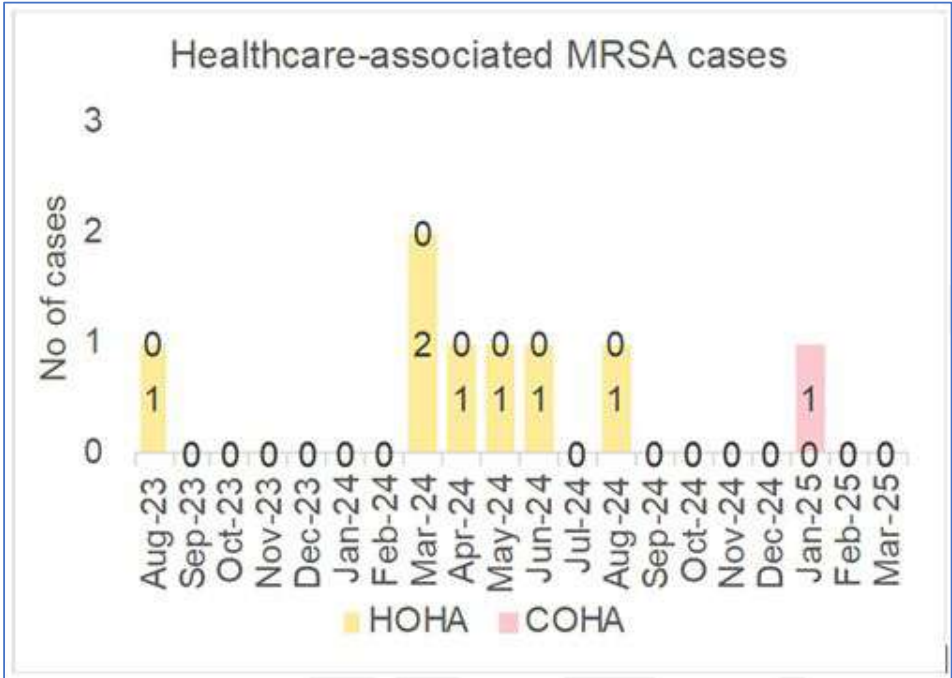


Figure 1: Healthcare-associated MRSA BSIs at UHSussex by month.

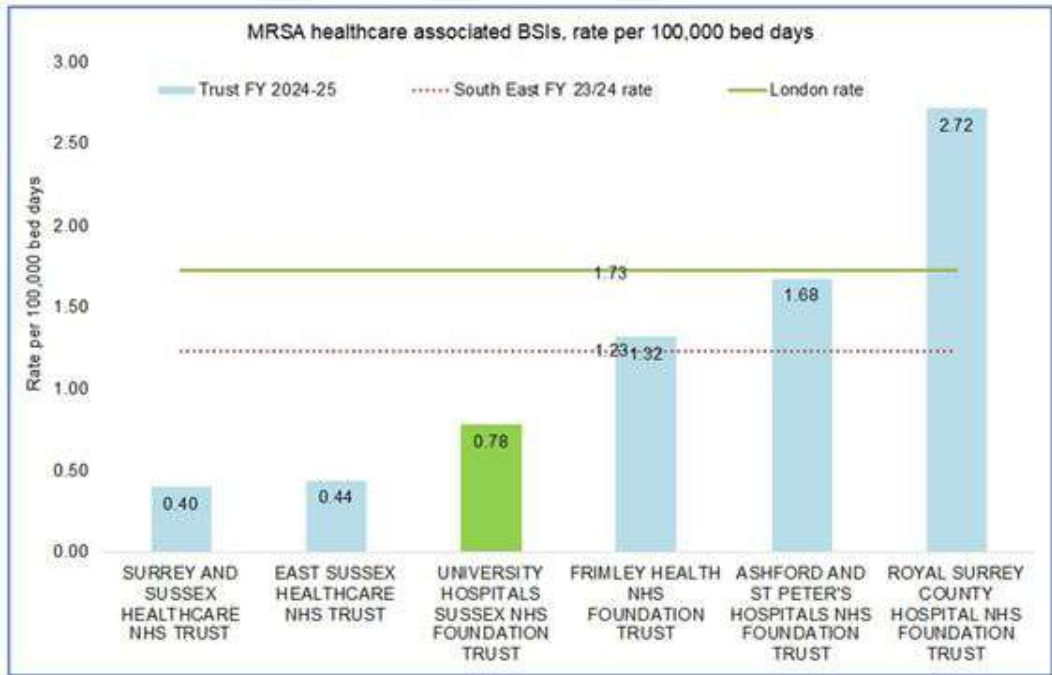


Figure 2: MRSA healthcare associated BSI rate comparison – South-East region and London.

- **Screening Policy:** In line with national guidance, the Trust introduced a new MRSA screening policy in October 2022 and consequently no longer routinely screen all patients on admission. Three of the MRSA BSI cases occurred in patients who were not screened as they did not meet the risk factor threshold.

4.5 MSSA

- **Reported cases:** In 2024/25, there were 116 cases of MSSA BSI reported (figure 3). There is no national target for these cases.
- **Infection rates:** The UH Sussex rate (18.13) sits above both the London and South-East rate, 12.8 and 15,7 respectively. UHSussex sits second highest amongst SE Trusts (figure 4).
- **Investigations and Actions:** Risk factor analysis (Figure 5) noted almost 11% of all BSI during a 10-month period attributable to vascular access devices, with the divisions of Medicine and Surgery claiming the vast majority, followed by Women’s and Children and Specialist.
 - In recognition of line-associated infections making up the top source for both MRSA and MSSA BSI, IPC will lead of a surveillance programme in FY 25/26, focusing on key specialities including renal and haematology.

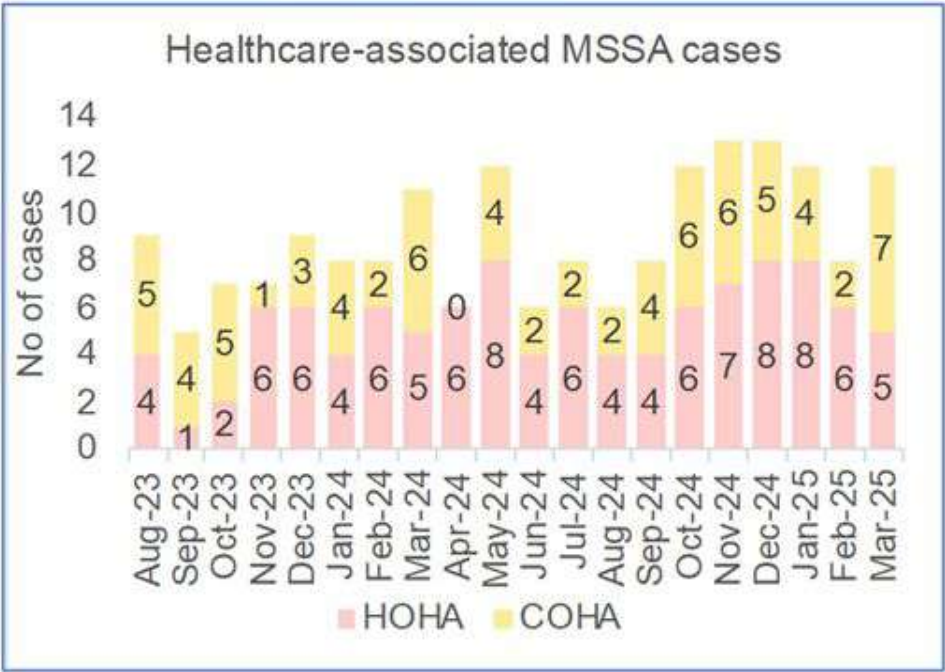


Figure 3: Healthcare-associated MSSA BSIs at UHSussex by month.

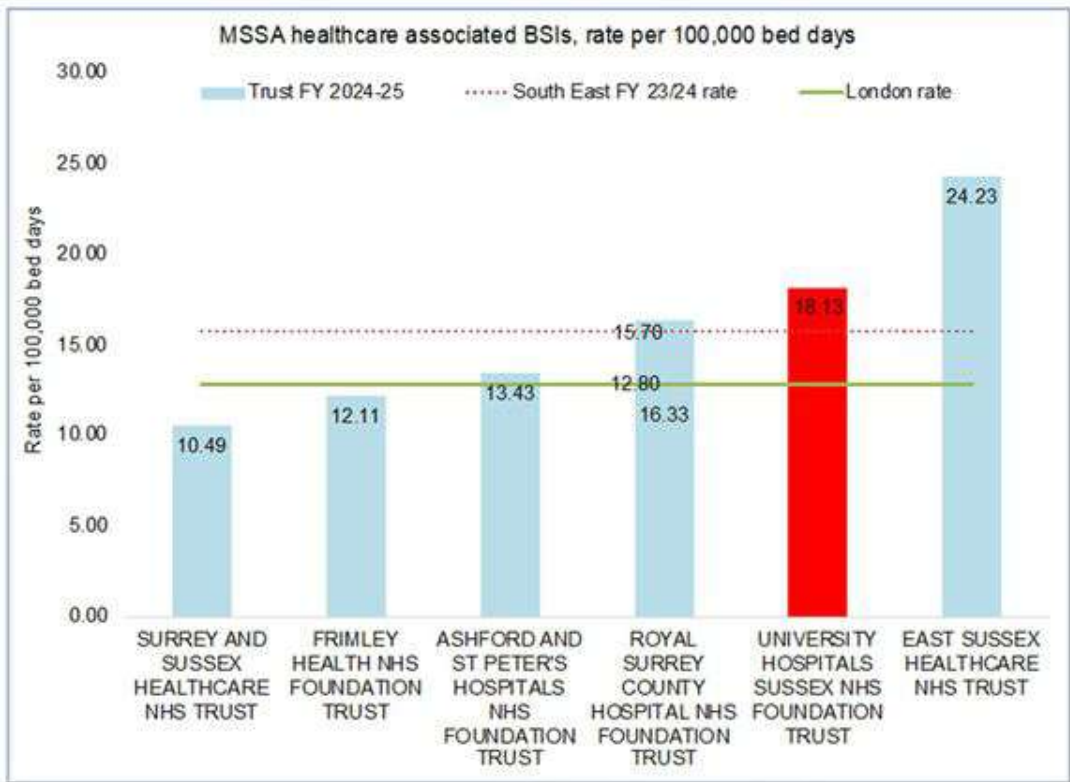


Figure 4: MSSA healthcare associated BSI rate comparison – South-East region and London.

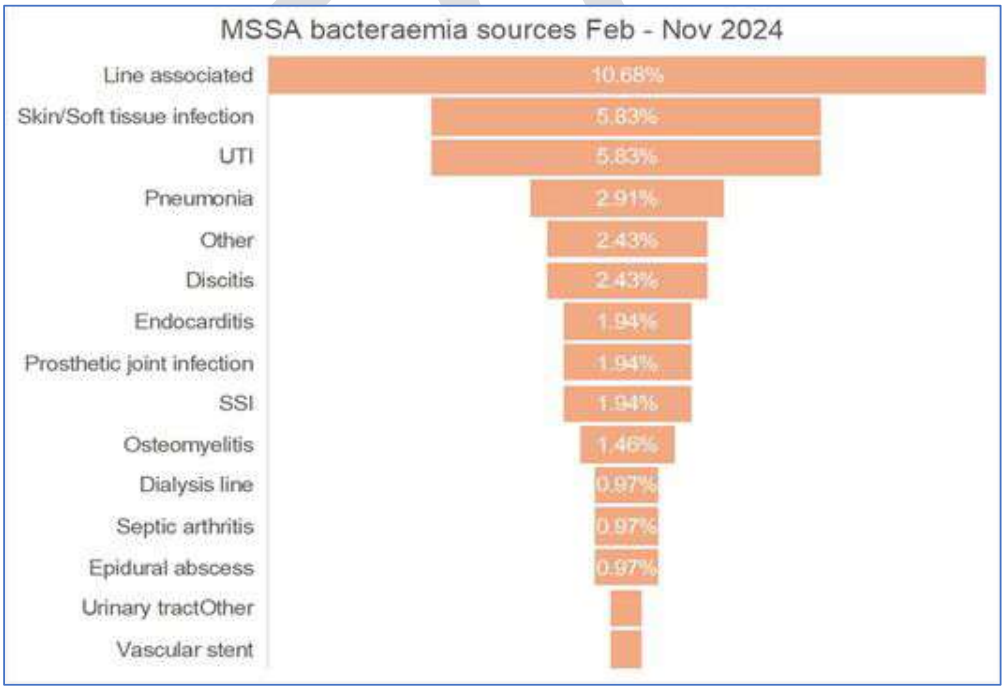


Figure 5 Analysis of MSSA Bacteraemia source Feb-Nov 2024

4.6 *C. difficile* infections

C. difficile infections (CDI) are a major concern due to their high morbidity, mortality, and healthcare costs, especially among elderly and immunocompromised patients. These infections often occur after antibiotic use, which disrupts normal gut bacteria, leading to severe diarrhoea and potentially life-threatening complications like toxic megacolon and sepsis. The recurrent nature of these infections makes treatment challenging and increases the risk of long-term health issues. As with other infections monitored as part of the DCS, CDI has shown a rise nationally since the COVID-19 pandemic (figure 6).

- **Reported cases:** In 2024/25, there were 209 cases of *C. difficile* infections reported, within the context of a UKHSA threshold of 152 (figure 7).
- **Infection rates:** The UH Sussex rate (32.67) sits above the London and the South-East rate, 21.8 and 27.7 respectively. UHSussex sits second highest across the South-East (figure 8).
- **Prevention and Management:**
 - **Stringent IPC Measures:** Hand hygiene, environmental cleaning, and careful antibiotic use are crucial to prevent the spread within healthcare facilities.
 - **Early Diagnosis and Management:** Prompt diagnosis and targeted antimicrobial therapy are essential to improve patient outcomes.

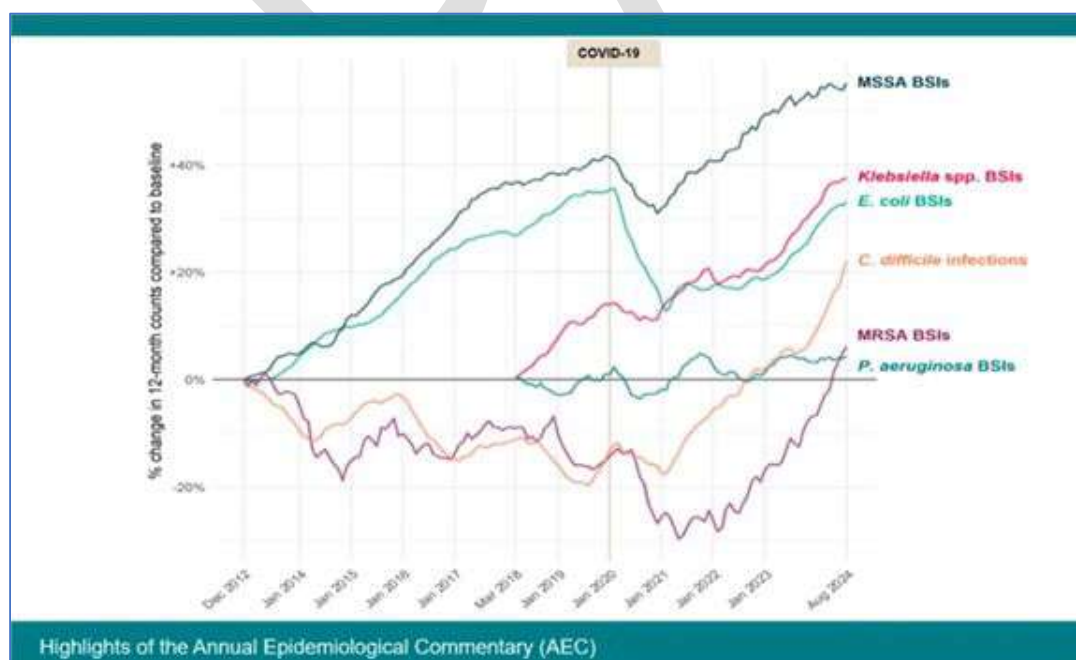


Figure 6 English national data for healthcare associated infections since 2012.

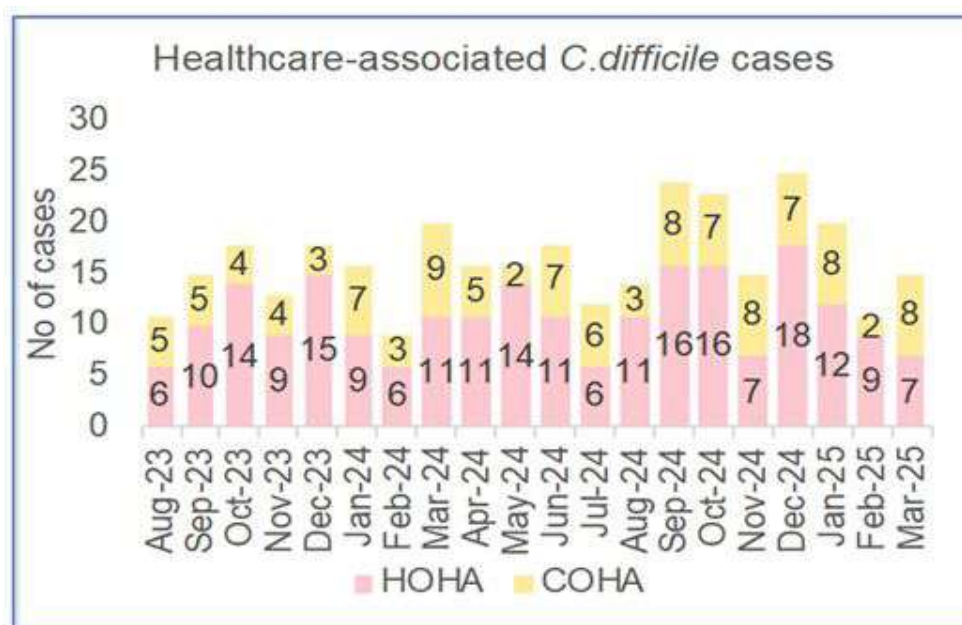


Figure 7: Trend in healthcare-associated *C.difficile* infections, FY 2024/25

- **Ribotyping** helps identify specific strains of *C. difficile* that are hard to control during outbreaks or may lead to poor clinical outcomes. This method is used when there is an increase in cases or suspected transmission within the same area and time frame.
- In response to the year on year rise in *C. difficile* cases, IPC formulated a Trust-wide action plan, outlining key interventions – a) establishment of a monthly MDT meeting to discuss key themes driving *C. difficile* cases, b) develop and deploy *C. difficile* specific Patient Safety Incident Response Framework (PSIRF) alongside the DATIX system, to drive our understanding of risk factor data and direct learnings, which will go live in mid-May 2025, c) provide targeted training at ward level, d) drive *C. difficile* agenda via the monthly Antimicrobial Stewardship Group (ASG) – looking at prescribing among other factors, and e) promoting audit and peer-reviews to drive Trust wide learning and consistency of clinical approach. The Trust-wide action plan came into effect in mid-Feb 2025. In Q4 we noted a drop in *C. difficile* numbers, with the final figure for the quarter standing lower than the previous three quarters (n=46). We will continue to monitor progress against the plan in the coming FY 2025/26.
- Current thematic analysis of these cases highlights sub-optimal IPC practices, particularly in relation to commode audits, which assesses the cleanliness of bedpans, shower chairs, toilet seats, commodes, and the accuracy of labelling. The most common reasons for audit failures include inadequate cleaning of toilet seats and commodes, as well as incorrect or missing labelling.

- The incidence spread is across the divisions of Medicine and Surgery claiming the vast majority, followed by Specialist and the division of Women’s and Children.

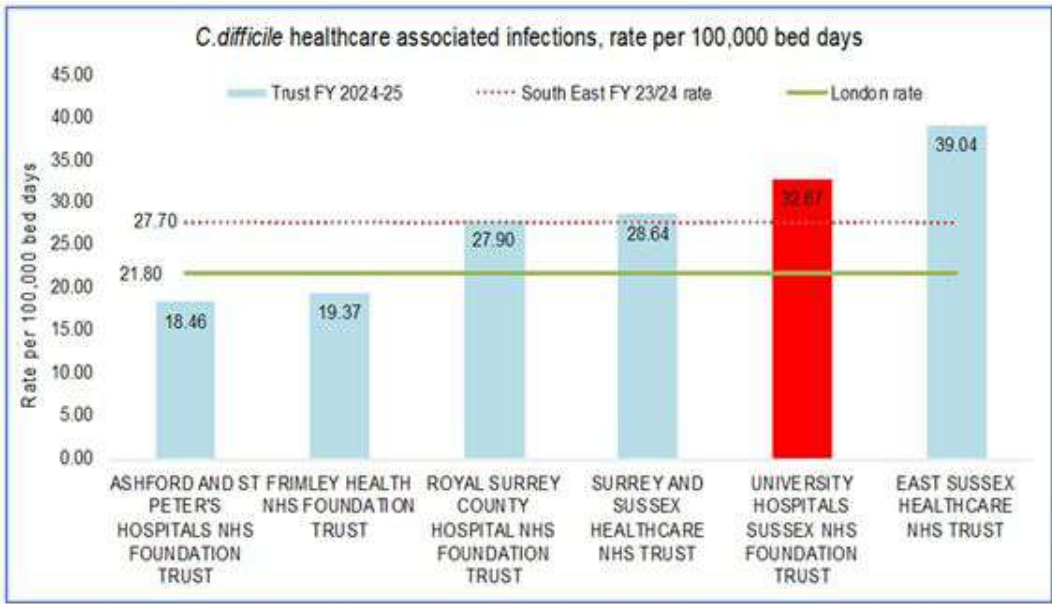


Figure 8: C.difficile healthcare associated infection rate comparison – South-East

Figure 8b below shows the Statistical Process Chart (SPC) for C.difficile. There is a spike in Dec-24 standing out as the only point passing the upper control limit. To date this calendar year has not yet seen a datapoint exceeding the upper control limit. Over the period Apr-2020 to June-2025, we see a steady rise in the number of data points over the mean, suggesting an upward trend in infection incidence, which chimes with the National and internal picture

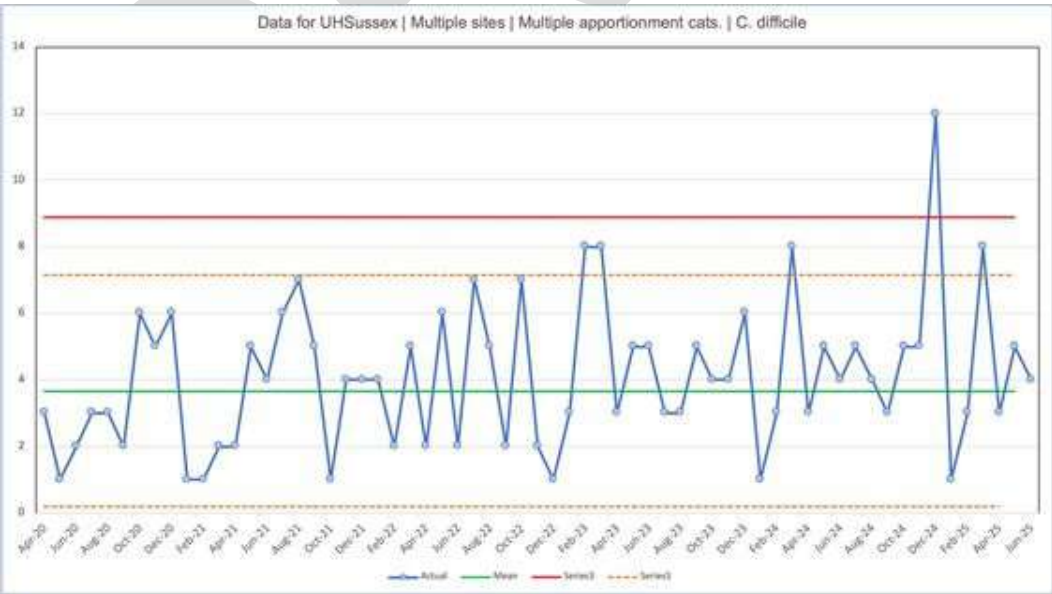


Figure 8b: C.difficile healthcare associated infection rate – Statistical Process Chart.

4.7 Gram-negative blood stream infections

Infections caused by Gram-negative bacteria like *E. coli*, *Pseudomonas aeruginosa*, and *Klebsiella* species are serious due to their high morbidity, mortality, and increasing antibiotic resistance. These infections often occur in patients with long hospital stays, invasive devices, or underlying health conditions, leading to severe complications such as septic shock and organ failure.

- ***E. coli***: Commonly originates from urinary or gastrointestinal sources.
- ***P. aeruginosa* and *Klebsiella* species**: Notable for their ability to develop resistance to multiple antibiotics.
- **Multidrug-Resistant Strains**: The rise of strains like Carbapenem-Resistant Enterobacterales (CRE) complicates treatment, requiring more toxic and less effective therapies.
- **Effective IPC Measures**: Crucial to prevent the spread of these infections.
- **Prompt Diagnosis and Targeted Therapy**: Essential to manage infections and improve patient outcomes.

4.8 *E. coli* Infections

- **Reported Cases**: There were 240 healthcare-associated *E. coli* BSI's, exceeding the UKHSA threshold of 219 cases (figure 9).
- **Infection Rate**: The UH Sussex rate (37.5) sits above the London rate (33.6) and below the South-East rate of 45.7. UHSussex sits lowest across the South-East Trusts (figure 10).
- **Investigations and Actions**
 - Risk factor analysis (Figure 11) showed that 23% of BSIs over a 10-month period were attributable to urinary tract infection with a further 12% linked to a hepatobiliary source, with the divisions of Medicine and Surgery claiming the vast majority, followed by Women's and Children and Specialist.
 - Hydration is increasingly recognized as a crucial factor in reducing Gram-negative BSI. The Trust is part of a Sussex-wide project led by the ICB to explore how promoting hydration can help reduce these infections. This two-year collaborative project focuses on improving the hydration status of people over 65 living in their own

homes. It involves using a hydration plan and addressing educational barriers to proper hydration. Additionally, we aim to better understand the origin and specialty of *E. coli* bacteraemia, starting with healthcare-associated infections, to develop a targeted strategy for reducing their incidence.

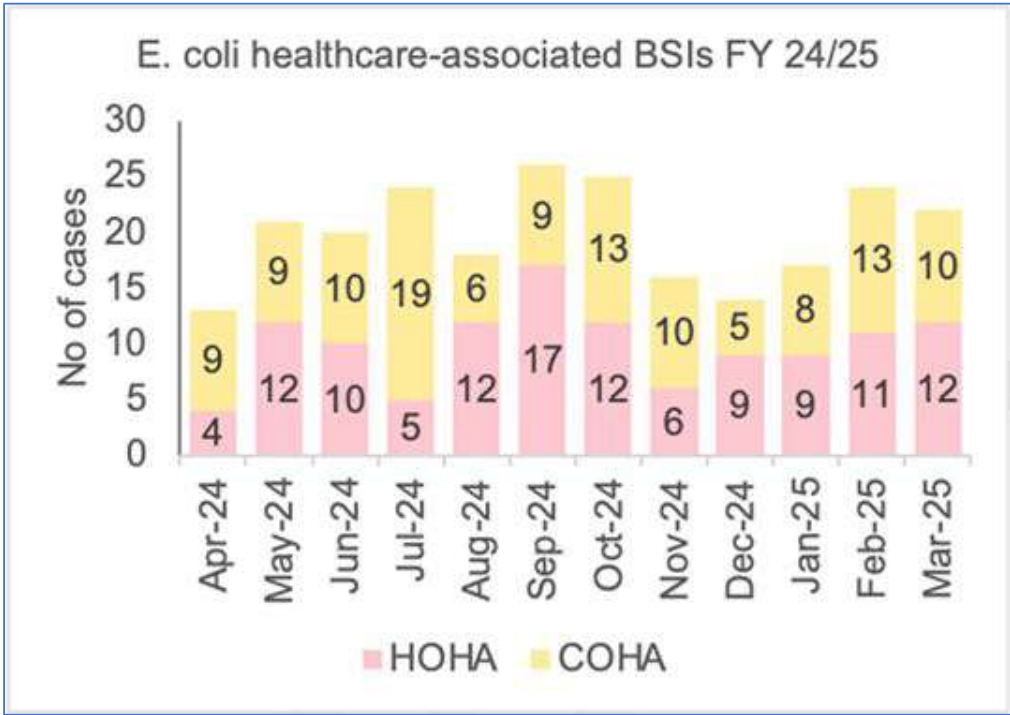


Figure 9: Healthcare-associated *E. coli* BSIs at UHSussex by month.

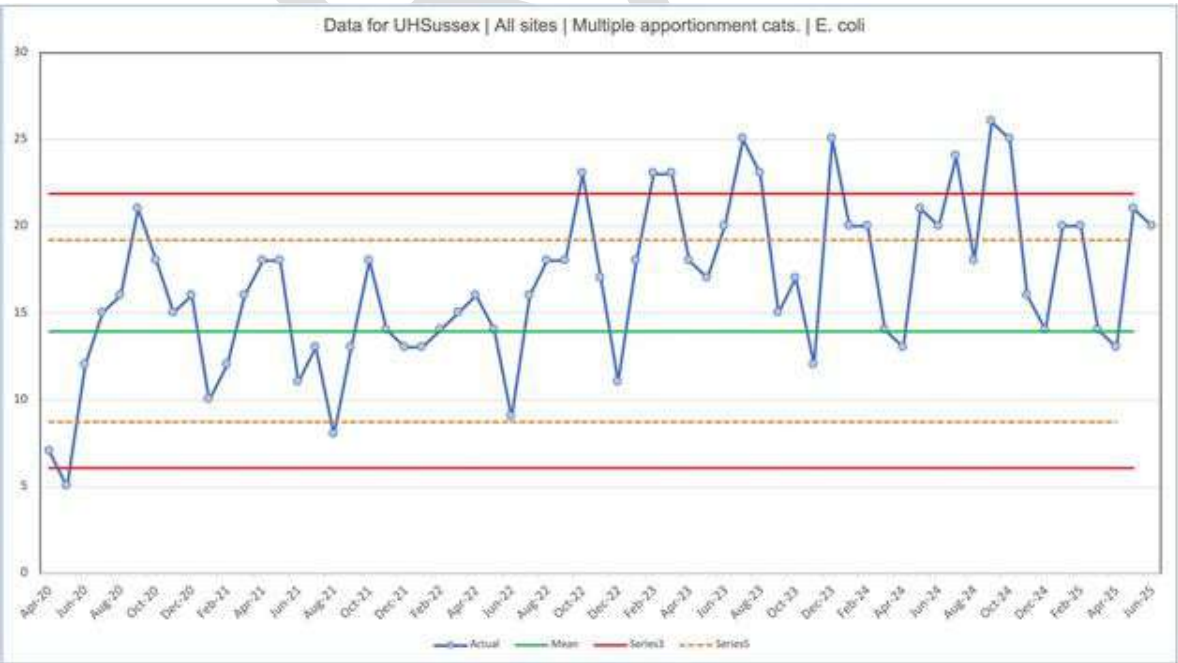


Figure 9b: Healthcare-associated *E. coli* BSIs at UHSussex by month – Statistical Process Chart

Figure 9b shows the Statistical Process Chart (SPC) for E. coli. There is a spike in Q3 2024 where two data points were above the upper control limit, post which all subsequent data point have sat lower than the upper control limit. Over the period Apr-2020 to June-2025, we see a steady rise in the number of data points over the mean, suggesting an upward trend in infection incidence, which correlates with the National and internal picture.

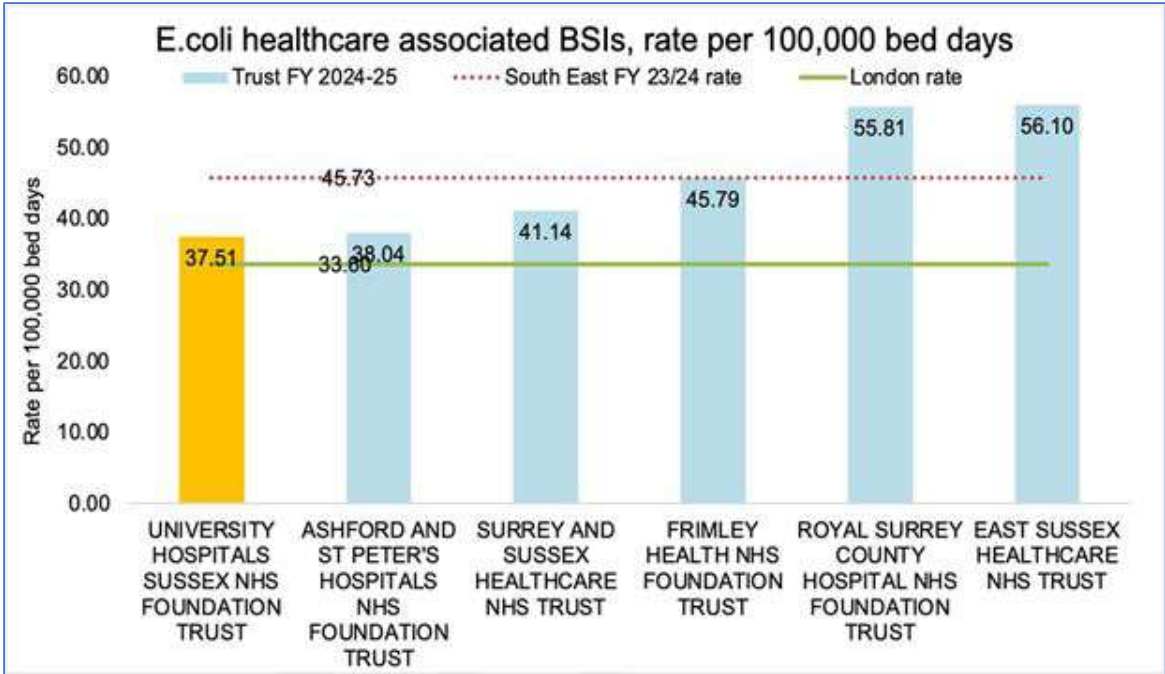


Figure 10: E. coli healthcare associated infection rate comparison – South-East region and London.

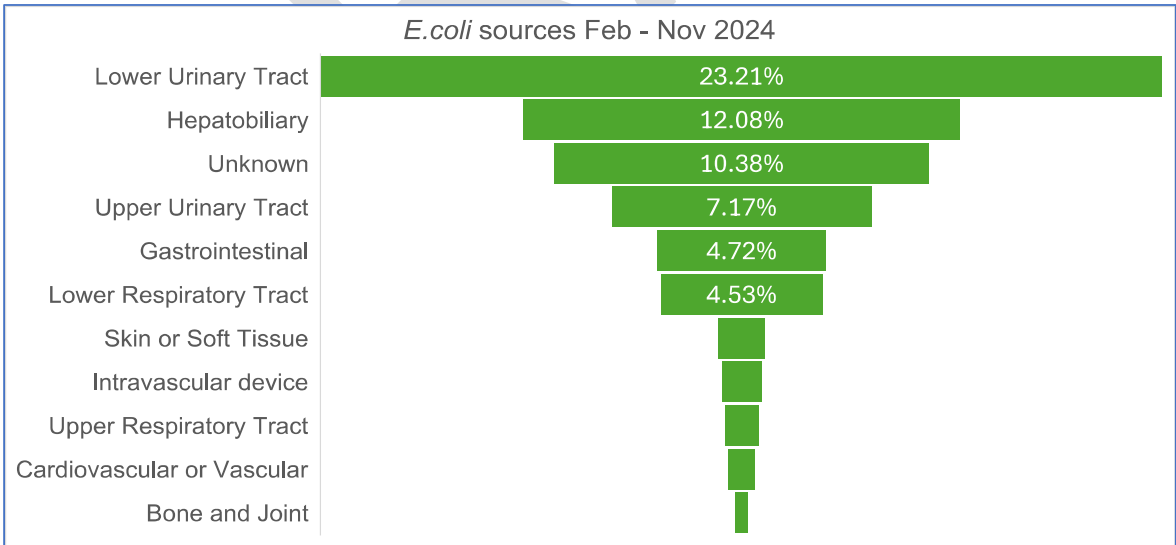


Figure 11 E. coli risk factor analysis

4.9 *Pseudomonas aeruginosa*

- **Reported cases:** There were 44 healthcare-associated BSI's reported, exceeding the UKHSA ceiling of 39 (figure 12).
- **Infection rates:** The UHSussex rate (6.8) sits below both the London and the South-East rate (figure 13).
- **Investigations and actions**
 - Risk factor analysis showed that 20% of all BSIs over a 10-month period were attributable to urinary tract infections, with the division of Medicine claiming the vast majority, followed by Surgery and Specialist.

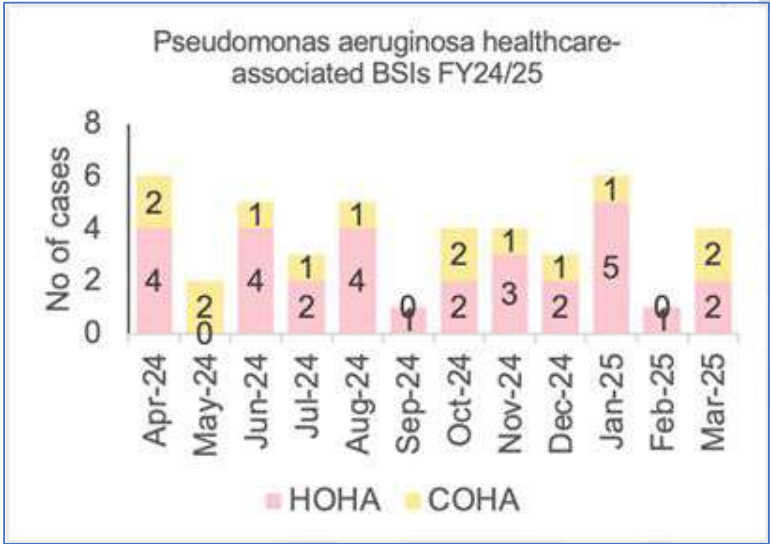


Figure 12: Healthcare-associated *P. aeruginosa* BSIs at UHSussex by month.

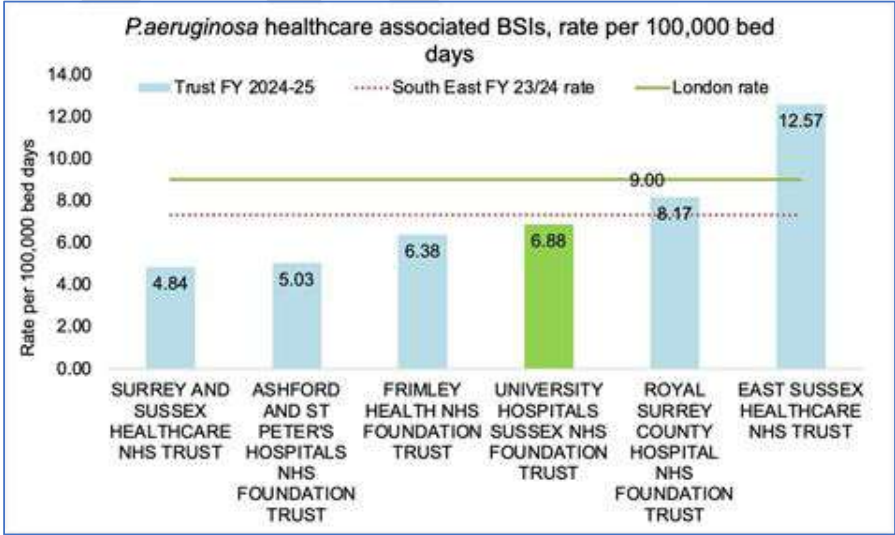


Figure 13: *P. aeruginosa* healthcare associated BSI rate comparison – South-East region and London.

4.10 Klebsiella species

Klebsiella pneumoniae, *Klebsiella oxytoca*, and other species are reportable to the UKHSA.

- **Reported cases:** There were 71 cases of *Klebsiella* spp. BSI below the UKHSA threshold of 89. Nationally, healthcare-associated *K. pneumoniae* bloodstream infections have been consistently rising (figure 14).
- **Infection rates:** The UH Sussex rate (11.1) sits lowest amongst the South-East NHS Trusts, and lower than the London and South-East rate, 18.7 and 16.0 respectively (figure 15).
- **Investigations and actions:**
 - Risk factor analysis showed 23.4% of all *Klebsiella* spp. BSI are associated with urinary tract infections, with Medicine claiming the majority, followed by Surgery, and Women’s and Children.
 - As part of our response to understand trends in Gram-negative BSI, and with access to whole-genome sequencing as part of IPC research, the IPC team are leading further investigation to identify any environmental links with patient cases.

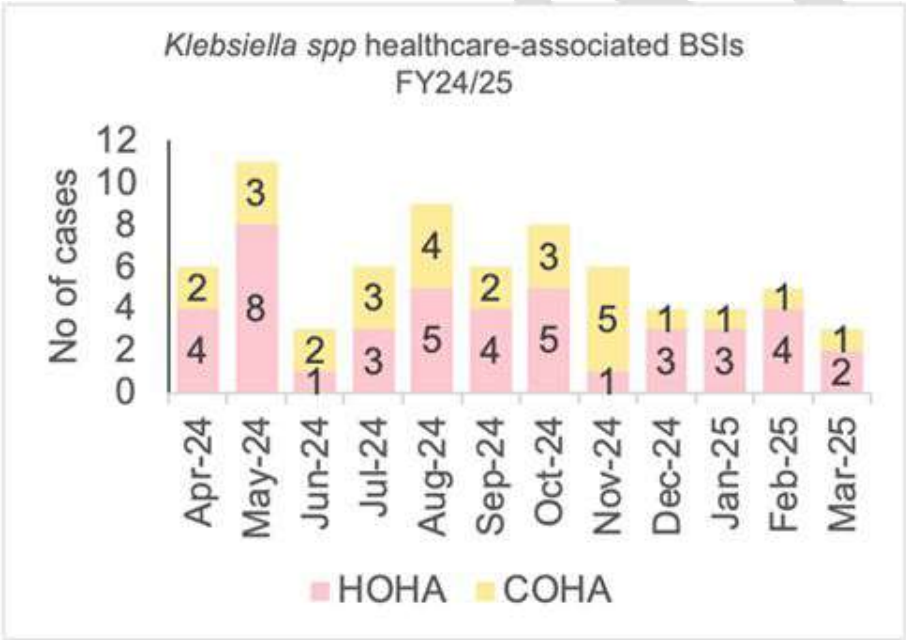


Figure 14: Healthcare-associated *Klebsiella. spp* BSIs at UHSussex by month.

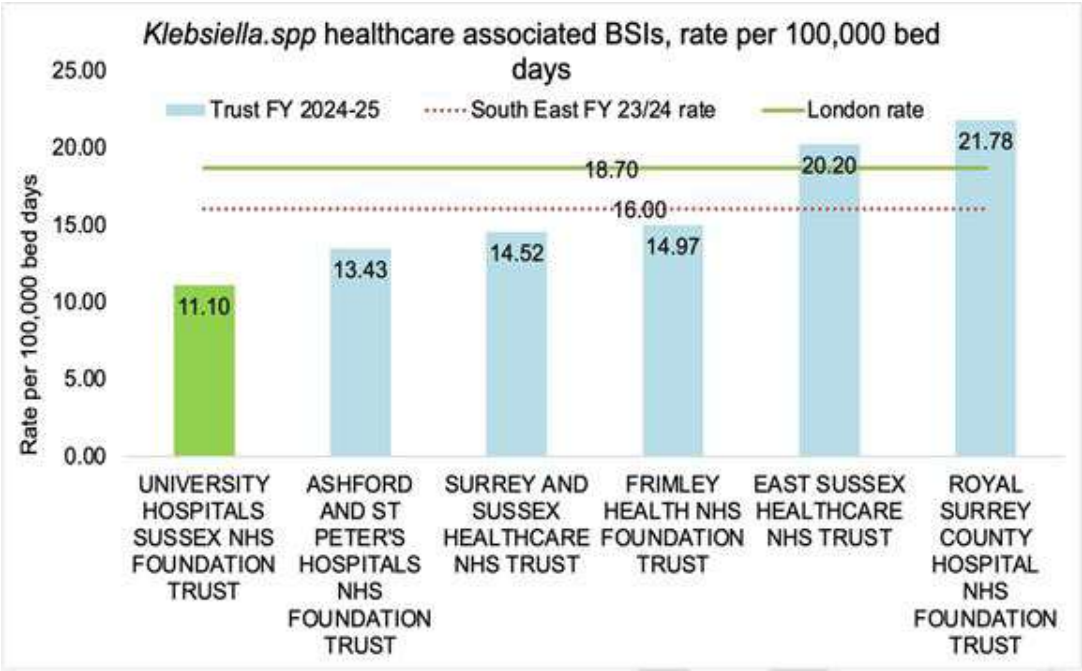


Figure 15: *Klebsiella* species healthcare associated BSI rate comparison – South-East region and London.

4.11 Multi-Drug Resistant Organisms (MDROs)

MDROs are bacteria resistant to multiple antibiotics, making infections difficult to treat. At UHSussex, MDROs are not endemic, and cases remain sporadic. We have a screening programme for high-risk individuals, to enable early detection and appropriate management. There were no significant outbreaks in 2024/25.

In late July a patient was admitted to Princess Royal with a pan-resistant *Acinetobacter baumannii* (resistant to all antibiotics) and *Candidoyzma auris*. The patient had returned from Greece (on a commercial flight) after spending time in ICUs in Crete and Rhodes.

They presented at PRH via ED and were admitted to a ward. Following deterioration they were admitted to ICU. A CPE screen identified the multi-drug-resistant *A. baumannii*, which was also found to be resistant to colistin (a final line antibiotic used to treat MDRO infections). Despite extensive searching and collaboration with national experts, there were no antibiotics the organism was susceptible to – so combination therapy of sub-optimal antibiotics was used to treat this infection. The patient died.

A total of 33 other patients required contact screening with no further transmission was identified.

The presence of a patient with such a resistant organism resulted in the ITU being closed other than for urgent treat and transfer.

A number of IPC issues were raised, including prompt identification and screening, safe isolation, environmental decontamination, equipment decontamination, environmental surfaces such as wood, water safety and compliance of outlets, human waste disposal, and last offices.

As a result of the incident (it was not an outbreak as the patient was admitted from Greece with the organism, there were no further cases); the ICU at PRH was given an extensive refurbishment to improve the fabric of the environment. There remains a need to undertake work on the dated and failing ventilation system, and we have also recommended updating the medical gas 'bollards' to improve space and efficiency and enable cleaning and maintenance.

Learning was shared in well received sessions at the Infection Prevention Society annual conference and at the Healthcare Infection Society/Federation of Infection Society Conference. Raising awareness of this incident helped identify further cases in other parts of the country and enabled UKHSA to undertake proactive surveillance. At the request of colleagues from the New Hospitals Programme a video was recorded of the 'story' to press home the need for a safe environment in a world where we are seeing such significant resistant infection.



Pat Cattini, Dr Jo Peters and Dr James Price discussing the Pan Resistant Acinetobacter case at FIS/HIS24 in Liverpool.

4.12 Respiratory viruses

4.12.1 Influenza A and B: The 2024/25 influenza season was worse than in recent years; with cases occurring earlier in the season and continuing for longer than expected, well into the spring. December 2024 was particularly challenging with a rise in patients presenting with influenza, a reflection of high community prevalence. The 2024 staff influenza and COVID-19 vaccination campaign ran from October to January delivering nearly 10,000 vaccinations (5,000 of each type) to staff across the Trust. Despite this overall uptake was poor, averaging 31% for influenza and 26% for COVID-19, and this was reflected in multiple ward outbreaks which included staff sickness. A set of 'IPC Winter Action Cards', which summarise key management aspects for confirmed or suspected respiratory tract infections was launched across the trust. Outbreak control meetings were held daily to review cases and management and affected wards received daily support from the IPC team.

4.12.2 COVID-19: Symptomatic COVID-19 patients were seen throughout the year, with a peak in winter. This led to bay closures but few full ward closures. Continuous education and training on IPC precautions were promoted.

4.12.3 RSV: The RSV season was consistent with national rates, with no healthcare-associated outbreaks.

4.12.4 Testing for Respiratory Viruses

The IPC team recommended implementation of a new lateral flow test that detects influenza, RSV and COVID-19. The use of LFD is about 1/10th of the cost of a PCR test, and the result is available in 10 minutes (as opposed to 6–12 hour turnaround time offered by laboratory-based PCR testing). Unfortunately, the LFT was identified and introduced relatively late in the season and did not fully embed, however further work has been undertaken to ensure we are ready for the 2025/26 season.

4.13 Norovirus

Throughout the year, there were intermittent cases of Norovirus, mirroring national trends. Several small ward outbreaks occurred particularly in Q3 and Q4. There were larger outbreaks in February (WH) and March (SRH). The SRH outbreak led to significant bed losses, prompting the Trust to declare a critical incident and activate business continuity plans. Daily outbreak meetings were held, and the IPC team provided intensive support to the affected wards. Risk factors identified on the wards included poor cleaning of tables and lockers, as the work had been assigned to kitchen staff, poor commode cleaning and hand

hygiene practices. The outbreak was controlled by early April. Key learnings included ensuring full attendance at outbreak control meetings for comprehensive situational reports, improving communication and coordination during incidents, and enhancing education for all staff on outbreak recognition and management.

4.14 MPox

UHSussex successfully managed a suspected, then confirmed patient with a High Consequence Infectious Diseases (HCID) via the Infectious Diseases (ID) Unit based at RSCH. The patient was admitted overnight on ID ward prior to a nationally coordinated HCID transfer to St Thomas's hospital in London.

The IPC and ID Teams participated in the national incident call, and the handling of the case at RSCH was commended and the patient was allowed to remain overnight on the ward as they had been securely isolated and managed.

Mpox Clade 1b was derogated by UKHSA in March 2025 as no longer a HCID.

To ensure that the trust is prepared for any HCID the IPC Team have ensured that the multi-disciplinary teams on each site have discussed the safest and least risk averse admission pathways for patients suspected or confirmed with a HCID. Safe assessment, testing and admission pathways for all HCID, are now in place for emergency departments across UHSussex. 'Live' action cards have been developed and are available on the intranet.

A HCID PPE ensemble training course is now available on the IRIS platform to relevant staff. In addition to which bespoke face-to-face PPE ensemble training is being delivered by IPC.

The finance and storage facilities for the vast HCID PPE ensemble was clarified during and the HCID PPE kit is available, with cascade training for safe donning and doffing procedures.



An IPC Training session on correct donning and doffing of HCID PPE

5. Surgical Site Infection surveillance

Criteria 4: The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

The National Surgical Site Infection Surveillance (SSIS) programme in England, established in 1999 and run by the UKHSA, monitors patient outcomes post-surgery to track and reduce the risk of surgical site infections (SSI). This programme helps healthcare providers to collect and compare data, identify infection causes, and promote improvements. Providers receive quarterly reports comparing their data with others, and an annual report is published. Monitoring for orthopaedic surgeries (total hip and knee replacements) is mandatory for at least three months each year, with surveillance of SSIs in other surgical specialties remaining optional, albeit recommended. The UKSA quarters run per calendar year rather than financial year.

5.1 SSIS at UHSussex

SSI are a common cause of HCAs. Whilst most SSI are localised to the incision site they can develop in deeper tissues. Rates of SSI vary between specialities, with higher rates associated with operations undertaken on parts of the body that harbour a higher burden of micro-organisms.

At UHSussex, the SSIS program is well-established across both the Specialist and Surgical divisions.

Unfortunately, the SSI nurses for both surgical divisions left their posts in December leaving a gap in provision over Q1 (Jan to March 2025). These posts were recruited with the new post holders starting in April 2025.

Over the year SSI surveillance was carried out to review primary (elective) hip and knee replacements, fractured neck of femur surgery, breast surgery, and coronary artery bypass graft (CABG) surgery.

Table 9 below provides a quarterly view of SSI rates by operation and hospital site. SSI data is reported by calendar year quarters. The most recent data is up to end of UKHSA Q1 2025 (January to March). Please note that the UKHSA reporting system excludes patient-reported infections, as it focuses on infections detected by hospital clinicians or during readmissions, not via optional patient reports unless they are confirmed by a clinician. This data is not included in national benchmarks or outlier assessments because the patient-reported data

method is optional and inconsistent across hospitals. Data may change from that previously published if further cases are added due to late diagnosis.

Operation	2023 Q1 (Jan-Mar)	2023 Q2 (Apr-Jun)	2023 Q3 (Jul-Sept)	2023 Q4 (Oct-Dec)	2024 Q1 (Jan-Mar)	2024 Q2 Apr-Jun	2024 Q3 July-September	2024 Q4 (Oct-Dec)	2025 Q1 (Jan-Mar)	National (5 year rolling average)
TKR SRH	0.0%	1.5%	0.0%	0.0%	0.8%	0.9%	0.0%	0.0%	0.0%	0.4%
THR SRH	2.2%	0.0%	0.0%	0.0%	0.8%	1.8%	1.7%	0.0%	0.0%	0.6%
THR PRH	0.0%	2.2%	0.0%	2.0%	0.0%	0.0%	0.0%	0.8%	-	0.6%
TKR PRH	0.0%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.9%	-	0.4%
#NoF WGH	-	-	-	-	2.6%	-	-	-	-	0.9%
Breast SRH	0.0%	0.0%	0.0%	1.4%	0.0%	0.0%	1.4%	0.0%	1.8%	0.6%
Breast WGH	1.2%	0.0%	1.1%	1.0%	0.0%	1.9%	0.8%	0.0%	3.3%	0.6%
Large Bowel RSCH	-	-	-	-	2.2%	2.0%	-	-	-	8.0%
CABG RSCH	2.0%	12.3%	9.0%	13.3%	1.3%	0.0%	3.5%	6.5%	2.2%	2.7%
Other Cardiac								4.6%	1.6%	3.0%

Table 9: Summary of latest Trust verified SSI rates by procedure and site August 2025. Unavailable data is marked by a dash (-). Key: Total knee replacement (TKR), total hip replacement (THR), fractured neck of femur (#NOF).

There is ongoing work using the One-Together gap analysis framework to review and refine clinical pathways. Senior multidisciplinary groups led by the Chiefs in both surgical and the specialist divisions, meet to review all identified SSI cases, and determine learning and areas for improvement.

Pat Cattini gave presentations about the work and outputs from the One Together framework used by the trust at the annual Association for Perioperative Practitioners conference in August, and at the One Together expert conference in March. Dr Sam Machen, Associate Director of Patient Safety also gave a presentation at the One Together Conference on the use of patient safety incident response framework has been used to investigate and manage SSI risks in cardiac surgery.



Pat Cattini Presenting UH Sussex work at the OneTogether Expert Conference

5.2 Orthopaedics

The surgical divisions continue to hold quarterly multi-disciplinary meetings using the 'OneTogether' framework to review and improve the orthopaedic surgical pathway. This framework provides a comprehensive, evidence-based approach to prevent SSI and improve patient outcomes through standardized best practices and collaboration among healthcare professionals.

From these meetings, new improvement actions are trialled to see if they can enhance patient safety. Quarterly multi-disciplinary team (MDT) meetings, led by the Chiefs of Surgery, review all SSI cases to identify learning opportunities. Efforts are ongoing to identify high-risk patients early and implement targeted preventative measures, such as using negative pressure dressings.

5.3 Cardiac

The IPC team have continued to provide support to the cardiac surgery team in reducing SSI among patients undergoing CABG and other cardiac surgeries. This has included support to the weekly surveillance monitoring meeting and the quarterly review panels. The support for early recognition and intervention to prevent infection developing has resulted in improvements in infection rates in CANG and other cardiac surgeries.

All cardiac theatres have been reviewed and meet required ventilation standards, although some improvements have been identified. These are planned for funding in 2025-26. Some environmental improvements have been achieved, and the cardiac ICU will be fully refurbished when an agreed move takes place to the ITU in the LMB in 2025.

Infection rates significantly improved to below the national benchmark from January to March, and support is ongoing.

5.4 Breast

The IPC team continues to support the development of SSI surveillance following breast surgery. Formal UKHSA SSI surveillance for breast surgery is conducted at SRH and WH. Work is needed to establish similar surveillance at PRH.

5.5 Blood culture contamination

In response to a concern regarding the incidence of blood culture contamination, a 6-month analysis of all blood cultures cultured at RSCH, Royal Alex, and PRH was undertaken, with

an average contamination rate of 3.6% (of all cultures taken). Contaminated cultures from Accident and Emergency units were overrepresented in the results. Scientific consensus is that a contamination rate more than 2-3% is a trigger for epidemiological investigation. In response the IPC team have encouraged a renewed focus on aseptic-non-touch-technique (ANTT) and teaching on blood culture contamination as part of the junior doctor induction, across the Trust.

6. IPC in built environment

Criteria 2: The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

6.1 Facilities

The Trust manages its facilities contract in-house. Ward sisters conduct weekly checks of clinical areas against The Hygiene Code, with monthly validation by matrons. Results are recorded on the Tendable system.

The IPC team have a weekly meeting with Facilities to discuss any operational issues identified in the week and agree rectifications and solutions.

All NHS Trusts must conduct an annual PLACE assessment, which evaluates non-clinical aspects impacting patient care, such as cleanliness, maintenance, privacy, food quality, and dementia-friendly facilities. At UHSussex, PLACE assessments are part of weekly routines, conducted by patient assessors and staff teams, including facilities, estates, and infection prevention and control. These assessments cover all clinical departments and some non-clinical areas like main receptions and gardens. Outcomes from weekly inspections lead to both immediate and future improvements in patient environments. Results are discussed at bi-monthly PLACE review meetings, and a quarterly report with an action plan is provided to the Patient Engagement and Experience Committee.

6.1.1 Environmental Cleanliness

The Facilities and Estates Division ensures a safe, clean environment for patients, staff, and visitors. The Domestic department uses both manual and automated cleaning methods. Technical audits of all hospital areas are conducted, categorized into four risk levels, with very high-risk areas being the top priority. Audit results are reviewed monthly at IPOG meetings, with multi-disciplinary discussions to drive continuous improvements.

Where issues with the cleaning standards are identified these are discussed with Facilities for prompt rectification.

Work is in progress to improve clarity on cleaning responsibilities to ensure all necessary equipment receives adequate decontamination.

The F&E team have a comprehensive list of the areas which need improvement, particularly for the Estates team. This is managed on a weekly basis through the weekly PLACE inspections, work tickets for repairs. Larger pieces of work that need to be completed by the Estates or Capital Projects teams are listed and discussed with Hospital Directors and priority-rated in preparation for any minor works monies that become available.

The National Patient Led Assessment of the Clinical Environment (PLACE) is undertaken in the autumn every year. Figure 16 shows how UH Sussex compares with the national average score.

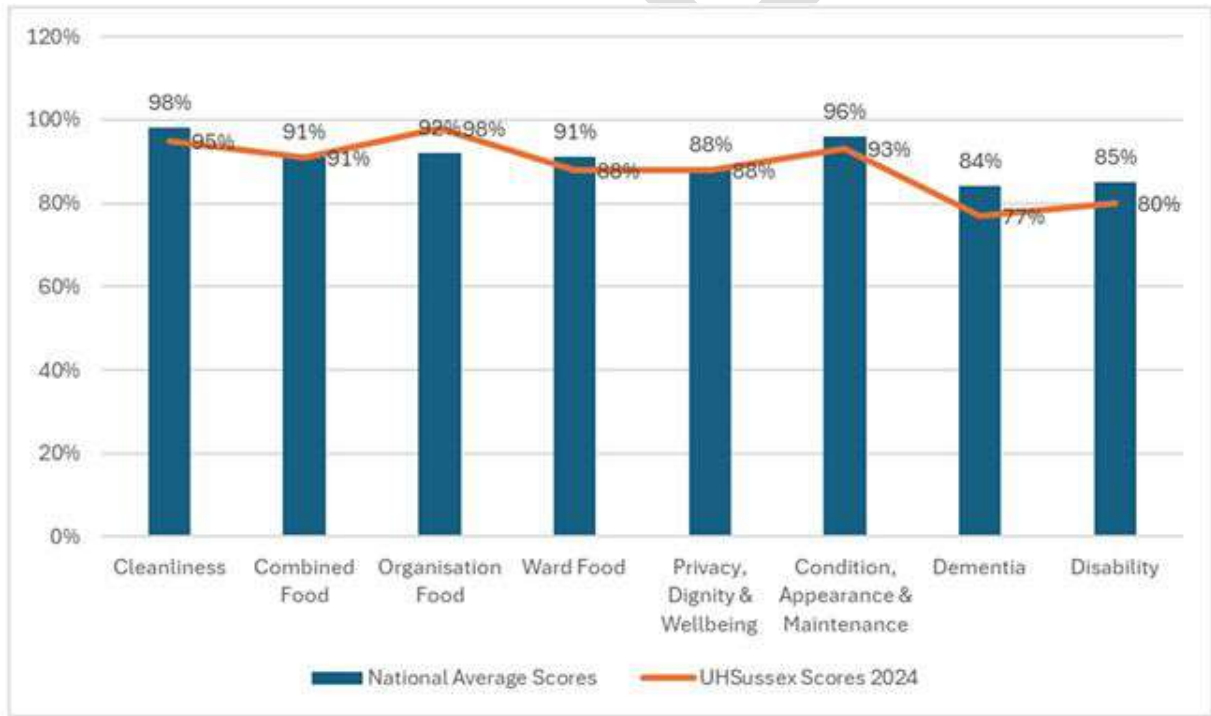


Figure 16; National PLACE inspection scores UH Sussex 2024

6.1.2 Automated Room Disinfection

Effective room decontamination is crucial to prevent cross-infection, especially for pathogens like C. difficile and multi drug-resistant organisms. Automated systems, such as Hydrogen Peroxide Vapour (HPV), are used for enhanced disinfection. HPV is available at SRH and WH. A planned trial and purchase of Ultraviolet-c (UVC) light technology for RSCH/ PRH has

not been possible. UVC and HPV were used successfully at PRH when we cared for the patient with the pan-resistant *Acinetobacter baumannii*. UVC was used to decontaminate portable equipment including beds in an empty side room. After the patient died, the whole unit was decontaminated using HPV.

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6.2 Capital Projects

The IPC team collaborates with the Estates and Capital Project Teams to ensure facilities meet IPC standards.

Work has been undertaken to standardise equipment used in new builds such as basins and taps, floor and wall finishes etc.

IPC have been involved in all the major capital builds including RSCH ED redevelopment, Theatre 6 Bi Plane and the Sussex Cancer Centre and the new UTCs at WH and SRH

6.3 Planned Preventative Maintenance

Maintaining buildings and equipment is crucial for safe patient care. The Trust has a significant backlog of maintenance work, but progress has been made in replacing flooring in many areas. The Estates team conducts weekly and quarterly maintenance, servicing, and filter changes for ventilation systems.

6.4 Ventilation

Proper ventilation is essential in healthcare settings to provide a safe environment and control odours. Specialised ventilation reduces airborne infection risks in areas like operating rooms and critical care. The Estates department manages ventilation systems, following HTM 03-01 guidelines. The Trust wide Ventilation Safety Group (VSG), a multidisciplinary team, oversees ventilation, monitors reports, and recommends improvements. The VSG met

quarterly. Reports are taken at the TIPC meeting, and the Director of Estates and Facilities now also reports into QGSG.

Many theatre air handling units are nearing the end of their lifespan, causing frequent breakdowns and operational disruptions. A 10-year capital plan has been developed with funding for replacement of units according to priority. There has been engagement with clinical teams and agreement for annual operating theatre shutdowns to enable the annual validation and any planned preventative maintenance, though this is sometimes difficult to achieve due to the competing priority to reduce waiting lists and thus not take the theatre out of service. The VSG have requested robust logs be kept of each system, any failings and remedial works needed to ensure that the systems remain safe to use.

The VSG maintains logs of system performance and updates the trust risk register as required.

6.5 Water

Water is essential in healthcare settings for keeping patients clean and hydrated, and for running equipment. Common water outlets include handwash basins, showers, toilets, hydrotherapy facilities, ice machines, and drinking fountains. However, these outlets can pose risks to patient safety by exposing them to waterborne pathogens like *P. aeruginosa* and *Legionella pneumophila*.

The Trust follows national guidance (HTM 04-01: Safe water in healthcare premises), monitored by the Trust wide Water Safety Group (WSG). This multidisciplinary group is responsible for developing and managing the water safety plan (WSP). They also advise on remedial actions when water systems or outlets are contaminated, increasing risks to vulnerable patients. The WSG meet quarterly during the year. The WSG is working to further develop process and governance. The WSG reports to TIPC and escalates identified risks to QGSG for mitigation.

The Trust continuously monitors for signs of *Legionella pneumophila* across all services and *P. aeruginosa* in augmented care areas, which provide advanced medical support and continuous monitoring for patients with critical or complex health conditions.

Work was progressed on the new Sussex Cancer Centre at RSCH. The Water Safety Group, led by the IPCT at UHSussex sought and obtained approval for a reduction in clinical handwash basins. Water outlets in healthcare premises are now widely recognised as risk to patient safety. The body of scientific literature indicates that reduced exposure to water

outlets is associated with a reduction in healthcare associated infection. The push to increase access to hand hygiene needs to be balanced against the risk of water borne infection by gram negative organisms such as *P. aeruginosa*. To mitigate this risk we proposed reducing the number of water outlets in key areas including the clean utility/drug prep rooms and single patient bedrooms. This approach was approved by colleagues at the 'New Hospitals Programme' and later endorsed following publication of the NHS Estates Technical Bulletin 2024/3 Designing safe spaces for patients at high risk of infection from nontuberculous mycobacteria and other waterborne pathogens. This approach was shared at the IPS Conference in Sept 2024.

An audit of facilities at the Park Centre for Breast Care in Brighton revealed several maintenance issues including problems with hand wash basins. Many did not work and had not been serviced. There was no water testing in place. IPC worked with lead nurse Lynette Awdry and Estates colleagues, and all the clinical handwash basins were either replaced or fixed. Other remedial work was also undertaken to improve the environment.

Plans to move the haematology-oncology unit at RSCH into the Courtyard building were significantly delayed due to ongoing contamination of the water supply. Extensive work was undertaken to make the building safe for use including regimented flushing of water, temperature monitoring, Authorised Engineer for Water (AE (W)) assessments and installation of Omnia-Klenz (non-invasive monitoring and analytical system). As per HTM 04-01, water sampling and testing continues to be monitored as per guidance for an augmented care area. The Oncology team took occupancy in February 25.

The Estates team at PRH were extremely helpful in replacing some non-compliant handwash basins in the ITU when we cared for the patient with the Pan-Resistant *Acinetobacter baumannii*. This was an important improvement as resistant Gram-negative organisms are known to inhabit drains and spread may be exacerbated by non-compliant basins such as the one shown in the picture below. This was an important improvement as resistant Gram-negative organisms are known to inhabit drains and spread may be exacerbated by non-compliant basins.

IPC highlighted concern over the temporary use of 'Water Leek Diverters', which are used when there is a roof or pipework leak. A drain outlet hose is put into a WHB for water discharge. IPC recommended the use of a self-contained system due to concern that it will lead to drain contamination.

6.6 Decontamination of medical devices

The Trust-wide Decontamination Committee has met quarterly, and the terms of reference were updated.

UHSussex operates four Central Sterile Services Departments (CSSD), one at each main site. These departments are responsible for reprocessing instruments used in surgeries and other procedures that require sterile equipment. The performance of CSSDs is benchmarked against national regulations to ensure high standards.

The endoscopy unit at WH/SRH hold Joint Advisory Group on Gastrointestinal Endoscopy (JAG) Accreditation. The unit at RSCH does not hold JAG accreditation currently.

Local decontamination audits were completed at SRH, WH and PRH and are in progress at RSCH.

There were 2 endoscopy incidents that were investigated. The first involved an external provider (18-week support) who used an endoscope that had been washed but had not been through the appropriate automated process on a second patient at RSCH. After assessment the incident was considered low risk to the patient with the patient being informed at the time. The external company investigated the incident and have highlighted training requirements, and the surgical division presented the incident to the patient safety incident group.

The second involved use of a previously condemned TOE (Trans-oesophageal endoscope) probe that was put into use in an emergency. The staff member unfortunately overlooked the prepared trolley and instead took another scope out of a case on a high shelf, despite it being labelled condemned. The scope had been cleaned before being stored and the learning was to move condemned scopes to another area to avoid mix up.

7. Antimicrobial stewardship

Criteria 3: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial resistance (AMR) is one of the biggest challenges in modern healthcare, with significant social and economic impacts. The UK Government's 20-year vision includes national objectives to manage antimicrobial resistance, emphasizing the appropriate use of antimicrobials. An updated 5-year action plan was launched in May 2024 adopts a "One Health" approach across humans, animals, food, and the environment—focusing on reducing unnecessary antimicrobial exposure, optimising use, strengthening surveillance, investing in

innovation, and maintaining global collaboration to advance the UK's 20-year vision to contain, control, and mitigate AMR by 2040.

The Trust employs three Antimicrobial Pharmacists (plus one rotational post at RSCH) to oversee stewardship and guide appropriate prescribing practices. The two pharmacists based at RSCH also support the infectious diseases ward with clinical pharmacy cover.

Specialist pharmacists support Infection Consultants in managing infections in patients, including those who may acquire infections during their stay or as a side effect of other treatments. This includes cancer patients needing antibiotics to prevent infections during immunosuppressant therapies and intensive care patients with multiple invasive devices.

National workforce challenges, including a shortage of trained Pharmacists and Consultant Microbiologists, have impacted stewardship activities. This has reduced the number of general ward Pharmacists and pulled Antimicrobial Specialist Pharmacists into core pharmacy services.

7.1 Antibiotic consumption

Antibiotic consumption is tracked using data from a system called 'RxInfo'. There was no national target for reduction of antimicrobial use for secondary care in 2024-25 due to the new 5-year action plan being published after the date of the national contract for commissioning. However, the ASG continued to monitor the use of WHO watch and reserve classification antimicrobials with the historical contract measure of reduction of 10% from use in 2019. The Trust did not meet the target, which was challenging based on use growth in the years post COVID-19, but we have seen continued reductions in use over the last 2 financial years which is gratifying. The ASG plan to continue to monitor use of broad-spectrum use going forward and focus on clinical areas of high use for stewardship interventions.

7.2 CQUINS

There were no national mandatory CQUINs in 2024-25. However, the national AMR team supported a continuation of the intravenous to oral switch CQUIN for the year. UHSussex agreed with our local commissioners to continue with the CQUIN as a quality measure of good care within our local contract.

Data was collected across the 4 hospital sites and submitted every quarter by the antimicrobial pharmacists. 100 patients on IV antibiotics per quarter were reviewed using the Antimicrobial Intravenous to Oral switch Decision Aid developed by the UKSHA and assessed

as either appropriate to remain on IV or would be eligible for switch. The minimum target set was less than 25% not switched at the point of review and the maximum target less than 15%. The ASG set the target to meet as the stretch less than 15% target. The cumulative end of year result was 15.87% (within minimum target (25%) but just above maximum target (15%))

The trust met the lower target but missed the higher local target by a small percentage. Reasons for this were assessed to be multifactorial including higher patient numbers and the use of temporary escalation spaces, reduced nurse/doctor/patient ratios, low numbers of pharmacist staff on ward areas due to vacancies and a lack of Consultant Microbiologists at Worthing/SRH due to vacancies. The ASG plan to continue this as an area of focus with a review of the last 2 years data to look for trends and develop an action plan for further improvements in this area.

The results can be seen in table below

Quarter	% of prescriptions not appropriately switched at time of audit	Target	Comment
Q1 - April – June 24	9%	Less than 15%	Target met
Q2 Jul – Sept	13.4%	Less than 15%	Target met
Q3 – Oct – Dec	18%	Less than 15%	Over target.
Q4 – Jan – March 25	23%	Less than 15%	Over target.

Figure 17 IV Oral Switch target data 24/25

7.3 ASG meetings & Guidelines

Cross-site ASG meetings have continued, despite significant challenges in staffing both within pharmacy and in microbiology. Work to unify the empiric antimicrobial guidelines across the organisation has continued this year and an ongoing workplan of outstanding guidelines to unify has been put in place. ASG work has been impacted by the staffing challenges in pharmacy. The previous shortages in Microbiology staffing have been mitigated with new appointments at RSCH, but are still an issue at St Richards where we rely on locum cover.

Pharmacy shortages will improve in 2025 with an over recruitment of newly qualified Pharmacists following a successful business case by the Interim Chief Pharmacist.

8. Information on infections

Criteria 4: The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

The IPCT is dedicated to supporting public health by effectively managing and communicating important IPC results to both internal and external stakeholders. Our IPC epidemiologist has enabled us to use data more effectively to identify trends and improve patient safety and quality outcomes. The procurement of the new pan Sussex Laboratory Information Management System (LIMS) will improve data management but has unfortunately been delayed.

8.1 Patient and Staff Communication

Information leaflets are available for staff to discuss with patients, and the IPCT provides additional support as needed. The IPCT also collaborates with the communications team to ensure important information is effectively communicated to staff and patients, promoting safe care and compliance with national guidelines. An example of this collaboration is the HCID and the Respiratory virus action cards.

9. Infection Management

Criteria 5: That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

At UHSussex, we continuously monitor for infections to ensure early detection and effective management. During working hours, the IPCT visits clinical areas daily, attends operational site meetings, and reviews microbiology and virology results throughout the day. Outside of these hours, site teams continue to monitor and manage patients with suspected or known infections, passing this information to the IPCT as soon as possible. The Microbiology team communicates any key infection indicators or early warnings to the IPCT and is available on call for urgent specialist advice outside of regular hours.

10. Health care worker responsibilities

Criteria 6: Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

During 2023-24 the IPCT have supported a series of initiatives aimed at enhancing healthcare workers engagement, awareness, and involvement in IPC.

10.1 Link Champions

IPC Link Champion meetings are held every other month. Sessions covered a variety of topics to promote and embed good practices across the Trust. IPC team members liaise with the Link Champions as a conduit to effective communication among clinical teams.

10.2 Education and training

All staff members, both clinical and non-clinical, receive IPC training during their induction. Clinical staff also complete annual virtual IPC training through the Health Education England e-learning tool. Currently, overall IPC training compliance is 92.3%. To improve uptake, we plan to reintroduce face-to-face training sessions over the coming year, based on feedback.

New resident doctors attend face to face sessions where they have the opportunity to meet with IPC, the antimicrobial pharmacy team and the IV team.

IPC Team members also provide ward based teaching sessions as requested.

The IPC team also use other opportunities such as the Annual General Meeting to showcase work and key messaging.



IPC Team members in the 'art space' at the 2024 Trust AGM

10.3 IPC Audit and monitoring

10.3.1 IPC Environmental spot check

The rolling programme of quarterly IPC environmental audits in clinical areas has continued via the Tendable programme in conjunction with the Matron and a member of the domestic team where possible. Feedback is given to ward and departmental staff, including domestics, to enable rectifications and communicate learnings. In addition, an IPC spot check audit is completed and available for the clinical teams to share and discuss during their patient safety huddles.



Figure 18 Trend analysis of environmental spot check audit data over 1 year.

10.3.2 IPC Weekly assurance audits

IPC Weekly Assurance audits are conducted using Tendable across the Trust and undertaken by the senior departmental nursing team.

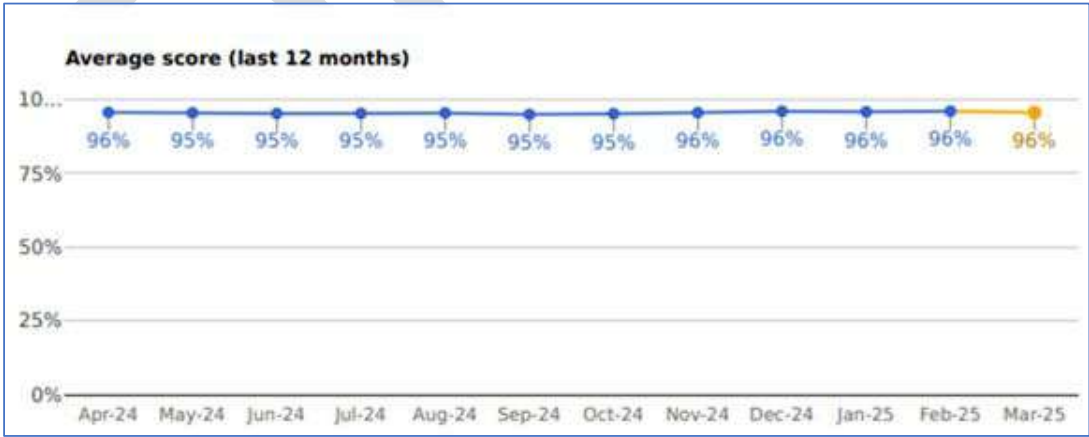


Figure 19: Trend analysis of weekly cleaning assurance audit data over 1 year.

The IPC weekly assurance audit allows clinical leads to directly review key aspects of IPC and action any issues identified.

10.3.3 Hand Hygiene Compliance audits

The rolling programme of monthly IPC Hand Hygiene compliance audits in clinical areas continues conducted by clinical staff on the Tendable programme.

The average hand hygiene compliance score recorded on the wards for Q4 was 93%.

Hand Hygiene audit scores inform the IPC team of areas that require additional support with hand hygiene compliance through targeted education sessions.



Figure 20: Trend analysis of hand-hygiene audit data over 1 year, available on Tendable.

10.3.4 IPC Commode Audits

The IPCT aim to complete monthly commode cleaning validation audits across all sites. These reviews include commodes, shower chairs, raised toilet seats and bed pans. The IPC team continue to work with clinical teams to promote the importance of commode hygiene in line with the ‘Get It Right First Time (GIRFT) ethos.

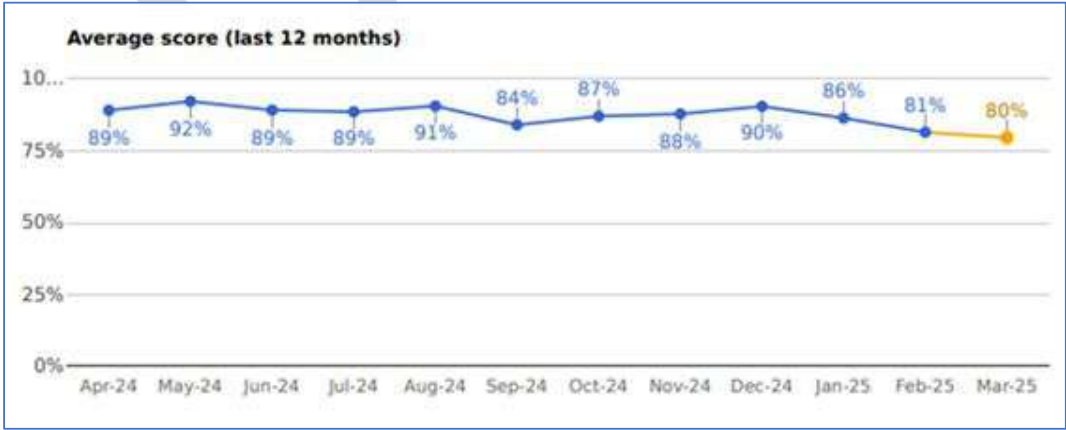


Figure 21 Trend analysis of commode audit data over 1 year, available on Tendable.

10.4 IPC supporting decarbonising healthcare

The IPC Team continue to support the national 'Gloves Off' campaign to reduce unnecessary use of gloves in healthcare.

Other areas where work is being carried out includes looking at re-processing of some low-risk medical equipment and reusable fabrics in theatre.

11. Isolation facilities

Criteria 7: The provision or ability to secure adequate isolation facilities.

UHSussex currently has a reasonable proportion of single rooms, although many lack *en suite* facilities. Isolation rooms are in the minority, and most do not have the appropriate mechanical ventilation to support negative or positive pressure ventilation. Additionally, the distribution of isolation rooms is uneven, with the majority located at RSCH. The Louisa Martindale Building at RSCH is equipped with 60% single rooms, including 10 isolation rooms in the new infectious diseases' unit and ICU. Where there are difficulties in locating a single room, risk assessments are used to determine priority.

12. Laboratory support

Criteria 8: The ability to secure adequate access to laboratory support as appropriate.

Having reliable laboratory support is essential for effective infection prevention and control. Our Trust operates two Clinical Pathology Accreditation accredited microbiology laboratories at RSCH and SRH. These labs are working to harmonize their approaches following the merger and are working towards a new Sussex wide LIMS.

13. Policy

Criteria 9: That they have and adhere to policies designed for the individual's care, and provider organisations that will help prevent and control infections.

13.1 Guidelines and Policies

All IPC policies are up to date as per Appendix 2

UHSussex follows the National Infection Prevention and Control Manual (NIPCM) for England, which is referenced in our IPC policies. Additionally, we use EOLAS an IT system that provides clear (MS principles to support the prescribing of targeted antimicrobial therapies. The IPCT have been working on adding additional IPC key advice to support the guidelines.

14. Staff Health

Criteria 10: That they have a system or process in place to manage staff health and wellbeing, and organisation obligation to manage IPC.

14.1 Staff Winter Vaccination Programme

Vaccination uptake fell as compared to previous years with 31% of staff receiving influenza vaccine and 26% receiving a COVID-19 vaccine. These figures are in line with national uptake figures indicating a degree of vaccine apathy. IPCT continues to work with divisions, occupational health, communications team and pharmacy to optimise uptake through information giving and ease of access to the vaccine.

14.2 FFP3 Respiratory Fit testing

Filtering Face Piece 3 (FFP3) respirators provide the highest level of protection against airborne particles, including viruses and bacteria, filtering at least 99% of airborne particles. They are commonly used in healthcare settings to protect against highly infectious diseases.

FFP3 respirator fit testing is mandated for patient-facing staff every two years, in line with NHS England resilience principles. During 2024/25, this service was provided by bank staff, leading to inconsistent availability across Trust sites. When staff pass a fit test, the mask type is recorded in their Health Roster profile.

The Trust has been challenged with improving fit testing numbers and a new team of Fit testers is being actively recruited to ensure a more robust offering going forward.

15. Research and scholarship

Over the last year the IPC department made substantial progress in developing its research and academic activities under the leadership of Dr James Price. The team has grown

significantly, with several new academic colleagues undertaking research that spans infection genomics, AMR), environmental hygiene, healthcare sustainability, and global health.

15.1 New team members and their projects include:

- Dr Maria Krutikov (NIHR Clinical Lecturer) – researching AMR in wastewater and the implications for environmental and healthcare transmission routes.
- Dr Simon Stoneham (NIHR Clinical Lecturer) – exploring host–pathogen interactions underpinning MRSA infections, with a focus on host susceptibility and bacterial virulence.
- Dr Lizzie Cross (NIHR Clinical Lecturer) – leading clinical trials for novel diagnostics and therapeutics in the management of skin and soft tissue infections.
- Dr Opeyemi Makanjuola (NIHR Academic Clinical Fellow) – evaluating safe reuse of surgical instruments using novel disinfection technologies to support healthcare decarbonisation.
- Ida Sey (PhD student) – investigating the role of whole-genome sequencing (WGS) in outbreak detection and IPC decision-making within hospital settings.
- Dr Lauren Hookham (Wellcome Trust CREATE PhD Fellow) – assessing transmission pathways of multidrug-resistant organisms in maternal and neonatal care settings in Uganda using WGS.
- Dr Jack Leach (Academic Foundation Doctor) – analysing local epidemiological trends in healthcare-associated infections using routine microbiological and clinical surveillance data.
- Dr Lena Al-Hasan (Research Fellow) – studying environmental sources of gram-negative bloodstream infections in hospital settings, including sink and surface contamination.
- Sid Mookerjee, (Academic Epidemiologist) - support applied epidemiology and modelling across IPC and global health themes.

15.2 Key departmental achievements include:

- **Academic Leadership:** Dr Price was appointed Director of the Centre of Infection and Antimicrobial Research (CINAMR) at Brighton and Sussex Medical School. CINAMR brings together clinicians and academics across Sussex, Surrey and Kent to advance translational research on infection and AMR. In addition, Dr Price led the inaugural GENOTIPE (Genomics to Optimise Infection Prevention) Network meeting. The

event, funded through Higher Education Innovation Funding (HEIF), convened over 40 stakeholders from across the NHS, academia, UKHSA, professional societies and industry to define research priorities and implementation challenges for WGS in IPC practice.

- **Research Capacity Building:** IPC Matron Andrew Davies was appointed to the Chief Nurse Fellowship Programme, developing artificial intelligence tools to predict and prevent healthcare-associated infections. In addition, the department supported four NIHR academic training applications (three ACFs, one CL) across infection-related specialties including GUM/HIV, orthopaedics, and healthcare sustainability.
- **Strategic Appointments:** Dr Price was appointed Research Lead for the Department of Global Health and Infection at BSMS, Research Lead for the Department of Infection at University Hospitals Sussex, and NIHR Regional Delivery Network Specialty Co-Lead.
- **Sustainable IPC:** The IPC team is a key partner in the new Green Healthcare Hub at BSMS, leading research on safe, evidence-based reuse of medical equipment to reduce environmental impact.

15.3 Research income and outputs:

- The IPC team supported successful research grants totalling £3.5 million
- Research was presented at major conferences, including the European Society of Clinical Microbiology and Infectious Diseases (ESCMID Global) 2024 and the Federation of Infection Societies (FIS) Conference 2024, Infection Prevention Society and OneTogether. Dr Price served as conference chair the FIS Conference 2024.

15.4 Selected publications:

- Osborne-Grinter M, Cousins S, Ramirez J, Price JR, et al. Delivering surgery outside operating theatres: scoping review. BJS Open. 2024. DOI: 10.1093/bjsopen/zrae104
- Shutt AE, Ashiru-Oredope D, Price JR, et al. The intersection of the social determinants of health and antimicrobial resistance in human populations: a systematic review. BMJ Global Health. 2025. DOI: 10.1136/bmjgh-2024-017389
- Leiser R, Shutt AE, Price JR, et al. Insights into the implementation of a whole genome sequencing report form (SRF) to reduce nosocomial SARS-CoV-2 in UK hospitals: a qualitative evaluation. PLoS One. 2025. DOI: 10.1371/journal.pone.0321534

This growing research programme exemplifies the department's commitment to innovation, real-world evidence generation, and building capacity in applied IPC research to improve patient safety and health system resilience.

16. External work with national IPC groups

James Price (i) Healthcare Infection Society Secretary, (previously chair of Professional Development Committee), (iv) UK representative for the European Committee for Infection Control (EUCIC), (v) expert panellist on national guidelines committees including surgical site infections, *S. aureus* panton valentine leucocidin, and epic-4

Pat Cattini, is (i) Member of the expert advisor group to New Hospitals Programme, (ii) member of the Healthcare Infection Society Professional Development Committee, (iii) Infection Prevention Society (IPS) Scientific Programme Committee member, (iv) Member of the OneTogether Board, (v) Member of Central Sterilising Club Board.

Sid Mookerjee is Member of the Healthcare Infection Society Professional Development Committee

Sharon Reed, Deputy DIPC Incoming IPS Wessex Branch Deputy Coordinator

17. Other External Work

We have extended our contract to provide IPC cover and support to the local hospices across Sussex. This includes undertaking IPC audits and giving clinical support.

An audit of IPC provision was undertaken for Pioneer Healthcare, an independent provider of wound care services in Sussex and other parts of the country.

Engagement and leadership within the Sussex IPC cell which includes representatives from all acute, community and local authority providers.

Engagement with NHSE South East IPC cell. Contributor to several projects including *C difficile* and *E. coli* working groups.

The IPC team is a key partner in the new Green Healthcare Hub at BSMS, leading research on safe, evidence-based reuse of medical equipment to reduce environmental impact.

18. Achievements

We would like to congratulate Sharon Reed our Deputy DIPC, who was awarded Bronze in the British Journal of Nursing Infection Prevention Nurse of the Year 2025 award in March.



Karen Wares (IPS Board) with Sharon Reed Deputy DIPC at the BJN Award ceremony

19. Priorities for 2024-25

Our IPC annual programme of work is shown in appendix 3.

Our priorities focus on achieving full compliance with the IPC Board Assurance Framework, including antimicrobial stewardship and a robust fit testing service. We will strengthen surveillance of surgical site and line-associated bloodstream infections, extend IPC reviews across all Trust sites, and embed PSIRF methodology to ensure effective learning from investigations. Robust audit feedback and divisional accountability will remain central to our assurance processes. Alongside this, we will support Facilities and Estates in maintaining water and ventilation safety, while expanding engagement through the IPC Link Champion programme and wider clinical networks. Finally, we will broaden our research, innovation, and sustainability agenda—enhancing team capability, advancing projects such as hydration and mouth care, and increasing regional and national impact to support safer, greener healthcare.

20. Conclusion

The Trust demonstrates compliance with the Hygiene Code across all its sites, as outlined in the Board Assurance Framework.

The IPCT works collaboratively with staff across UHSussex to ensure that infection prevention is fully integrated into all activities. This helps protect both patients and staff from avoidable infections.

For the year ahead, there is a comprehensive IPC programme that incorporates learning opportunities, experience, and empirical research. This programme aims to improve patient safety and experience while reducing infection rates.

21. References

[English surveillance programme for antimicrobial utilisation and resistance \(ESPAUR\) report 2023 to 2023 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

[NHS England » National infection prevention and control manual \(NIPCM\) for England](#)
[Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK \(www.gov.uk\)](#)

22. Appendices

Appendix 1 TIPC Membership

Appendix 2 IPC Policies

Appendix 3 - Summary of IPC Annual Programme of work 2025/26

Appendix 1 TIPC Membership

TIPC membership includes:

- Chief Nurse /DIPC (Chair)
- Corporate DIPC (Co chair)
- Medical Director
- Infection Prevention & Control Doctor / Consultant Microbiologist
- Deputy DIPC
- Infection Prevention Matron(s)
- Surgical Site Surveillance Lead Nurses
- Antimicrobial Pharmacist(s)
- Decontamination Lead(s)
- Divisional Director of Nursing (DDoN) /Head of Nursing (HoN) - Medicine
- DDoN/ HoN Surgery
- DDoN/ HoN Women & Children
- DDoN/ HoN Cancer
- DDoN/ HoN Women and Children
- Director of Estates & Facilities/ Associate Director of Estates & Facilities
- Health and Safety Lead(s)
- Occupational Health Manager(s)
- UKHSA representative
- NHS Sussex Integrated Care Board (ICB) Infection Prevention Lead Nurse(s)

Appendix 2 List of IPC Policies

Policy Title
UHSIC001 Infection Prevention and Control Organisational and Assurance Framework Policy
UHSIC002 Standard and Transmission Based Precautions Policy
UHSIC004 Isolation of Patients Policy
UHSIC006 Decontamination Policy
UHSIC007 Prevention and Control of Meticillin Resistant Staphylococcus Aureus (MRSA) Policy
UHSIC008 Clostridioides difficile Infection Policy
UHSIC009 Norovirus (Viral gastro-enteritis) Policy
UHSIC010 Blood Borne Virus Policy (Including Management of Sharps Exposure Incidents and HIV Post Exposure Prophylaxis)
UHSIC0011 Infection Control and Prevention Management of Tuberculosis Policy
UHSIC0012 Aseptic Non-Touch Technique Policy
UHSIC013 Respiratory Viruses Policy
UHSIC014 Creutzfeld Jacob Disease (CJD) and variant CJD (vCJD) Policy
UHSIC015 Policy for the prevention of surgical site infection
UHSIC017 Prevention of Aspergillosis and infection from other fungi during demolition/construction and renovation activities Policy
UHSIC018 Infestation Policy
UHSIC020 Control of Multi Drug Resistant Organisms (MDRO) (including glycopeptide-resistant enterococci (GRE) and multidrug resistant Gram negative bacilli Policy
UHSIC026 Management of a Patient's Body Following Death with an Infection Policy
UHSIC027 Surgical Instrument Loan Policy
UHSC049 Viral Haemorrhagic Fevers: Management and Control Policy
UHSC059 Blood Culture Collection Technique Policy
UHSTW014 Animals and Pets in Hospital Policy
UHSTW015 Outbreak Management of Healthcare Associated Infection Policy

UH Sussex Infection Prevention and Control Report 2024-2025

Appendix 3 Summary of IPC Annual Programme 2025/26

Summary

The Infection Prevention and Control (IPC) Annual Plan 2025/26 sets out the proposed activities for the IPC service at University Hospitals Sussex NHS Foundation Trust. This plan will ensure that the Trust continues to meet the requirements of the Department of Health and Social Care, the Care Quality Commission, and other requirements such as alert organism reductions. The plan specifying Trust agreed actions as well as internal programmes of work that IPC will endeavour to support/deliver on.

The Trust has a series of policies and expert committees, along with strong engagement with the clinical divisions, to prevent and manage healthcare-associated infections (HCAI) and optimise antimicrobial usage. Actions arising from these committees underpin the programmes of work referenced in this plan.

This plan will be reviewed annually, with progress and evidence of completing actions will be regularly reviewed at the Trust Infection Prevention and Control Committee. Progress on actions will also be followed up through Infection Prevention Operational Group (IPOG).

Quarterly review RAG rating	
	Action complete
	Action on track
	Action underway
	Action not on track

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
Criterion 1 - Systems to manage and monitor the prevention and control of infection.	1.1 To fully implement, manage and upload all alert organisms to UKHSA DCS via Power Apps (Power BI).	Optimise power BI tool, educate users, validate data entries and include thematic data analysis.	IPC team including Epidemiologist, Power BI team				
	1.2 Recognise set NHSE alert organism thresholds for 2025/26. 5% reduction target set in healthcare associated infections.	Review and analyse HOHA/COHA attributed HCAI	IPC team, Divisional leads, PSIRF team				
		Standardise IPOG divisional template to ensure hand hygiene, environmental audits, commode audits, indwelling insertion and on-going management is monitored consistently.	DDIPC, Divisional leads.				
		Alert surveillance, thematic reviews, trend analysis for discussion at IPOG/TIPC and antimicrobial stewardship group meetings.	IPC team including Epidemiologist, Divisional leads.				
	1.3 Develop new approaches to investigate HOHA/COHA HCAs, hospital outbreaks, to seek learning	Following training, introduce PSIRF methodology into IPC service.	IPC team (band 8's), Epidemiologist, Patient safety team,				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
	opportunities to change future practice.		Datix team.				
		Transfer remaining alert organism RCA templates onto a PSIRF template.	Patient safety team				
		Undertake thematic analysis using Datix and Power BI platforms.	Epidemiologist, Datix team.				
	1.4 The surgical site surveillance team will establish the burden of SSI in key surgical settings through optimisation of surveillance.	Undertake mandatory SSI surveillance in line with national recommendations.	SSI teams, IPC support				
		Undertake voluntary SSI surveillance in key surgical areas and reactionary SSI surveillance in areas of increased infection rates.	Surgical site surveillance team. Divisions with IPC support.				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
	1.5 Implement the IPC audit programme for 2025/26.	All audits to be carried out as detailed in the approved audit programme and action plans automatically sent via Tendable. Divisions to report at IPOG any delayed actions that require IPC support to escalate.	IPC team, Divisions				
		IPC team to liaise with clinical teams post audit to offer face to face/interactive education and support completion of recommendations.	IPC team				
	1.6 Support relevant Trust auditing including National PLACE, PLACE lite and peer reviews.	IPC CNS to manage relevant audit requests by site.	IPC CNSs				
Criterion 2 - The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the	2.2 IPC will work with Estates to effect improvements across the trust (inclusive of water, ventilation, capital builds) throughout the year.	Specialist (W/V) group members to receive all commissioning, validation, interim/full reports for water and ventilation results, ensuring AE (W/V) is involved at every opportunity.	IPC team, Estates team, Capital team				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
prevention and control of infections.		IPC to attend all capital project meetings to ensure HTM/HBN standards are delivered for every new build or refurbishment.	IPC team, Capital team				
Criterion 3 - Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.	3.1 There will be appropriate antimicrobial use and stewardship across UHSussex, that is reviewed at each AMR meeting.	IPC to be an integral stakeholder on AMSG meetings and provide quarterly infection data.	AMSG, IPC team				
		Gain an understanding of Trust antimicrobial resistance rates (Blood cultures, urine positive for gram negative infections) using PPS and thematic analysis.	Epidemiologist, ICD				
Criterion 5 - That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the	5.1 The IPC and micro teams will liaise closely for early identification and IPC measures to be initiated daily (working days).	Microbiology/Virology team to attend Clinical IPC weekly meeting.	Microbiologist, Virologists, IPC team ICD				
		IPC to send updates to micro team in preparation for weekend work if appropriate.	IPC CNS				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
risk of transmission of infection to other people.	5.2 Pathology and IT will collaborate databases to ensure all patient results reach the IPC team for action as soon as the result becomes available.	IPC team to participate with Southeast LIMs project to align lab data feeds.	IPC team & Epidemiologist				
	5.3 IPC team to visit and support patients/NOK with education	IPC team to visit patients/ NOK and offer advice and support	IPC team				
Criterion 6 - Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	6.1 The IPC team with support of the Divisions will strengthen and expand the IPC link champion scheme during the year.	IPC CNS to lead link champion programme. Bimonthly meetings to include appropriate use of PPE/gloves, standard precautions, staff health and hand hygiene initiatives (involve patients either at ward level or part of a group).	IPC CNS IPC Matrons for oversight.				
	6.2 The IPC team will support with Sustainability and Net Zero Target over the coming fiscal year:	IPC designated green ambassador(s).	IPC 8's to discuss and assign.				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
	6.3 The IPC team will establish & review current education being delivered by IPC team in line with national IPC framework.	Collect data on current education delivered by IPC and develop a strategy to expand educational opportunities to support staff.	Senior IPC Matron, IPC team				
		Develop a ten-week IPC educational program for IPC link practitioners.	Senior IPC Matron				
	6.4 Develop and provide further education, learning opportunities for the IPC Team over the coming year.	Identify what education IPC team members wish to undertake in 2025/26 and formalise within a training need analysis document. Team being active members of the IPS and join relevant branch meetings	IPC Matrons/ Senior Matron				
	6.5 The IPC team will continue expanding, engaging and supporting research (local and national) relevant to IPC throughout the year and beyond.	ICD to highlight research opportunities.	ICD & Epidemiologist				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
		IPC team members to attend and engage with CINAMR.	IPC Matrons/ Senior Matron				
Criterion 7 – The provision or ability to secure adequate isolation facilities.	7.1 Capital/ minor works will involve IPC in the plans for new builds throughout 2025/26 and beyond as standard collaboration.	Review plans for refurbishment and new builds to ensure the scheme includes adequate and appropriate isolation facilities.	IPC team Capital Team				
Criterion 8 – The ability to secure adequate access to laboratory support as appropriate.	8.1 IPC will further strengthen relationships with the wider infection department at UHSussex.	IPC team to explore visits/placements within the microbiology laboratories. In addition to exploring the development of an IPC rotation for infection trainees.	IPC team, ICD, Lab leads				
		IPC team to join clinical infection ward rounds at all sites.	Micro leads, IPC team				
Criterion 9 -Adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.	9.1 IPC will review, and update IPC policies as they approach expiry or when new information is published.	Policy updates and reviews will follow the Trust governance pathway and be uploaded to IPC policy page on SharePoint.	DDIPC, Senior IPC Matron, IPC secretaries				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
	9.2 IPC will ensure audit processes are in place for policy compliance over the year 2025/26	Disseminate policies as per local governance processes and support education as per criterion 6.	IPC team				
Criterion 10 – That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.	10.1 Substantive Trust Fit testing team to be recruited and trained to provide the service across all sites. Support the People Directorate in shaping the Occupational Health offer as relates to IPC	Job descriptions to be approved by Executive Team (band 4/band 3). Followed by advertising and recruiting to the substantive positions. Advise People Directorate re IPC staff screening, occupational exposure assessments, inoculation injuries and vaccination.	DDIPC, Band 8's, IPC secretary, cDIPC, People Directorate leads and OH leads				

References

Department of Health & Social Care (updated 13th December 2022) *Guidance: Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance* [online] available from: [Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance) [Accessed 03.04.2025]



University Hospitals Sussex
NHS Foundation Trust

Mortality and Learning from Deaths 2025/26 Q2 Report

Caroline Wiggs - Mortality & Learning from Deaths Manager
October 2025

Learning from Death Mortality Overview - 2025/26 Q2

*Data source SHMI Module HEDS and includes of out of hospital deaths. Latest data available.

		Total Adult Deaths	Total Inpatient Deaths	Total A&E/ED Deaths	Total Adult Deaths within 30 days of discharge*	Crude Mortality*	HSMR (12 Month Rolling)*	SHMI (12 Month Rolling)*
Jul-25	WGH	80	77	3		3.05		
	SRH	75	67	8		2.67		
	RSCH	102	96	6		2.41		
	PRH	32	29	3		1.54		
		289	269	20		2.51		
Aug-25	WGH	73	67	6		3.00		
	SRH	60	53	7		2.63		
	RSCH	81	76	5		2.35		
	PRH	26	24	2		1.55		
		240	220	20		2.47		
Sep-25	WGH	79	70	9		2.94		
	SRH	87	78	9		2.67		
	RSCH	100	94	6		2.31		
	PRH	37	34	3		1.58		
2025/26		303	276	27		2.45		
Q2	UHSx	832	765	67				

2025/26 Q2 Deaths per 1000 Bed Days				
	WGH	SRH	RSCH	PRH
Jul-25	1.66	1.79	1.07	1.30
Aug-25	1.67	2.14	1.01	0.91
Sep-25	1.39	3.13	0.85	0.92
Q1 Total	1.57	2.28	0.97	1.02

Note: Bed days data taken from dashboard [PB004 - Length of stay insights](#)

Key Observations

➤ 832 acute adult deaths; decrease from 916 in 2024/25 Q2.

➤ 765 (92%) inpatient adult deaths; decrease from 828 (90%) in 2024/25 Q2.

➤ 67 (8%) adult deaths in A&E/ED; decrease from 88 (10%) in 2024/25 Q2.

➤ Total adult deats within 30 days of discharge; HSMR and SHMI data for 2025/26 Q2 awaited. Available 2025/26 Q1 data provided opposite.

➤ Deaths per 1000 bed days shown above. Expected higher numbers at WGH and SRH due to older population.

NHS

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		Total Adult Deaths within 30 days of discharge*	Crude Mortality*	HSMR (12 Month Rolling)*	SHMI (12 Month Rolling)*
Apr-25	WGH	43	3.11	97.81	100.95
	SRH	31	2.78	99.97	100.78
	RSCH	25	2.50	101.10	113.16
	PRH	9	1.60	76.74	93.74
		108	2.60	96.56	103.05
May-25	WGH	38	3.08	96.25	99.86
	SRH	30	2.75	100.60	99.69
	RSCH	34	2.47	100.66	113.65
	PRH	7	1.61	78.30	95.73
		109	2.57	96.36	102.82
Jun-25	WGH	46	3.06	95.07	99.84
	SRH	38	2.76	101.74	100.72
	RSCH	31	2.44	100.05	112.78
	PRH	25	1.55	75.54	93.56
2025/26		140	2.55	95.84	102.60
Q1	UHSx	357			

The SHMI is the ratio between the actual number of patients who die following hospitalisation at UHSx and the number that would be expected to die on the basis of average England figures.

Learning from Death Mortality Outliers - 2025/26 Q2

*Data source SHMI Module HEDS. Latest data available.

Key diagnostic groups with higher than expected mortality rate over 12 month period.
VLAD alerts help detect changes in mortality rates over time.

The table below shows SHMI diagnosis groups that fall outside an over-dispersed 95% Poisson funnel plot using data from the last 12 months.

SHMI - Key Diagnosis Groups excluding groups with < 7 observed deaths or < 7.5 expected deaths			
SHMI Diagnosis Group	Observed Deaths	Expected Deaths	SHMI
113 : Other connective tissue disease	102	57.05	178.79
128 : Complication of device; implant or graft	70	52.68	132.88
140 : Administrative/social admission, Allergic reactions, E Codes: All (external causes of injury and poisoning), Medical examination/evaluation, Other aftercare, Other screening for suspected conditions (not mental disorders or infectious disease), Rehabilitation care; fitting of prostheses; and adjustment of devices, Residual codes; unclassified	21	9.25	227.15

- SHMI diagnosis group 140 continues to be an outlier on the 95% over-dispersed Poisson funnel plot; however, the difference between observed and expected deaths is much smaller than found in preceding months. Use of the 'placeholder' diagnosis code "Z048 - Examination and observation for other specified reasons" is now much less prevalent.
- SHMI diagnostic group 113 has the largest difference between observed and expected deaths across all SHMI diagnostic groups.

The table below shows the number of deterioration VLAD alerts over the last 3 months:

SHMI Diagnosis Group	Group Description	Deterioration Triggers (latest 3 months)
15	Cancer of bronchus; lung	1
68	Peripheral and visceral atherosclerosis	1
128	Complication of device; implant or graft	1

The table below shows the number of improvement VLAD alerts over the last 3 months:

SHMI Diagnosis Group	Group Description	Improvement Triggers (latest 3 months)
73	Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	1
101	Urinary tract infections	1
123	Joint disorders and dislocations; trauma-related, Other fractures, Skull and face fractures, Spinal cord injury, Sprains and strains	1
130	Superficial injury; contusion	1

Update: Plan to commence diagnostic group "deep dives" in 2025/26 Q3.

Extract from latest HEDs report (17/10/2025.)

Learning from Death Mortality Demographics - 2025/26 Q2

Deaths by IMD Decile (1 = most deprived, 10 = least deprived) Breakdown of acute adult deaths by underlying population and deaths per 1000 as well as SJR referrals during the period.

Demographics for Adult Deaths 2025/26 Q2	No. of Adult Deaths	Underlying Population	Deaths per 1000
1	21	30919	0.68
2	33	43807	0.75
3	59	68282	0.86
4	34	54516	0.62
5	90	93678	0.96
6	89	122144	0.73
7	103	113860	0.90
8	88	99685	0.88
9	83	104283	0.80
10	67	110984	0.60
2025/26 Q2 UHSussex Total	667	842158	0.79
No. in most deprived postcodes (D1-4)	147	197524	0.74
% in most deprived postcodes (D1-4)	22.0%	23.5%	
Note: Horsham, Crawley and East Sussex Local Authorities excluded as UHSussex do not serve the whole of the population.			

Key Observations

Of **667 acute** adult deaths within Adur, Arun, Brighton & Hove, Chichester, Mid Sussex and Worthing Local Authorities:

- **22% (147)** within most deprived postcodes (D1-4) equal to **23.5%** of underlying population, same as in 2025/26 Q1.
- Highest number of deaths in **D7 (103)** with **0.90** deaths per 1000, shift from **D6** in 2025/26 Q1.
- However, highest deaths per 1000 related to **D5 (0.96)**, shift from **D3 (1.20)** in 2025/26 Q1

Of all **832 acute** adult deaths:

- **21.6% (180)** within most deprived postcodes (D1-4); % decrease from **24.7% (228)** in 2024/25 Q2.
- Joint highest related to D7 and D8 **14.4% (120)**; shift from **D6 (17.1%)** in 2024/25 Q2.

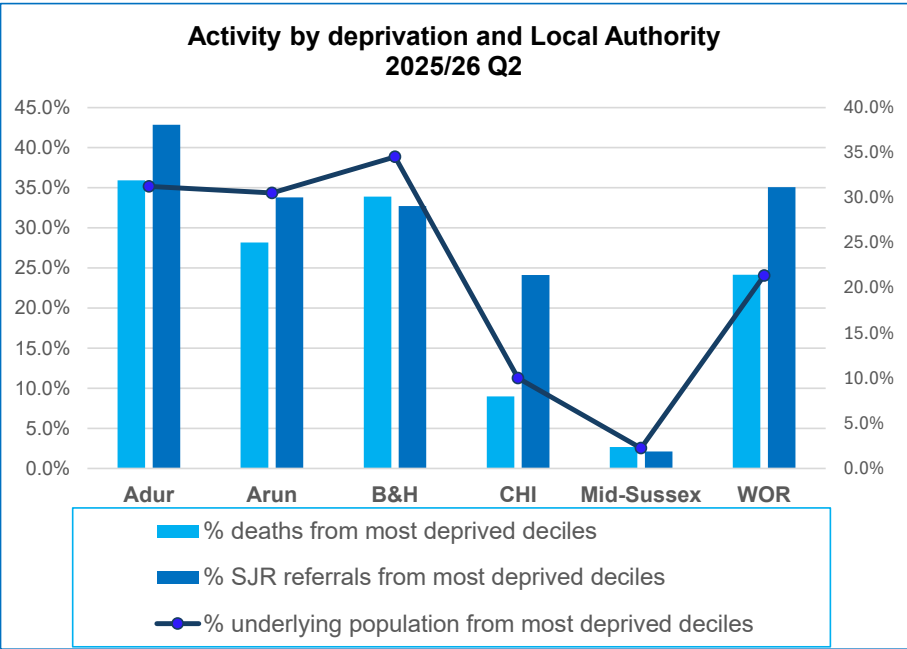
Demographics for SJR Referrals					
	Jul-25	Aug-25	Sep-25	UHSx Q2 Total	% of all SJR referrals
1	2	0	1	3	3.2%
2	2	1	2	5	5.4%
3	4	2	4	10	10.8%
4	5	2	3	10	10.8%
5	2	4	2	8	8.6%
6	7	1	6	14	15.1%
7	3	4	2	9	9.7%
8	3	2	5	10	10.8%
9	6	3	4	13	14.0%
10	4	2	4	10	10.8%
Missing	0	0	1	1	3.6%
UHSx Q2 Total	38	21	34	93	
No. in most deprived postcodes (D1-4)	13	5	10	28	
% in most deprived postcodes (D1-4)	34.2%	23.8%	29.4%	30.1%	

- **30.1% (28)** of SJR referrals within most deprived postcodes; % decrease from **27.4% (32)** in 2024/25 Q2.
- Highest number of SJR referrals related to **D6** at **15.1% (14)**; % decrease from **16.2% (19)** in 2024/25 Q2.

Learning from Death Mortality Demographics - 2025/26 Q2

Deaths by IMD Decile (1 = most deprived, 10 = least deprived) Local Authority overview

Activity by deprivation and Local Authority	Adur	Arun	B&H	CHI	Mid-Sussex	WOR
% underlying population from most deprived deciles	31.3%	30.6%	34.5%	10.0%	2.2%	21.4%
% deaths from most deprived deciles	35.9%	28.2%	33.9%	9.0%	2.7%	24.2%
% SJR referrals from most deprived deciles	42.9%	33.8%	32.7%	24.1%	2.1%	35.1%



Key Observations

- **Adur:** **4.6%** more deaths in most deprived than expected based on underlying population, even more **(11.6%)** SJR referrals.
- **Arun:** **2.4%** fewer deaths in most deprived than expected based on underlying population, **3.2%** more SJR referrals.
- **Chichester:** **1%** fewer deaths in most deprived than expected based on underlying population, significantly more **(14.1%)** SJR referrals.
- **Brighton:** **0.6%** fewer deaths in most deprived than expected based on underlying population, **1.8%** fewer SJR referrals.
- **Mid-Sussex:** **0.5%** more deaths in most deprived than expected based on underlying population, fewer SJR referrals.

Learning from Death #NOF Mortality - 2025/26 Q2

Overall performance/mortality related to fracture of neck of femur (#NOF) during the quarter.

Breakdown by hospital site. *Data sources National Hip Fracture Database/SHMI module. Latest data available.

		No. of patients	Hours to operation (annual)	30 day mortality % (annual)
Jul-25	WGH	41	37.0	4.7
	SRH	33	36.4	8.6
	RSCH	47	28.7	4.1
	National		39.3	5.2
		121	34.0	5.8
Aug-25	WGH			
	SRH			
	RSCH			
	National			
		0	0	0
Sep-25	WGH			
	SRH			
	RSCH			
	National			
2025/26		0	0	0
Q2	UHSx	121	34.0	5.8

*Data source National Hip Fracture Database.
Latest data available.

#NOF listed on MCCD 2025/26 Q2					
WGH	SRH	RSCH	PRH	UHSx Q1 Total	% of all Adult Deaths
0	0	1	1	2	0.2%

Key Observations

- **121** patients treated for #NOF across **WGH**, **SRH** and **RSCH** in July 2025; **372** during 2025/26 Q1; **381** during 2024/25 Q4.
- Total number of patients treated with #NOF, hours taken to operate and % 30 day mortality for 2025/26 Q2 awaited. Available 2025/26 Q1 data provided opposite.
- **Hours taken to operate** in 2025/26 Q1 and July 2025 consistently less than national average.
- **SRH** outlier for % 30 day mortality; **WGH** and **RSCH** below national average in 2025/26 Q1 and July 2025.
- Reduction in annualised crude mortality at **WGH** and **RSCH** in 2025/26 Q1, compared with 2024/25 Q1. Upward trend at **SRH**. **2025/26 Q2 data awaited as of 17/10/2025.**
- **2 (0.2%) acute** adult death MCCDs recorded #NOF in 2025/26 Q2.
- #NOF removed as 'alert' for mandated SJR.

Note: PRH activity not captured as part of National Falls and Fragility Fracture Audit Programme

Crude Mortality (annualised)

	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/26 Q1
WGH	7.9	8.7	8.8	6.5	5.0
SRH	4.5	4.7	5.0	5.1	6.7
RSCH	3.6	3.8	3.2	2.4	3.0

*Data source National Hip Fracture Database.

		No. of patients	Hours to operation (annual)	30 day mortality % (annual)
Apr-25	WGH	44	38.7	4.5
	SRH	42	35.8	7.6
	RSCH	42	28.1	3.1
	National		39.1	5.2
		128	34.2	5.1
May-25	WGH	34	38.4	5.5
	SRH	31	35.7	8.4
	RSCH	50	28.6	4.5
	National		39.3	5.9
		115	34.2	6.1
Jun-25	WGH	38	37.7	5.3
	SRH	43	37.1	9.4
	RSCH	48	28.7	4.1
	National		39.3	5.7
2024/25		129	34.5	6.3
Q1	UHSx	372	34.3	5.8

*Data source National Hip Fracture Database.

Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
Fracture of neck of femur (hip)	120	1,575	125	125	0.9889	As expected SHMI

*Data Source SHMI deaths associated with hospitalisation (Jun-24 to May-25)

Learning from Death Mortality Deaths by Age Group - 2025/26 Q2

Breakdown of adult deaths by age group

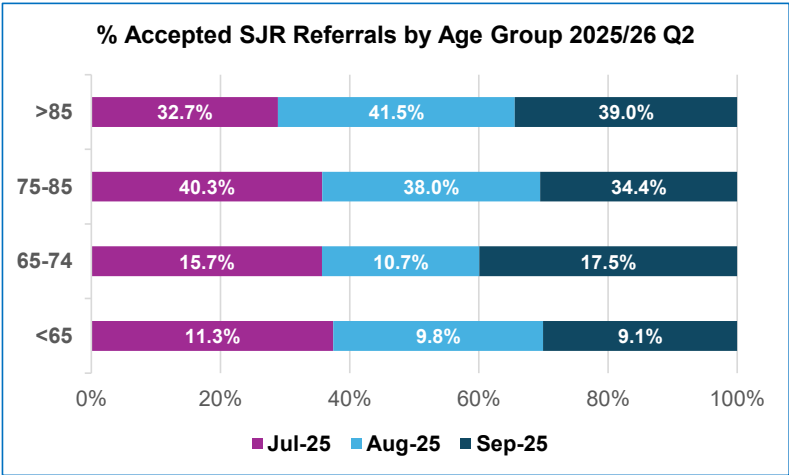
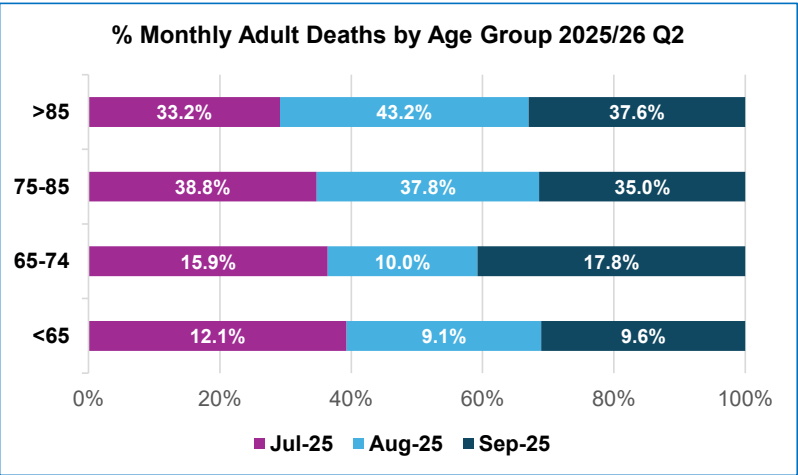


% Adult Deaths by Age Group			
Age	Jul-25	Aug-25	Sep-25
<65	12.1%	9.1%	9.6%
65-74	15.9%	10.0%	17.8%
75-85	38.8%	37.8%	35.0%
>85	33.2%	43.2%	37.6%

Key Observations

- Highest proportion of **acute** adult deaths remains the 75-85 age group.
- Most adult deaths in over 85 age group occurred in the month of August (**43.2%**), attributable to summer heatwave.
- Consistently fewer deaths in under 65 age group, with majority of SJR referrals accepted.
- Minimal variance between % adult deaths and % accepted SJR referrals.

% Accepted SJR Referrals by Age Group			
Age	Jul-25	Aug-25	Sep-25
<65	11.3%	9.8%	9.1%
65-74	15.7%	10.7%	17.5%
75-85	40.3%	38.0%	34.4%
>85	32.7%	41.5%	39.0%



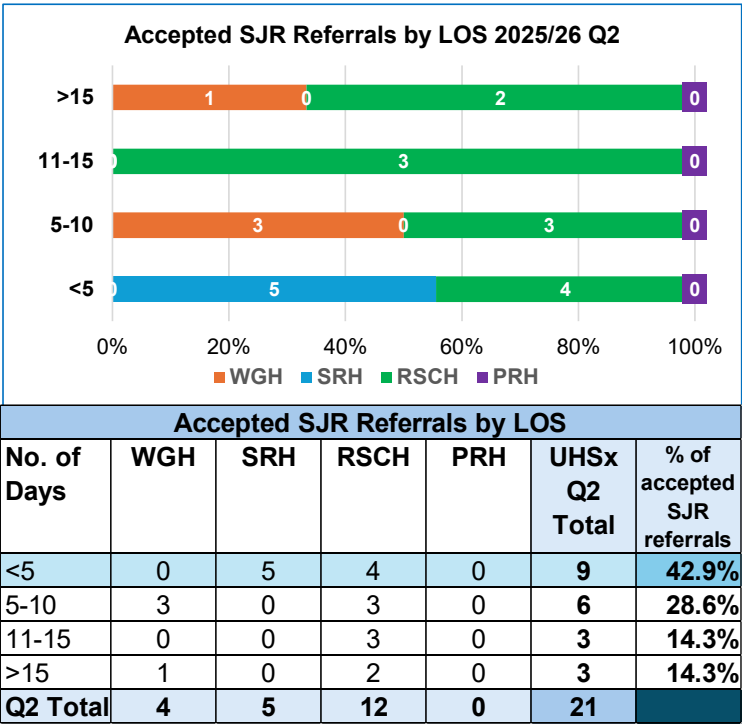
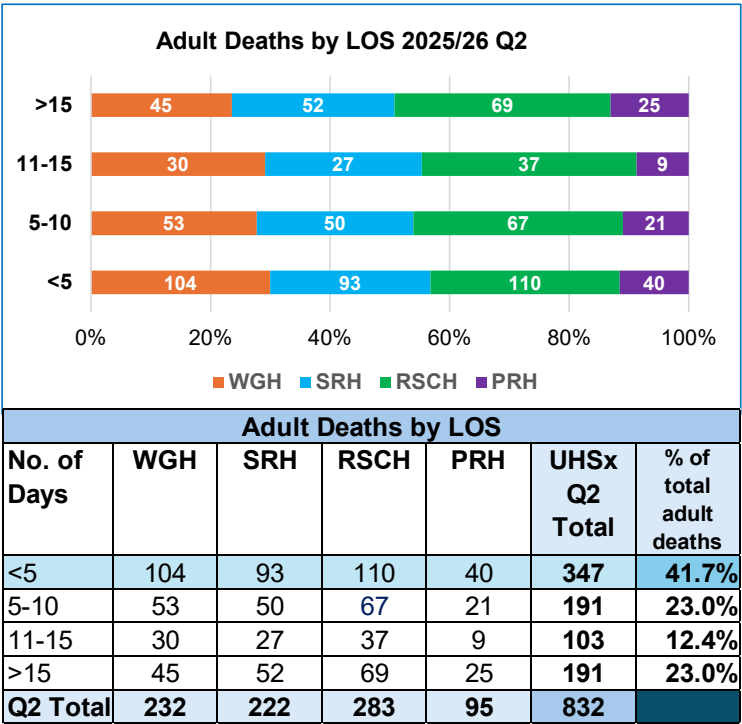
Learning from Death Mortality Deaths by Length of Stay (LoS) - 2025/26 Q2



Breakdown of adult deaths by Length of Stay (by number of days)

Key Observations

- **41.7% (347) acute** adult deaths with LoS less than 5 days; % increase from **39.3% (365)** in 2025/26 Q1.
- Positive reduction in number of adult deaths with LoS greater than 15 days from **29.2%** in 2025/26 Q1 to **23%** this quarter (Q2.)
- Highest number of **accepted** SJR referrals with LoS less than 5 days - **42.9%**, % increase from **38.9% (14)** in 2025/26 Q1.



Learning from Death Mortality Deaths by Ward - 2025/26 Q2

Breakdown of adult deaths by ward (by highest number of deaths and deaths per 1000 bed days.)

Adult Deaths on Ward 2025/26 Q2				
Adult Deaths on Ward (order of incidence for no. of deaths)	No. of deaths	No. of deaths per 1000 bed days	% of site specific deaths	% of all adult deaths
WOR Beacon (Vasc,Diab&Endo)	27	9.8	10.4%	3.2%
RSCH LMB - A7 (ICU)	26	57.1	7.9%	3.1%
SRH Petworth (Acute Gen Med)	25	15.5	9.7%	3.0%
RSCH Acute Assessment Unit	23	27.4	7.0%	2.8%
RSCH LMB - B8 (Resp)	23	14.5	7.0%	2.8%
RSCH LMB - C7 (ICU)	22	113.4	6.7%	2.6%
RSCH LMB - C9 (Resp)	22	12.2	6.7%	2.6%
PRH Pyecombe (Resp)	22	9.9	27.5%	2.6%
WOR Critical Care	21	66.2	8.1%	2.5%
PRH Ardingly (Acute Gen Med)	21	14.0	26.3%	2.5%
RSCH LMB - C8 (Stroke)	19	13.7	5.8%	2.3%
SRH Emergency Floor	18	26.8	6.9%	2.2%
SRH Lavant (Stroke)	18	18.0	6.9%	2.2%
RSCH LMB - C10 (Stroke)	18	11.4	5.5%	2.2%
WOR EF Zone C	16	34.0	6.2%	1.9%
PRH Balcombe (Acute Gen Med)	16	14.2	4.9%	1.9%
PRH Hurstpierpoint (Elderly Med)	16	10.7	20.0%	1.9%
SRH Ashling (Gen Med)	15	8.8	5.8%	1.8%
WOR Becket (Elderly Med)	14	8.2	5.4%	1.7%
SRH Fishbourne (Gastro)	14	6.7	5.4%	1.7%

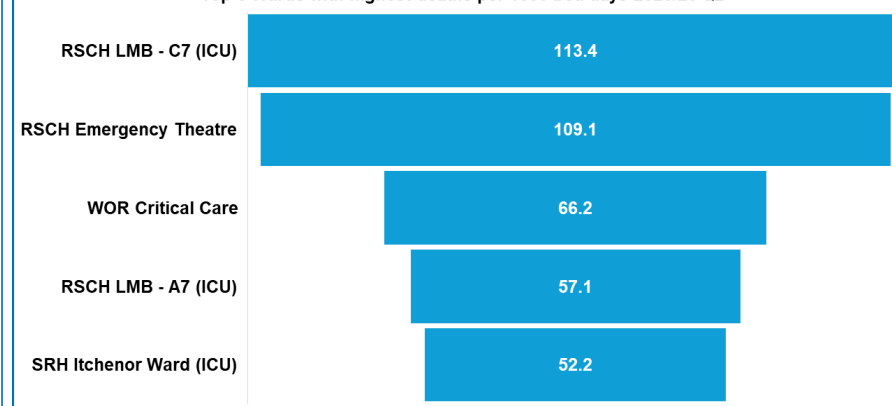
Note: Bed days data taken from dashboard PB050 - LOS Programme dashboard

- Highest number of PRH deaths at Pyecombe (Respiratory) 27.5% at PRH, 2.6% across UHSx, with 9.9 deaths per 1000 bed days..

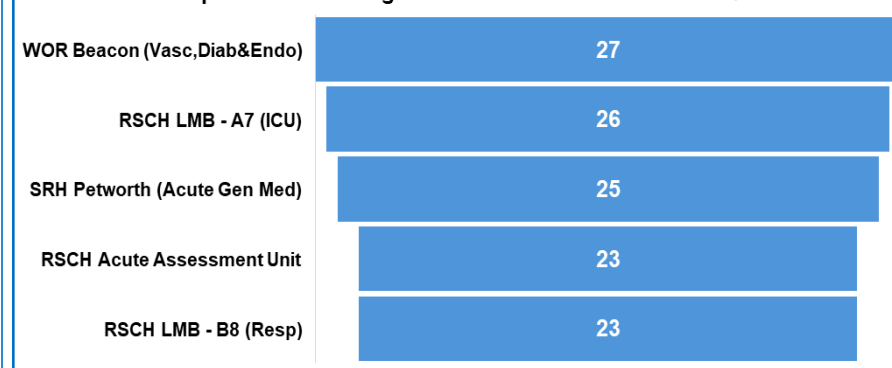
Key Observations

- Majority of inpatient adult deaths across ICU/Acute Gen Med, Stroke, Respiratory and Vascular, with top 20 between 14 and 27.
- 27 deaths on WOR Beacon (Vascular, Diabetes & Endocrinology); 10.4% at WOR; 3.2% across UHSx, with 9.8 deaths per 1000 bed days.
- 26 adult deaths on RSCH LMB A7 (ICU); 7.9% at RSCH; 3.1% across UHSx; with 57.1 deaths per 1000 bed days.
- RSCH LMB C7 (ICU) had highest number of deaths per 1000 bed days (113.4) with 22 deaths.
- RSCH Emergency (Theatre Admissions) had second highest number of deaths per 1000 bed days (109.1) but only 6 deaths. This represents a reduction from 266.7 in 2025/26 Q1.

Top 5 Wards with highest deaths per 1000 bed days 2025/26 Q2

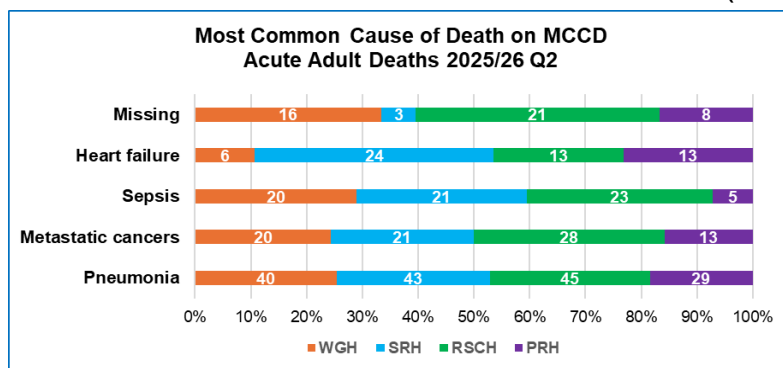


Top 5 Wards with highest number of deaths 2025/26 Q2



Learning from Death Mortality Cause of Death - 2025/26 Q2

Most common causes of acute adult deaths listed on MCCD (1a, 1b, 1c, 1d and 2.) Breakdown by hospital site.



Common Cause of Death on MCCD Acute Adult Deaths 2025/26 Q2						
Cause of Death (order of incidence)	WGH	SRH	RSCH	PRH	UHSx Q2 Total	% of all Adult Deaths
Pneumonia	40	43	45	29	157	18.9%
Metastatic cancers	20	21	28	13	82	9.9%
Sepsis	20	21	23	5	69	8.3%
Heart failure	6	24	13	13	56	6.7%
Missing	16	3	21	8	48	5.8%
Top 5 CoD Q2 UHSx Subtotal	102	112	130	68	412	49.5%
Stroke	14	7	11	2	34	4.1%
Frailty of old age	5	9	8	5	27	3.2%
Brain injury/subdural haemorrhage	6	3	13	2	24	2.9%
Respiratory failure	4	3	11	3	21	2.5%
Multi organ failure	3	2	5	2	12	1.4%
Liver disease/failure	2	3	7	0	12	1.4%
Renal disease/failure	2	1	3	2	8	1.0%
Fractured neck of femur (#NOF)	0	0	1	1	2	0.2%

Note: A CoD may be missing from the ME referral if referred to the Coroner.
Multiple CoD may be listed on the MCCD.

Key Observations

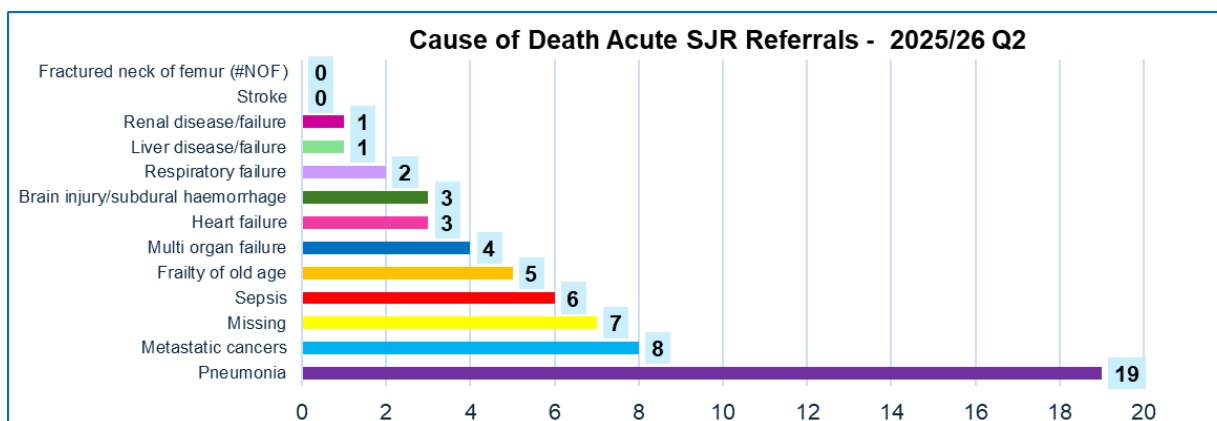
- **18.9% (157)** of all **acute** adult deaths had **pneumonia** listed on the death certificate - expected finding. **20.5%** in 2025/26 Q1.
- The top 5 common causes of deaths on MCCDs were **pneumonia, metastatic cancers, sepsis, heart failure** and **missing**. These accounted for **49.5% (412)** of all **acute** adult deaths.
- **5.8% (48)** cases had no given cause(s) of death on the ME referral form; increase from **4.6% (43)** in 2025/26 Q1. Attributed to cause of death not being agreed and/or referral to the Coroner.
- **Frailty of old age** was listed on MCCDs for **3.2% (27)** of all **acute** adult deaths; marginal difference from **3.1% (29)** in 2025/26 Q1.
- **2 (0.2%)** death certificates noted a recent **fractured neck of femur (#NOF)**; **equal** to 2025/26 Q1.

Learning from Death Mortality Cause of Death - 2025/26 Q2

Most common causes of acute adult deaths listed on MCCD (1a, 1b, 1c, 1d and 2) in cases referred for SJR.
Breakdown by hospital site.

Most Common Cause of Death on MCCD Acute SJR Referrals 2025/26 Q2						
	WGH	SRH	RSCH	PRH	UHSx	% of all SJR referrals
Pneumonia	5	4	6	4	19	20.4%
Metastatic cancers	3	1	3	1	8	8.6%
Missing	0	0	2	5	7	7.5%
Sepsis	3	0	3	0	6	6.5%
Frailty of old age	3	0	1	1	5	5.4%
Q2 UHSx Total	14	5	15	11	45	48.4%

Note: A CoD may be missing from the ME referral if referred to the Coroner.
Multiple CoD may be listed on the MCCD.



Key Observations

- **20.4% (19)** of **acute** adult deaths referred for SJR had **pneumonia** listed on the death certificate - expected finding. **13% (13)** in 2025/26 Q1.
- The top 5 common causes of deaths on MCCDs in cases referred for SJR were **pneumonia, metastatic cancers, missing, sepsis** and **frailty of old age**. These accounted for **48.4% (45)** of **acute** adult deaths referred for SJR.
- **7.5% (7)** cases had no given cause(s) of death on the ME referral form; decreased from **4.6% (43)** in 2025/26 Q1. Attributed to cause of death not being agreed and/or referral to the Coroner.
- **Fractured neck of femur (#NOF)** no longer treated as mandated SJR criteria.

Learning from Death Structured Judgement Review (SJR) Referrals - 2025/26 Q2

SJR referrals received, accepted and completed during quarter.

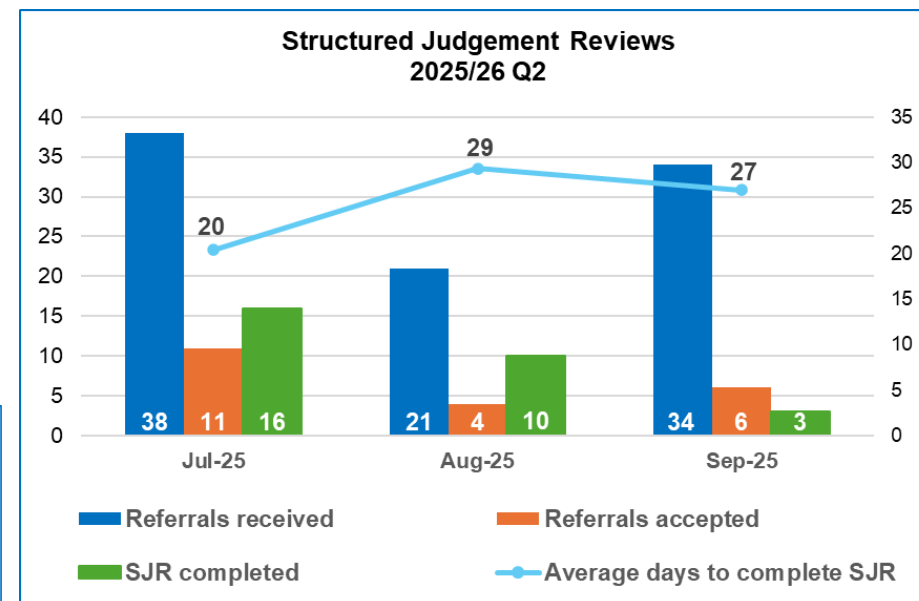


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Adult Deaths Referred for SJR							
	WGH	SRH	RSCH	PRH	25/26 Q2	% of all Deaths referred for SJR	24/25 Q2
Jul-25	8	5	17	8	38	13.1%	85
Aug-25	8	4	7	2	21	8.8%	53
Sep-25	11	5	14	4	34	11.2%	41
Q2 Total	27	14	38	14	93		179
% of all Deaths referred for SJR	11.6%	6.3%	13.4%	14.7%	11.2%		19.5%

Key Observations

- **11.2% (93) acute** adult deaths referred for SJR; decrease from **19.5% (179)** in 2024/25 Q2.
- Highest number of SJR referrals related to adult deaths at **RSCH** - **13.4% (38)**; significant % decrease from **55.3% (99)** in 2024/25 Q2. Attributed to review of SJR 'alert' triggers.
- **29** SJRs completed; decrease from **160** in 2024/25 Q2 attributed to implementation of SJR referral triage.
- **23%** SJR referral acceptance rate in quarter (any cases not accepted redirected to relevant M&M/DQSM.) **35%** in 2024/25 Q2.
- Significant reduction in average time taken to complete SJR - **26 days** in 2025/26 Q2, compared to **171 days** in 2024/25 Q2.



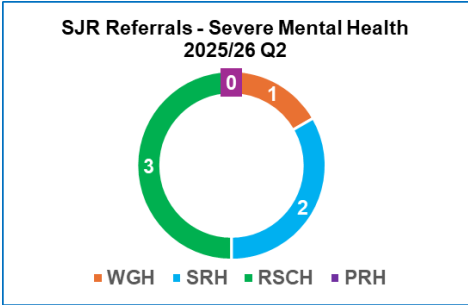
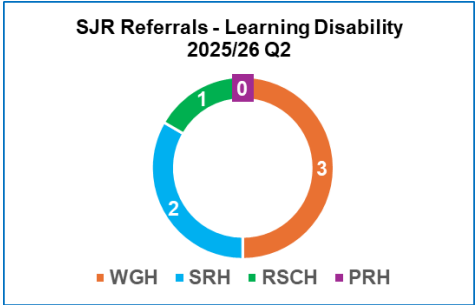
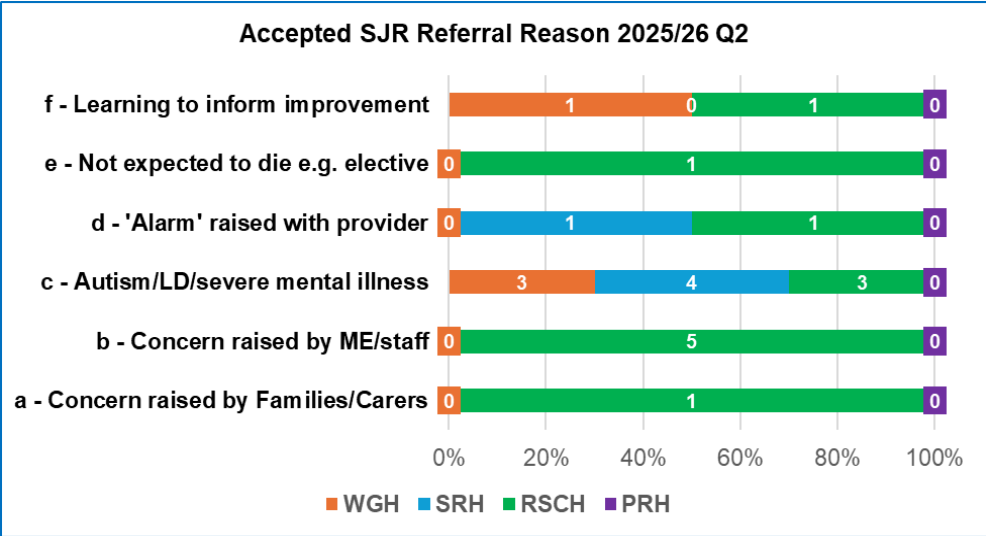
Structured Judgement Review Progress					
	Jul-25	Aug-25	Sep-25	25/26 Q2	24/25 Q2
Referrals received	38	21	34	93	179
Referrals accepted	11	4	6	21	62
SJR completed	16	10	3	29	160
Average days to complete SJR	20	29	27	26	171

Note: 24/25 Q2 totals include significant number from previous backlog project.

SJR consistently completed within 60 days from date of referral

Learning from Death Structured Judgement Review Referrals - 2025/26 Q2

SJR referrals may be received from the ME office, DQSM, Medico-Legal and/or Patient Safety



Accepted SJR Referral Reason							
	WGH	SRH	RSCH	PRH	25/26 Q2	% accepted SJR referrals	24/25 Q2
a - Concern raised by Families/Carers	0	0	1	0	1	4.8%	1
b - Concern raised by ME/staff	0	0	5	0	5	23.8%	28
c - Autism/LD/severe mental illness	3	4	3	0	10	47.6%	10
d - 'Alarm' raised with provider	0	1	1	0	2	9.5%	5
e - Not expected to die e.g. elective	0	0	1	0	1	4.8%	1
f - Learning to inform improvement	1	0	1	0	2	9.5%	17
Q2 UHSx Total	4	5	12	0	21		62

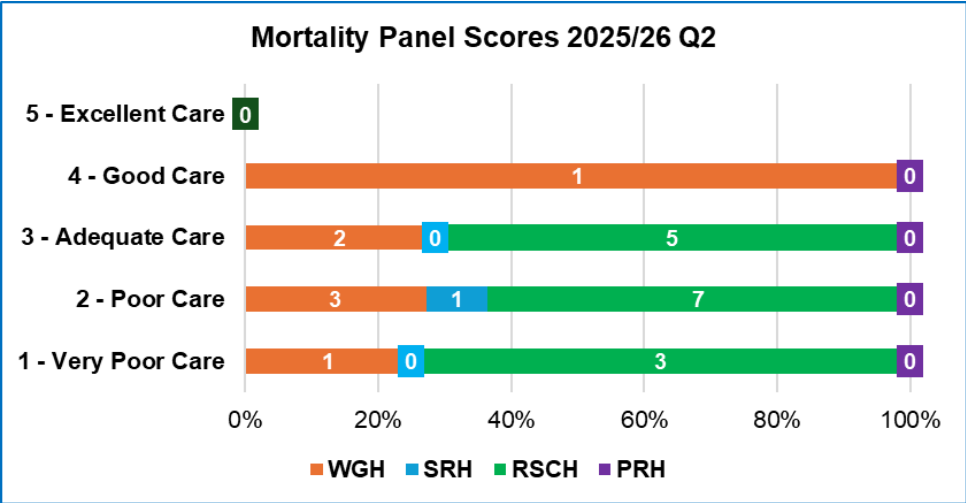
Note: Table only includes accepted referrals.

Key Observations

- **Autism/LD/severe mental illness** was the highest reason for accepted SJR referrals at **47.6% (10)**; % decrease from **16%** in 2024/25 Q2.
- **4.8% (1) accepted** SJRs referred due to **Concern raised by Families/Carers**; **equal to** 2024/25 Q2.
- **23.8% (5)** SJR referrals related to **Concerns raised by ME/staff** compared to **45% (28)** in 2024/25 Q2.
- **9.5% (2)** SJR referrals related to **'Alarm' raised with provider**; % increase from **8% (5)** in 2024/25 Q2.
- **6.5% (6)** Learning Disability referrals; decrease from **6.1% (11)** 2024/25 Q2.
- **6.5% (6)** Severe Mental Health referrals; decrease from **4.5% (8)** in 2024/25 Q2.

Learning from Death SJR Mortality Panel Outcome Scores - 2025/26 Q2

Mortality Panel scores following completion of SJRs by SJR Reviewers.



SJRs Reviewed at Mortality Panel (Scores) 2025/26 Q2							
	WGH	SRH	RSCH	PRH	25/26 Q2	% SJR Reviewed	24/25 Q2
1 - Very Poor Care	1	0	3	0	4	17.4%	24
2 - Poor Care	3	1	7	0	11	47.8%	40
3 - Adequate Care	2	0	5	0	7	30.4%	26
4 - Good Care	1	0	0	0	1	4.3%	11
5 - Excellent Care	0	0	0	0	0	0.0%	4
Q2 UHSx Total	7	1	15	0	23		105

Key Observations

- 23 SJRs reviewed at Mortality Panel; decrease from 105 in 2024/25 Q2, attributed to new processes.
- 65.2% (15) of SJRs reviewed at Mortality Panel scored 1 (Very Poor Care) or 2 (Poor Care); increase from 61% (64) in 2024/25 Q2.
- 47.8% (11) of SJRs reviewed at Mortality Panel scored 2 (Poor Care); decrease from 38% (40) in 2024/25 Q2.
- 95.7% (22) of all SJRs reviewed scored between 1 and 3; increase from 85.7% (90) in 2024/25 Q2. Attributed to cases scored 4 (Good Care) and 5 (Excellent Care) not being routinely discussed at Mortality Panel.
- 30.4% (7) scored 3 (Adequate Care); increase from 25% (26) in 2024/25 Q2, attributed to new processes and lower number of cases discussed at Mortality Panel.
- 1 (4.3%) scored 4 (Good Care) compared to 11 (10%) in 2024/25 Q2.

A Panel of SJR Reviewers and the Mortality & Learning from Deaths Manager review completed SJRs with a score of 1 (Very Poor Care), 2 (Poor Care) or 3 (Adequate Care.)

Learning from Death SJR Mortality Panel Identification of Potentially Avoidable Deaths - 2025/26 Q2

Cases where the Mortality Panel identifies that the death may have been avoidable, for which a Datix will be raised.

0

Deaths identified as ‘may have been avoidable’ by Mortality Panel in 2025/26 Q2

Key Observations

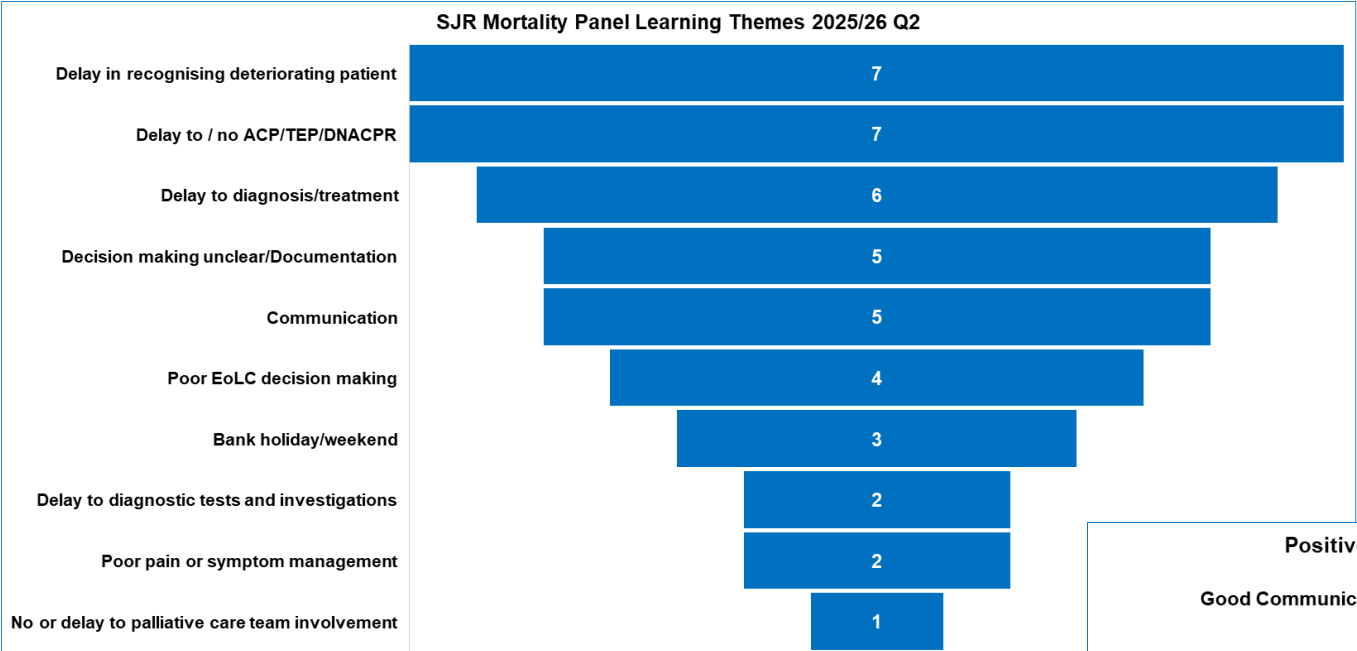
- **No** cases identified by the Mortality Panel as ‘**may have been avoidable**’; decrease from **6 (5.7%)** in 2024/25 Q2.
- The Mortality Panel no longer routinely grades harm - this will be decided by the Division/at PSIRG.
- Most problems in care identified during **ongoing** and **end of life** phases of care.

Mortality Panel, SJR and Panel discussion outputs shared with the relevant DQSM to disseminate learning.

Potentially Avoidable Deaths Identified by Mortality Panel							
	WGH	SRH	RSCH	PRH	25/26 Q2	% Reviewed	24/25 Q2
Jul-25	0	0	0	0	0	0.0%	3
Aug-25	0	0	0	0	0	0.0%	2
Sep-25	0	0	0	0	0	0.0%	1
Q2 Total	0	0	0	0	0		6
%Reviewed					0.0%		5.7%

Learning from Death SJR Mortality Panel Learning Themes - 2025/26 Q2

Recurrent and emergent learning themes identified during the reporting period.



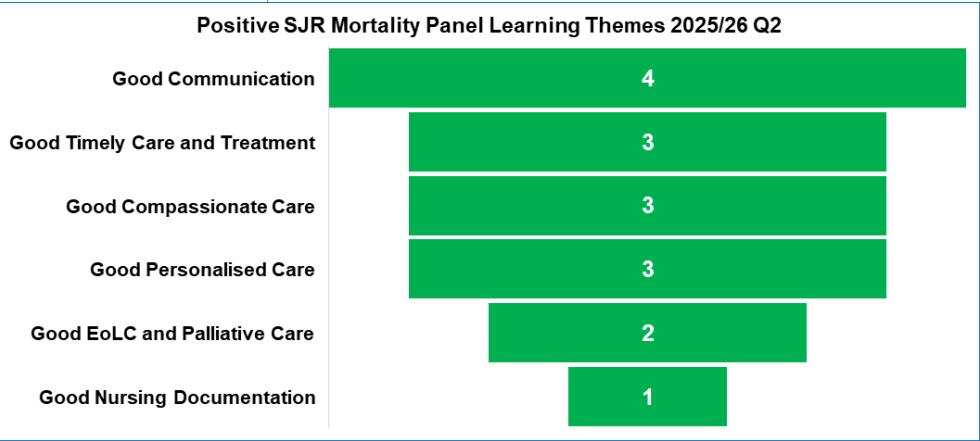
Note: More than one theme may be identified on case discussion

Key Observations - positive learning

- **Good communication (4)** was the top positive learning theme in 2025/26 Q2. This accounted for **25%** of those identified at Mortality Panel, with a high incidence each quarter.
- **Timely, compassionate and personalised care** was identified.

Key Observations - learning

- **Delay in recognising deteriorating patient and Delay to/no ACP/TEP/DNACPR (7, 17.1%)** were joint top learning themes in 2025/26 Q2.
- **Delay to diagnosis/treatment (6, 14.6%)** was the next highest learning theme in 2025/26 Q2.
- These top three learning themes accounted for **48.8%** of learning themes identified at Panel.



Learning from Death LeDeR Focused Review Learning Themes - 2025/26 Q2

Learning from lives and deaths - People with a learning disability and autistic people (LeDeR.)

Learning themes identified at LeDeR Focused Review where UHSx was the main stakeholder during the reporting period.



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Learning themes identified at LeDeR Focused Review 2025/26 Q2

Professional practice and the provision of care

7

Safeguarding

2

Training on specific conditions

2

DNACPR recommendations and end of life care

1

This is me
My Care Passport



Key Observations

- Higher number of learning themes in 2025/26 Q2 attributed to expedited turnaround times for LeDeR reports.
- **7 (58.3%)** UHSx cases discussed at LeDeR Focused Review identified learning related to **Professional practice and provision of care**; increase from **2 (40%)** in 2025/26 Q1.
- **Key take aways** - importance of robust mechanisms to prevent letters being sent posthumously; support plans and risk assessments relating to epilepsy across all services and promotion of learning disability awareness.
- **Action** - My Care Passports promoted in August 2025 WGH-SRH Medicine newsletter.
- **Plaudit** - Acute Liaison Learning Disability Nurse (ALLDN) plaudit for person-centred care.

A Panel of system stakeholders led by LeDeR meet to discuss adult deaths reviewed by LeDeR Reviewers, to identify care issues, propose actions and disseminate learning to relevant teams/organisations. The Mortality & Learning from Deaths Manager and Safeguarding Lead attend on behalf of UHSx. Copies of UHSx SJRs and assurance regarding learning/actions taken routinely shared with LeDeR. Note: More than one theme may be identified on case discussion.

Medical Examiner Office Update - 2025/26 Q2

ME Service overview during reporting period, including general update, observations and concerns, challenges and celebrations.

Updates:

- Noticeable improvement in timely issuing of death certificates to bereaved families since 2024/25 Q4. However, there remains room for improvement, as MEOs (rather than Attending Doctors) are regularly needing to start the ME referral form, so as not to delay pre-scrutiny.
- Patient safety and dignity audit due to start, which will quality check completion of notice of death forms.

Escalations:

- Protracted delay with PAS integration impacting move to Datix IQ. This has been flagged with UHSx IT Network team to prioritise. Focused work continues to ensure templates meet ME Service requirements.
- Currently no viable option for co-location of ME and Bereavement teams at SRH due to large desk requirement - [Property Management Team](#) advise expected to take >12 months.

Challenges:

- Limited space in current ME office at SRH which means it is not possible to site all team members in the same office on certain days of the week.
- Delays to MCCDs being written by UHSx Attending Doctors.

Celebrations:

- Successful offer to vacant RSCH-PRH/Brighton & Mid-Sussex MEO role - start date awaited.

Medical Examiner Office Update - Acute Inpatient Data - 2025/26 Q2

Information provided by Lead MEOs, on behalf of independent ME Service.

Adult Deaths (Acute)		Scrutinised (No.)	Scrutinised (%)	Average time taken to complete MCCD (Days from referral to sending)	Average time taken to complete MCCD (Days from death to sending)	Referred to Coroner (No.)	Referred to Coroner (% of total adult deaths)	Investigated by Coroner (No.)	Investigated by Coroner (% of total adult deaths)	Investigated by Coroner (% of referred to Coroner)
Jul-25	WGH	79	98.75%	1.4	3.8	15	18.75%	12	15.00%	80.00%
	SRH	75	100.00%	1.8	4.4	12	16.00%	6	8.00%	50.00%
	RSCH	99	97.06%	3.4	5.5	28	27.45%	22	21.57%	78.57%
	PRH	32	100.00%	1.9	4.4	11	34.38%	8	25.00%	72.73%
		285	98.95%	2.1	4.5	66	22.84%	48	16.61%	72.73%
Aug-25	WGH	73	100.00%	2.0	4.3	13	17.81%	4	5.48%	30.77%
	SRH	60	100.00%	1.0	3.8	14	23.33%	22	36.67%	157.14%
	RSCH	81	100.00%	2.2	4.2	20	24.69%	8	9.88%	40.00%
	PRH	26	100.00%	0.6	2.9	5	19.23%	3	11.54%	60.00%
		240	100.00%	1.5	3.8	52	21.67%	37	15.42%	71.15%
Sep-25	WGH	79	100.00%	1.6	3.0	10	12.66%	7	8.86%	70.00%
	SRH	87	100.00%	1.1	3.4	15	17.24%	8	9.20%	53.33%
	RSCH	99	99.00%	1.6	2.9	30	30.00%	18	18.00%	60.00%
	PRH	37	100.00%	1.0	3.0	4	10.81%	4	10.81%	100.00%
		302	99.75%	1.3	3.1	59	19.47%	37	12.21%	62.71%
Q2 Total UHSx		827	99.57%	1.6	3.8	177	21.40%	122	14.66%	68.93%

Key Observations

- **99.57% acute** adult deaths scrutinised; **100%** in 2024/25 Q2. **Note:** There were **5** cases with police/coroner involvement sent without scrutiny to avoid delay.
- Average time taken from referral to issuing MCCD **1.6 days**; compared to **66.8% (561)** completed *within 3 days* in 2024/25 Q2.
- Average time taken from death to issuing MCCD **3.8 days**, attributed to Coroner delay.
- Longer turnaround times at RSCH and PRH attributed to staffing levels (vacant MEO post - successful candidate due to start shortly.)
- **21.4% (177) acute** adult deaths referred to Coroner; decrease from **22.4% (205)** in 2024/25 Q2.
- Of those referred, **68.9% (122)** investigated; % decrease from **49.3% (101)** in 2024/25 Q2.
- **14.6%** of **acute** adult deaths investigated by Coroner; increase from **11%** in 2024/25 Q2.

Medical Examiner Office Update - Community Deaths Data - 2025/26 Q2

Information provided by Lead MEOs, on behalf of independent ME Service.



Adult Deaths (Community)		Scrutinised (No.)	Scrutinised (%)	Average time taken to complete MCCD (Days from referral to sending)	Average time taken to complete MCCD (Days from death to sending)	Referred to Coroner (No.)	Referred to Coroner (% of total adult deaths)	Investigated by Coroner (No.)	Investigated by Coroner (% of total adult deaths)	Investigated by Coroner (% of referred to Coroner)
Jul-25	West Sussex	327	100.00%	1.7	4.5	39	11.93%	8	2.45%	20.51%
	Brighton & Mid Sussex	119	100.00%	2.3	5.4	10	8.40%	4	3.36%	40.00%
		446	100.00%	2.0	4.9	49	10.99%	12	2.69%	24.49%
Aug-25	West Sussex	283	100.00%	1.7	4.9	37	13.07%	8	2.83%	21.62%
	Brighton & Mid Sussex	145	100.00%	2.5	6.0	19	13.10%	5	3.45%	26.32%
		428	100.00%	2.1	5.5	56	13.08%	13	3.04%	23.21%
Sep-25	West Sussex	263	100.00%	1.6	4.4	39	14.83%	8	3.04%	20.51%
	Brighton & Mid Sussex	109	100.00%	2.0	5.5	10	9.17%	2	1.83%	20.00%
		372	100.00%	1.8	5.0	49	3.93%	10	2.69%	20.41%
Q2 Total		1246	100.00%	2.0	5.1	154	12.36%	35	2.81%	22.73%

Key Observations

- **1246 community** adult deaths; **873** occurred in West Sussex and **373** in Brighton & Mid Sussex. This compares to **870*** community adult deaths in 2024/25 Q2. **However, new legislation did not come into effect until 09/09/2024 so this may not necessarily capture all deaths.*
- **100% community** adult deaths scrutinized, **same** as in 2024/25 Q2.
- Average time taken from referral to issuing MCCD **2 days**. (West Sussex **1.6 days**; Brighton & Mid Sussex **2.3 days**.)
- **12.36% (154) community** adult deaths referred to Coroner; increase from **9.8% (82)** in 2024/25 Q2.
- Of those referred, **22.73% (35)** investigated; decrease from **29.3% (24)** in 2024/25 Q2.
- **2.8%** of adult deaths investigated by Coroner; slight decrease from **2.9%** in 2024/25 Q2.

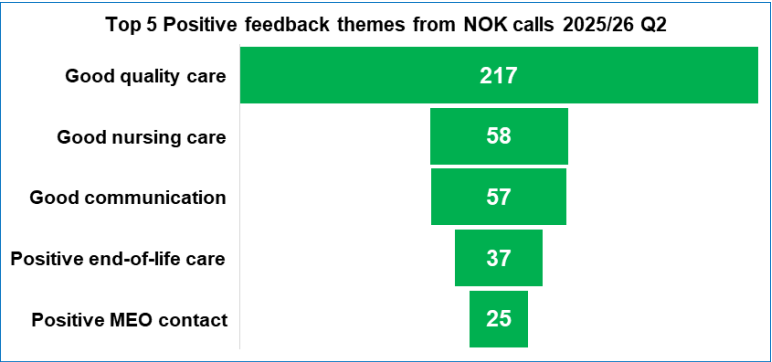
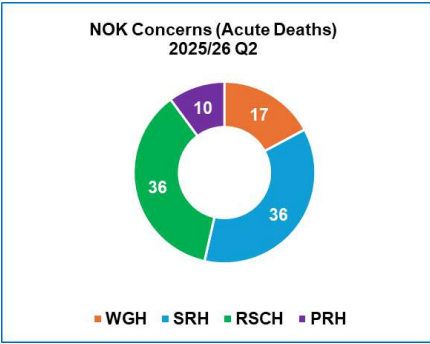
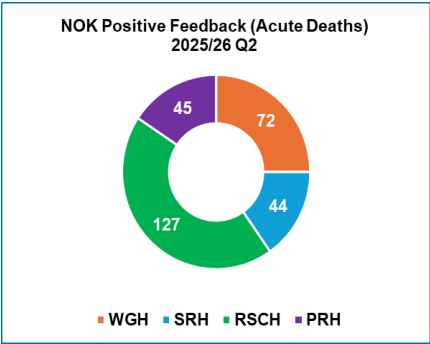
Medical Examiner Office Update - Acute NOK Feedback - 2025/26 Q2

Key concerns raised by families/Next of Kin (NOK) calls are referred for SJR and learning is identified through the SJR outputs.

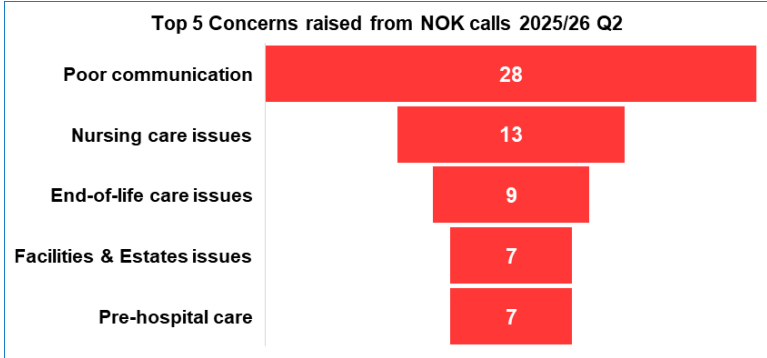


Key Observations

- **288 (74.4%)** positive feedback responses; % increase from **71% (203)** in 2024/25 Q2.
- **99 (25.6%)** negative feedback responses; % decrease from **29% (81)** in 2024/25 Q2.
- High volume of positive feedback for **Good quality care**.
- Highest number of concerns related to **Poor communication**.



Note: NOK may indicate more than one theme when giving feedback



Positive Feedback Received from NOK Calls (Acute Deaths)					
	WGH	SRH	RSCH	PRH	UHSx
Jul-25	22	22	41	8	93
Aug-25	18	11	36	15	80
Sep-25	32	11	50	22	115
Q2 Total	72	44	127	45	288

Negative Feedback Received/Concerns Raised from NOK Calls (Acute Deaths)					
	WGH	SRH	RSCH	PRH	UHSx
Jul-25	5	13	14	1	33
Aug-25	6	9	9	3	27
Sep-25	6	14	13	6	39
Q2 Total	17	36	36	10	99

Medical Examiner Office Update - Community NOK Feedback - 2025/26 Q2

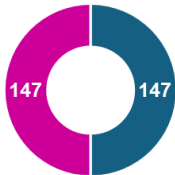
Key concerns raised by families/Next of Kin calls where deaths have occurred in the community.



Key Observations

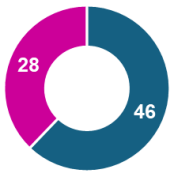
- **80% (294)** positive feedback responses; decrease in % but numerical increase from **83% (143)** in 2024/25 Q2.
- **19% (64)** negative feedback responses; increase in % but numerical decrease from **17% (29)** in 2024/25 Q2.
- Consistently high volume of positive feedback for **Good quality care**.
- Highest number of concerns related to **End-of-life and nursing care**.

NOK Positive Feedback (Community Deaths) 2025/26 Q2



■ West Sussex ■ Brighton & Mid Sussex

NOK Concerns (Community Deaths) 2025/26 Q2



■ West Sussex ■ Brighton & Mid Sussex

Top 5 Positive feedback themes from NOK calls (Community Deaths) 2025/26 Q2

Good quality care	203
Positive end-of-life care	53
Good nursing care	45
Positive MEO contact	25
Good communication	19

Reasons for Coroner referral (Community Deaths):

- C1NA (often referred via Police)/C1NB
- NOK concern regarding cause of death
- Missed diagnosis
- Previous trauma
- Previous procedure
- Unknown cause

Top 5 Concerns raised from NOK calls (Community Deaths) 2025/26 Q2

End-of-life care issues	12
Nursing care issues	12
Poor communication	11
Discharge planning	8
Query over cause of death	6

Positive Feedback Received from NOK Calls (Community Deaths)

	West Sussex	Brighton & Mid Sussex	Total
Jul-25	36	41	77
Aug-25	60	63	123
Sep-25	51	43	94
Q2 Total	147	147	294

Note: NOK may indicate more than one theme when giving feedback

Negative Feedback Received/Concerns Raised from NOK Calls (Community Deaths)

	West Sussex	Brighton & Mid Sussex	UHSx
Jul-25	13	5	18
Aug-25	20	16	36
Sep-25	13	7	20
Q2 Total	46	28	74

Mortality and Learning from Deaths Measurable Improvements - 2025/26 Q2

Improvement works during the reporting period to improve co-morbidities coding.

*Data source SHMI Module HEDS. Latest data available.



University Hospitals Sussex
NHS Foundation Trust

Top 10 Diagnoses

Coders Need to See in Acute Admissions

Clinical coders must document conditions in acutely unwell patients

	Diagnosis	Why It Matters
1	Sepsis	Drives HRG complexity, mortality risk and is a national safety metric
2	Acute Kidney Injury (AKI)	Important for risk stratification; especially if on CKD background
3	Chronic Kidney Disease (CKD) (with stage)	Stage 3+ increases expected mortality and defines complexity
4	Dementia/ cognitive impairment	Influences SHMI risk and planning for ACP/ DNACPR
5	Frailty/ Rockwood score ≥5	Critical for identifying high-risk elderly patients, often undercoded
6	Heart failure (acute or chronic)	Common mortality-associated condition under recorded in non-cardiac teams
7	Liver Disease (esp decompensated)	Major driver of risk-adjusted mortality and complications
8	Cancer (especially metastatic)	Adjust SHMI significantly, not just "history of cancer" or "cancer"
9	Diabetes with complications	Especially if hypoglycaemia, ketoacidosis, or organ involvement
10	Delirium (acute confusional state)	Flags vulnerability and increases care complexity but often missed in coding

Bonus: Key Documentation Tips

Instead of ...	Write ...
"Known to have dementia"	Alzheimer's dementia (moderate)
"AKI"	Stage 2 AKI on CKD3b
"cancer"	Metastatic colorectal cancer with liver mets
"Confused"	Hyperactive delirium secondary to UTI

Why it Matters for SHMI/HSMR

SHMI is case-mix adjusted, so failure to code co-morbidities can:

- Make a death seem unexpected, when it wasn't
- Inflate a department's mortality profile unfairly
- Undermine quality assurance and lead to false outlier alerts

Challenge:

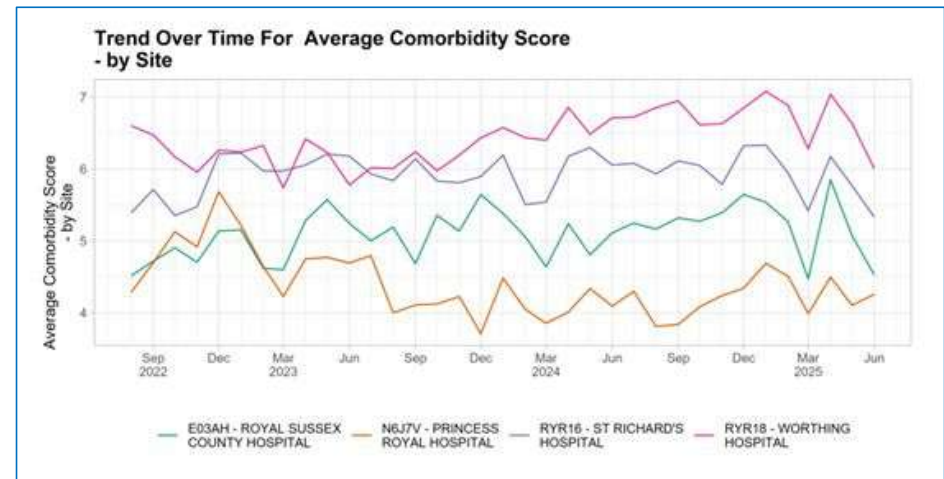
- Inadequate co-morbidity coding leading to an inflated SHMI and outlier alerts.

Solution:

- Top 10 Diagnoses poster produced by Edward Pineles, Consultant in Acute Medicine. Ratified by Clinical Coding and disseminated to residents and registrars. A3 posters in display in EF zones and doctor offices at WGH.

Trend:

- The Average Comorbidity Scores recorded for **PRH** have been lower than those of **RSCH**, **SRH** and **WGH** since March 2023.
- **WGH** have the highest recorded levels of selected sites since July 2023.



Mortality & Learning from Deaths 2025/26 Q2 Report Highlights

84 fewer **acute** adult deaths in 2025/26 Q2 (**832**) compared to 2024/25 Q2 (**916**.) **21.6% (180)** acute adult deaths and **30.1% (28)** SJR referrals within most deprived postcodes (D1-4.)

Average time taken from referral to issuing MCCD **1.6 days** in 2025/26 Q2 compared to **66.8% (561)** completed *within 3 days* in 2024/25 Q2.

21.4% (177) acute adult deaths referred to Coroner and **14.6% (122)** investigated. Of those cases referred, **68.9%** investigated. Compares to **22.4% (205)** cases referred and **11% (101)** investigated in 2024/25 Q2.

18.9% (157) of all **acute** adult deaths and **20.4% (19)** SJR referrals had **pneumonia** listed on MCCD. Pneumonia remains highest cause of death on MCCD.

Majority of inpatient adult deaths across ICU/Acute Gen Med, Stroke, Respiratory and Vascular, with between **14** and **27** deaths per ward in top 20 ranking. **WOR Beacon (Vascular, Diabetes & Endocrinology)** had most deaths while **RSCH LMB C7 (ICU)** had the highest number of deaths per 1000 bed days in 2025/26 Q2.

Significant reduction in average time taken to complete SJR - **26 days** in 2025/26 Q2, compared to **171 days** in 2024/25 Q2.

86 more SJR referrals in 2024/25 Q2 (**179**) compared to 2025/26 Q2 (**93**.) 2025/26 Q2 SJR acceptance rate **23%** Any cases not accepted for SJR redirected to relevant M&M/DQSM.

