University Hospitals Sussex NHS Foundation Trust

Meeting of the Board of Directors

10:00 to 13:15 on Thursday 07 November 2024

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** *Apologies: David Curley*	*To note*	Verbal	Presenter: Philippa Slinger
		Confirmation of Quoracy *A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present this being eight Board members. With a minimum of two Executives and two Non-Executive Directors.*	*To agree*	Verbal	Presenter: Philippa Slinger
Item:2	10:00	**Declarations of Interests**	*To determine if any action is required*	Verbal	Presenter: All
Item:3	10:00	**Minutes of UHSussex Board Meeting held on 01 August 2024**	*To approve*	Enclosure	Presenter: Philippa Slinger
Item:4	10:05	**Matters Arising from the Minutes**	*None*	N/A	Presenter: Philippa Slinger
Item:5	10.05	**Questions from the public** To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	*To respond*	Verbal	Presenter: Philippa Slinger
Item:6	10:30	**Patient Story**	*To note*	Verbal	Presenter: Maggie Davies
Item:7	10:45	**Service Presentation: Organ Donation**	*To note and celebrate this work*	Presentation	Presenter: Dr. Andrew Hetreed
Item:8	11:00	**Report from Chief Executive**	*To receive and note overview of the Trust's activities*	Enclosure	Presenter: George Findlay
		<u>Performance and Risk</u>			
Item:9	11:10	**Integrated Performance Report**	*To receive and note*	Enclosure	Presenter:

		• ***Chief Executive's Introduction*** • ***Patient*** • ***People*** • ***Sustainability (financial performance)*** • ***Quality*** • ***Systems and Partnerships*** • ***Research and Innovation*** • ***National Oversight Framework***			George Findlay
Item:10	11:30	**Single Improvement Plan**	*To note*	Enclosure	Presenter: Darren Grayson
Item:11	11:40	*At this point the Chair will invite Board members to ask questions and discuss any pertinent areas of the Integrated Performance Report and agree any necessary actions.*			
Item:12	12:05	**Board Assurance Framework and Corporate Risk Register highlight report**	*To approve*	Enclosure	Presenter: Darren Grayson Glen Palethorpe
Item:13	12:10	**Maternity Update**	*To note*	Enclosure	Presenter: Tim Taylor
	12:20	***5 Minute Break***			
		<u>ASSURANCE REPORTS FROM COMMITTEES</u> ***<u>Escalated Items Only:</u>***			
Item:14	12:25	**Report from the Research Innovation & Digital Committee from the meeting held on the 30 October 2024** To note assurance and action recommendations from the Committee	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Jackie Cassell
Item:15	12:30	**Report from Patient & Quality Committee** - **from the meetings held on the 27 August, 24 September and 29 October 2024** To note assurance and action recommendations from the Committee	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Lucy Bloem
Item:16	12:35	**Report from People & Culture Committee** - **from the meetings held on the 29 October 2024** To note assurance and action recommendations from the Committee	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Paul Layzell

Item:17	12:40	**Report from Finance & Performance Committee** - **from the meetings held on the 26 September and 31 October 2024** To note assurance and action recommendations from the Committee	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Philip Hogan
Item:18	12:45	**Report from Single Improvement Programme Committee** - **from the meetings held on the 28 August, 25 September, and 30 October 2024** To note assurance and action recommendations from the Committee	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Paul Layzell
Item:19	12:50	**Report from Audit Committee** - **from the meeting held on the 24 October 2024** To note assurance and action recommendations from the Committee	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Glen Palethorpe on behalf of the Committee Chair
		WELL LED & COMPLIANCE			
Item:20	12:50	**UHSussex Strategy – Developing our roadmap to 2030**	*To discuss*	Presentation	Presenter: Roxanne Smith / Joe Mills
Item:21	13:10	**Company Secretary Report** For information only	*For information only*	Enclosure	Presenter: Glen Palethorpe
		OTHER			
Item:22	13:15	**Any Other Business** To receive any notified urgent business and action	*To receive any notified urgent business and action*	Verbal	Presenter: Philippa Slinger
Item:23	13:15	**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 06 February 2025. **To resolve to move to into private session** *The Board now needs to move to a private session due to the confidential nature of the business to be transacted*		Verbal	Presenter: Philippa Slinger

Supporting Appendices:

Item 7.	Organ Donation	Summary Report Detailed Report Letter	*To receive and note*
Item 13	Maternity	Perinatal Quality Surveillance Update ATAIN & Transitional Care Saving Babies Lives	*To receive and note*

Minutes

University Hospitals Sussex
NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 01 August 2024, held in Room 3, Level 11, Louisa Martindale Building, RSCH, Brighton and virtually via Microsoft Teams Live Broadcast.

Present:

Philippa Slinger	Chair
Professor Jackie Cassell	Non-Executive Director
Lucy Bloem	Non-Executive Director
Professor Paul Layzell CBE	Non-Executive Director
Bindesh Shah	Non-Executive Director (from Item 13)
David Curley	Non-Executive Director
Philip Hogan	Non-Executive Director
Dr George Findlay	Chief Executive
Dr Andy Heeps	Chief Operating Officer and Deputy CEO
Clare Stafford	Chief Financial Officer
Dr Maggie Davies	Chief Nurse
David Grantham	Chief People Officer
Professor Catherine (Katie) Urch	Chief Medical Officer
Darren Grayson*	Chief Governance Officer
Roxanne Smith	Chief Strategy Officer
Sandi Drewett*	Chief Culture Officer

*Non-voting member of the Board

In Attendance:

Emma Chambers	Director of Midwifery
Glen Palethorpe	Company Secretary
Tamsin James	Board and Committees Manager (Minutes)
Ben Smith	Deputy Company Secretary (Production)
Rachel Robertson	Board and Committees Manager (Production)

TB/08/24/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chair welcomed all those present to the meeting.

1.3 There were apologies for absence received from Wayne Orr and Gordon Ferns.

TB/08/24/2 DECLARATIONS OF INTERESTS

2.1 There were no other interests declared.

TB/08/24/3 MINUTES OF THE MEETING HELD ON 02 MAY 2024

3.1 The Board received the minutes of the meeting held on 02 May 2024.

3.2 The minutes of the meeting held on 02 May 2024 were **APPROVED** as a correct record.

TB/08/24/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

4.1 There were no Matters Arising from the previous Board meetings requiring action.

TB/08/24/5 QUESTIONS FROM MEMBERS OF THE PUBLIC

5.1 The Board received a number of questions from members of the Public in advance of the meeting.

5.2 The Board members answered the questions in detail and assured each individual who was either in attendance' or was viewing the live meeting online' that matters raised were taken seriously.

5.3 The Board **NOTED** the questions received by the members of the public and agreed that the subsequent detailed response would be provided individually to those who raised the question and that the answers to all the questions would be placed on the Trust's website, available here: https://www.uhsussex.nhs.uk/resources/public-board-1-august-2024-questions-answers/

TB/08/24/6 CHIEF EXECUTIVE REPORT

6.1 George Findlay began by taking the opportunity to say thank you to all staff for their dedication, compassion, and service and continuing to demonstrate exemplary commitment to patients, to provide safe high-quality care for people living locally.

6.2 George shared that the Trust was seeing more patients than ever before and was endeavouring to improve access and experience for patients. He stated that the Trust is delivering a fifth more elective activity every month than in 2019/20. . This is being achieved through a combination of a wide-ranging programmes of improvement and waiting time reduction initiatives. George told the Board the the Trust is one of only a small number of Trusts that has consistently reduced it's total waiting list, month on month, since October 2023.

6.3 George added that Maternity was one of the key improvement themes. The hard work and commitment to improvement was having impact and , the most recent safety data highlighted that outcomes for mothers and babies at UHSussex was now better than most other Trusts in the country, with patient feedback also similarly improving.

6.4 George drew the Board's attention to the achievements, awards and recognition section of the report and drew out some of the key highlights, including the Ambulatory Clinical Decision Unit (ACDU) at Princess Royal Hospital which had treated more than 15,000 patients since it opened last year. This marks a significant achievement and heartfelt thanks for the team's exceptional commitment and tireless efforts in elevating patient care standards were shared.

6.5 George went on to share that the Louisa Martindale Building (LMB) in Brighton had won two awards at the prestigious European Healthcare Design Awards 2024. The building was awarded the 'Healthcare Design' award in recognition of its design, focus on sustainability, and delivering an excellent clinical environment for patient care. It also won the 'Interior Design and Arts' category.

6.6 Within the Supporting our People section of the report, George drew out the comprehensive, broad-ranging, and growing programme to provide support for

colleagues across the organisation and shared his thanks and recognition for everything they do for our patients and each other.

6.7 The Board echoed George's thanks to the Trust's workforce for their continued exemplary commitment.

6.8 The Board **NOTED** the Chief Executive Report.

TB/08/24/7 INTEGRATED PERFORMANCE REPORT

7.1 The Chair introduced the performance report for University Hospitals Sussex, and informed the Board that this report shows the Trust's performance to June 2024 which 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.

7.2 George Findlay presented all the sections of the Integrated Performance Report and drew out the following:

PATIENT

7.3 The True North metric for the Patient Committee was to have 90% or more of patients rating Friends and Family Testing (FFT) surveys as Very Good or Good. Based on available FFT data, 89% of patients in Quarter 1 were satisfied that they had a good or very good experience against a target of 90%. This was based on 44,000 patient surveys returned, a response rate of 23%. George recognised that timeliness of care and crowded emergency departments are a significant inhibitor to patient experience and advised that further improvement plans are underway.

PEOPLE

7.4 The Trust's True North for Our People is to be the Top Acute Trust for Staff Engagement. Staffing indicators remain broadly stable or are improving although there remained much to do to further support staff with actions in place on culture and the Trust's People Plan for 2024/25.

QUALITY

7.5 There had been continued improvement in the Trust's SHMI mortality rate - a trend that has continued over the last 10 months, and the focus continues on reducing harm. In June – our falls rate is 4.15 per 1000 bed days compared to national average of 6.3. As a learning organisation we have been working to ensure the reporting of incidents increases and George reflected it is pleasing to see that in May we reached a reporting rate of 52.04 per 1000 bed days compared to national average of 54.9. 80% of incidents are graded as no harm or near miss.

SYSTEMS & PARTNERSHIPS

7.6 George advised that during Quarter 1 the Trust saw continued performance challenges. Emergency Care pathways treated 69.6% of patients within 4 hours of attending compared to 69.2% in Q4 2023/24. The Trust's Emergency Departments recovery plans include all divisional actions to improve flow across the hospital sites and there remained the aim to improve flow through the hospitals. These measures include improving the time to triage/treatment and improving flow from the ED to reduce the long stays. The Trust has remained in the national Tier 1 process for RTT and Cancer performance; Elective activity has improved considerably in quarter 1, compared to 2023/24.

Improvements to the trajectory to reduce RTT long waits had seen an improvement in RTT 65 and 78 weeklong waits within the quarter.

SUSTAINABILITY

7.7 The financial position is challenged with additional key drivers of increased direct costs. Enhanced cost control measures had been introduced across the Trust in endeavour to stabilise the position and support the efficiency target being delivered in full. Additional measures are being considered linked to the development of refreshed strategy, to address the underlying deficit.

At this point the Chair invited Board members to ask questions and discuss any pertinent areas of the Integrated Performance Report and agree any necessary actions.

7.8 Lucy Bloem noted that the RSCH ambulatory handovers within 60-minutes were increasing, whilst levels at PRH had significantly improved, and asked how these improvements could spread to other sites. George advised that the Emergency Department (ED) improvements continue to be overseen by the Finance & Performance Committee breakthrough objectives with A&E performance correlating with patient reported experience. An urgent and emergency care improvement workstream is now in place, with the aim of reducing 4 and 12 hour waits and ambulance handover times across all sites. Andy Heeps built on George's comments and advised there remained the aim to improve outflow through the hospitals. These measures include improving the time to triage/treatment and improving flow from the ED to reduce the level of long stays, and expediting the Median Hour of Discharge work.

7.9 The Chair asked how the Trust could do more to support its workforce, to maintain resilience, given the challenging ED environment. George responded by stating that the majority of the issues within ED pertains to patient flow, however improvements were being implemented to support the workforce through local leadership support.

7.10 The Board reflected on the updates regarding patient flow across the hospital sites and supported the priority action being undertaken by the Trust , however the pace of change in a number of areas must improve.

7.11 Andy Heeps reflected on the Trust's incident reporting via Datix IQ and asked whether it was supporting improvements. Katie Urch firstly shared her thanks to the Trust's safety team for their support in embedding the Datix IQ system and explained that the system was supporting the safety and learning culture within the divisions demonstrating the importance of using the reporting mechanism appropriately, which was making a positive difference as evidenced by the data.

7.12 The Board further discussed People performance, particularly the time to hire metrics, with the Chair asking whether the People scorecard was being monitored appropriately. George explained that given the Trust's challenged financial position steps have been taken to stabilise the environment which does include holding a number of non-clinical positions vacant. This is likely to show some pressure on staff engagement scores and this metric. George went on to assure the Board that Band 5 HCA and certain clinical vacancies would continue to be fulfilled. The Chair went on to question what the Trust communications plan was regarding the financial recovery plan. Clare Stafford advised the Board that information on the processes, planning and control mechanisms have been shared across the Trust appropriately

[Bindesh Shah joined the meeting in person at this point.]

TB/08/24/8 NATIONAL OVERSIGHT FRAMEWORK

8.1 Darren Grayson presented the National Oversight Framework (NOF) section of the Integrated Performance Report and began by reminding the Board that the Trust is subject to the framework that allows the ICB to take a view on the performance of the Trust. In endeavour to focus on improvement the Trust has consolidated its quality and performance improvement plans into a Single Improvement Plan. The oversight of the delivery of that plan is undertaken by the Single Improvement Plan Committee, Chaired by the Vice Chair of the Trust with a membership that includes other Board members.

8.2 The Board **NOTED** the Integrated Performance Report.

TB/08/24/9 SINGLE IMPROVEMENT PLAN

9.1 George Findlay provided an update on the Quality and Safety Improvement Plan (SIP) and referred to previous updates whereby the Trust had entered into undertakings with NHSE to address a series of performance, quality and safety metrics together with processes that had been identified by regulators as requiring improvement. The Trust has developed a coherent single improvement plan focusing on nine domains: CQC; quality improvement; culture; surgery; planned care; urgent and emergency care; equality, diversity and inclusion; specialised services; and maternity; in order to deliver those improvements quickly and provides assurance to the Board and its regulators.

9.2 George added that each of these domains are led by an Executive supported by the Programme Management Office. The SIP sets out ambitions for improvement and is backed by detailed delivery plans focusing on an ambitious long-term programme of improvement that will be delivered over the next few years and that will improve services and experiences for patients, families and staff.

9.3 The Board reflected on the foundations of the improvement plan and the necessity to capture the complexities to ensure the relevant Board Committees are receiving oversight of and from the individual programmes. The Board was assured that the work on the Strategy2030 project which would underpin the improvement plan priorities would be aligned to the Sussex system transformation plans developed through the Committee in Common. In respect of the financial impact of delivering the plan the Board heard that work is being undertaken to understand these costs and the options for resourcing of the work. .

9.4 The Board **NOTED** the Single Improvement Plan update.

TB/08/24/10 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER HIGHLIGHT REPORT

10.1 Darren Grayson introduced the Board Assurance Framework (BAF) and accompanying Corporate Risk Register summary and explained that the report had been received by and considered by the Board Committees and reflected the views of each Committee responsible for their specific risks.

10.2 Glen Palethorpe explained that for each of the 10 strategic risks the expected assurances have been received over the period of quarter 1 enabling a determination to be made as to the opening quarter 2 score. The review of the 10 risks saw the quarter 2 scores not change. Therefore, all but two strategic risks, 3.1. People Risk and 4.2. Quality Risk, exceed their target scores.

10.3 The BAF continues to record the receipt of assurances with a most prominent a mix of management and executive assurance, however there has been a number of externally provided assurances from Internal Audit, Guardian Services, FFT results. Whilst there were a small number of sources of expected assurance for quarter 1 which did not materialise, the respective oversight Committee agreed the lack of these did not impact on the risk scores.

10.4 David Curley advised the Board that the respective Committees should continue to consider the adequacy of the actions being taken to secure a risk reduction by the year end, and that any missing assurances continue to be highlighted to the Board to support and drive improvements during these challenged circumstances.

10.5 The Board **APPROVED** the respective risk scores as recorded within the Board Assurance Framework and **NOTED** the Corporate Risk Report, recognising that the respective Committees had reviewed and were recommending these risk scores as being a fair reflection of the risks facing the Trust.

TB/08/24/11 REPORT FROM THE RESEARCH, INNOVATION & DIGITAL COMMITTEE CHAIR FROM THE MEETING ON THE 24 JULY 2024.

11.1 The Chair invited Jackie Cassell, Chair of the RI&D Committee which includes the oversight of the RI domain and digital, to update the Board on their recent meeting and the assurances received in relation to patients and research and innovation.

11.2 Jackie shared that the Committee had welcomed the work undertaken in respect of the Digital maturity assessment against 'what good looks like' which provides a framework and enables benchmarking. The Committee was assured that the Trust has reached Standards Met rating for the Data Protection Security Toolkit following the review of the evidence by Internal Audit. Jackie flagged that the Board should consider the link between Digital Maturity, cybersecurity and risks to compliance within the Well Led domain and any implications for quality, safety and clinical productivity. Rox Smith suggested this may be addressed through the implementation of the Trust Strategy, and discussions would need to be undertaken on appropriate investment choices around the digital agenda.

11.3 The Board reflected on the importance of the Digital agenda that has elements in support of innovation and elements in support of day-to-day core functions. The Chair questioned whether the Committee had sufficient time to focus on both elements, noting that there is a large EPR project ahead as an example, The Committee Chair recognised the scope of the committee was considerable but felt that at present, the committee could provide adequate oversight of the full agenda, noting this may change as the committee matures

TB/08/24/12 REPORT FROM PATIENT & QUALITY COMMITTEE CHAIR FROM THE MEETING ON THE 28 MAY, 25 JUNE, 23 JULY

12.1 The Chair invited the Chair of the Quality Committee, Lucy Bloem, to update the Board on their recent meeting and the assurances received in relation to Quality.

12.2 Lucy advised the Board that the Committee had met three times since the last Board meeting and during those meetings had received updates including the review of the outstanding actions from previous CQC reports and the approach to validating their status. The Committee had received the Quality governance map of the sub-committees which through their reporting highlighted the gaps in assurance.

12.3 Lucy confirmed that the Committee continued to receive the Trust's Perinatal Quality Surveillance Reports & Dashboards for all four of its maternity units, which included the Ockenden data sets within the current dashboards. This has continued to show the perinatal mortality rate as sustained below the national average. Lucy explained that a number of perinatal reports had been included as appendices to the meeting papers and invited Emma Chambers, as Director of Midwifery to provide an overview these reports and the Maternity services.

12.4 Emma drew the Board's attention to the slides and drew out the following:

12.5 By way of background Emma explained that in 2021 the CQC inspected the Trust's Maternity services across the four sites. The Maternity Safety Support Programme (MSSP) support commenced in early 2022, and the informal CQC visit in April 2022 showed improvements being made,. There has been no further formal inspection of the service since 2021., Only one of the CQC actions remains incomplete and relates to Estates and Facilities at PRH which is planned to be actioned in September.

12.6 In relation to MSSP, Emma explained that the supporting Maternity Improvement Plan is monitored under bi-monthly executive led meetings., The Review and Reset meeting by the MSSP and regional and national stakeholders highlighted demonstrable improvements from ward to board and the trajectory to move to the Sustainability phase of the programme by later in the year, with a view to exit the programme early next year.

12.7 Emma drew out the positive data outcomes showing statistically significant reductions in both perinatal mortality rates and Hypoxic Ischaemic Encephalopathy (brain injury) rates, both measures are well below national benchmark rates for equivalent service configurations. Emma highlighted that quality improvements within the Saving Babies Lives care bundle v3 have contributed to this; and the numbers of serious incidents (SI) now known as Patient Safety Incident Investigations (PSSIs) have also reduced. The Board did however recognise that sadly some families do experience devastating loss and the service offers unwavering support and compassion to those affected during and after these very sad events.

12.8 Emma concluded by highlighting the positive service user feedback, along with the improvements to workforce satisfaction, through improved communications channels, and safety forums and listening events, chaired by Maggie Davies and Lucy Bloem.

12.9 The Board thanked Emma for the update and noted the outstanding improvements to the maternity service during the last few years and shared their thanks to the workforce for their support and commitment throughout.

12.10 The Board **NOTED** the:

- Saving Babies Lives Report
- ATAIN Transitional Care report
- Fetal Wellbeing report

12.11 In relation to the End of Life Care report Jackie Cassell commented that the Sussex system was national outlier on out of hours admissions of individuals on end of life care and asked what work was being done in this area. Katie Urch shared the details of the project to address this in 2024/25.

12.12 Lucy Bloem concluded and invited the Board to note the following items that followed this report, the Board **NOTED** and **APPROVED** the:

- Annual Learning from Deaths Report 2023-24
- Annual End of Life Care Report 2023-24
- Annual Patient Experience Report 2023-24
- National Infected Blood Inquiry
- Supportive End of Life Care Annual Report for 2023/24
- Patient Experience Annual Report 2023/24
- National Infected Blood Inquiry Summary Report

TB/08/24/13 REPORT FROM PEOPLE COMMITTEE CHAIR FROM THE MEETING ON THE 28 MAY, 23 JULY.

13.1 The Chairman invited the Chair of the People Committee, Paul Layzell, to update the Board on their recent meeting and the assurances received in relation to People.

13.2 Paul highlighted the work underway and the positive progress on the breadth of support provided to staff and the focus on seeking to keep people healthy and to support staff to return to work quickly., Paul noted this work covered both support for staff members mental and physical health

13.3 Paul also shared an update on the progress made in reviewing the Trust's volunteer service and setting out the formation of the Trust's ambition for the volunteers and how this can support the Trust's move forward as an anchor institution.

13.4 Paul advised that the Committee received and discussed the annual nursing establishment review report which provided information on the process applied by the Trust which highlighted the differences in practice across the various sites and divisions and the work being undertaken to align these.

13.5 Paul drew the Board's attention to the annual reports from Equalities and Diversity, the Freedom to Speak Up Guardian (FTSU) and the Guardian of Safe Working Hours (GOSW), which all highlighted the supporting work on cultural engagement and improvement. The Board were assured that matters escalated were being acted on appropriately by the FTSU Guardian and the key indicators were being correlated and tracked.

13.6 The Board were assured that the Committee had agreed that at its next meeting it would have a wider discussion on the areas for EDI improvement identified in the annual report, particularly that of Violence and aggression. There would be, meetings with chairs of the staff network to better understand the impact of current EDI work. It was agreed that the Board would hold a future workshop on the EDI programme and its impact.

13.7 In relation to the GOSW Annual report the Board noted that one of the themes highlighted pertained to the clinical workload exceeding the capacity of a full team. The Committee was assured that the investments and implementation of the rostering systems will be appropriate interventions

13.8 The Board **NOTED** and **APPROVED** the:

- Annual Equalities Report 2023-24 including Workforce Race Equality Standard (WRES) & the Workforce Disability Equality Standard (WDES) reports
- Freedom to Speak Up Annual Report 2023-24
- Guardian of Safeworking Annual Report 2023-24
- Nursing Establishment Report 2023-24

TB/08/24/14 REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE CHAIR FROM THE MEETING ON THE 30 MAY, 27 JUNE, 25 JULY.

14.1 The Chair invited Philip Hogan to update the Board on the meeting and the assurances received in relation to Finance & Performance.

14.2 Philip advised the Board that the Committee had discussed at length the Trust's current financial and efficiency position and focussed on understanding the causes, risks and mitigations taken so far. In addition, it was noted that the Committee had spent time discussing the financial and performance recovery plans and the best use of recruitment to ensure maximum workforce effectiveness. The Board noted that the Committee had received and discussed the assumptions, risks and mitigations which Philip confirmed had been made clear in the respective papers to the Committee.

14.3 Philip drew attention to the Financial Recovery Plan update and reminded the Board of the Trust's underlying deficit but shared the journey of the financial recovery plan development which was stratified into three categories, structural drivers; strategic drivers; and operational drivers. Philip advised that the delivery of the control total remained challenged particularly in the current operating environment and competing priorities, and that further work was ongoing to identify further opportunities to support financial recovery.

14.4 The Board were updated on the enhanced grip and control actions being taken, and noted the risks relating to the cross-cutting schemes which aim to support the delivery of the financial plan in 2024/25.

14.5 The Board reflected on the multifaceted levels of the plan and continued their support that action should be focused on transformation. Whilst noting the difficulties, there remained intensive focus on maintaining oversight of the Trust's ambition whilst continually monitoring the trajectories against the risks to the efficiency programme, the Board agreed that it remained imperative that a focus on workforce culture is integral to the transformation plan, whilst noting the joint oversight of the wider system plan delivery.

14.6 The Board heard that following the June resubmission of the plan, further discussions had taken place with NHSE and the revenue control limit had been confirmed as a £50m deficit for the Sussex system. The deficit of which would be fully cash backed through NHSE deficit funding.

14.7 The Board **NOTED** the Financial Recovery Plan Approach and **ACCEPTED** the change in the system control total and the impact this has on the Trust's financial plan.

TB/08/24/15 REPORT FROM THE SINGLE IMPROVEMENT PLAN COMMITTEE CHAIR FROM THE MEETING ON THE 25 JULY 2024.

15.1 Paul Layzell, Chair of the QSIP Committee advised the Board that the update on the Quality and Safety Improvement Programme had largely been provided to the Board earlier in the meeting but invited the Board to Approve the Committee's revised terms of reference which reflect the Committee's oversight of the broader single improvement plan.

15.2 The Board **APPROVED** the Committees Terms of Reference.

TB/08/24/16 REPORT FROM AUDIT COMMITTEE CHAIR FROM THE MEETING ON 16 JULY 2024

16.1 David Curley as Chair of the Audit Committee, presented the Chair's report from the meeting held on 18 April 2024 and it was noted that the Committee had received updates from the Local Counter Fraud Services, the External

Auditors, and Internal Audit whereby the Committee had received updates on the Internal Audit activity and had approved the Trust's the 2024/25 internal audit plan recognising this activity was appropriately aligned to the Trust BAF.

16.2 David presented the Committee Chair's Annual report highlighting that it provided a balanced view of the Committee activities and effectiveness over the 2023/24 year.

16.3 The Board **NOTED** the Reports from the Audit Committee.

TB/08/24/17 CQC UPDATE INCLUDING CHILDREN AND YOUNG PERSONS SERVICE INSPECTION

17.1 Maggie Davies explained to the Board that the CQC had undertaken an unannounced inspection of the Children and Young People Service at Worthing Hospital in June 2024. The inspectors reflected that during their inspection they saw positive examples of high quality care being delivered in particular on Bluefin Ward. However, the inspectors did identify a small number of areas where immediate improvements should be made, which included the need for the Trust to review the staffing levels in the paediatric emergency and a review of aspects of medicines management and processes within the paediatric emergency department and urgent treatment centre.

17.2 The Board discussed that once the formal report was received it would be subject to factual accuracy checks and this along with the associated improvement plan would be presented to the Board with the delivery of the improvements being incorporated into the established CQC action tracker workstream.

17.3 The Board **NOTED** the update.

TB/08/24/18 OPERATION BRAMBER

18.1 Darren Grayson confirmed that a police enquiry continues which relates to allegations of medical negligence within the General Surgery and Neurosurgery departments between 2015 and 2021. Darren confirmed that the Trust continued to cooperate with the police requests to share information to support their investigation but that the Police continue to indicate that the investigation remains at an early stage and advised that an incident control group along with a tactical local group had been established to support the investigation in an open and accessible manner.

18.2 Darren confirmed that the Trust remained supportive of all its surgical workforce and whilst some are facing unprecedented challenges there had been little negative patient communications or impact, and the Trust's continuing transparency over the support for staff and the police continued.

TB/08/24/19 COMPANY SECRETARY REPORT

19.1 Glen Palethorpe introduced the Company Secretary Report and the Board noted the outcome of the recent Governor Elections and that an induction programme for the new governors will commence on 8 August; and that the Trust had expressed its thanks for the contribution of those Governors who retired during the election process.

19.2 The Board also noted that the Trust held its AGM on the 30 July, this meeting received a presentation from the Chief Executive and was combined with the formal Council of Governors meeting which received the Trust's 2023/24

Annual Report and Accounts along with the External Audit Findings Report, noting these papers are available on the Trust's website

TB/08/24/20 OTHER BUSINESS

20.1 The Chair concluded the meeting and reflected on the themes highlighted today, noting that it was very challenging to meet the expectations of ourselves and our regulators to deliver measurable improved outcomes for our patients and our staff within the very constrained financial environment.

20.2 The Chair also announced that the Trust was aiming to move toward more meetings being held in public throughout the latter part of the year and next, and further information would be provided in due course.

TB/08/24/21 RESOLUTION INTO BOARD COMMITTEE

21.1 The Board resolved to meet in private due to the confidential nature of the business to be transacted.

TB/08/24/22 The Chair formally closed the meeting.

TB/08/24/23 DATE OF NEXT MEETING

23.1 It was noted that the next meeting of the Board of Directors was scheduled to take place at **10.00** on **Thursday 07 November 2024**.

Tamsin James
Board & Committees Manager
August 2024

Signed as a correct record of the meeting

…….. Chair

..…… Date

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	7.	**Meeting:**	Trust Board in Public	**Meeting Date:**	7 November 2024
Report Title:	Organ Donation Annual Report				
Sponsoring Executive Director:	Katie Urch, Chief Medical Officer				
Author(s):	NHS Blood & Transplant: Alex Harrison, Consultant in Nephrology and Intensive Care Medicine Claire Phillips, Consultant in Anaesthesia and Intensive Care Medicine Andrew Hetreed, Consultant in Anaesthesia and Intensive Care Medicine				
Report previously considered by and date:	COEG - 01 August 2024 Quality Governance Steering Group – 21 October 2024 Patient & Quality Committee – 29 October 2024				

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

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

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

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

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

Regulatory / Statutory reporting requirement
NHS Blood and Transplant (NHSBT)

Communication and Consultation:

Executive Summary:
Annual report from NHSBT on the organ donation performance for UHSx: The Trust continues to make significant progress on the key metrics (referral to organ donation nurses, their presence when organ donation is first raised, brainstem testing, and family consent for organ donation) and there are no areas where significant concern is raised by NHSBT on our performance. There has been a significant improvement in the metric looking at presence of a specialist nurse and a collaborative approach. Our consent rates continue to be amongst the highest for the country for similar sized units.

In 2023-24 the Trust facilitated 38 deceased organ donors, which resulted in 93 patients receiving a lifesaving or life-changing solid organ transplant. The previous year had been 31 donors and 72 patients receiving an organ transplant.

There is much better collaborative working partly due to the environment the new LMB unit provides at the Royal Sussex County Hospital which allows dedicated space for the embedded team at the site and better visibility to the MDT team. The embedded specialist nurses also have the opportunity to attend the unit morning meeting and meet the team leaders for that shift.

Areas of Risk:
Reputational damage (Trust and NHSBT if we are unable to continue to deliver high quality organ donation outcomes. This does include missing consented donors from avoidable delays (especially lack of access to theatres in a timely fashion at RSCH).

Actions:
There is continued work going forward within the region. One of the metrics we score less well on is our referral rate for donation after cardiac death. There is ongoing work including other departments who are involved in this process including anaesthetics and ED.
Support for organ donation promotion, especially with artwork installation in the LMB which still remains a goal for the group.

Key Recommendation(s):

The Board is asked to **NOTE** the Organ Donation Annual Report.

University Hospitals Sussex
NHS Foundation Trust

Organ Donation Annual Report

1st April 2023 to 31st March 2024

Dr Andrew Hetreed
Clinical Lead for Organ Donation

UHSussex Performance

University Hospitals Sussex NHS Foundation Trust

- 47 Consented donors
- 38 Proceeding donors
- 93 Patients received life-saving or life-changing transplants as a result

- Sadly 28(404) people died on the transplant list
- 829(7404) patients still await transplant

UHSussex Performance

University Hospitals Sussex
NHS Foundation Trust

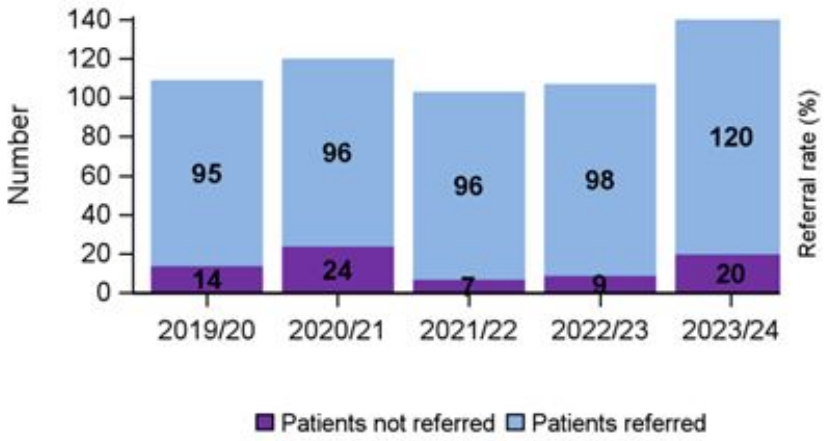
Best quality of care in organ donation

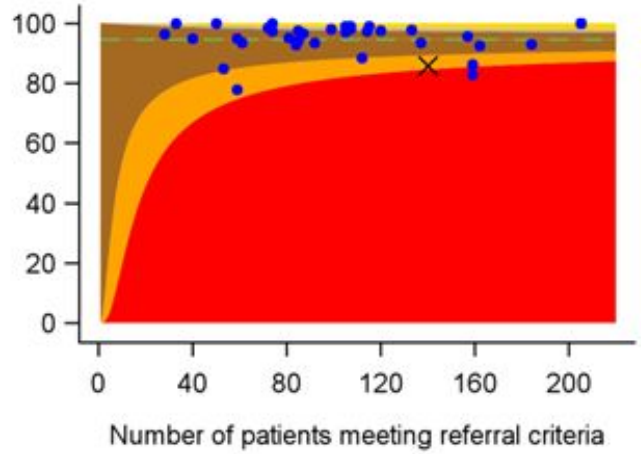
Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart

Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold





X Trust • Other level 1 Trusts – – – UK rate

Gold | Silver | Bronze | Amber | Red

The Trust referred 120 potential organ donors during 2023/24. There were 20 occasions where potential organ donors were not referred.

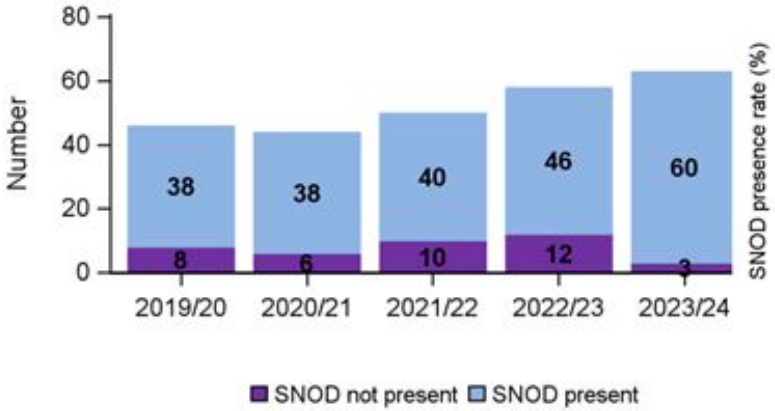
SN-OD Presence

University Hospitals Sussex
NHS Foundation Trust

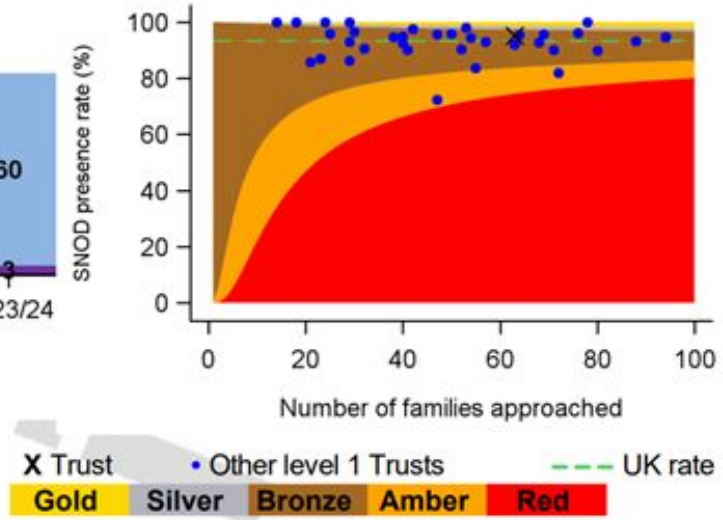
Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold

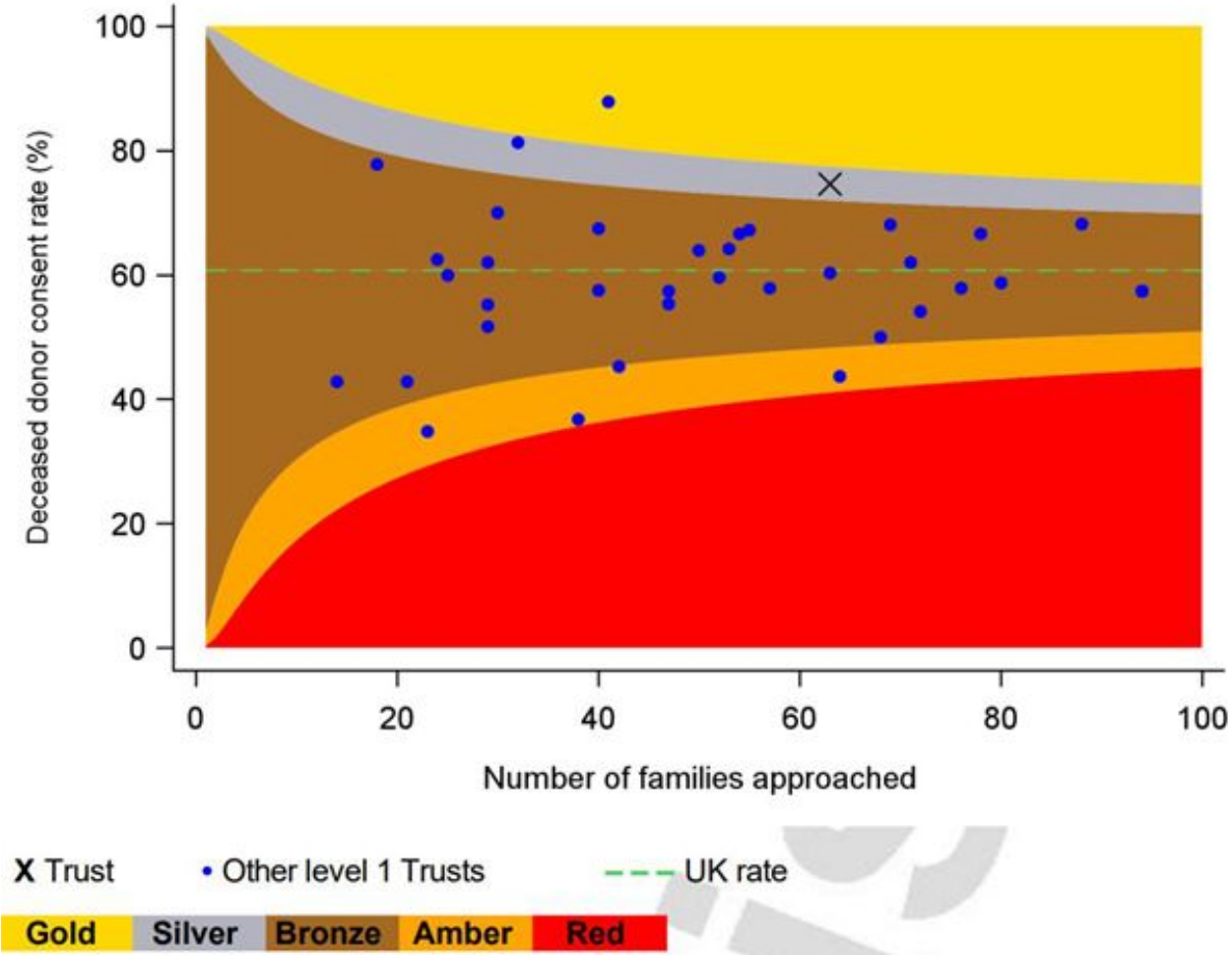


A SNOD was present for 60 organ donation discussions with families during 2023/24. There were 3 occasions where a SNOD was not present.

When compared with UK performance, the Trust was average (bronze) for SNOD presence when approaching families to discuss organ donation.

Consent rate

University Hospitals Sussex
NHS Foundation Trust



When compared with UK performance the consent rate in University Hospitals Sussex NHS Foundation Trust was good (silver).

Quality Domain Summary

University Hospitals Sussex NHS Foundation Trust

Successes:	Improvements Required:
• Highest number of deceased donors ever for UHSussex • Significant improvement in quality metrics at RSCH site in last 3 years • Consistently high consent and referral rates at SRH and WGH	• DCD missed referrals • Tissue donation (esp. corneas) • Trust-wide policy for organ & tissue donation
Risks/Escalations:	**Opportunities/Actions:**
• Theatre access for donation activity • Echocardiography (out of hours) for potential heart donors	• Trust minibus wraps • Feedback of positive donation outcomes to wider team (e.g HEMS, theatres, ED)

NHS
University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	8.	**Meeting:**	Trust Board in Public	**Meeting Date:**	07 November 2024
Report Title:	Chief Executive's Report				
Sponsoring Executive Director:			Dr George Findlay, Chief Executive		
Author(s):					
Report previously considered by and date:					

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

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

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

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

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

N/A

Executive Summary:

This report gives the Trust Board a summary of highlights from the Chief Executive and the work of UHSussex over the last quarter.

Key Recommendation(s):

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

To: Trust Board **Date: November 2024**

From: Chief Executive – Dr George Findlay

CHIEF EXECUTIVE REPORT

1. THANK YOU

1.1. The past three months have been characterised by celebration, insight and learning as huge numbers of staff, as well as partners and patients, have been involved and inspired by our Patient First STAR Awards, UHSussex Staff Conference and Big Conversation engagement programme.

1.2. Each of the events proved uplifting and inspirational in different ways, but with consistent themes of improvement and looking forward to a bright future weaving them all together into a strong foundation University Sussex Hospitals can build upon with confidence.

1.3. Our annual **Patient First STAR Awards** in September was a joyous evening of celebration and saying thank you for the great work going on across our hospitals and many of the incredible people behind it. When times are as tough as we find them right now, it's easy to lose sight of the huge amount of fantastic, innovative and life-changing work colleagues do, day in and day out.

1.4. Taking the time to recognise those efforts and thank each other for them is hugely important to us within our teams and through wider celebrations like our staff recognition awards. I want to take this opportunity to congratulate all our winners (listed below) as well as thank the 1,500 people who nominated someone for an award. That record-breaking number alone says a great deal about how much colleagues and patients appreciate our staff.

1.5. While the STAR Awards are the most visible expression of that sentiment, I see colleagues recognising, supporting and thanking one another with care and kindness every day of the year too – this is what makes our Trust such a special place to work, and it is this collegiate spirit that will drive our improvement efforts forward.

1.6. Also critical to our improvement journey is having the right 'mindset' - being open and honest with ourselves with a genuine willingness to recognise our

shortcomings, learn from them, and be confident that we have both the ability and power to act with confidence, grow and improve upon our performance.

1.7. This was a key take-away from the inspirational lead speaker at our **UHSussex Staff Conference** in October - British competitive diver and Olympic Silver Medal winner Leon Taylor. Leon captivated an audience of more than 600 colleagues over two days, reflecting on his remarkable journey from a restless child to performing at the pinnacle of professional sport for more than two decades. Key to his success was his attitude or having a 'growth mindset' as he described it. This was fundamental to achievements, including the creation of 'world's most difficult dive' to challenge other people's bias.

1.8. Our conference theme this year was 'Bright Horizons' and the event was a brilliant opportunity for teams and colleagues that don't usually interact to come together and talk about what our future could look like and how we can make that change happen. There was a real buzz in the air and investment from everyone present in the future of our hospitals and services we provide. I wish we could bottle the energy as it should be a real source of optimism for our patients, partners and stakeholders.

1.9. Our staff conference was followed by our first ever **Black History Month Conference** in October, held in partnership with NHS Sussex and supported by *My University Hospitals Sussex Charity*. I was privileged to provide the opening address and took the opportunity to acknowledge the pain caused by racism and assert my steadfast commitment to addressing a pervasive and glaring disparity in our organisations – the underrepresentation of Black, Asian, and minoritised ethnic staff in senior leadership roles.

1.10. Our Board, our executive committees, and our senior leadership must reflect the diversity of the talent within our organisation. This is not about filling quotas - this is about building a team that truly represents the best of who we are, bringing different perspectives, backgrounds, and lived experiences to the table. I told the conference that I will hold myself accountable to this, and I will make sure our actions are public and transparent. I invite others to hold me accountable, too.

1.11. Over the summer, we launched a large-scale engagement programme with our staff called **The Big Conversation**. More recently, this has entered its second phase as we reach out to patients, partners and stakeholders. We are asking everyone to help inform our new strategy for University Hospitals Sussex. What should be our ambitions for 2030, and what does our roadmap need to look like to get there?

1.12. We have two surveys open until 19 November, seeking views from patients and public, and healthcare professionals and partners - details are available via our @UHSussex social media channels and website. We have been hosting in-

person engagement events and interviews with partners and stakeholders too, and I wish to thank everyone who has taken the time to meet with us.

1.13. We also encouraging our staff and others to participate in the new national conversation on the future of the NHS, launched by Wes Streeting, Secretary of State for Health and Social Care, and Amanda Pritchard, Chief Executive, NHS England. We are not alone in the issues we face as a large acute hospital trust, and we welcome the opportunity to contribute to a new 10-year plan for the NHS.

1.14. Our new Trust Strategy will ensure we are preparing locally for the same national challenges the NHS 10-year plan will need to address, such as a 3% growth in population by 2030 and a projected 7% increase in the number of over 85-year-olds. How can we ensure our services are appropriate, inclusive, available and protected for all those who need them, while making best use of our finite resources? I look forward to discussing our strategy development in much more detail at our next public board meeting.

1.15. The strategy will build upon the foundations being laid now through our **Single Improvement Plan (SIP).** In the three months since launching the SIP at Trust Board in August, steady progress has been made in several areas, and NHS Sussex and our regional NHS England partners have agreed with our ambitions and the measures we are employing to deliver wide-ranging and fast-paced improvements. However, while some improvements are already observable, many others remain challenged and will take more time to gain traction as our improvement journey matures.

1.16. However, this must not diminish the immensity of effort and acknowledgement of what our staff are already achieving through their relentless hard work, compassion and innovation. For example, over the past 12 months we have delivered the greatest improvement in total waiting list numbers of any trust in the country. Many factors have contributed to this, but key among them is delivering a fifth more activity than we did in the year before the pandemic. I want to put on record my huge thanks to everyone involved who has worked extra hours and in new ways to deliver such unprecedented levels of care.

1.17. Innovations, such as setting up our own Ear, Nose and Throat (ENT) community service or establishing and running a new Elective Coordination Centre in Sussex have also been critical to our success in reducing our total waiting list by more than 25,000 people since its peak last year. Now, we have started a six-month programme with the national ‘Getting it right in first time’ (GIRFT) programme to provide focused support for our specialties that still have the longest waits, as we are determined to reduce these and improve access for all our patients.

1.18. Improving our surgical services is another key theme from our improvement plan. In August, we approved the business case for a new Surgical Assessment Unit to support the Emergency Department in Brighton, and the new facility has

now opened. We have recently restarted in-hospital teaching for higher surgical trainees and responded to several other recommendations made by the Royal College of Surgeons following their invited review and report published earlier this year. We also continue to fully support Sussex Police's enquiry into historic allegations of negligence at Royal Sussex County Hospital. However, at present, we have no further information to share.

1.19. We know much more remains to be done in all the work streams associated with our improvement plan, but overall, I believe we have just cause for optimism and our patients should have confidence in us. We have the right people in place, support from our partners, and the necessary 'growth mindset' to deliver our ambitions that consistently meet the high standards our patients rightly expect of us. Care for our patients is our top priority and, most of all, we care about improvement for them – and this is what has been consistently clear, palpable in the atmosphere, and truly heartening to experience at all our events over the past three months.

2. ACHIEVEMENTS, RECOGNITION AND INVESTMENT – CONGRATULATIONS!

2.1. Despite the relentless demands upon our staff and hospitals, there are many positive developments and achievements it is important we take time to celebrate and share. I am delighted to be able to highlight a broad selection of achievements below that have occurred since our last Public Board three months ago. On behalf of the board, I wish to commend and thank all colleagues involved.

2.2. The compassion, dedication and life-changing work of staff and volunteers at University Hospitals Sussex were celebrated at our annual **Patient First STAR Awards** in September. Congratulations to everyone nominated and shortlisted for a prize, and in particular our 13 category award winners:

Mentor of the Year: Chris North, Senior Biomedical Scientist at St Richard's Hospital, recognised for his calm and patient teaching style.

Visionary Award: The Day Case Hysterectomy Team at St Richard's Hospital, for their innovative same-day surgery pathway.

Clinical Team of the Year: Neuro Theatres Nursing Team at Royal Sussex County Hospital, for their resilience under pressure.

Non-clinical Team of the Year: 3Ts Commissioning Team at Royal Sussex County Hospital for their essential role and dedication in supporting the opening of the Louisa Martindale Building.

Care: Gill Yates, Neuro-pharmacist at Princess Royal Hospital for her impressive skills, knowledge, and dedication to patient care.

Volunteer of the Year: Val and the gals (Audrey, Wendy, Margaret, and Ann) at Worthing and St Richard's hospitals for their dedication and empathy to bereaved parents and helpful hand to staff.

Royal Sussex County Site Hospital Hero: Dr Claire Phillips, ICU Consultant for displaying a great deal of compassion and putting others before herself.

Princess Royal Hospital Hero: Gary Segger, Portering Assistant Duty Manager for his caring and stable influence in difficult circumstances and friendly and comforting presence to patients.

St Richard's Hospital Hero: Anna Lambert, Multi-Disciplinary Coordinator noted for her efficiency, communication and organisation skills as well as her care, compassion and attention to detail.

Worthing & Southlands Hospital Hero: Marcia Savage, Housekeeping **Supervisor** for being a beacon of positivity and encouragement, uplifting her team and others at Southlands, making staff and patients feel valued and respected every step of the way.

Charity's Champion of the Year: Kat Chapman, Volunteer at Royal Sussex County Hospital who despite waiting for a kidney transplant ran the Benidorm 10k to raise funds for the Trust's charity.

Star of the Year: Sussex Orthopaedic Treatment Centre at Princess Royal Hospital, for their unwavering commitment to patient care.

Chair & Governors' Award: Beacon Ward at Worthing Hospital for their passion to deliver person-centred care, treating individuals with respect and dignity.

Thank you to our awards sponsor My University Hospitals Sussex Charity for supporting the event. For pictures and video please visit our website news pages.

2.3. **Professor Mahmood Bhutta**, a consultant Ear Nose and Throat (ENT) surgeon at University Hospitals Sussex and Professor in ENT at Brighton and Sussex Medical School, has been recognised for his groundbreaking work. The UK National Institute for Health and Care Research (NIHR) has awarded Professor Bhutta £3 million to enhance ear and hearing care in Malawi, Zambia, and Cambodia, and separately he has been honoured with the 2024 Nikhil J Bhatt International Humanitarian Award by the American Academy of Otolaryngology, to recognise his work on ear disease and hearing loss in countries with limited medical resources.

2.4. More than 130 colleagues have graduated from the **Facilities & Estates Supervisors' Academy** this year and have been invited to special celebration events. The Academy, which first launched in 2018, has been updated to include

all F&E teams, from housekeeping and porters to laundry and estates. The course includes more than 20 hours of training across 10 comprehensive modules, covering teamwork, appraisals, sickness absence, health and wellbeing, difficult conversations, coaching, huddles, improvement boards, waste and compliance, finance, and risk assessment.

2.5. **Sarah Randall, Clinical Nurse Specialist** (CNS), has won the national Tricia Moate Award for her commitment to the care of patients with sarcoma. Sarah, lead for service development in sarcoma services, was recognised for the instrumental role she played in establishing a sarcoma clinical nurse specialist team at UHSussex, having gained funding from Friends of Brighton & Hove Hospitals and the Surrey and Sussex Cancer Alliance.

2.6. **Mark Holmes, Stroke Ward Manager**, won Star of the Month for September for his quick-thinking and decisive action that helped save the life of a man who went into cardiac arrest in the reception area of the Louisa Martindale Building. Mark had noticed the man was looking seriously unwell and acted swiftly, ensuring the man received CPR immediately.

2.7. **Amy Braganza, senior nurse** at St Richard's Hospital, won Star of the Month in August for her unwavering compassion and dedication to patient care. Amy was recognised for her extraordinary efforts in supporting a critically ill patient and family. She is described as a fantastic nurse and role model and commended for her passion and dedication to improvement projects for critical care, making a real impact to enhance patient experience.

2.8. **Thirty-five new midwives** are set to begin their careers at University Hospitals Sussex, following a successful recruitment drive and induction event at Worthing Hospital. Most of the new team members have been training with the Trust as student midwives and will now support our successful maternity improvement programme which has seen our safety outcomes perform better than national benchmarks. Separately, we have also recently introduced virtual tours of our neonatal units to help parents and families views the wards from home.

2.9. St Richard's Hospital welcomed acclaimed actor Hugh Bonneville to officially open a new, bigger and better **Children's Emergency Department** in September. The event featured a special treat for young patients, with kindly donated Paddington teddy bears and books given out to children at the department. Thank you to My University Hospitals Sussex Charity and supporters for helping to fund the improvements.

2.10. Essential enabling works have begun at Worthing Hospital, to support the expansion of the Emergency Department and development of a **new Urgent Treatment Centre** (UTC). The UTC will provide urgent medical help to around 40,000 people a year. A temporary external entrance to A&E is being introduced while the works take place.

2.11. Neurosurgery colleagues hosted a new **Annual Neurosurgery Network Event** in October, the first of its kind in the UK bringing together regional neurosurgical units and all the professional groups and colleagues involved in improving patient access and quality of care for neurosurgery patients. Held at the Royal Sussex County Hospital, the programme also included a tour of the newly transformed neurosurgery unit in the Louisa Martindale Building, which now has access to three theatres, including a dedicated emergency theatre, reducing waiting times for patients and enabling the team to treat 300 more patients a year.

2.12. The **Cardiac Team at St Richard's Hospital** have gained international recognition for the work they are doing to improve care for patients that have an irregular heartbeat. Presenting their work at the European Heart Rhythm Association (EHRA) conference in Berlin, the team showcased their nurse-led Rapid Access Atrial Fibrillation (RAAF) clinics, which provide quick treatment for patients who visit the Emergency Department with heart problems.

2.13. University Hospitals Sussex won the **Health Tech Award for Partnership of the Year** for our innovative work to improve patient care with partners e18 Innovation and Netcall. The innovative project uses advanced technology to make administrative tasks easier, which in turn helps reduce waiting lists and improves overall efficiency. The project, led by Assistant Director of Performance and Improvement **Donna Steeles,** also earned a finalist spot in the Most Promising Pilot category.

2.14. The **Paediatric Audiology team** at Royal Sussex County Hospital (RSCH) achieved a perfect 100% score following a national review aimed to ensure top-quality hearing care for children. The team achieved an overall quality rating of A – Good, and a 'No Risk' status, in the review by NHS England, underscoring the exemplary standard of care they provide.

2.15. On October 14 we celebrated the incredible work and contribution of our **Allied Health Professionals** (AHP) who help assess, diagnose and treat our patients and bring real diversity in terms of their skills and experience. We have more than 1,000 AHPs working across eight specialisms – dietitians, occupational therapists, operating department practitioners, orthoptists, physiotherapists, diagnostic radiographers, therapeutic radiographers and speech and language therapists. Thank you to all our AHP colleagues for everything you do for our Trust and the excellent care you provide to our patients.

2.16. **Edmund Tabay**, Director of Nursing at Princess Royal, has been appointed as Queen Victoria Hospital's (QVH) new Chief Nurse. Edmund has been a compassionate and dedicated nursing leader at University Hospitals Sussex since 2021 and will prove a great asset to our neighbouring trust in East Grinstead. When he joined us, Edmund broke new ground for the Philippines nursing community in the UK by becoming one of the first Filipino nurse directors in the NHS. With his new promotion, he continues to trailblaze for the profession and his country of birth by joining the board of QVH.

2.17. Please join me in welcoming Jonathan Reid, our new Chief Financial Officer, to the Trust. Jonathan joins us from London North West University Healthcare NHS Trust, where he also served as their CFO. I also want to thank Clare Stafford, for her interim CFO leadership and congratulate her on her appointment to NHS Surrey Heartlands ICB as their Chief Finance Officer.

3. SUPPORTING OUR PEOPLE

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

3.2. Throughout October we marked **Speak Up Month,** with the theme 'Listen Up' and a focus on the power of listening, and its important role in encouraging people to feel confident to speak up. Our independent Freedom to Speak Up Guardian, Trish Marks, promoted the importance of speaking up during the month, with more hundreds of new interactions with staff across the Trust.

3.3. We marked **World Mental Health Day** on 10 October when staff were reminded of our wellbeing offers, as well as the Action for Happiness online zoom webinar on 15 October entitled Mindset & Relationships.

3.4. **World Menopause Day** was 18 October and an opportunity to celebrate our Menopause Café membership of more than 280 colleagues. At our latest Café on 23 October, we had more than 85 attendees benefitting from advice, support and networking.

3.5. We invited the **ZEN BUS**, a converted American school bus, back to the trust last month to visit Worthing, St Richard's and Princess Royal. The Zen Project offers guided sessions to lower stress and anxiety. More than 250 colleagues attended, thanks to the support of My UHSussex charity.

3.6. Our in-house **Managing Mental Health and Wellbeing at Work** training course has been oversubscribed since launching in July. So far, more than 70 staff have received the new training with new dates being released later this month.

4. INTERESTED TO FIND OUT MORE?

4.1. The news section of our website provides more detail and great images related to some of the events and achievements I have referenced above. Please visit www.uhsussex.nhs.uk/news. We are also active on social media. Please join the conversation, comment, like and share by searching for @UHSussex on your favourite platform or use the hashtag #UHSussex. We also invite people living locally to join UHSussex as a member, volunteer in our hospitals or develop their career with us. With seven hospitals across Sussex and numerous satellite services, we are proud to be at the heart of the communities we serve. We wish to welcome others to our UHSussex family too. Visit www.uhsussex.nhs.uk/join-us - thank you.

6. RECOMMENDATIONS

6.1 The Board is asked to **NOTE** the Chief Executive Report.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	9.	**Meeting:**	Trust Board in Public	**Meeting Date:**	07 November 2024
Report Title:	Integrated Performance Report				
Sponsoring Executive Director:	Darren Grayson, Chief Governance Officer				
Author(s):	Executive Directors/Corporate Directors				
Report previously considered by and date:					

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

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

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

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

Regulatory / Statutory reporting requirement

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

Communication and Consultation:

Executive Summary:

I am pleased to introduce the Integrated performance report for University Hospitals Sussex. It shows our performance to September 2024 and sets out the progress we are making to deliver the Trust's Patient First Strategy, the NHS National Oversight Framework and the NHS Operating Plan.

Key Recommendation(s):

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

NHS
University Hospitals Sussex
NHS Foundation Trust

Integrated Performance Report

September 2024

University Hospitals Sussex
NHS Foundation Trust

Chief Executive Summary

Please see enclosed the performance report for University Sussex Hospitals. It shows our performance to September 2024 and sets out the progress we are making to deliver the Trust's Patient First priorities, the NHS National Oversight Framework and the NHS Operating Plan. My summary highlights our performance against some of the key metrics with more detail provided in the body of the report.

During Quarter 2 more than 30,000 patients provided feedback on the care they received within the Trust. 89.5% of those patients were satisfied that they had a good or very good experience, slightly below our target of 90%. However, patients cared for only in our emergency departments reported lower levels of satisfaction. We recognise timeliness of care and crowded emergency departments are a significant patient experience and quality concern and we have plans to make improvements - these sit withing our Single Improvement Plan. From a quality perspective, there has been continued improvement in the SHMI mortality rate - a trend that has continued over the last 13 months.

We continue to focus on reducing harm and through the efforts of our multidisciplinary teams have reduced falls further in September - our falls rate is 4 per 1000 bed days compared to national average of 6.3. As a learning organisation we have been working to ensure reporting of incidents increases and it is pleasing to see that in August we reached a reporting rate of 52.32 per 1000 bed days compared to national average of 54.9. 81% of incidents are graded as no harm or near miss. Furthermore, our friends and family test (FFT) data shows an improvement in patient reported experience in September for the third consecutive month, and marginally higher than September-23.

During Quarter 2 the Trust saw continued performance challenges. For our Emergency Care pathways, we treated 71.5% of patients within 4 hours of attending compared to 69.6% Q1 2023/24 and 70.3% Q2 2023/4. Our hospitals are working at around 95% occupancy which limits flow from emergency departments. We continue to work with system partners to address the large number of patients who are not able to leave our hospital when medically ready to do so. The Trust has remained in the national Tier 1 process for RTT and Cancer performance. Elective activity improved considerably in quarter 2, compared to 2023/24. We continue to have some specialty specific challenges for RTT long waits however. The waiting list has continued to fall since September-23 which means that the Trust and system capacity solutions have been higher than demand in Q2. While the performance for the Trust remains challenging in certain specialties, mitigation plans have been constructed which helped materially reduce the longest waiting 65 week cohort to September, and will continue to do so as we target zero 65 Week waiters with system support by March-25.

Staffing indicators remain broadly stable or improving, with the exception of the monthly staff survey score for staff engagement, which whilst improved September compared to August, has shown deterioration in Q2 compared to Q1 2024. Actions targeting improvement are underway including those regarding culture and a 'people plan' for 2024/25.

The financial position shows an actual deficit of £34.91m, which is £5.44m adverse to plan. Key drivers of the adverse variance to plan are: medical staff premium costs (£6.6m), expenditure on high cost drugs (£1.7m), underachievement of SMSKP activity (£1.35m. To address the deteriorating financial position we introduced a series of controls in July , identify and secure efficiency savings, and target structural and strategic issues associated with the underlying financial deficit.

In delivering this very challenging agenda the Trust leadership continues to prioritise patient safety and staff well-being. We are also continuing to work with our partners in the local care and health system to identify and implement improvements.

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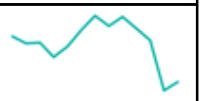
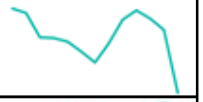
True North Metrics

	Patient First Domain	Metric	Value	Target	Trend
Pt	Patient	Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good	88.7%	90.0%	
P	People	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	6.29	7.06	
S	Sustainability	Financial Stability - Variance from breakeven plan YTD	-5,440k	0k	
Q	Quality	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	103.6	100.0	
Q	Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	594		
SP	Systems & Partnerships	A&E and Emergency flow - % treated and admitted/discharged within 4 hours	71.6%	78.0%	
SP	Systems & Partnerships	Cancer - To achieve the 62 day standard (All referrals - National standard revised Oct 2023)	60.30%	70.00%	
SP	Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	579	0	
SP	Systems & Partnerships	RTT Elective care - >=65 Weeks	2525	0	
SP	Systems & Partnerships	A&E and Emergency flow - Hour of discharge median will be 10am to 10.59am (home for lunch) (Trust Level)	15:00	11:00	
RI	Research & Innovation	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	51	35	

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Patient

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

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Patient First Domain
The patient true north is for patients to have excellent care every time. The patient true north is measured using the friends and family test (FFT). Based on available FFT data, the significant majority of patients (89.5% in Q2) are satisfied that they have a good or very good experience, based on more than 30,000 responses. This is comparable to each quarter throughout 2023/24 and Q1 2024/25 against a target of 90%, although there has been a small (<0.5%) reduction in patient reported experiences over the past 12 months. Surveys are distributed for inpatients, outpatients, maternity and A&E, in line with national requirements. Trust-wide A&E average positive reported experience is above the national average although the gap has closed. Patient reported experience of A&E closely aligns to 4-hour performance. Inpatient reported experience, with 92.5% of patients reporting their care as good or very good, remains slightly below the national average of 95%, with the exception of at PRH. Overall outpatient reported experience is 96% - above the national average of 94%. Maternity patient experience is in line with national averages at 93%. The most prevalent theme in negative reviews is waiting, in particular for care and treatment, or for a bed, in A&Es. As such, there is a correlation between our patient true north and urgent care performance, in particular 4 hours. Other themes in negative experiences include appointment cancellations, staff attitude and behaviour, inpatient care and discharge. Our fundamental standards of care programme is raising inpatient care standards through audits on handwashing, falls, patient experience and nutrition, amongst others. Our charities-funded 'Welcome Standards' programme is improving customer service, with increasing numbers of patients providing positive feedback about receptions. Emergency department improvements are overseen by F&P breakthrough objectives with A&E performance correlating with patient reported experience. An urgent and emergency care improvement plan is now in place as part of the Trust's single improvement plan, with the aim of reducing 4 hour and 12 hour waits, and ambulance handover times. To improve inpatient care, patient experience audits are being undertaken on the wards to identify concerns early for resolution as part of the fundamental standards of care programme. The Welcome Standards programme is being rolled out to improve experience of reception and those in greeting roles. Improvements to the discharge process are also being implemented, with embedding of board rounds and a new visiting policy being written to support improved family engagement.

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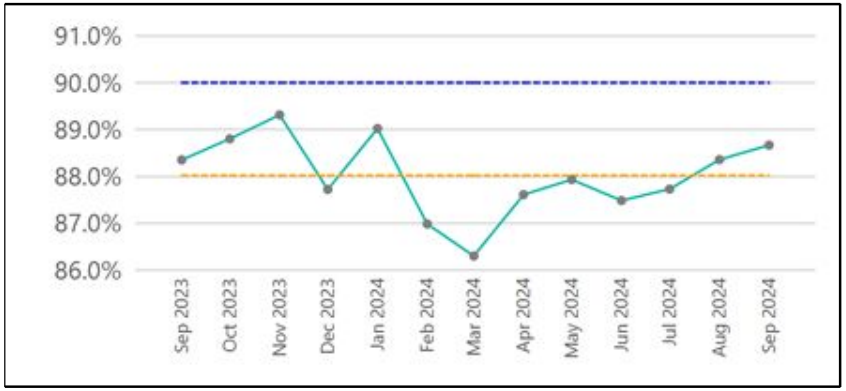
True North

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
88.4%	88.8%	89.3%	87.7%	89.0%	87.0%	86.3%	87.6%	87.9%	87.5%	87.7%	88.4%	88.7%

Overview

Overall, Trust FFT positive rating remained approximately 88.7% in quarter. As such, the patient true north ambition of 90% or more patients rating their care as good or very good was not met.
A&E average positive reported experience is above the national average although the gap has closed. Patient reported experience of A&E closely aligns to 4-hour performance.
Maternity rated above 90% for all sites. More challenged workforce vacancies have impacted on patient experience in recent months, however positivity rates remain in line with national averages.
Average inpatient positivity was 92.5% against a national average of 95% and outpatients averaged 96% against a national average of 94%.
The most prevalent theme in negative reviews is 'waiting'.



What the chart tells us

No Data

Intervention and Planned Impact

The Friends and Family Test (FFT) involves a survey being distributed to ask patients to rate their care on a scale of very good (1) to very poor (5) and to give a reason for their score. The survey is grouped into four touchpoints – A&E, maternity, inpatients and outpatients.
Based on available FFT data, the significant majority of patients (88.7% in Q2) are satisfied that they have a good or very good experience, based on more than 30,000 responses. This is comparable to each quarter throughout 2023/24 and Q1 2024/25 against a target of 90%, although there has been a small (<0.5%) reduction in patient reported experiences over the past 12 months.

Emergency department improvements are overseen by F&P breakthrough objectives with A&E performance correlating with patient reported experience. An urgent and emergency care improvement plan is now in place as part of the Trust's single improvement plan, with the aim of reducing 4 hour and 12 hour waits, and ambulance handover times.
To improve inpatient care, patient experience audits are being undertaken on the wards to identify concerns early for resolution as part of the fundamental standards of care programme. The Welcome Standards programme is being rolled out to improve experience of reception and those in greeting roles. Improvements to the discharge process are also being implemented, with embedding of board rounds and a new visiting policy being written to support improved family engagement.

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

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Watch Metrics for Patient

Metric	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
Patient experience - Number of complaints	250	196	242	148	102	108	125	132	125	116	121	126	143
Patient experience - Total open formal complaints	860	816	760	768	406	378	383	434	437	412	374	352	343

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People

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

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Patient First Domain
The Trust's workforce / people KPIs remain broadly stable with the exception of engagement which has dropped. The Trust continues to pursue priorities for action on culture and in its 'people plan' for 24/25 recently reviewed to support the Trust's Winter Plan. Given the challenges the Trust faces in 24/25 and some of the changes necessary to deliver improved operational performance it was anticipated these would and will continue to impact morale and motivation of some staff. Similarly staff are being affected by controls on recruitment or Trust spending as it seeks to live within the resources allocated. The objective remains to at least maintain and as far as possible improve the Trust's people metrics (to the equivalent of peers) over 24/25. Indications are that this remained 'on track' for Q1 and Q2 but may be more challenging in Q3 & Q4. The programmes of activity on culture include significant engagement with staff on the future of the Trust and its hospitals and services which should also help develop and align staff around a shared future vision.

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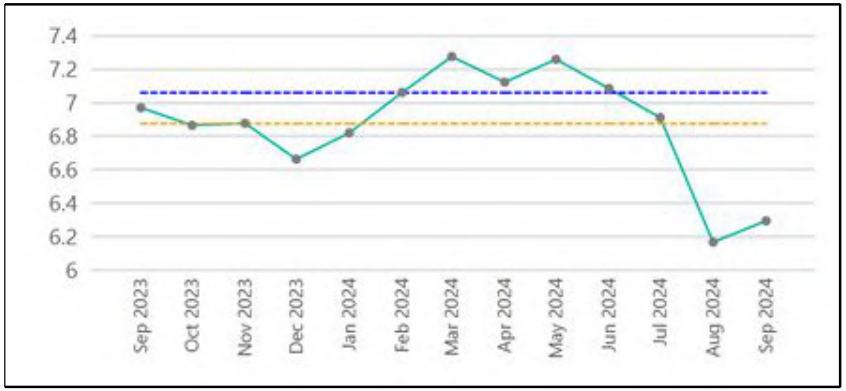
True North

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
6.97	6.87	6.88	6.66	6.82	7.06	7.28	7.12	7.26	7.09	6.91	6.17	6.29

Overview

The Trust's People True North is to have the most engaged staff and students in the NHS. Studies have shown that higher levels of staff engagement in the NHS are associated with higher quality of patient care and more generally that high levels of engagement are linked to improved efficiency and productivity.



What the chart tells us

The Trust measures engagement using a monthly staff survey and applying the same methodology as the national NHS staff survey to produce a composite 'engagement score'. This reflects the extent to which staff respond positively about their motivation and involvement at work and sense of advocacy for the organisation (do they speak well of it?). Over the course of 23-24 the Trust saw a positive improvement in its engagement score, ending the year with a score of 7.3 - equivalent to the best performing Trusts in the NHS staff survey 2023. From May 24, the monthly engagement score declined month on month to a low of 6.17 in August 24. September 24 has seen an improvement in the engagement score to 6.29. Divisions continue to review their monthly data and engagement plans.

Intervention and Planned Impact

A six-month review of the 'People Plan' for 24-25 which builds on work in 23-24 to support staff satisfaction and engagement across the seven NHS 'people promises' has been completed. Significant progress has been made across all the workstreams. Key priorities for the next six months include; implementation of our culture plan, supporting the health and well-being of our staff, improving our sickness absence rates, delivering our workforce plan and workforce efficiencies, improving our people processes and addressing legacy terms and condition issues. The Trust is part of an 'exemplar programme' across the SE Region supporting Trusts to share learning and approaches to great people management and on delivering the NHS people promises. The delivery of the people plans is overseen by the People and Culture Committee and Board. The aim is to bring the Trust up to the level of others across the seven people promises in the 2024 NHS staff survey. Currently it is below average for 6 of the 7.

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Risks/Mitigations
There is a risk that making improvements is challenged by lack of capacity to engage in this work eg through operational pressures and/or that external factors such as the cost of living or dissatisfaction with NHS pay and impact on staff morale. The Trust also has a number of improvement programmes to implement in 24-25 that will involve changes for some staff to their work, and which may also therefore impact morale in the short term. These risks will, as far as possible, be mitigated by clear communication and engagement of staff on such cases for change and the benefits they will bring. The Trust has policies and procedures to cover organisational change to support staff. There is also a significant piece of engagement with Trust staff on the future medium term strategy for the Trust ('the Big Conversation') that is underway, which helps staff inform future change.

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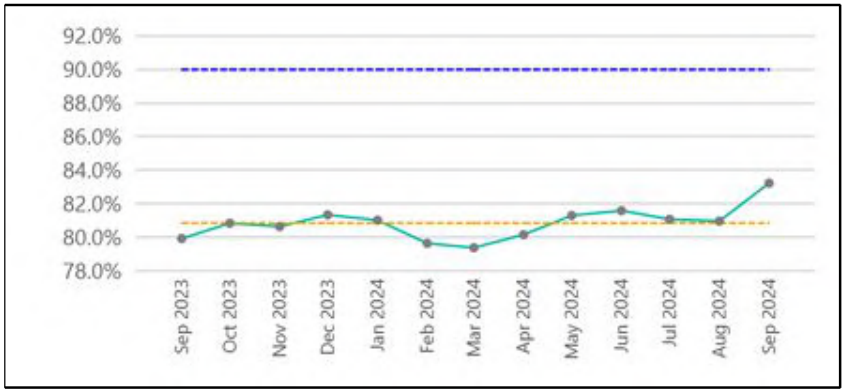
Driver

Metric: Training & development - Appraisals completed

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
79.9%	80.8%	80.6%	81.3%	81.0%	79.6%	79.4%	80.2%	81.3%	81.6%	81.1%	81.0%	83.2%

Overview

The metric reports completed appraisals on non-medical staff.



What the chart tells us

The Trust non-medical appraisal rate was 84.5% as at September 2024. This is 2.2% point increase over August 2024 (82.3%). While this remains below the 90% target, it is the highest level achieved in the previous 12 months and represents a 3.9% point improvement over September 2023.

By Division, performance ranges from 91.9% (Chief Financial Officer) to 76.1% (Chief Governance Officer). 13/17 Divisions have improved their appraisal rate since August 2024 – notably Cancer Division (+10.3% points) and Chief Nurse (+10.1% points).

By staff group, Healthcare Scientists (77.4%) are the notable outlier – all other staff groups are within the 80-88% range.

Intervention and Planned Impact

The steady increase reflects Divisional and HRBP focus on this issue. In addition, staff with significantly overdue appraisals have been contacted individually. In some cases this identified longstanding management issues, which the process has also helped to address.

The Trust-level rate masks significant variations. 225/732 (31%) Cost Centres are reporting 100% compliance, with 110/732 (15%) reporting 90-100%. By contrast, 93/732 (13%) Cost Centres are < 50% compliance, of which 49/732 (7%) Cost Centres < 40% compliance.

Risks/Mitigations

Well conducted appraisal is positively associated with improved staff engagement, and in turn with reduced sickness absence, reduced turnover, improved wellbeing.

Next actions are to contact staff individually with longstanding overdue appraisals, and to follow up with the respective line managers of teams reporting < 40% compliance to provide targeted management support.

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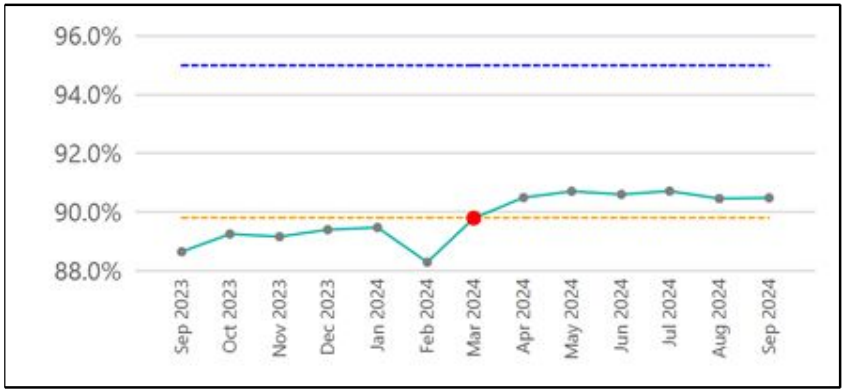
Driver

Metric: Training & development - STAM Weighted Average

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
88.6%	89.3%	89.2%	89.4%	89.5%	88.3%	89.8%	90.5%	90.7%	90.6%	90.7%	90.5%	90.5%

Overview

The report shows the breakdown of the STAM weighted average



What the chart tells us

The UHSussex STAM compliance rate continues to perform very strongly, with a rate of 90.5% in September, and rates of over 88% in each month for the past year. STAM compliance within Admin & Clerical is exceptionally high, with a rate of 95.3% currently being achieved. All other staff groups are above 90%, however, compliance rates for Medical staff still continues to be an outlier at 79.9% and have not been over 80% since March 23.

10/17 divisions are currently above 90% weighted average and 7/17 are between 84% - 89%. CFO are best at 98.4% and CEO worst at 84%

Intervention and Planned Impact

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

Risks/Mitigations

We do expect that compliance rates fluctuate quite heavily across August, September and October given significant movement around resident doctor rotations, but time is given to complete the required training.

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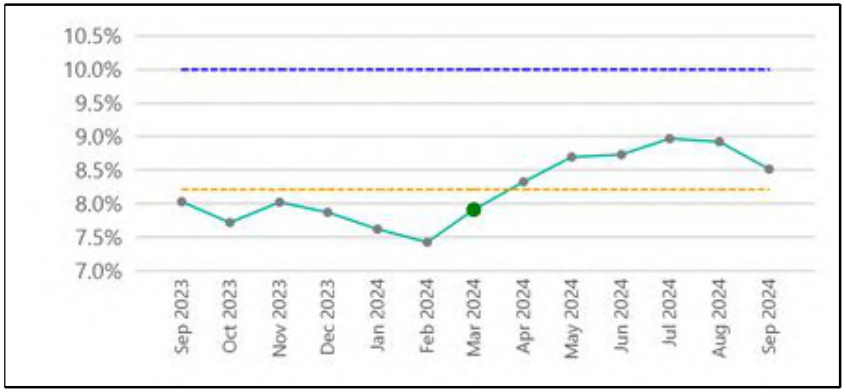
Metric: Workforce capacity - Vacancy Factor (Substantive contracted FTE) - monthly

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
8.0%	7.7%	8.0%	7.9%	7.6%	7.4%	7.9%	8.3%	8.7%	8.7%	9.0%	8.9%	8.5%

Overview

Vacancy factor for September 24 remains stable at 8.5%, vacancies within NHS infrastructure have increased. Band 5 nurse vacancies are holding at 14% and HCA vacancies have increased to 7.1%. Overall, the Trust FTE increased from 15,704 to 15,840, an increase of 136 FTE.



What the chart tells us

•Non-clinical vacancy controls have started to have an impact with a decrease of 35 NHS infrastructure staff.
•Even without the use of a high-volume international nurse recruitment campaign, band 5 nurse vacancies are stable at 14%.
•HCA vacancies are on an upward trend and focused work has started to understand the reasons, delays to DBS and OH processes are contributing factors.
•Growth in M6 relates to medical expansion (WGH/SRH residents/locally employed doctors), nursing expansion and consultant growth.

Intervention and Planned Impact

•Deep dive on HCA/RN candidate pipelines
•Further strengthening of non-clinical vacancy controls
•Review of clinical vacancy controls
•Series of HCA recruitment events
•Continued focus on graduate nurse recruitment
•Appointment of Head of Resourcing & Workforce to lead resourcing strategies
•Restructure of resourcing team to create a resourcing partner role to support hard to recruit roles

Risks/Mitigations

•No planned international nurse recruitment, challenges regarding local domestic and newly qualified clinical and nursing staff supply.
•Remain focused on newly qualified and domestic nurse recruitment.
•Close management of time to recruit metrics and further development of the UHSussex employer brand and campaigns for nursing and AHP roles.

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Driver

Metric: Workforce efficiency - Absence Sickness in month

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
4.7%	5.4%	4.4%	4.9%	4.6%	5.1%	4.9%	4.9%	4.9%	4.9%	5.4%	3.8%

Overview

This metric shows the Trust's in month sickness absence rate..

Part 1 of 'what the chart tells us' : The in month sickness absence rate has remained at around 5% since February 2024. There was a spike in the rate in July 24 (5.4%) followed by a significant drop in August 24 to 3.8%. September's data is not yet available; however the weekly absence data from the rostering system indicates that sickness rates have gone back up to above 4%.

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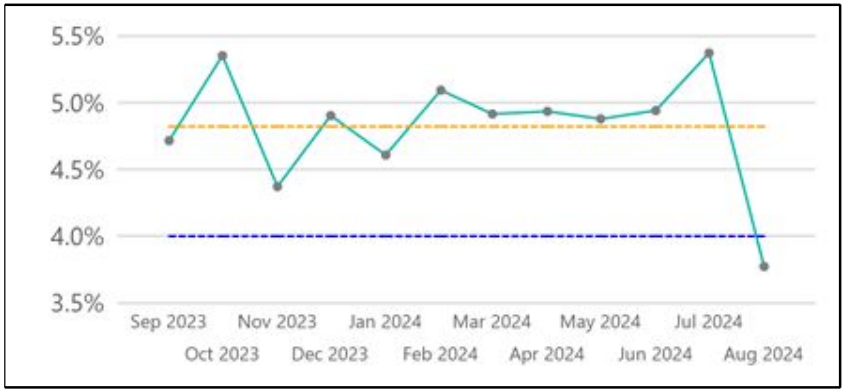

What the chart tells us

Part 2 of what the chart tells us: The scale of the UK's challenge with ill health and absence was exposed in the CIPD's Annual Health and Wellbeing at work report in 2023. It reported the highest reported sickness rates across UK employers for over a decade. Nationally the overall NHS sickness absence rate for England was 4.7% in May 2024 which was a slight decrease from 4.8% in April 2024 and a slight increase on the 4.5% nationally reported in May 2023. Anxiety/stress/depression/other psychiatric illnesses was the most reported reason nationally for sickness in May 2024. The Trust mirrors the national trend with anxiety/stress/depression/other psychiatric illnesses being the highest reason for absence for the last 5 calendar years, and showing a slight decrease in 2023.

Intervention and Planned Impact
•A dedicated team in HR continue to support the management of long term sickness absence and "hot spot areas" •500 managers and supervisors have been trained in sickness absence management •Divisions have formulated plans to reduce sickness absence to achieve the Trust target of 4%. •The Nursing and Midwifery Steering Group is targeting the management of absence in areas that will achieve a reduction in both sickness absence rates and bank and agency costs. •Ongoing delivery of the Trust's 3 year health and well-being programme •Review of Occupational health services internally and with the ICB •Improvement plan currently in development around supporting mental ill health
Risks/Mitigations
High sickness rates impact on staff health and wellbeing, staffing levels, patient continuity of service, morale and resourcing costs. The interventions are having an impact on reducing sickness levels. There is a risk that the Trust cannot adequately support staff mental health needs through limited staff psychological support service (SPSS) capacity and long waits. Governance arrangements are in place to both monitor sickness absence with daily absence information being shared and to control the impact on services e.g. ensuring safe staffing levels are in place whilst controlling costs.

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Watch Metrics for People

Metric	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
Turnover (12 month)	8.8%	8.7%	8.5%	8.4%	7.8%	7.8%	7.7%	7.4%	7.5%	7.3%	7.2%	7.2%	6.9%
Workforce capacity - FTE Budgeted	16799	16866	16906	16889	16896	16908	16967	17075	17129	17133	17154	17243	17314
Workforce capacity - FTE Substantive contracted	15450	15564	15550	15559	15609	15653	15624	15653	15639	15637	15615	15704	15840
Workforce capacity - FTE Substantive contracted variance from Budget	1349	1302	1356	1329	1288	1256	1342	1422	1490	1496	1539	1539	1474
Workforce capacity - Number of leavers	153	116	99	94	98	91	117	76	91	89	116	166	94
Workforce capacity - Number of Starters	297	290	195	143	192	204	147	175	113	106	142	488	251
Workforce efficiency - Absence 12 month sickness rate	5.1%	5.1%	4.9%	4.9%	5.0%	5.1%	5.2%	5.2%	5.2%	5.3%	5.4%	5.2%	
Workforce efficiency - Absence Total in month.	15.7%	16.6%	15.5%	15.6%	15.7%	16.3%	16.3%	16.1%	16.3%	15.5%	15.9%	13.9%	

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Sustainability

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

Patient First Domain

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

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

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

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

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True North

Metric: Financial stability - Variance from breakeven plan YTD

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
YTD Actual	7.21	16.04	24.30	31.10	33.92	34.91
YTD Plan	6.52	12.44	17.61	23.93	26.76	29.47

Overview

The Trust originally submitted a deficit financial plan of £26.5m for 2024/25, which was revised to deficit financial plan of £19.47m (excluding deficit support funding); the revised YTD planned deficit at M06 is £29.47m. The actual deficit is £34.91m, which is £5.44m adverse to plan.

Elective activity performance (ERF) is 119% YTD, earning additional income of £12.82m (calculated against the 109% target) which is reflected in the reported position and offsets costs of delivery.

The cash position is £3.53m, £16.49m worse than plan. This is driven by £8.59m of 3Ts and £13.79m of ERF funding not yet received (including £3.0m relating to 2023/24) and an unfunded year-to-M05 deficit against plan of £7.16m, offset by £14m of revenue support funding.

Capital expenditure is £6.02m below plan, with expenditure of £25.43m against a plan of £31.45m. Full delivery of the plan is expected by year-end.

Efficiency performance is £0.36m behind plan, with £22.14m of efficiencies delivered year-to-date. Work up of additional schemes needs to be urgently concluded to prevent a continuation of under-delivery.

The agency ceiling for 2024/25 is set at 3.2% of total pay expenditure (a reduced target from 3.7% in 2023/24). YTD agency expenditure is £11.85m, 2.4% of total pay, £4.27m below the ceiling.

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2024/25 M06 £m	Annual Plan	YTD		
		Plan / Ceiling*	Actual	Variance Fav/(Adv)
I&E (Surplus) / Deficit**	19.47	29.47	34.91	(5.44)
Cash	20.02	20.02	3.53	(16.49)
Capital	81.90	31.45	25.43	6.02
Efficiency	82.51	22.50	22.14	(0.36)
Agency Ceiling	30.12	16.12	11.85	4.27

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

What the chart tells us

The actual deficit is **£34.91m**, which is **£5.44m** adverse to plan.

Key drivers of the adverse variance to plan are: medical staff premium costs (£6.56m), expenditure on high cost drugs funded in block (£1.72m) and underachievement of SMSKP activity (£1.35m), which have been partially offset by non-recurrent mitigations.

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

Intervention and Planned Impact

The underlying financial deficit presents a challenging outlook to 2024/25. The actual position in M5 and M6 of Q2 is in line with plan, however this was mainly due to the application of non-recurrent mitigations, and despite some evidence of improvement in Q2, the Trust needs to move swiftly to implement a financial recovery programme.

The financial recovery programme is structured in three parts:
1. Stabilising our financial position and ensuring the financial deficit does not deteriorate further. In December we introduced some enhanced financial controls and additional controls have been introduced during July. A number of these controls will create non-recurrent opportunities to reduce spend and are being put in place to create the headroom for the Trust to implement recurrent savings opportunities.
2. Bridging the gap between what we are spending and what we are funded. Good progress has been made to identify efficiency savings and further work to identify savings, linked to key operational spend areas, is being led at an Executive level.
3. Addressing the underlying deficit. More than 40% of the underlying deficit is driven by structural issues with a further 30% from strategic issues. Addressing these issues will require transformational change and will be taken forward alongside the strategy development work that is underway.

Risks/Mitigations
There is an over-arching risk that the Trust will not deliver the financial plan as a result of a number of key contributors: a) delivery of the full efficiency target, b) cost of elective recovery within tariff and funded envelopes, c) affordability of current pay arrangements for additional work, and d) inability to reduce the cost of MH Specialling. Regular monitoring and review of these issues is embedded in the Finance department approach to business partnering. Regular financial review meetings take place with each Division to review financial performance and opportunities for run rate reduction. The Trust has met the deficit plans in Months 5 and 6, however this has required the use of non-recurrent mitigations. The profile of the financial plan, which requires the delivery of surpluses in future months and emerging risks will require further actions to be taken to reduce the run-rate and increase efficiency delivery. This work is being led by the Efficiency Delivery Director with the support of the Executive Team.

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Breakthrough

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

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	YTD	FY
24/25 Actual	120%	119%	124%	115%	118%	117%							**119%**	
24/25 Target	122%	119%	120%	119%	123%	114%	112%	107%	120%	115%	115%	113%	**120%**	**116%**
23/24 Actual	104%	109%	102%	99%	101%	103%	104%	104%	107%	106%	107%	112%		**104%**

Overview

The Elective Recovery Framework (ERF) target for the Sussex System and the Trust is 109% (income value of activity earned above the 19/20 baseline). The Trust has planned to deliver 115.6% of the 19/20 baseline, which was the income value of activity to meet the requirement of zero 65 week waits when the plan was submitted.

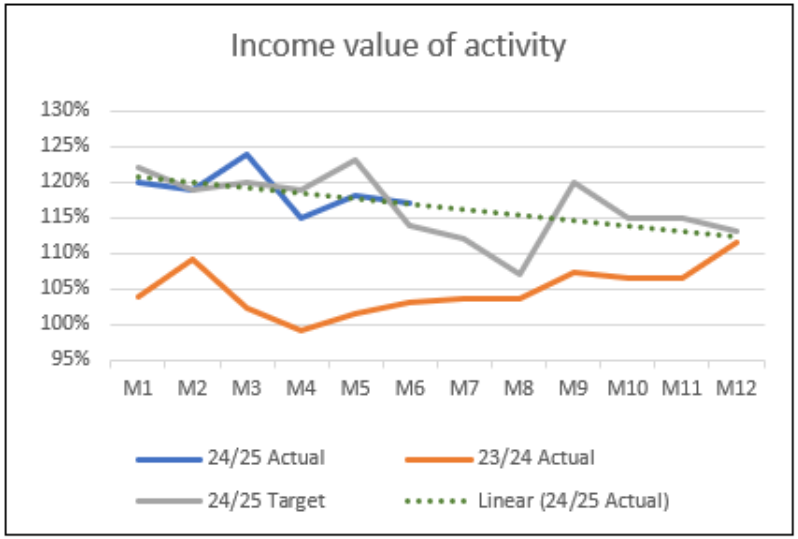
Waiting lists do not remain static and increased coding depth can result in higher income performance without a corresponding attainment in performance targets. This income performance is therefore to be taken in conjuction with activity performance data.

Overperformance will be paid at tariff, for income achieved above the 109% target and conversely, income can also be clawed back, if performance is below the 109% target.

The YTD ERF performance at month 6 is 119% compared to the 19/20 baseline. This equates to a **+£12.82m v**alue variance compared to the 109% ERF Target.

The required ERF performance in the plan was 120% YTD, performance was therefore 1% below this target, resulting in the Trust reporting c £1m income behind plan.

The ERF target last year was 105% and delivery was 104%, although NHSE implemented a year end estimated settlement negating recognition in year of the full value of productivity improvements implemented in M8, the final outcome of an appeal against the income settlement is pending.



What the chart tells us

YTD performance for the 24/25 financial year is **119%** in comparison to the 2019/20 baseline target (100%). This means that the income value of activity was 10% above the 109% target, resulting overperformance of £12.82m.

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

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

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

Intervention and Planned Impact

Weekly planned care meetings monitor delivery against the required performance trajectory, with oversight provided through fortnightly ERF Boards. Internal productivity and increased coding depth and capture, implemented at the end of Q4 last year continues to positively influence performance.

The further opportunities to increase income and increase % performance in comparison to 19/20 activity levels, via a focus on ensuring all activity is captured and coded has continued, with data trends being monitored.

IA at the end of June / start of July has impacted delivery in full of the demand plan to-date, however Independent Sector capacity has been secured to support delivery in specialties with capacity constraints into the latter half of the year with the aim to revover year to date shortfalls. Performance is forecast to deliver 118% by year end, £20m expected overperformance.

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Risks/Mitigations

Industrial action - There were 5 days of junior doctor IA in the first half of the year, the lost income opportunity was £1.0m. There remains a risk that this income will not be recovered by year end and income clawback could then be applicable if the year end activity target is not met. Monitoring, oversight and agile planning are mitigations being deployed to maxmise activity delivery and income.

ERF baseline & actuals - The baseline target, which the ERF performance is being measured against is draft, the Trust is awaiting NHSE to publish a new baseline incorporating last years performance. Actual performance for ERF has also not been shared by NHSE for validation. The risk is the target could increase as well as decrease, resulting in required adjustments to the income performance. **(This risk remains unchanged from Q1).**

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Quality

	Metric	Target
True North	Safety - Reduction of 5% in preventable harm - UHSx approved	
True North	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	100.0
Breakthrough	Safety - To reduce falls whilst in the care of UHSussex by 30%	202

Patient First Domain

Trustwide it is expected that patients do not suffer harm whilst in our care. However, it is recognised that there are patients who suffer new harm which is acquired during their time in hospital. This has a significant impact on patients, families , carers and staff and within the wider organisation.

The Quality True North for harm at UHSussex is 'Zero harm occurring to our patients when in our care', with a target to reduce the number of all harms categorised as 'low, moderate, severe harm and death' by 5%.

August has seen Trustwide increase in rate of reporting to 52.32 (per 1000 bed-days) which remains marginally below the NRLS *2022 national average of 54.9, and the Trust target of 60. August evidenced an increase in reporting (3175 from 3105 reported in July) and a continued levelling in reporting of low harm (96% of actual harm**) -Falls and pressure damage are the most common themes within the low harm categories.

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The majority of all incidents recorded are no harm 81%. Of actual harm recorded (low/moderate/severe and death) 96% were recorded as low harm- this is an ever-increasing picture of a good reporting and safety culture.

**National Reporting and Learning System replaced in 2024 with NHSE Learning from Patient Safety Events (LfPSE) - no current benchmark available or established.*

***low/moderate/severe/death (not including no harm/near miss)*

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True North

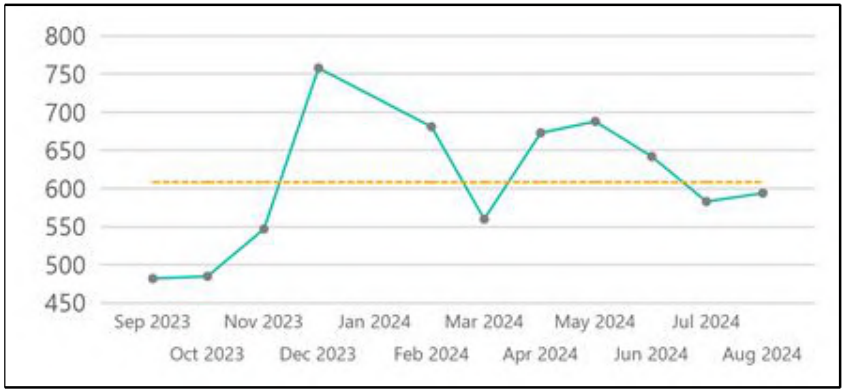
Metric: Safety - Reduction of 5% in preventable harm - UHSx approved

Sep 23	Oct 23	Nov 23	Dec 23	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
482	485	547	758	681	560	673	688	642	583	594

Overview

Trustwide it is expected that patients do not suffer harm whilst in our care. However, it is recognised that there are patients who suffer new harm which is acquired during their time in hospital. This has a significant impact on patients, families , carers and staff and within the wider organisation.

The Quality True North for harm at UHSussex is 'Zero harm occurring to our patients when in our care', with a target to reduce the number of all harms categorised as 'low, moderate, severe harm and death' by 5%.



What the chart tells us

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The majority of all incidents recorded are no harm 81%.Of actual harm recorded (low/moderate/severe and death) 96% were recorded as low harm- this is an ever-increasing picture of a good reporting and safety culture.

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Intervention and Planned Impact
• Themes for incidents presented to PSIRG include patient harm from patient deterioration and lost to follow up, cancer, surgery delays, patient flow. RTT neurology/ophthalmology. • Mental Health: High risk remains in both emergency departments and paediatric areas with Tier 4, LA and specialist placement. 2 high profile inquest pending regarding suicide on hospital premises. • PSIRF Face to Face training modules commenced following go live from SIF to PSIRF on 04/12/23. • Divisions are being encouraged to review and close legacy incidents (pre DCIQ launch February 2024) as soon as possible. • The Trust uses an electronic reporting system RLDATIX IQ which is used to report nationally and verified data to the National Reporting and Learning System (NRLS) and LfPSE (from February 2024). • In addition, all near miss, moderate/severe harm and death are reviewed by a senior panel on a weekly basis at the Patient Safety Incident Response Group (PSIRG). Following PSIRF the level of harm, patient/family engagement and investigation is decided. Learning is shared via early learning reviews/local learning reviews and patient safety incident investigation, • DCIQ and Duty of Candour suite of training materials and videos now available on IRIS.
Risks/Mitigations
• PSIRF Face to Face training modules commenced following go live from SIF to PSIRF on 04/12/23. • Divisions are being encouraged to review and close legacy incidents (pre DCIQ launch February 2024) as soon as possible. • The Trust uses an electronic reporting system RLDATIX IQ which is used to report nationally and verified data to the National Reporting and Learning System (NRLS) and LfPSE (from February 2024). • In addition, all near miss, moderate/severe harm and death are reviewed by a senior panel on a weekly basis at the Patient Safety Incident Response Group (PSIRG). Following PSIRF the level of harm, patient/family engagement and investigation is decided. Learning is shared via early learning reviews/local learning reviews and patient safety incident investigation, • DCIQ and Duty of Candour suite of training materials and videos now available on IRIS.

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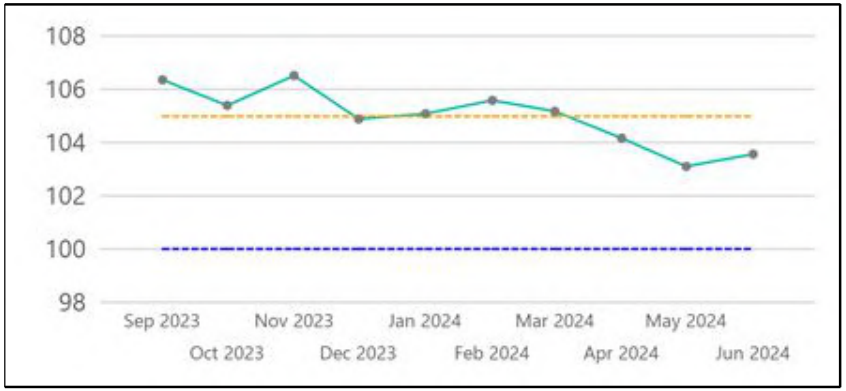
True North

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
106.4	105.4	106.5	104.9	105.1	105.6	105.2	104.2	103.1	103.6

Overview

No Data



What the chart tells us

The SHMI for the 12 months to June 24 is 103.56 for UHsussex. The SHMI has been coming down from a high of 109 in June 23. The current SHMI sits within the confidence limits using a 95% over dispersed plot. Eight diagnostic groups account for 40% of the deaths that make up the SHMI, within this group of 8 the largest number of deaths by diagnostic group is pneumonia which has a SHMI of 92.55. Nine diagnostic groups fall outside an over-dispersed 95% Poisson funnel plot for the period Jul 23 – Jun 24. Three of this group have previously been investigated, data is being collated for three conditions and the other three are new outliers.

Intervention and Planned Impact

A new process for investigating SHMI outliers being finalised. Data collection/extraction in progress for the following outliers, with clinical leads TBC: 1. Cancer of head and neck 2. Nutritional Deficiencies; Disorders of lipid metabolism; Other nutritional, endocrine and metabolic disorders 3. Cardiac Dysrhythmias The following conditions are on the pending list for review: 1. Phlebitis, thrombophlebitis and thromboembolism; Varicose veins of lower extremity; Hemorrhoids; Other diseases of veins and lymphatics. 2. Melanomas of Skin 3. Congestive heart failure 4. Other perinatal conditions 5. Fluid and electrolyte disorders
The Trust is also planning further work to review the key drivers associated with the observed improvement with support from the coding team.

Risks/Mitigations

No Data

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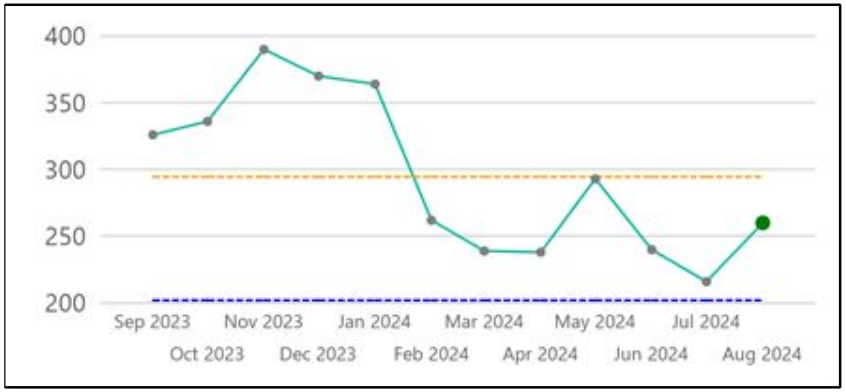
Breakthrough

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
326	336	390	370	364	262	239	238	293	240	216	260

Overview

The quality True North for harm in our organisation is zero harm to our patients when they are in our care. Harms contribute significantly to poor patient experience, outcomes, and staff experience. Falls are the top contributor in terms of harms across UHSussex.



What the chart tells us

Falls Rate per 1,000 bed days August 2024 = 4.09 (4.73 average rolling year)

•Overall, 239 falls which is a slight increase from previous month, (227); 15 moderate and above falls significantly increased from previous month, (July 3); 27 near misses reported increased from previous month, (July 16). 22 patients have had recurrent falls in month, which is an increase from previous month (July 12).
•Falls with harm have increased in month - 8 moderate and 7 severe harms.
•11 falls resulting in harm were first fall during admission
•28 patients had 2 or more falls in month.
•65% of falls in month resulted in no harm to the patient
•Falls day are marginally higher (53%) than overnight (47%)
•Unwitnessed falls remain consistently high at 77% of all falls reported.

Intervention and Planned Impact

HFC nurses are supporting divisions in the wards with the highest number/bed stay days to support key initiatives and help develop areas such as timeliness and compliance of lying and standing blood pressure assessments as part of fall safe actions.
A key stakeholder meeting is scheduled to agree a Trustwide post fall management that is evidence based and improves timeliness of care delivery including (medical assessment and management, pain management, radiology, and post-fall neurological observations.
Work continues within the frailty wards to reduce deconditioning of patients. This includes using day rooms and other break out areas, recruiting activity coordinators, leadership to promote patients wearing their own clothes and well- fitted footwear and the implementation of breakfast clubs.
LoS/deconditioning prevention tabletop displays were held on 11/09/2024 to showcase available resources. These were well attended by staff, patients and visitors.
Improvement work continues to encourage MDT attendance at ELRs which is starting to show an improvement.

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Falls with harm have increased in month - 8 moderate and 7 severe harms.

11 falls resulting in harm were first fall during admission

28 patients had 2 or more falls in month.

65% of falls in month resulted in no harm to the patient

Risks/Mitigations

Falls policy and post falls management has been identified been reviewed to ensure it meets national guidelines
FSoC falls working group is now in place , where key improvement work are driven and monitored
Falls Assessment and lying/standing BP assessment now live on Patientrack for the RSCH-PRH site.
Dissemination of themes from ELRs using Patient Stories are a regular agenda item presented by Divisions/HFC team at the HFC Group monthly meetings

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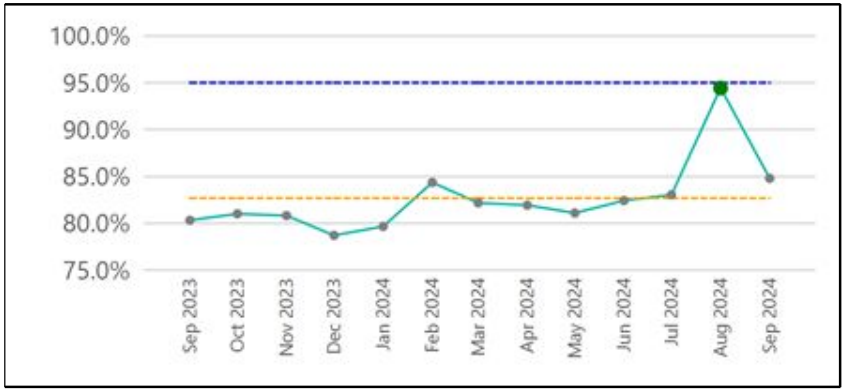
Driver

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
80.3%	81.0%	80.8%	78.7%	79.7%	84.4%	82.2%	81.9%	81.1%	82.4%	83.0%	94.4%	84.8%

Overview

Patients have the right to be cared for by appropriately 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). Safe levels of staffing and an adequate skill mix are central to the delivery of high-quality care (volume 2 Government response to Mid-Staffordshire NHS Foundation Trust public enquiry.



What the chart tells us

The chart shows the fill rate % for care staff for the day shifts each month. Care staff has seen an improving trend in the fill rate for support staff since June 23 when the fill rate was 79% and the vacancies 9.9%. Between April and September 24, the fill rate has gradually improved across UHSussex to 84.8% and the vacancies 7.3%. The ambition is 95%, the fill rate is the highest at RSCH where the average is 85% each month between April and September 24.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce that is appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and reporting the associated workforce. A trust wide review of rosters and establishments has been completed in March/April 24 by the Deputy Chief Nurse (DCN) for Workforce and Professional Development, the review aligned rosters to budget. The Safer Nursing Care Tool (SNCT)audit is being completed in November 24 for all inpatient areas including children's and young people ahead of establishment reviews in December and January 25. The Emergency Department (ED) SNCT audit is being completed in December and repeated in February 25 ahead of the ED establishment reviews in February. The steering group has introduced a Safe Care work stream lead by the DCN, the aim is to use safe care as the sole tool to deploy staff safely by December 24.

Risks/Mitigations
There are currently 7.3% Band 2 care staff vacancies and turnover of 8.2% for support staff across UHSussex. There has been significant work on recruitment to improve the care staff vacancy and we have launched a foundation programme in this financial year to aid HCA retention. There is also high demand for registrants and HCAs with specialist skills to care for patients with mental ill health. 26 enhanced care support workers commenced in post in January to care for patients with mental illness ill health as part of a trust pilot. The pilot has been evaluated in July to determine next steps; next steps will be presented in November. Rolling recruitment continues for band 2, included targeted campaigns with the Department of Work and pensions (DWP) supporting our local population into employment. The trust has a healthy pipeline of care assistant and are fully recruited on 3 of our sites to all vacant HCA posts once the pipeline has been onboarded.

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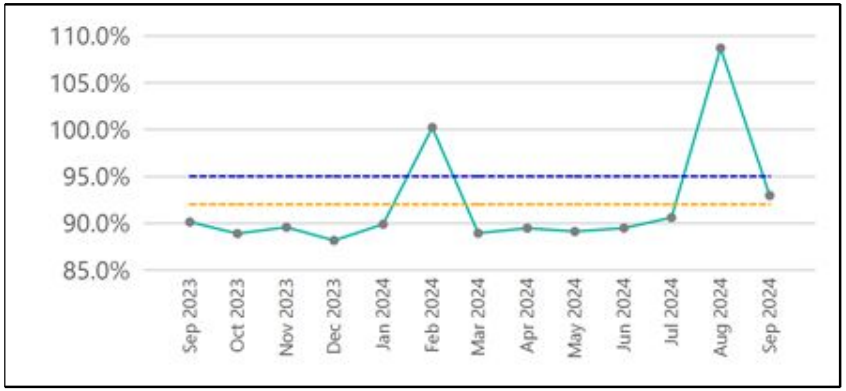
Driver

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
90.1%	88.9%	89.6%	88.2%	89.9%	100.2%	88.9%	89.5%	89.1%	89.5%	90.6%	108.7%	93.0%

Overview

Patients have the right to be cared for by appropriately 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). Safe levels of staffing and an adequate skill mix are central to the delivery of high-quality care (volume 2 Government response to Mid-Staffordshire NHS Foundation Trust public enquiry.



What the chart tells us

The chart shows the fill rate % for care staff for the night shifts each month. The fill rate despite a spike in August 24, has seen the continuation of the increasing trend and achieved 93% in September 24. Please note the fill rate is better than the day fill rate due to night pay enhancements. The ambition is achieve above 95%. The fill rate at RSCH hospital is consistently the highest in all our sites achieving above 95%, noting RSCH has no HCA vacancies.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce that is appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and reporting the associated workforce. A trust wide review of rosters and establishments has been completed in March/April 24 by the Deputy Chief Nurse (DCN) for Workforce and Professional Development, the review aligned rosters to budget. The Safer Nursing Care Tool (SNCT)audit is being completed in November 24 for all inpatient areas including children's and young people ahead of establishment reviews in December and January 25. The Emergency Department (ED) SNCT audit is being completed in December and repeated in February 25 ahead of the ED establishment reviews in February. The steering group has introduced a Safe Care work stream lead by the DCN, the aim is to use safe care as the sole tool to deploy staff safely by December 24.

Risks/Mitigations
There are currently 7.3% Band 2 care staff vacancies and turnover of 8.2% for support staff across UHSussex. There has been significant work on recruitment to improve the care staff vacancy and we have launched a foundation programme in this financial year to aid HCA retention. There is also high demand for registrants and HCAs with specialist skills to care for patients with mental ill health. 26 enhanced care support workers commenced in post in January to care for patients with mental illness ill health as part of a trust pilot. The pilot has been evaluated in July to determine next steps, next steps will be presented in November. Rolling recruitment continues for band 2, included targeted campaigns with the Department of Work and pensions (DWP) supporting our local population into employment. The trust has a healthy pipeline of care assistant and are fully recruited on 3 of our sites to all vacant HCA posts once the pipeline has been onboarded.

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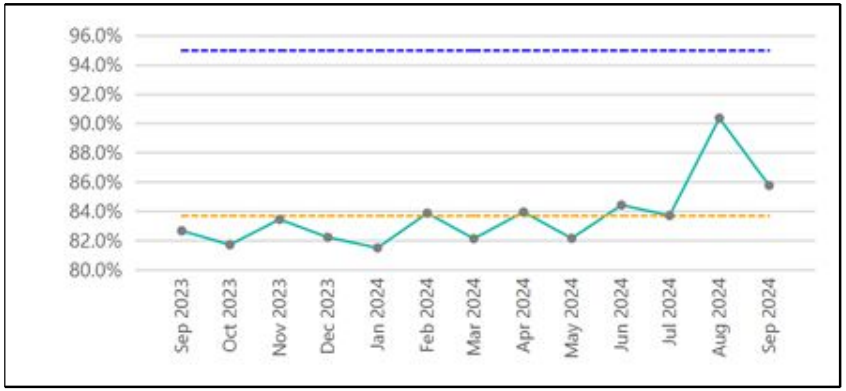
Driver

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
82.7%	81.7%	83.5%	82.2%	81.5%	83.9%	82.2%	84.0%	82.2%	84.4%	83.7%	90.4%	85.8%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Safe levels of staffing and an adequate skill mix are central to the delivery of high-quality care (volume 2 Government response to Mid-Staffordshire NHS Foundation Trust public enquiry.



What the chart tells us

The chart shows the fill rate % for Registered Nurses/Midwives for the day shifts each month. Registered Nurses/Midwives fill rate has seen a gradual improvement since March 24 to 85.8% trust wide, the ambition is to achieve above 95%. The fill rate peaked on all sites in August and Worthing hospital achieved 91% for the last two month. RSCH is consistently the lowest and remains at 82.7%, this is reflected in the band 5 vacancy with 133 of the 332 band 5 nursing vacancies at RSCH. Band 5 vacancies remain high at 14.3 in June.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce that is appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and reporting the associated workforce. A trust wide review of rosters and establishments has been completed in March/April 24 by the Deputy Chief Nurse (DCN) for Workforce and Professional Development, the review aligned rosters to budget. The Safer Nursing Care Tool (SNCT)audit is being completed in November 24 for all inpatient areas including children's and young people ahead of establishment reviews in December and January 25. The Emergency Department (ED) SNCT audit is being completed in December 24 and repeated in February 25 ahead of the ED establishment reviews in February 25. The steering group has introduced a Safe Care work stream lead by the DCN, the aim is to use safe care as the sole tool to deploy staff safely by December 24.

Risks/Mitigations
There are currently 14.3% Band 5 Registered Nurse vacancies and turnover of 4.8%. The impact of this is that there may be an inability to fill absence and escalation shifts. Turnover has improved reflected in a slight improvement in band 5 vacancy with the position which sat at 15.7% in September 23. Rolling recruitment continues for band 5, including targeted campaigns for areas with high vacancy and a focus targeted recruitment of student nurses. There are 105 registered nurses in the pipeline and will join the workforce between October and December 24. The onboarding has been delayed due to delayed registration for approximately 160 students from the University of Brighton. In 2024 we are introducing a guaranteed post to all student nurses and midwives who train at UHSussex and safety join the register. A monthly steering group oversees the governance of nursing and midwifery workforce.

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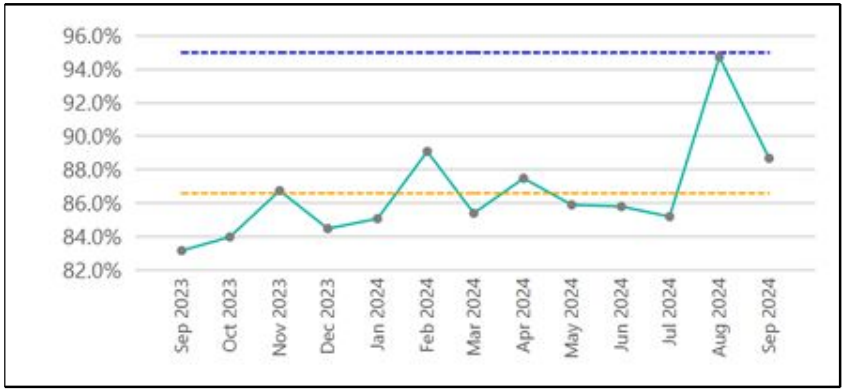
Driver

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
83.2%	84.0%	86.7%	84.5%	85.1%	89.1%	85.4%	87.5%	85.9%	85.8%	85.2%	94.7%	88.7%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Safe levels of staffing and an adequate skill mix are central to the delivery of high-quality care (volume 2 Government response to Mid-Staffordshire NHS Foundation Trust public enquiry.



What the chart tells us

The chart shows the fill rate % for Registered Nurses/Midwives for the night shifts each month. The fill rate despite a spike in August 24, has been consistently averaging 85% since March 24 and achieved 88.7% trust wide in September 24. The fill rate is better than the day fill rate due to night pay enhancements. The fill rate at Princess Royal hospital (PRH) is consistently the highest in all our sites achieving above 90% in August and September 24. Band 5 vacancies at PRH is lowest in the trust and the current vacancy position at PRH is 8.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce that is appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and reporting the associated workforce. A trust wide review of rosters and establishments has been completed in March/April 24 by the Deputy Chief Nurse (DCN) for Workforce and Professional Development, the review aligned rosters to budget. The Safer Nursing Care Tool (SNCT)audit is being completed in November 24 for all inpatient areas including children's and young people ahead of establishment reviews in December and January 25. The Emergency Department (ED) SNCT audit is being completed in December 24 and repeated in February 25 ahead of the ED establishment reviews in February. The steering group has introduced a Safe Care work stream lead by the DCN, the aim is to use safe care as the sole tool to deploy staff safely by December 24.

Risks/Mitigations
There are currently 14.3% Band 5 Registered Nurse vacancies and turnover of 4.8%. The impact of this is that there may be an inability to fill absence and escalation shifts. Turnover has improved reflected in a slight improvement in band 5 vacancy with the position which sat at 15.7% in September 23. Rolling recruitment continues for band 5, included targeted campaigns for areas with high vacancy and a focus targeted recruitment of student nurses. There are 105 registered nurses in the pipeline and will join the workforce between October and December 24. The onboarding has been delayed due to delayed registration for approximately 160 students from the University of Brighton In 2024 we are introducing a guaranteed post to all student nurses and midwives who train at UHSussex and safety join the register. A monthly steering group oversees the governance of nursing and midwifery workforce.

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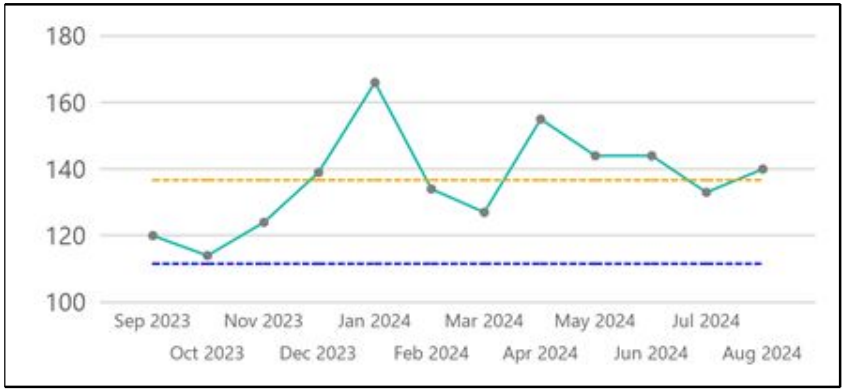
Driver

Metric: Safety - Grade 2+ pressure ulcers

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
120	114	124	139	166	134	127	155	144	144	133	140

Overview

Hospital-acquired Pressure injury, a common yet largely preventable condition, underscores the urgent need for healthcare professionals' commitment to prevention. Risk factors for developing a hospital-acquired pressure injury include older age, immobility, altered mental condition, urinary or faecal incontinence, hospitalisation for fracture, surgical intervention, reduced appetite and nasogastric tube or intravenous nutrition. Research has shown that pressure injuries are preventable. The strategy for preventing pressure injuries relies on two interdependent domains: pressure injury risk identification and pressure injury risk mitigation.



What the chart tells us

PU Rate per 1,000 bed days August 2024 = 2.36 (2.35 average rolling year)
Overall, 138 patients with hospital acquired Category 2 and above pressure ulcers, a slight improvement on previous month, (140). There were 48 patients with hospital acquired moisture associated skin damage.
Themes identified:
•Missed opportunities in recognising deteriorating pressure damage and timely referrals to TVN WH.
•Skin checks not being documented consistently.
•Poor communication between nursing staff when pressure ulcer identified.
•Delay in pressure prevention for heels delays in pressure ulcer preventative equipment being implemented, particularly around off-loading heels.
•Miscommunication between transferring wards.
•Lack of awareness and use of non-concordance form.
o

Intervention and Planned Impact
The FSoC working group is in place and ensuring that the policy is evidence based.. The learning from the thematic review, ELR's and Coroners cases has informed the HFC priorities and programmes of improvement work The TVN team has reviewed their priorities and referral criteria which will be shared with the Divisions a the next FSoC meeting. The Dressing Formulary has been reviewed across the Trust to standardise dressings selection. Procurement are leading to ensure the processes align across the 4 main sites and that supplies come from stores and not Pharmacy Proforma is being developed for external transfers by the Specialised Division Categorisation bitesize teaching sessions are being offered which include referral process and reporting of HAPU. Slide sheets are now consistent across the Trust- bespoke training is being arranged by the company for clinical areas on RSCH/PRH. Through the STAM training the Back care/Manual handling team are using the sheets to demonstrate good practice covering a minimum of 4 sessions a week. Audits/compliance with also be monitored through the Back Care/Manual Handling Team. Pressure Ulcer prevention and categorisation training is now available for all staff on Iris.
Risks/Mitigations
FSoC pressure damage working group now in situ, where key improvement work will be driven and monitored. *Purpose T risk assessment for skin assessment has now been standardised across all UHSussex sites* Dissemination of themes from ELRs using Patient Stories are a regular agenda item presented by Divisions/HFC team at the HFC Weekly harm free care meeting chaired by the DCN / HON to discuss all category two and above pressure damage to understand key learning points for onward dissemination

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Watch Metrics for Quality

Metric	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
Clinical outcomes/effectiveness - Timeliness of observations against targets (NEWS2)	64.6%	64.4%	65.0%	63.7%	64.4%	64.4%	65.4%	66.9%	68.3%	68.5%	69.2%	70.2%	72.0%
HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	15	18	13	18	16	9	20	16	16	18	12	14	24
HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	15	17	12	25	20	20	14	13	21	20	24	18	26
HCAI - Number of hospital attributable Klebsiella species cases (HOHA/COHA)	12	11	6	8	9	4	3	6	11	3	6	9	6
HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)							2	1	1	1		1	
HCAI - Number of hospital attributable MSSA bacteraemia cases (HOHA/COHA)	5	7	7	9	8	8	11	6	12	6	8	6	8
HCAI - Number of hospital attributable Pseudomonas cases (HOHA/COHA)	7	6	4	4	1	2	4	6	2	5	3	5	1
Safety - % of Deaths with Comfort Obs in Place	73.5%	64.8%	69.2%	73.0%	74.5%	76.7%	67.3%	79.0%	75.2%	70.8%	74.6%	76.6%	77.1%
Safety - Total moderate, severe or death incidents	23	18	8	8	23	60	58	89	86	74	91	89	

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Systems & Partnerships

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

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Patient First Domain

The Systems & Partnerships True North domain of 'delivering timely, appropriate access to acute care as part of a wider integrated system' is measured through the key national elective and emergency care NHS Constitutional access standards:

- A&E: treatment and admission or discharge within 4 hours;
- Referral To Treatment (RTT) definitive treatment within 18 weeks;
- Cancer: diagnosis and treatment within 62 days
- Diagnostics: investigation undertaken within 6 weeks

There was marginal improvement in all standards through Q2 2024/25, but performance remains challenged.

A&E performance (including Minor Injury Units and Walk In Centres) was 71.6% in Sep-24, in line with performance in Aug-24 and better than 12-month average. The Trust has been placed in Tier 2 oversight for UEC performance.

The Trust remains in Tier 1 as part of the NHSE oversight framework for RTT, cancer and diagnostics.

65-week waits reduced to lowest level since the pandemic, but remains the highest in the country. 78-week waits reduced marginally but remain higher than Mar-24 position. The Trust reported 4 104-week waits and 65-week waits increased. The overall RTT waiting list reduced month-on-month throughout Q2, continuing the trend over the past 12 months with a ~31k reduction during that period.

Cancer performance remains challenged, and the Trust did not achieve its recovery trajectory for either 28-day 'faster diagnosis' standard or 62-day cancer waiting time standard. The backlog of over 62-day prospective waits increased over the course of Q2 and is above the level required to sustain improved waiting time performance.

Diagnostics performance improved in Sep-24, with notable reduction in 6-week waits in echocardiography and MRI. The total Diagnostic waiting list and backlog both reduced. However, the Trust remains worse than national average performance.

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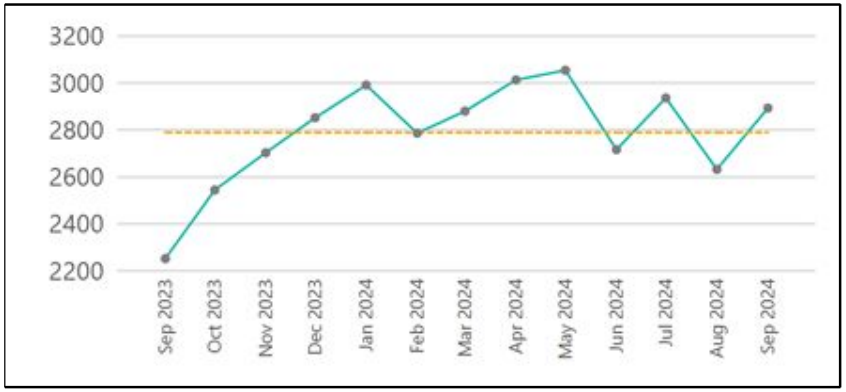
True North

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
2252	2544	2703	2852	2991	2786	2880	3013	3054	2716	2936	2632	2893

Overview

The number of 12-hour breaches decreased through the summer months in 2023 and increased again during the winter period. However, this year the number of patients waiting more than 12 hours in ED has remained consistently high and has not improved during the summer period. In May 2024 a UEC improvement plan was submitted to the ICB which included a targeted reduction of the number of ED 12 hours waits to 2% which has not been achieved.



What the chart tells us

The number of patients 12 hours in A&E department increased to 2878 patients in September 2024 (8.2%) compared to August 24 (7.48%) and higher than September 2023 (6.45%). Performance is most challenged at RSCH with 16.6% on average of RSCH attendances in department more than 12 hours in September 2024, compared to 16.5% August 2024, and 14.2% in September 2023.

Intervention and Planned Impact

The UEC recovery plan contains hospital flow schemes which will release hospital capacity earlier to enable movement out of ED and reduce the number of 12 hr breaches to a target of no more than 2%. Schemes include the continuous flow model to create early morning patient flow out of ED which has been implemented by the Medicine Division and will soon be followed by the Surgery and Specialist Divisions. Work is also underway to increase the usage of the discharge lounge.

The Breakthrough Objective of Improving the Median Hour of Discharge and the Length of Stay Corporate Project also contribute to reducing the number of 12 hour waits in ED.

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Risks/Mitigations
There is a risk of harm to patients who spend more than 6 and 12 hours in Emergency Departments. Mitigations include streaming patients to alternative pathways, improving early patient discharge processes to create early capacity and flow, and improving use of the discharge lounge. A risk to the LOS project is that discharge planning processes are not applied consistently across the wards. This leads to a delay in patients being discharged in timely way and increases the length of time patients reside in ED whilst waiting for a bed.

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True North

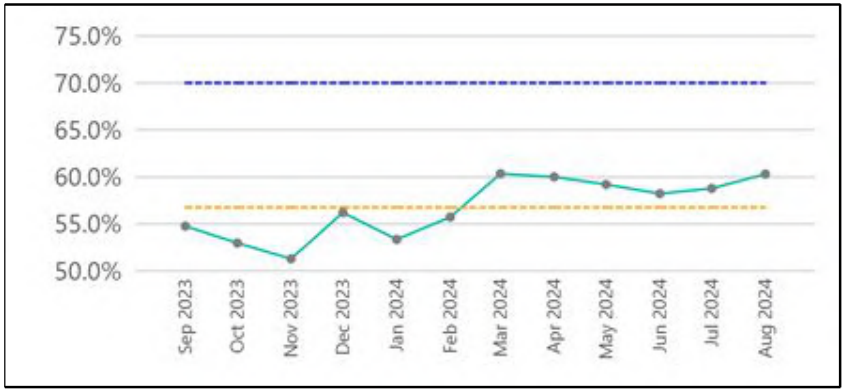
Metric: Cancer - To achieve the 62 day standard
(All referrals - National standard revised Oct 2023)

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
54.75%	52.96%	51.28%	56.20%	53.34%	55.72%	60.34%	60.00%	59.19%	58.21%	58.77%	60.30%

Overview

Cancer 62 day performance is a constitutional standard, with a target of 85% of patients to be referred and commence definitive treatment within 62 days.

Please not that the constitutional standard changed in Oct-23 to include patients from all referral sources, having previously covered only urgent GP referral only.
UHSX has committed to improving performance to 70% by Mar-25, in line with national planning guidance.



What the chart tells us

The chart shows the % of patients who commenced treatment each month within 62 days. Cancer information runs a month in arrears, to allow for collation of shared pathways with tertiary providers and improve the accuracy of reporting.
Aug-24 performance was 60.3%, compared to 58.8% in Jul-24 and national standard of 85%. Improved performance will only be achieved if reduced backlog is sustained going forward.

Intervention and Planned Impact

The Trust has developed recovery plans for each of its challenged tumour sites. These are being overseen through enhanced governance led by the COO and MD (planned care), and supported by Surrey and Sussex Cancer Alliance

Tumour site plans are focused on improving diagnostic and treatment capacity, shortening the front of the pathway and reducing the backlog. 62-day performance will only materially improve once the backlog has been reduced and sustained at a lower level.
NHS England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress.
The Trust has been awarded additional financial support by NHS England to recover cancer performance as part of the 'Tier 1' regime.

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

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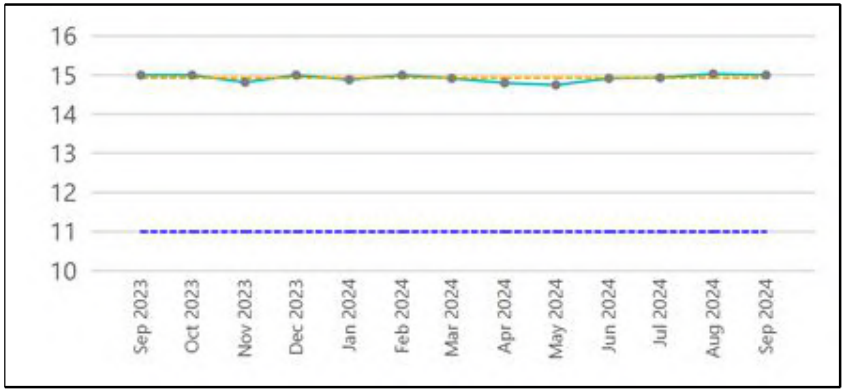
Breakthrough

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
15:00	15:00	14:49	15:00	14:53	15:00	14:55	14:48	14:45	14:55	14:56	15:02	15:00

Overview

The Trust MHD metric has not moved since this was brought in as a breakthrough objective. There has been some fluctuations during some months but the movement has not been significant.
The Trust data does not show the areas where some divisions have made some progress. However these positive movements are counter balanced by other divisions MHD getting worse and hence the position does not look like it has shifted. from Sept 23



What the chart tells us

The chart only gives the Trust overview of the MHD and does not describe the change in the divisions. This data is available for the divisions and this is being worked through to establish which wards need greater focus to move the dial on this metric

Intervention and Planned Impact

There is now only one Breakthrough objective for the divisions and wards and this is the MHD. This allows clear focus on one improvement metric.
The responsibility of the MHD now sits with the divisions and not the Hospital Leadership team as the main factors which influence hour of discharge are those which sit under the divisions. For example; twice daily board rounds, TTOs and transport bookings (if required) being done the day before discharge.
Consistent intervention along with review of the data allows correlation with the change in the required behaviours against the MHD time and allows the divisions to track progress and alter interventions as required.

Risks/Mitigations

There is the risk that this data is not reviewed on a regular enough basis to track interventions back to the impact of any changes. The data also needs to be reviewed at a ward by ward level to understand what needs to happen to improve the MHD.
The mitigation in place to prevent this is that the MHD is now part of the data in the Divisional monthly SDRs. The data for each division will be tracked and monitored monthly and presented to the exec team which will include current actions required to importve the position.

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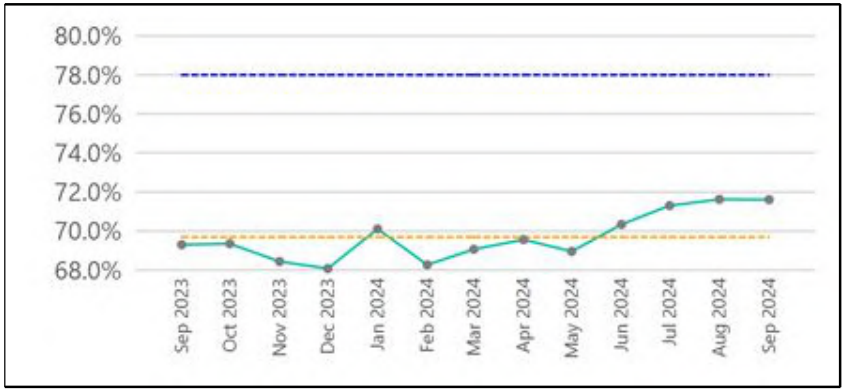
Driver

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
69.3%	69.4%	68.4%	68.1%	70.1%	68.3%	69.1%	69.6%	69.0%	70.3%	71.3%	71.6%	71.6%

Overview

UHSx did not achieve the year-end standard of 76% discharged from ED within 4 hours and the standard has been raised to 78% for 2024/25. A revised trajectory was agreed with the ICB in May 2024 and the trust is currently off trajectory.
UHSx reported an overall position of 71.50% against the four-hour standard for September 2024 (including the minor injury unit and walk-in centre) which is a marginal improvement on the previous three months but behind the internal trajectory which has been set for 2024/25



What the chart tells us

In September 2024 UHSx (excluding MIU and WIC) treated 67.3**%** of patients within 4 hours of attending all A&E departments, a 1.5% improvement from June 2024, but a fall in performance since June 2023.
There was improvement at all the Trust's main acute sites compared to the position at the end of Q1, with PRH (+3.9%), Worthing (+2%), RACH (+1%) and RSCH (+5 %), however a deterioration of 2% at SRH.
National A&E performance in the same period was 74.2%.

A revised recovery trajectory has been agreed by site and UEC plan developed, focused on improving performance :

- 78% of patients in ED seen, treated, admitted or discharged within 4 hours by March 2025
- Reduction in patients waiting over 12 hours from arrival in ED to 2%
- Zero 60 mins handover delays
- 10% reduction in Length of Stay Patients over 7 days

The improvement plans have been developed looking at different areas across the organisation, including: -

1. Front door & UTC model
2. ED flow
3. Whole hospital flow
4. System partners

The Deputy Chief Operating Officer has introduced oversight meetings with Medicine Divisions to focus on implementing immediate actions to improve quality and safety in the Emergency Departments and improve performance. Actions are tracked on a weekly basis.

Intervention and Planned Impact

A revised trajectory for UHSx and each site has been agreed and each Hospital Director has developed a UEC improvement plan which is focused on improving performance against four key NHS standards and targets:

- 78% of patients in ED seen, treated, admitted or discharged within 4 hours by March 2025
- Reduction in the number of patients waiting over 12 hours from arrival in ED to 2%
- Achieve zero 60 mins handover delays
- 10% reduction in number of patients with a Length of Stay of over 7 days

The improvement plans have been developed looking at different areas across the organisation, including: -

1. Front door & UTC model
2. ED flow
3. Whole hospital flow
4. System partners

In addition, the Deputy Chief Operating Officer has recently introduced oversight meetings with the leadership team of the Medicine Divisions to focus on identifying and implementing immediate actions to improve quality and safety in the Emergency Departments and improve urgent and emergency performance standards and targets. Actions are tracked and monitored on a weekly basis.

Risks/Mitigations

Risks

- Increased ED attendances, particularly walk-in patients (non-admitted)
- High number of NCTR patients on P1, P2, P3 pathways still residing in a UHSx bed

Mitigations

- Improved pathways to triage to UTC and admission avoidance
- UEC improvement plan will involve a whole hospital approach
- Work with system partners together to find solutions to the complex discharge patient cohort; targeted reduction in the number of NCTR patients across Sussex ICS to be achieved by 8 November.
- Transfer of Care Hubs established at Worthing Hospital and the Royal Sussex County Hospital

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Driver

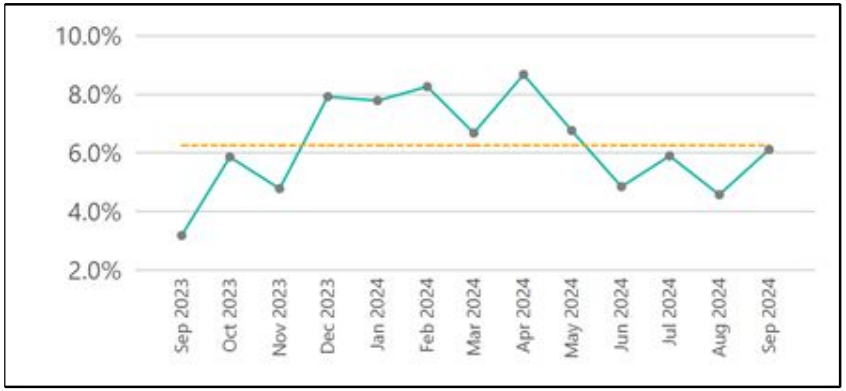
Metric: A&E and Emergency flow - Ambulance Handovers > 60 minutes

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
3.2%	5.9%	4.8%	7.9%	7.8%	8.3%	6.7%	8.7%	6.8%	4.9%	5.9%	4.6%	6.1%

Overview

Ambulance to hospital handovers above 60 mins have deteriorated from October 23 as a consequence of the overcrowding in the Emergency Departments; This has a detrimental effect on how quickly crews can be released to go back into the community to respond to other 999 calls

The UHSx UEC Improvement Plan agreed with the ICB set out a target to eliminate all over 60-minute ambulance handovers however this has not been achieved to date



What the chart tells us

The number of over 60 minute handovers at UHSx increased from 4.9% at the end of Q1 to 6% by the end of Q2. The largest number of ambulance handover delays occurred at the Royal Sussex County Hospital (268) followed by St. Richard's Hospital (85), and Worthing Hospital (55).

Intervention and Planned Impact

Work is being concentrated mainly at RSCH as this is where the majority of the delays happen, and this site is consistently having the worst handover delays in the region.

Improvement schemes include:

- Improved streaming to UTC to decrease number of patients in majors
- Increase fit to sit area in majors
- Increased usage of CDU

SECAMB and UHSx are working jointly on a project to implement a clinical navigation hub in Brighton and Hove to reduce the number of category 3 and 4 ambulance conveyances to hospital.

Risks/Mitigations
The weekly UEC oversight meetings are focussed on developing plans to eliminate the number of ambulance handover delays which includes taking measures to reduce the number of patients in ED on trollies and increase the number of patients in chairs in the Ambulatory Clinical Decision Unit. Missed Opportunities audit being undertaken with SECAMB to look at SECAMB conveyances to hospital.

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Driver

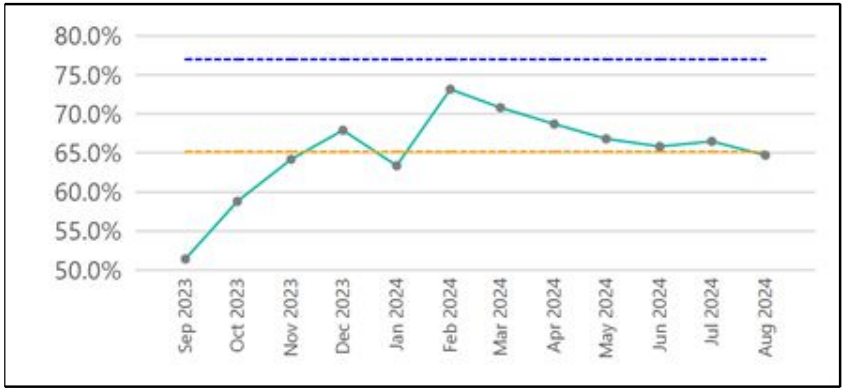
Metric: Cancer - 28 day faster diagnosis standard

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
51.43%	58.80%	64.18%	67.92%	63.37%	73.17%	70.80%	68.71%	66.82%	65.83%	66.49%	64.72%

Overview

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

UHSX has committed to achievement of 77% by March 2025, in line with national planning guidance ask.



What the chart tells us

FDS performance deteriorated in Aug-24 to 64.7% against the 77% target (from 66.5% in Jul-24), but remains above 12-month average.

Intervention and Planned Impact

The **FDS performance** has been most significantly impacted by Breast, **Colorectal, Gynaecology, Skin, UGI and Urology**.

•**Breast** performance is mainly affected by triple assessment capacity at the front of the pathway.
•**Colorectal** performance is mainly affected by vacant nursing posts managing the assessment and onward referral for first diagnostic leading to batches of referrals hitting Endoscopy in particular, unable to perform scopes in pace with batched referral demand.
•**Gynaecology** performance is mainly affected by the shortage of sonographer USS capacity and hyst delays.
•**Haematology** performance is mainly affected by late referrals across from other tumour sites.
•**UGI** performance is currently affected by delayed endoscopic and radiological diagnostics.
•**Urology** performance is mainly affected by delays to biopsy and OP capacity.

Tumour site improvement plans to address these issues are in place,

England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress, and support with recovery including £1.1m of schemes to improve cancer wait times.

Risks/Mitigations

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

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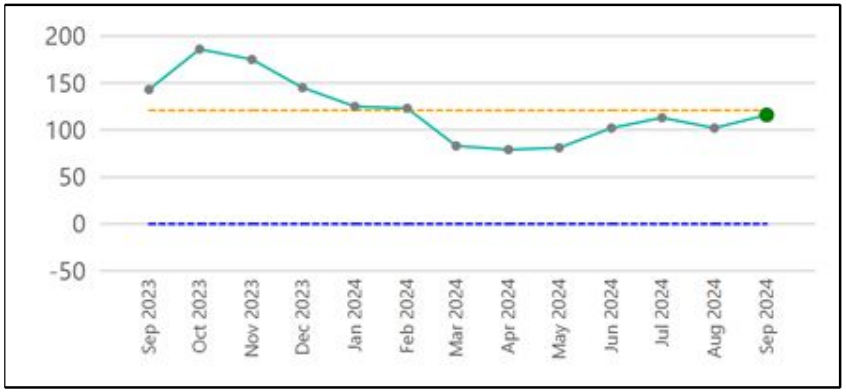
Driver

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
143	186	175	145	125	123	83	79	81	102	113	102	116

Overview

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



What the chart tells us

There has been an increase in over 104-day waits from 102 in Aug-24 to 116 in Sep-24, but it remains below 12-month average.

Intervention and Planned Impact

The trust has developed recovery plans for each challenged tumour-site. These are being overseen through enhanced governance led by the COO and MD (planned care), and supported by the Surrey and Sussex Cancer Alliance.

NHS England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress.

The Trust has been awarded additional financial support to help contribute to recovery of the cancer performance position as part of NHS England's 'Tier 1' regime.

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

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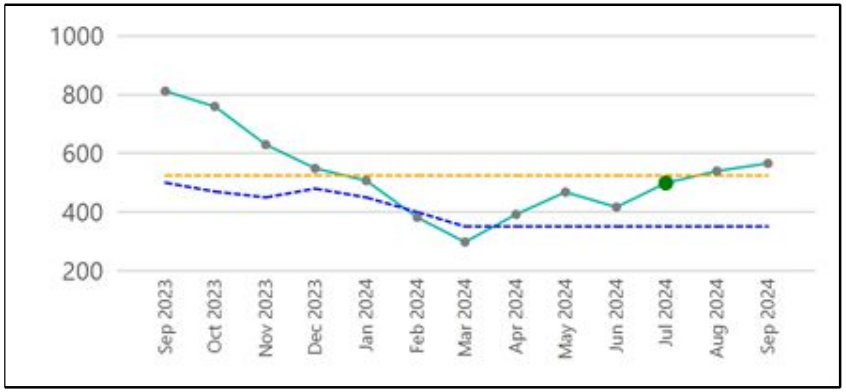
Driver

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
812	760	630	549	507	382	298	392	468	417	499	540	566

Overview

The NHS operating framework 24/25 requires Trusts to improve 62-day performance to 70% by Mar-25. To deliver this, UHSX has to maintain a backlog below it's 'fair share' target of 351.
The Trust is required to reduce and sustain the 62-day backlog at or below 351 patients as a result of being placed in Tier 1 by NHS England.



What the chart tells us

62-day prospective waits decreased from 540 to 566 in Sep-24, back above the 12-month average.

Intervention and Planned Impact

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

The Trust was awarded additional financial support to help recovery cancer performance as part of the 'Tier 1' regime.

Risks/Mitigations

Management bandwidth to engage, given scale of challenges in other areas (for example A&E and RTT). This is being mitigated through use of additional PMO and analytical support from Surrey and Sussex Cancer Alliance.

Diagnostic capacity is a risk for the Trust as patients progress through their cancer pathways, and with similar pressure at this stage of treatment from the RTT recovery programme and emergency pathways. This has been mitigated through additional Tier One funding for diagnostic capacity.

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Driver

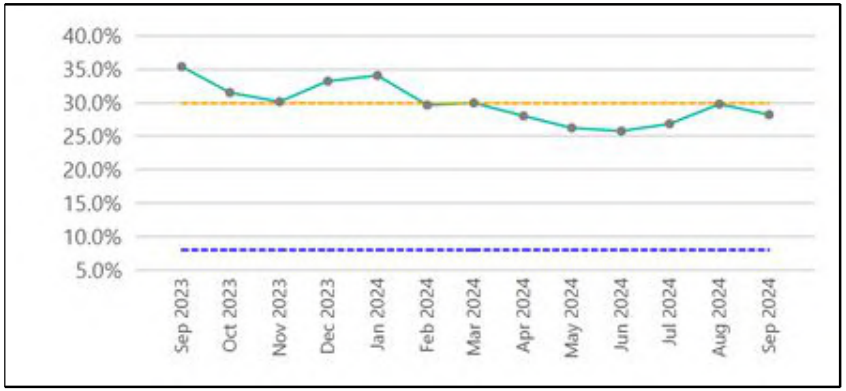
Metric: Diagnostics - % Breaching 6 week target (DM01 modalities)

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
35.4%	31.5%	30.2%	33.2%	34.1%	29.7%	30.0%	28.0%	26.3%	25.8%	26.9%	29.8%	28.2%

Overview

Diagnostics are an important phase of elective care for patient care and are an essential part of decision-making towards definitive treatment. Performance is measured using the 'DM01' standard, which tracks waits across 15 diagnostic tests, ranging from imaging modalities, to physiological measurement, to endoscopic investigations.

The 2024/5 operating framework includes ambition to achieve no more than 8% of over 6-week waits by end March-25.



What the chart tells us

UHSX achieved 28.2% in Sep-24 against the DM01 standard, and improvement of 1.6 percentage points compared to Aug-24. This was below the 12-month average.

Intervention and Planned Impact

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

Risks/Mitigations

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

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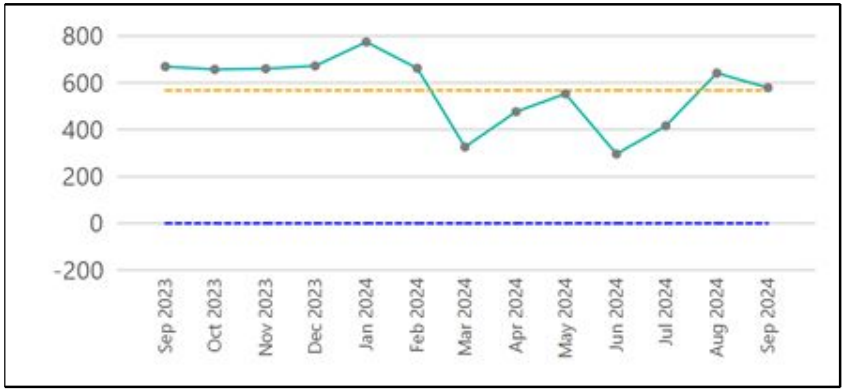
Driver

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
669	657	660	672	774	662	326	476	553	296	416	641	579

Overview

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



What the chart tells us

The chart shows the number of patients who are waiting over 78 weeks at the end of each month. At the end of Sep-24 there were 579 patients waiting over 78 weeks, and improvement from 641in Aug-24.

Intervention and Planned Impact

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

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

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Driver

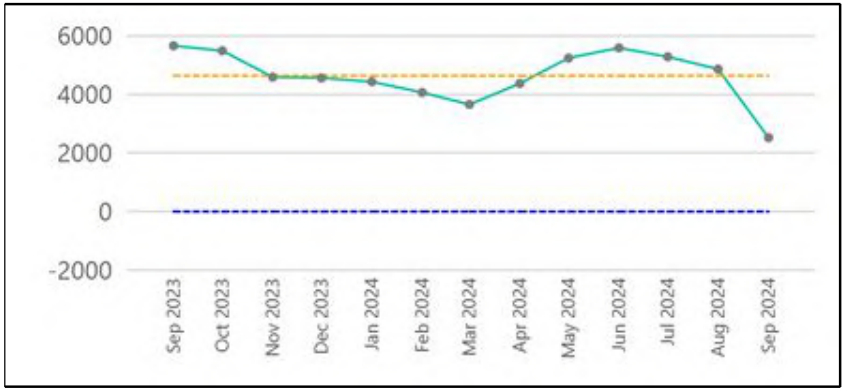
Metric: RTT Elective care - >=65 Weeks

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
5664	5495	4594	4566	4434	4067	3658	4374	5245	5592	5288	4866	2525

Overview

Elective waiting times are a key constitutional target. Elective Waiting times materially increased as a result of the covid pandemic. The 2024/25 national target is to reduce the number of 65-week waits to zero by the end Sep-24. UHSX did not acheive this, and has agreed an H2 plan to reach zero 65-week waits by Mar-25.

Due to challenges with 65-week wait performance, the Trust has been placed in Tier 1 level support by NHSE.



What the chart tells us

The number of patients waiting over 65 weeks decreased from 4,866 in Aug-24 to 2,525 in Sep-24. This is the lowest total for over two years and close to the lower confidence limit for past twelve months.

Intervention and Planned Impact
UHSX has, along with ESHT & QVH, jointly agreed a plan to reach zero for H2. This is based on: 1. Opening forecast of ~6100 on 'do nothing more' basis (Forecast as of 29/09) 2. UHSX increasing activity further (both through productivity & WLI/insourcing) to close by further ~2,900; UHSX is being supported by the national Getting It Right First Time team over the next 6 months to achieve this. 3. ESHT and QVH using their capacity to treat 2,081 and 550 UHSX patients from the cohort respectively. 4. Independent Sector capacity being used to close the gap to zero. UHSX Specialty-level plans for H2 have been agreed, and are currently subject to check and challenge. Patients will be transferred to ESHT & QVH by end of Nov-24. UHSX CEO is lead for this plan across sussex. UHSX MD is operationally leading delivery on behalf of the three NHS providers. Sussex system support is being overseen through weekly system capacity meeting, chaired by MD, with weekly oversight from COOs. Tier One oversight for RTT will now be of the whole Sussex System and not just UHSX.
Risks/Mitigations
Urgent and emergency pressures have exacerbated risk associated with 65 week waits over the past 12 months. Increases in urgent or cancer demand (which take precedence in terms of clinical priority order) also constrain capacity for routine waiters capacity. UHSX is reliant on system working and capacity being available at other providers (both independent sector and NHS) in order to deliver this objective.

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Driver

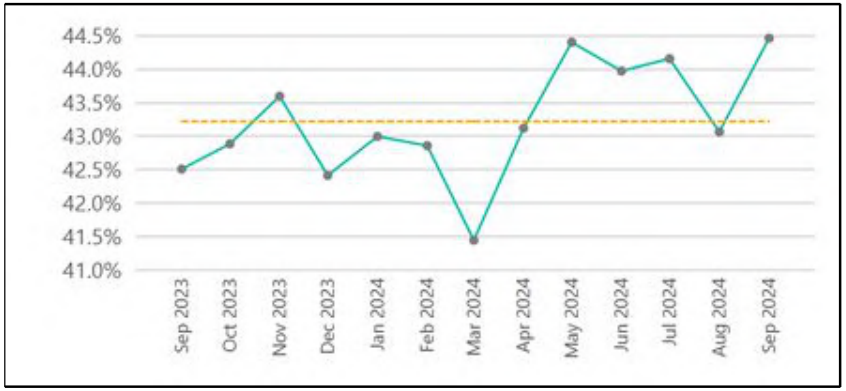
Metric: RTT Elective care - 18 Week Performance

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
42.51%	42.89%	43.60%	42.42%	43.00%	42.86%	41.45%	43.12%	44.41%	43.98%	44.16%	43.07%	44.47%

Overview

Under Referral to Treatment (RTT) incomplete pathways constitutional target, 92% of patients should be waiting under 18 weeks to commence first definitive treatment following GP or consultant referral. Incomplete performance was affected by Covid-19 pandemic due to a reduction in capacity in order to treat covid patients, which led to growth in the RTT backlog and total waiting list.

Reducing long waiters (104+,78+ and 65+ week waits) has superseded the 18 week target as acute Trusts look to tackle the very longest waits as part of staged recovery to reduced waits for elective care. It remains part of the constitutional targets, and system oversight framework however.



What the chart tells us

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

Performance was 44.5% in Sep-24, and improvement on Aug-24 (43.1%) and the best performance in over 12 months.

Intervention and Planned Impact
Key actions include: 1. Increasing activity delivered, through: • improved productivity and pathway redesign. For example reducing unnecessary follow ups by increasing use of Straight to Test pathways and PIFU (Patient Initiated Follow Up) • Increased weekend working • Increased use of independent sector • Mutual aid within Trust sites, across Sussex ICB catchment and where possible utilising the Digital Mutual Aid System (DMAS) to seek additional capacity support from beyond the Sussex System 2. Improved waiting list management, with refreshed standardised RTT meetings with operational teams to ensure access policy rules are followed and applied, ensure patients are booked in turn, and ensuring outcomes are captured on the information systems. 3.Enhanced planned care oversight and governance structure with divisional leadership led by MD (planned care) and Director of Performance, with divisions held accountable for improvement focused on all stages of treatment not just longest waits 4. Central validation of pathways over 12 weeks and continued DQ process re waiting list reporting, supported by technological transformation (including robotic process automation)
Risks/Mitigations
There are also some highly complex pathways, and specialist capacity constraints (eg in neurosurgery/spinal care), which have created risk in minimising longest waits. Increases in urgent or 2WR demand which take precedence in terms of clinical priority order can also constrain residual routine waiters capacity. Financial constraints limit the amount of activity that can be delivered outside of plain time.

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Watch Metrics for Systems & Partnerships

Metric	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
A&E and Emergency flow - % Patients with a 21+ day length of stay	7.9%	8.2%	7.9%	8.4%	9.2%	9.0%	8.2%	9.0%	8.4%	8.3%	8.8%	8.1%	8.2%
A&E and Emergency flow - A&E 4 Hour Breaches	10752	10927	11024	11285	10592	10885	11690	10737	11882	10667	10696	10020	9924
A&E and Emergency flow - A&E Attendances	35026	35655	34930	35356	35435	34305	37790	35274	38278	35964	37275	35313	34959
A&E and Emergency flow - Ambulance Handovers	7200	7544	7335	7733	7933	7193	7697	7303	7556	7278	7380	7444	7387
A&E and Emergency flow - Ambulance Handovers - % Under 15 mins	59.5%	56.1%	56.1%	49.8%	52.0%	52.4%	52.9%	49.1%	52.8%	54.6%	51.1%	55.2%	49.4%
A&E and Emergency flow - Average LOS (Excl LOS 0)	7.2	7.4	7.3	7.4	7.9	7.8	7.2	7.7	7.7	7.6	7.8	7.5	7.6
A&E and Emergency flow - Bed Occupancy	1645	1676	1729	1751	1799	1799	1816	1820	1819	1799	1782	1766	1800
A&E and Emergency flow - Emergency Admissions > 1 LOS	5580	5789	5704	5796	5704	5315	5830	5475	5632	5426	5479	5477	5492
A&E and Emergency flow - Mean Waiting Time	314	320	337	338	337	336	325	345	339	315	325	310	329
A&E and Emergency flow - Time to treatment in ED (Median time to treatment mins)	79	69	70	69	68	71	69	63	72	62	70	67	68
A&E and Emergency flow - Time to Triage in ED - % seen within 15 mins	64.8%	64.5%	63.1%	58.9%	60.9%	60.1%	59.9%	63.5%	60.2%	64.6%	62.5%	66.7%	62.1%
Cancer - Two week rule performance	43.5%	58.9%	62.8%	72.0%	69.5%	74.2%	74.1%	67.5%	63.2%	58.8%	66.2%	62.8%	
Diagnostics - 6 week backlog	8541	7226	6336	6829	7219	6427	6491	6036	5458	5331	5481	6044	5645
Diagnostics - Activity	34481	37145	39803	31927	48976	35138	35813	37418	38711	38494	39960	35950	37660
Diagnostics - Waiting List size	22550	21201	19823	19436	19874	20448	20320	20518	19712	19459	19127	19095	18688
Elective care - Activity compared to 2019/20	94.3%	97.6%	98.5%	101.6%	95.6%	96.2%	142.4%	114.1%	115.8%	115.9%	105.2%	106.4%	104.6%
RTT Elective care - >= 52 Weeks	16922	16379	14441	13673	13790	14218	15824	16480	16941	16157	15052	14168	10976
RTT Elective care - >104 Weeks (NHSi Criteria)	0	0	3	4	3	4	0	4	4	4	4	2	4
RTT Elective care - Clock Starts	20956	22845	23179	17246	22556	21484	19448	20563	21290	19011	20716	17698	17468
RTT Elective care - Clock Stops	20542	23996	28246	18437	22931	21460	19925	21765	22277	23470	24053	20976	22814
RTT Elective care - Waiting list size	155091	152018	145668	143841	142481	141662	141173	142917	141517	136410	133732	130232	123868

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Research & Innovation

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

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Patient First Domain
Data for Quarter 3 of 2024-25 for Acute Trust ranking in terms of total recruitment to studies on the NIHR portfolio. The Trust currently stands at 51st putting it outside of the top 20% of recruiting Acute Trusts over the past 12 months. The breakthrough objective of increasing recruitment by 10% year on year will not be achieved in 2024/25. The target annual target of 8328 has been artificially inflated due to the anomaly in recruitment figures for 2023/24. Over 3000 patients were recruited to three studies in 2023/4, one of which the GB3 study in maternal health recruited over 2000 patients. There are less large recruiting studies available to participate in on the NIHR portfolio at present for 2024/25. Unless the landscape changes the breakthrough objective will not be achieved. Through divisional research growth plans, the Trust is focusing upon increasing the number of open interventional studies and commercially sponsored interventional studies this year as a driver for increasing patient treatment access and options.

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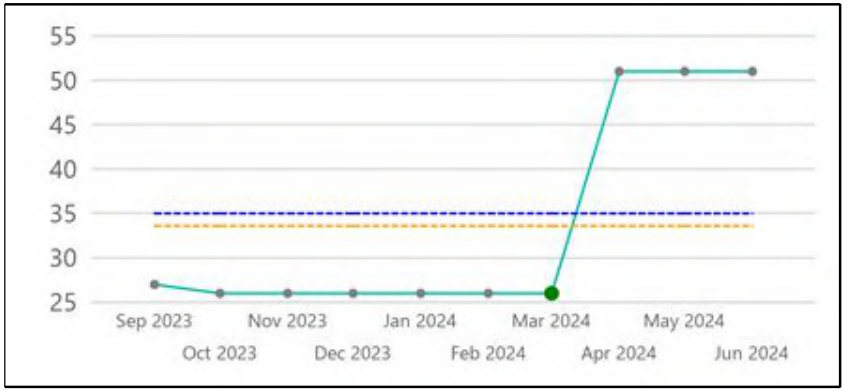
True North

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

Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
27	26	26	26	26	26	26	51	51	51

Overview

Research and Innovation drive continuous quality improvement in healthcare but very few staff and patients (1.15 % contribution of national recruitment 2023/24) participate in high quality studies. Participating in research improves patients' satisfaction with clinical care and patients are missing out on this benefit. Higher numbers of quality R&I studies results in better treatments, as well as improved diagnosis, prevention, care and quality of life for our patients and their families.



What the chart tells us

This chart shows shows the 12 month rolling Acute Trust ranking in terms of total recruitment to studies on the NIHR portfolio. The Trust currently stands at 51st putting it outside the top 20% of recruiting Acute Trusts over the past 12 months.

Intervention and Planned Impact

The Trust has a new R&I Strategy.
We have appointed Divisional Research Directors to support the embedding of research. These roles will help to promote research in the division through divisional targeted research growth plans, reviews of workforce with research PAs or similar, and reviews of capacity to support research. The development of divisional growth plans is currently underway.
Prioritised work is underway to secure estates for the reprovision of the Clinical Research Facility on RSCH site which is essential to the growth in delivery of commercial clinical research.
Research activity data is now available to all through a dashboard.
R&I strategic workstream are also developing research communication and engagement approaches, research training and education and a programme supporting UHSx research groups and clinical academic career opportunities.
Partnership working is essential to the development of research collaborations and shared infrastructure. The Trust is a key partner in the Brighton and Sussex Health Research Partnership.

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Risks/Mitigations
An application has been submitted to the NHIR for Commercial Research Delivery Status. If successful, this will provide support to grow the commercial research portfolio delivered through the CRF. Securing estates for the reprovision of the Clinical Research Facility to a high quality and accreditable standard is the key risk to delivering the Trusts R&I ambition. This is in the estates mater planning process and under Executive discussion – no final plan has been secured at this stage. Workforce and service department capacity to deliver research is also a risk to the delivery of the Trust's research ambition – detailed work with Divisional Directors for Research will help to better clarify the risks and mitigations for each division and support services in Q4.

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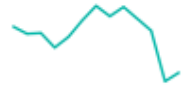
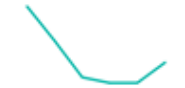
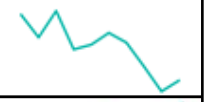
Watch Metrics for

Metric

Oversight Metrics				
Patient First Domain	Metric	Value	Target	Trend
People	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	6.29	7.06	
Sustainability	Financial Stability - Variance from breakeven plan YTD	-5,440k	0k	
Quality	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	103.6	100.0	
Quality	HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	24	3	
Quality	HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	26	4	
Quality	HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)	1	0	
Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	594		
Systems & Partnerships	Cancer - 28 day faster diagnosis standard	64.72%	77.00%	
Systems & Partnerships	RTT Elective care - >= 52 Weeks	10976	11184	

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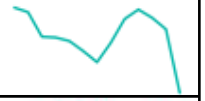
Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	579	0	
Systems & Partnerships	RTT Elective care - >=65 Weeks	2525	0	
Systems & Partnerships	RTT Elective care - >104 Weeks (NHSi Criteria)	4	0	
Systems & Partnerships	Cancer - Number of patients waiting over 62 days for treatment	566	500	
Systems & Partnerships	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	2893		

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Oversight Metrics Summary

Current segmentation

The Trust remains in Segment 3 of the National Oversight Framework (NOF) and continues to engage with NHS England and the ICB through the formal oversight processes.

The lead for the oversight of the Trust's performance remains with the ICB (not NHSE) and the Trust through quarterly meeting provides assurance on its delivery of its annual plan.

Drivers of the segmentation

During Q2 the Trust has continued to focus on Emergency care, Cancer and Planned care. The Trust remains within Tier 1 oversight for Cancer and Planned Care performance and is in Tier 2 oversight for Emergency Care performance. The Trust whilst meeting its planned care performance plan did not achieve zero patients waiting over 65 weeks. In respect of emergency care performance the Trust has not made the performance gains it expected to.

The Trust's financial plan continues to contain significant risk to its delivery and over the first half of the year the Trust's underlying run rate is adverse to the annual plan, with the Trust focusing on actions to improve its position across the second half of the year (H2).

The Trust's Single Improvement Plan is structured to include details of the specific improvement plans which when delivered will satisfy the undertakings which the Trust entered into with NHS England. The monitoring of the delivery of these improvements is overseen by a dedicated executive led steering group and NED chaired Board Committee as well as progress being reporting routinely to the ICB and NHSE

The Board Assurance Framework reflects the continuing level of elevated risk across the Trust's strategic objectives and shows a reduced level of confidence that the year end target scores will be achieved for around half of Trust's strategic risks within the domains of people, quality, performance and finance.

Implications of this segmentation

Segment 3 allows the Trust to have access to external advice and support which has included support to improve UEC performance and support for increased capacity and capability to address cultural improvement.

Actions being taken to move from segment 3

The Trust continues to progress the delivery of the Single Improvement Plan, as noted above assured through the dedicate Single Improvement Plan Committee, noting that the plan captures the specific concerns highlighted by the CQC with the delivery of their specific actions is complementary assured by the Patient and Quality Committee. The Undertakings in respect of operational performance and finance are assured by the Finance and Performance Committee and are also reported through the national Tiering meetings with NHS England (in respect of urgent and emergency, planned and cancer care). The People and Culture Committee assures the delivery of the plans that will satisfy the Undertakings in relation to people.

To exit segment 3, the Trust will need to deliver its operating plan for 2024/25 along with delivery of the Single Improvement Plan.

Agenda Item:	10.	**Meeting:**	Trust Board in Public	**Meeting Date:**	07 November 2024
Report Title:	Single Improvement Plan				
Sponsoring Executive Director:	Darren Grayson, Chief Governance Officer				
Author(s):	Nicole Chavaudra, Single Improvement Plan SRO, and Tolu Akande, Assistant Director of Programme Delivery				
Report previously considered by and date:	Not applicable				

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

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

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

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

Link to CQC Domains:			
Safe	Yes	Effective	Yes

Caring	Yes	Responsive	Yes
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement

University Hospitals Sussex is the holder of a licence granted under section 87 of the Health and Social Care Act 2012. Following an inspection by the CQC in August 2023, NHS England wrote to the Trust to advise that they had reasonable grounds to suspect that the Trust had provided healthcare services for the purposes of the NHS and was in breach of the following conditions of its licence: NHS2(4)(a) to (c), NHS2(5)(b) and (c), NHS2(6)(a) to (f) and NHS2(7).

In their letter following the inspections NHSE advised that breaches demonstrated a failure of governance arrangements by the Trust including, in particular, failure to:

- establish and implement (NHS2(4)(a) to (c) - clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and clear reporting lines and accountabilities throughout the organisation.
- establish and effectively implement systems or processes (NHS2(5)(b) and (c)) -for timely and effective scrutiny and oversight by the Board; to ensure compliance with health care standards binding on the Trust including but not restricted to standards specified by the CQC; and to ensure compliance with health care standards binding on the Trust including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions;
- to address matters relating to quality of care (NHS2(6)(a) to (f) – to ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Trust's organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its licence (NHS2(7)).

In response, NHSE identified a need for action in the form of undertakings, in line with Its enforcement guidance. The Trust agreed to give the following undertakings, pursuant to section 106 of the Act:

- Quality - The Trust will develop and agree a comprehensive improvement plan with Board level accountabilities, incorporating (as appropriate) feedback from NHS England and any external reviews commissioned as part of its improvement work.
- The plan will set out the Licensee's priorities and actions in relation to the areas for improvement including: the findings identified by the CQC in its inspection report dated 15 May 2023; in the s.31 notice in relation to oesophageal re- sectional surgery imposed in August 2022; the residual actions needed to address the October 2021 S29A Warning Notices in Maternity and Surgery in full; and to deliver on the Licensee's wider improvement priorities including 4- hour performance and planned care;
- set out a clear approach and plan for engaging and supporting staff in the improvement plan;
- ensure transparent internal processes and reporting is available to provide staff with the confidence to raise concerns without fear of detriment and feeling supported in doing so
- respond effectively to staff feedback including Staff Survey findings, grievances, complaints and whistleblowing concerns;
- ensure effective mechanisms for all staff to provide feedback and respond effectively to this feedback, including staff survey, complaints, and whistleblowing concerns; and
- include ongoing triangulation of the impact of improvement actions with wider quality metrics including patient and staff feedback incidents and complaints.

It was required that the demonstrates ongoing delivery of the comprehensive improvement plan through an open and transparent reporting framework. This includes:

- ensuring there is sufficient capacity and capability to lead and oversee the successful delivery of the comprehensive improvement plan and ensure effective Board oversight and accountability for incidents, clinical harm, complaints and patient feedback; and
- ensuring it has effective Board-level governance arrangements to oversee planned delivery, including response to whistleblowing cases, complaints, staff feedback and serious incidents.

The Trust is required to provide reports in relation to the matters covered by these undertakings as NHS England and the ICB may require.

Communication and Consultation:

This report has been shared with the Single Improvement Plan Committee.

Executive Summary:

University Hospitals Sussex holds a licence under the Health and Social Care Act 2012. In 2023, following a series of service inspections, NHSE advised the Trust to take action and make improvements. The Trust agreed to this and committed to specific actions, known as undertakings, which are detailed in our Single Improvement Plan.

The plan includes the following work streams:

- CQC
- Quality improvement
- Culture
- Surgery
- Planned care
- Cancer
- Urgent and emergency care
- Equality, diversity and inclusion
- Specialised services
- Maternity
- Finance

The report provides an update on progress and deliverables since the plan was approved in June 2024. It also sets out the performance of each of work streams, where improvement is in line with trajectory and where there are gaps between the ambitions and commitments in the SIP and the current position and trajectory.

The drivers of the above are described, along with the actions being taken to address the improvement requirements over the coming reporting period.

The Board is asked to **NOTE** the report

University Hospitals Sussex
NHS Foundation Trust

Executive Summary: October 2024

Title	Sponsor	SRO	PD Lead
Single Improvement Plan	Darren Grayson	Nicole Chavaudra	Tolu Akande

Overview

1. Introduction and context

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

The plan includes eleven domains: CQC; quality improvement; culture; surgery; planned care; cancer; urgent and emergency care; equality, diversity and inclusion (EDI); specialised services; maternity; and finance.

A process of alignment of the SIP with the emergent Trust strategy has begun, and a paper setting out the proposed roadmap is presented this month for consideration.

2. Progress and performance over the previous reporting period

During September the following progress has been made:

- A plan on a page for the cancer work stream has been developed, and a refreshed cancer plan has been signed off.
- The surgical assessment unit has opened at RSCH – this was an action from the Royal College of Surgeons report.
- A refresh of the CQC action planning process has commenced, with additional fixed term support
- Perinatal mortality has reduced for a further month demonstrating improving outcomes
- An SRO for the culture work stream has been appointed (Martyn Clarke)
- Compliance with fundamental standards of care audits has improved (69% June '24 to 82% Oct).

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3. Performance and assurance

Against the plan's domains, the following programme progress is provided by executive leads and SROs, using the risk rating table detailed below.

- **Maternity:** In addition to improved perinatal mortality rates, a further 33 midwives have been recruited and KPIs are on track.
- **Quality improvement:** Positive progress in some measures, such as complaints and fundamental standards of care audits; there is a requirement to consider how a strengthened compliance function and divisional resources can support further progress and assurance of compliance with regulations. This work is underway.
- **CQC:** Additional support for CQC action plans is now aligned to refreshing the approach with trajectories for closure of remaining actions to be produced by end of Q3.
- **Culture:** Culture programme now has an appointed SRO and mobilisation is in progress. Prioritisation of actions underway and a business case for organisational development and culture resource is being prepared.
- **EDI:** Programme continues to deliver its business-as-usual activities.
- **Planned care**: Trajectory of 2,525 >65 week waits delivered end Sep't, most specialties are close to having 0 65wk waiters and H2 plans for planned care have been reset. The Trust has engaged with the GIRFT programme to support further progress in challenged specialties.
- **Surgery**: The surgical assessment unit has opened at RSCH, merged PTLs are in place for a number of specialties, Higher Surgical Trainees have now returned to general surgery at RSCH and the business case for colorectal cancer surgery moves continues to develop.
- **UEC:** Completion of a maturity matrix regarding discharge has informed ward based improvement plans. GIRFT recommendations are being explored, the surgical assessment unit at RSCH has opened, and most KPIs remain static.
- **Specialised services:** A steering group has been established including divisions and Trust-wide services. A session held with NHSE however there remains a lack of clarity about required levels of activity against plans, or the financial consequences of this.
- **Finance:** The Trust has a deficit financial plan of £19.46m for 2024/25 (excluding deficit support funding). At the end of M06 the actual deficit is £34.91m, £5.44m adverse to plan.The M06 reported position is £0.99m surplus which is £1.72m favourable to plan. This reflects £1.71m of funding for industrial action. This also includes £2.6m income related to 2023/24 ERF appeal and £3.9m of central mitigations. The F&P will be considering proposals to improve the financial outlook in H2.

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4. Activity not completed in line with plan

The colorectal business case has been reviewed again by business case scrutiny panel and further work is required to finalise the financial considerations. As such, some of the actions under the surgery work stream from RCS action plan, such as recruitment of surgeons, and the rightsizing theatre capacity plan, is behind the planned implementation schedule.

Mobilisation of improvement plans from the compliance and assurance framework has not been actioned due to the scale of the compliance work required and current capacity issues. This will be considered by execs in coming weeks and a plan developed. Programme milestone plans will be adjusted accordingly.

Draft Implementation plan for a revised Surgical Clinical Operating Model is behind plan due to the nature and complexity of the requirements to determine a proposed model. In September, a proposed model has been developed, and programme is focused on developing an implementation plan should the proposed model be agreed.

To drive improvement in length of stay, a key deliverable is to implement discharge planning standards across all sites. This deliverable is slightly behind however a discharge planning standards maturity matrix has been launched to gain traction on this.

5. Expected delivery in the next period (October to December)

The following activities and delivery are planned for the next quarter:

- A multi-year investment plan and assumptions linked to financial planning and the future Trust strategy will be developed to support phased implementation of priorities within the SIP.
- Alignment of additional capacity to priorities and current gaps will be enabled – **complete**: additional support has been aligned to finance, UEC and CQC.
- Finalisation of the colorectal business case and mobilisation of the changes
- Compliance functions will be reviewed with a proposed delivery route
- Implementation of the culture programme plan will commence, within available resources – **now underway**
- ED pathways and flow redesign will be enabled, and improvement trajectories will be met
- Gap analysis on compliance of fundamental standards of care will be completed
- GIRFT planned care programme will mobilise focused on target specialities, and patient waiting lists will continue to reduce – **now underway**
- A cancer improvement plan will be developed
- SJR backlog will be cleared
- Mobilisation of the next phase for Planned Care programme including GIRFT

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Conclusion

Reasonable progress has been made in Q2 including the opening of the SAU at RSCH, the delivery of the RTT >65 weeks trajectory and the successful return of Higher Surgical Trainees. Priorities for Q3 include the production of a 'road map' for the SIP setting out investment priorities aligned to the emerging Trust strategy and financial plan, improvements in UEC performance, RTT, the mobilisation of the move of Colo-rectal surgery and a continued focus delivering our financial plan.

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Agenda Item:	12.	**Meeting:**	Trust Board in Public	**Meeting Date:**	7 November 2024
Report Title:	2024/25 - Quarter 3 BAF				
Sponsoring Executive Director:	Chief Governance Officer				
Author(s):	Company Secretary				
Report previously considered by and date:	The proposed quarter 3 BAF was considered by the Audit Committee 24 October 2024 and the BAF allocated risks were considered by each Board Committee in the last week of October.				

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

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

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

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	The BAF covers the strategic risks for this domain.
Sustainability	Yes	The BAF covers the strategic risks for this domain.
People	Yes	The BAF covers the strategic risks for this domain.
Quality	Yes	The BAF covers the strategic risks for this domain.
Systems and Partnerships	Yes	The BAF covers the strategic risks for this domain.
Research and Innovation	Yes	The BAF covers the strategic risks for this domain.

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

Regulatory / Statutory reporting requirement

The Trust is required to have an effective system of governance, risk management and internal control for which an effective BAF is key component. Commentary on the effectiveness of these processes is required within the Trust's annual governance statement and is subject to audit review and comment.

Communication and Consultation:

Report:

Introduction

The purpose of this report is to provide assurance to the Board that the Trust's Board Assurance Processes have been applied across the quarter. These processes see the respective executive leads for each strategic risk undertake a review of the assurances received and consider as to what they say in respect of the controls in place to reduce the specific strategic risk. In considering this information along with the progress against the key actions the Executive then determine the current risk score and if further actions are needed to address identified control or assurance gaps. The Executive view is then shared with the respective allocated oversight Committee for each strategic risk who consider this view in the context of the reports and assurances they have received and considered. Complementing these reviews is the work of the Audit Committee that consider the underpinning processes and through their receipt of the initial draft of the quarter 3 BAF consider if they which any committee to test out any aspect of the proposed scores.

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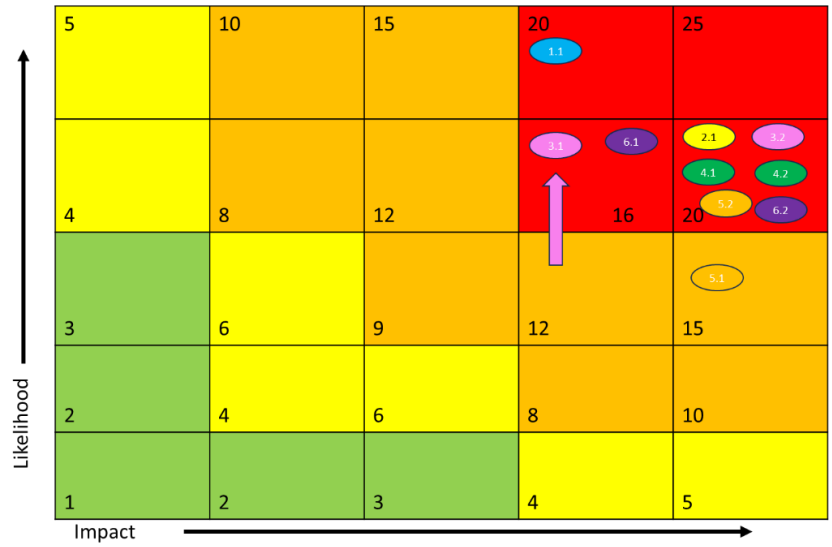
Quarter 3 BAF Overview and Context

For quarter 3 one risk is proposed to see its score move, this being risk 3.1 which is to increase to a score of 16 this change in score has been considered and agreed at its relevant oversight committee the People and Culture Committee.

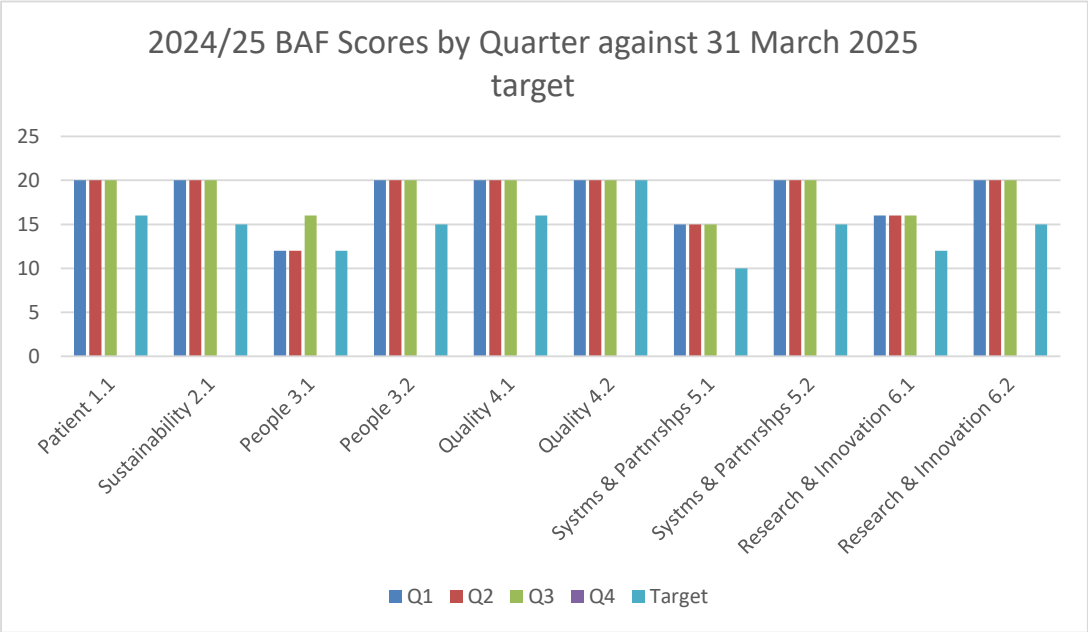
For quarter 3 there remain seven risks scoring 20 and with the movement in risk 3.1 two risks scoring 16.



Quarter 3 summary

The review of the BAF has shown for quarter 3 that the Trust continues to operate in an environment of elevated risk with only one risk achieving its target score and that risk 4.2 the target score was accepted by the Board to be significant.

Below is a summary chart showing for the 10 Strategic Risks their quarter 2 scores and the distance from their respective target score.



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Committee review

Following the review by each of the Board Committees during their last round of meetings considered the risks for which they have allocated oversight each agreed the scores reflected in BAF for quarter 3 are fairly represented specifically the increase in risk 3.1

The Research and Innovation Committee agreed that description of strategic risk 6.1 should be changed to *"We are unable to capitalise on research innovation and digital as drivers of transformational improvement at the Trust"* as this better reflects the place research and innovation has in supporting improvement.

Conclusion

The BAF continues to record the receipt of assurances with the most prominent mix of management and executive assurance being provided, however there has been a number of externally provided assurance from Internal Audit, the Guardian Service, FFT results etc. Whist there were a small number of sources of expected assurance for quarter 2 which did not materialise, the respective oversight committees did not feel these impacted on the quarter 3 scores and received information on the plans to receive these assurances over quarter 3.

The Board needs to reflect on the current level of risk as shown within the BAF for the second half of the year and the increased lack of confidence that target score reductions will be achieved for a number of Strategic Risks, covering Quality, People, Culture and Performance risks and that there remains the same degree of limited confidence that the financial sustainability strategy risk will achieve its 2024/25 target score reduction.

Recommendations

The Board is recommended

- to **NOTE** that the continued application of the Trust's BAF oversight processes applied by the Executives and the respective oversight Committees.

- to **AGREE** the risk revision to the description for risk 6.1, which has been discussed and agreed by the respective oversight Committee, that being Research, Innovation and Digital Committee (*"We are unable to capitalise on research innovation and digital as drivers of transformational improvement at the Trust" to better reflect the drive for improvement.)*

- to **AGREE** the minor risk description change for risk 6.2, again which has been discussed and agreed by the respective oversight Committee, that being Research, Innovation and Digital Committee *(add the word security within the risk description in respect of the potential impact is wider than operational and clinical performance)*

- to **AGREE** the BAF scores for quarter 3 are reasonable based on the review undertaken by the respective Board Committees and the Board itself through the receipt and discussion of the Trust Integrated Performance Report.

- to **DISCUSS** the reduced levels of confidence that despite the actions being taken target risk scores can be achieved for risks 2.1, 3.1, 3.2, 4.1 and 5.2 and how this impacts on the Boards risk tolerance levels and should those risk target scores be adjusted to align to a revision in this tolerance level.

University Hospitals Sussex NHS Foundation Trust

2024/25 Quarter 3 Board Assurance Framework Report

1 Introduction

1.1 At the Board workshop where the Trust's strategic risks were considered the Board reflected that their needed to be clearer delineation of some of the prior strategic risks and that their needed to be a specific risk in relation to the Trust's digital maturity, this culminated in 10 strategic risks being defined for 2024/25.

1.2 The Board approved in June the Trust's 10 2024/25 strategic risks alongside their target score to be achieved by 31 March 2025 and their longer term goal score aligned to the Trust's risk appetite statements.

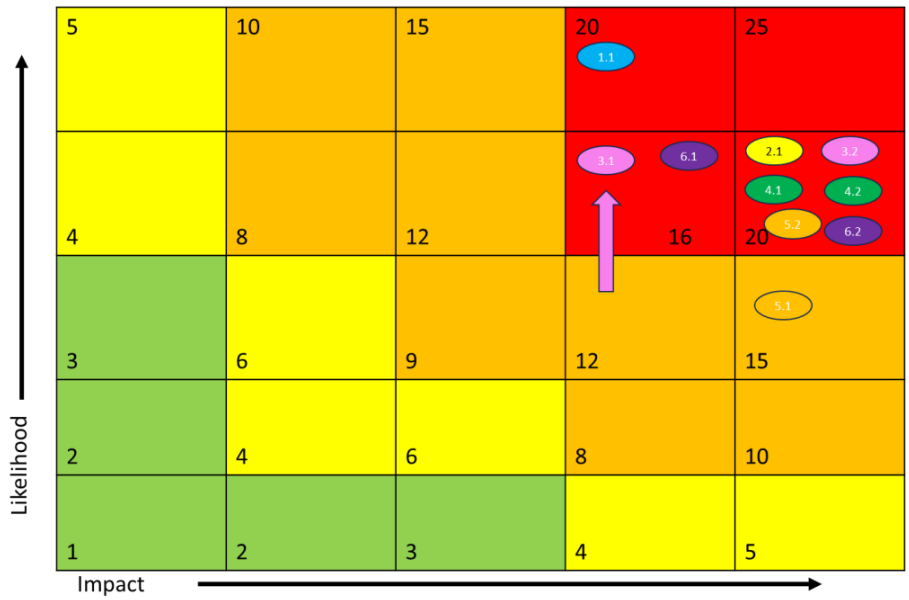
1.3 As in prior years each Strategic Risk has an Executive lead and is grouped within one of the Trust's six strategic domains with each domain being aligned to their respective allocated oversight Committee.

1.4 The Board Assurance Framework process sees the respective executive leads for each risk review the assurances received and consider what they say in respect of the controls in place to reduce the specific strategic risk. In considering this information along with the progress against the key actions the Executive determine the current risk score and if further actions are needed to address identified control or assurance gaps. The respective oversight Committees will through their meetings consider the proposed Quarter 2 risk scores against the assurances received to enable them to provide a recommendation to the Board.

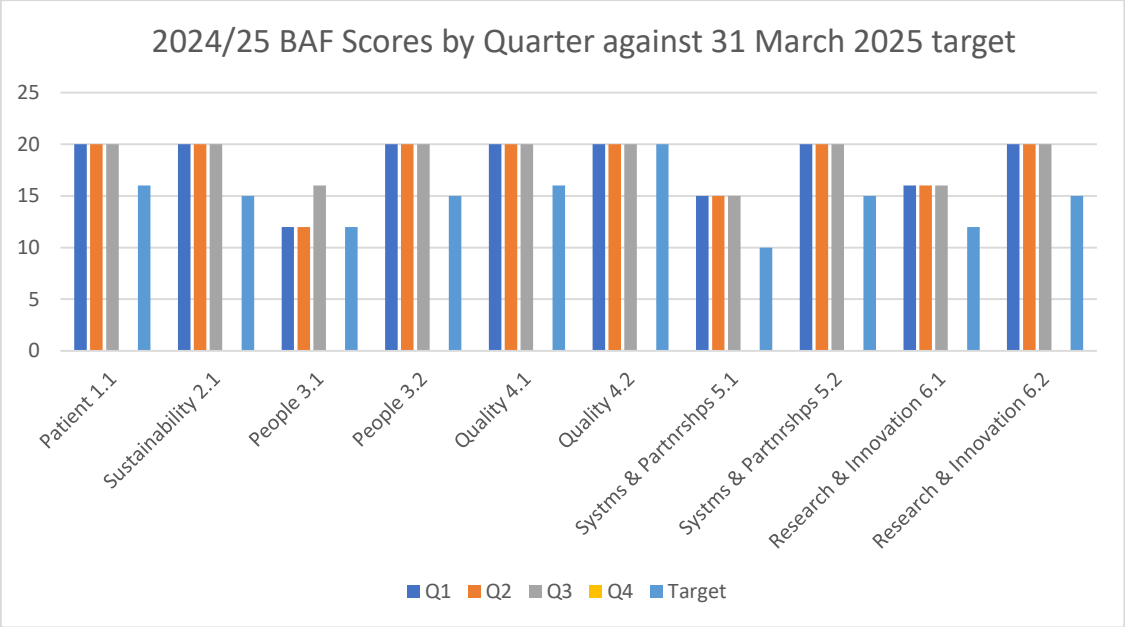
2 Quarter 3 BAF Overview and Context

2.1 For each segment of the BAF the respective lead executive has considered their risks along with the supporting highly scored and corporate risks when determining the proposed quarter 3 score, which will then been scrutinised by the respective oversight committee.

2.2 For each of the 10 strategic risks assurances have been received over the period of quarter 2 enabling a determination to be made as to the opening quarter 3 score.



Below is a summary chart showing for the 10 Strategic Risks their quarter 2 scores and the distance from their respective target score.



Appendix 1 shows the summary of changes in the BAF risks over 2024/25 to date

2.3 Movement in the Quarter

2.3.1 The executives are recommending to the respective oversight Committees **ONE** change in the Q3 scores to their respective Q2 scores, this relates to the People Risk 3.1.

- **People – Risk 3.1** *We are unable to recruit and retain a sufficient level of workforce if we do not have effective support for staff across the breadth of the NHS people promises (covering inclusion, health and safety, learning, recognition, teamwork, flexibility & staff voice) which adversely affects our capacity and capability to deliver services, continuous improvement and Patient First TNs.* This risk is recommended to increase from its target of 12 achieved in Q1 and Q2 to a score of 16 reflecting the deterioration in staff positive feedback which is regularly citing a staff view there are insufficient staff within the organisation to enable demands to be met.

2.4 There is ONE risks achieving their 2024/25 target score but it should be noted that the target score for this risk recognised the level of improvement work required to be delivered over the year which would see this risk remain for the whole of 2024/25 at 20, this risk being

- **Quality – Risk 4.2** *We are unable to deliver any safe and harm free care.* This risk remains scored at 20.

2.5 There are FIVE risks where the Executives have little confidence that 31 March 2025 target score will be achieved, this is an increase to those in the last quarter. These risks being

- **Sustainability – Risk 2.1** *We fail to deliver the in-year financial plan; alongside the requirement to return to a breakeven run-rate by M12 2025/26 and secure medium-term sustainability.* The target score was 15 but the view is that the current score of 20 will remain for the whole year.

- **People – Risk 3.1** *We are unable to recruit and retain a sufficient level of workforce if we do not have effective support for staff across the breadth of the NHS people promises (covering inclusion, health and safety, learning, recognition, teamwork, flexibility & staff voice) which adversely affects our capacity and capability to deliver services, continuous improvement and Patient First TNs.* The target score is 12 but the view is materialising that whilst interventions are being instigated there is a growing deterioration in staff positive feedback and whilst there is an understanding of the need for the enhanced control framework staff continue to regularly cite there are insufficient staff within the organisation to enable demands to be met.

- **People – Risk 3.2** *We will not achieve our strategic aims and realise the benefits of merger, including improving patient safety and recruiting and retaining talent unless we take action to; develop a clear strategy, invest in and prioritise focussed work on culture change from 'Board to Ward' including developing our leaders to be engaging, inclusive and empathetic, aligning sub-cultures and addressing cultural gaps and reducing cultural variation.* The target score was to see a marginal reduction to 15 but the Executive Team has reduced confidence that the target score of 15 can be achieved in this year, recognsing the impact reflected in the risks relating to workforce, quality, performance and finance.

- **Quality – Risk 4.1** *We are unable to demonstrate compliance with any regulatory and quality standards.* The target score was a marginal reduction to 16 but there is a reduced level of confidence that this reduction in score can be achieved by the year end given the level of CQC identified improvements that will remain outstanding at the year end.

- **Systems and Partnership – Risk 5.2** *We are unable to deliver and demonstrate consistent compliance with the 24/25 operational plan and NHS constitutional standards resulting in an adverse impact on patient care and the Trust's reputation and financial position.* Whist work is being undertaken to review the UEC implementation plans there is a significant degree of change needed to achieve the nationally expected performance standards. The Trust has developed an RTT improvement plan which is progressing but the shape of the Trust's patient wating list will see a significant level of demand in the second half of the year which presents a real challenge for the Trust.

2.6 The are NINE risks that are exceeding their 2024/25 target score, which is an increase of one risk to that for quarter 2 and of these seven these scoring 20 *(noting that whilst at its target score risk 4.2 relating to quality is also scoring 20)*

2.7 On reviewing Risk 6.1 the Research, Innovation and Digital Strategic Steering Group supported by the Clinical Director for Research and the Lead Executive (the Chief Medical Officer) have made adjustments to the strategic risk description from "We are unable to fully harness our research innovation and digital capacity to meet Trust ambition for staff recruitment training retention and patient care options" to "We are unable to capitalise on research innovation and digital as drivers of transformational improvement at the Trust" to better reflect the drive for improvement. It should be noted that whilst the description has been changed the prior quarters scored remain relevant as do the controls, assurance and key actions.

2.8 The wording of Risk 6.2 has been adjusted with the inclusion of the word security within the risk description in respect of the potential impact is wider than operational and clinical performance.

3. Committee Review

3.1 Each Committee considered the reports they received and the assurances these provided over the controls and mitigations in place against their allocated strategic risks alongside the information recorded within the BAF document itself.

3.1.1 Patient and Quality Committee

The Committee agreed that for the patient strategic risk the score should not change, but through the reports received in respect of the actions taken shared the executive confidence that this risk would reduce to its target score in line with the action plan by the end of the year.

The Committee agreed that for the quality risk, 4.2, they had received sufficient assurance that this risk remained at its target score and thus the score did not need to change. The Committee recognised that the Board in setting this target score at 20, had itself, recognised the timeline for all the planned quality improvements to be delivered would be after the year end.

The Committee agreed that the score for the other quality risk, risk 4.1, this should not reduce this quarter, and that whilst actions are being taken the work to fully address all the CQC recommendations, those needing infrastructure investment will take longer than the second half of the year to deliver and therefore shared the view that this risk is unlikely to achieve any further reduction in score before the end of March 2025

3.1.2 People and Culture Committee

The Committee agreed that the score for people risk 3.1 should increase for quarter 3 triangulating this with the reports it received at the meeting. The Committee agreed that the score for risk 3.2 should remain as it was scored for quarters 1 and 2 of the year.

The Committee also reflected that whilst work is being undertaken to address many of the drivers for the people and culture risks. neither risk was likely to see a reduction in score in the second half of the year as many of these actions need more time to deliver measurable change.

3.1.3 Finance and Performance Committee

The Committee has oversight of three risks and agreed that for all three of these risks, risk 2.1, 5.1 and 5.2, the quarter 3 score should remain unchanged.

In considering the finance and performance risk 2.1 the Committee reflected on the challenges the Trust is facing and agreed that the marginal reduction in score to achieve its target score was unlikely.

The Committee recognised the level of executive confidence that the actions taken and those planned for the next quarter in respect of risk 5.1 specifically in relation of system working and the Trust's own strategy development will see a reduction in this risk's score to its target score in line with the original plan by the year end.

The Committee whilst assured over the work undertaken in respect of planned care and the delivery of its improvement plan which has already seen a reduction in the number of the longest waiting patients the Committee recognised the challenges within the urgent care

pathway. Whilst improvement is being made in that area, it recognised the pressure that the second half of the year would bring and shared a reservation that the target score could be achieved through sustained improvement and thus the achievement of this risks overall target score was at risk.

3.1.4 Research, Innovation and Digital Committee

The Committee agree the scores for quarter 3 for the two risks it has allocated oversight for. risks 6.1 and 6.2 should not change and whilst these has not changed for the first three quarters of the year recognised the executive confidence that the actions planned would deliver the risk score reduction by the year end in line with the Board expectations when the target score was set.

The Committee agreed that the suggested description change to risk 6.1 should be recommended to the Board for agreement as the revised description brought a sharper focus that the research and innovation along with digitisation is a key driver for improvement. The Committee agreed the minor change to the description of risk 6.2 should also be recommended to the Board for approval as it makes explicit the role the Trust processes have in improving security of our systems and data.

3.2 **Following the review by each of the Board Committees during their last round of meetings considered the risks for which they have allocated oversight each agreed the scores reflected in BAF for quarter 3 are fairly represented specifically the increase in risk 3.1**

4 Quarter 3 Summary

Below is a summary of the strategic risk review undertaken by the executives, showing the rationale for the proposed Q3 score, the assurances received across Q2 detailing if provided by operational mgmt, executive led oversight or externally, the summary of future actions and the timeline to achieve the 31 March target score and any flagged risk to this delivery.

Risk	Score	Rationale for proposed Q3 score including link to key risks	Key assurance received in Q2 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
1.1	20 (no change)	Risk scores remain elevated as patient reported experience for most touchpoints is declining, there remain continued issues with performance in main drivers of patient experience (waits for planned care, ED treatment times), complaints received are increasing and national and local media coverage remains unfavourable. Although improvements in planned care are noted, this has not yet translated to reportable improvements in patient reported experience. Complaints capacity and processes have resulted in fewer open complaints and better responses.	1. FFT recommendation rates (ext) 2. Number of formal complaints & PALS concerns (ext) 3. CQC National Surveys (ext) 4. Healthwatch reports (ext) 5. Patient Experience reporting (op and exec) 6. QGSG report on divisional learning and complaints response levels (op) 7. Quality Scorecard (op and exec) *Gaps in assurance received in Q2* *Divisional Improvement Plans*	The main drivers of poor patient experience remain waiting – for planned care, and for urgent or emergency care. Work continues to implementation the RTT plans. For UEC where there has been less of a performance improvement then the UEC improvement plans are being subject to review by the interim deputy COO. The continuation of the complaint's improvement work will continue to reduce the over 60 days complaints during Q3. Other drivers of poor patient experience are inpatient experience and communication. Initiatives are underway to address this including the fundamental standards of care programme, staff wellbeing initiatives and the welcome standards programme.	The target score is not expected to be achieved until the end of the year (31 March 25) but will be dependent on sustained UEC performance, the maintenance of improved standards of care and through timely resolution of patient and family concerns.

Risk	Score	Rationale for proposed Q3 score including link to key risks	Key assurance received in Q2 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
2.1	20 (no change)	The risk score is maintained at 20 for Q3 24/25. The Trust's financial plan has again been resubmitted at £19.5m deficit; a further £7m stretch increasing the implied efficiency ask to £89.5m. Financial position as at M5 is off-track (YTD £7m adverse variance) with c£25m of the efficiency schemes being categorised as high risk. Given both the planning risks and underlying financial performance, delivery of the financial plan is considered high risk. As part of a multi-faceted response, the Trust has appointed an Efficiency Delivery Director, w/c 02/09/24, with a focus on reducing costs and developing a multi-year efficiency programme. This work will feed into recovery plans that 1) ensure the financial deficit does not deteriorate, 2) ensure the gap to efficiency target is minimised and 3) address the underlying deficit. Note, following the introduction of new national rating system for determining financial oversight and intervention, the Sussex System rating has increased to a 3+; with 4 requiring formal intervention.	1. CFO reporting to Sustainability (financial scorecard and risks) (Exec) 2. Productivity Reporting 3. Tender waivers, losses and comps reporting (Exec) 4. Capital Programme report (ops and Exec) 5. Efficiency programme report (op and exec) 6. Workforce deployment reports to People Committee (ops and exec) 7. ICS assurance meeting (ext) 8. Tender waivers, losses and comps reporting (Exec) 9. IA review of internal control environment (ext) and LCFS reporting on control environment (ext) 10. Reporting on DoI and FPP (op and exe) 11. Commercial activity reporting (op and exec) 12. Exec reporting of enhanced control environment (exec) *No identified gaps in assurance in Q2*	The proposed actions are • Identify actions to close residual gap and stretch target in the efficiency programme • Complete the rapid review of the operation of control environment with corrective action where weaknesses or opportunities are identified. • Develop multi-year approach to achieving and maintaining recurrent balance.	**The Executive Team has little confidence that the original target score of 15 can be achieved in this year. (noting that only the best case scenario achieves the financial plan)**
3.1	16 **(increase)**	This risk is proposed to INCREASE this month. A 2023/24 people plan was	1. People scorecard (ops and exec) 2. LCD reporting to People Committee / Trust SDR (exec)	Implementation of people plan workstreams (inc SIP elements) covering each people promise with particular focus on pay and	**The Executive Team has reduced confidence that the target score of 12can**

Risk	Score	Rationale for proposed Q3 score including link to key risks	Key assurance received in Q2 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
		approved by the People Committee in May. This set out key activities for the year based on the staff survey, single improvement plan and other information. The Trust also finalised a workforce plan as part of the annual plan to the ICB. Broadly the Trust has maintained a consistent level across sickness, vacancy and appraisal and STAM and other people metrics. However operational pressures and the financial challenges faced by the Trust and NHS as a whole continue to have an impact of staff feeling stretched. Although staff engagement did not appear to be impacted by this in Q1, as expected as the impact of grip and control measures are felt, coupled with a national narrative around NHS deficiencies has developed, staff engagement has started to fall across Q2. The CPO reflects it is too soon to tell whether this will continue to decline or stabilise and whilst there are interventions in place, such as the Big Conversation and progress in resolving some pay issues which can help mitigate staff morale is lower in Q2.	3. Equalities and Inclusion reports (ops and exec) 4. WRES and WDES report (ops and exec) 5. Patient First Strategic Initiative Programme report 6. H&W steering group reporting to People Committee (exec) 7. H&S Committee Chair report (ops) 8. F2SU Guardian annual report (ext) 9. Guardian of Safe Working Annual Report (ops) 10. Education and Training Assurance report (ops) 11. ER report (Exec) *No identified gaps in assurance in Q2*	Continued implementation of people plan workstreams (inc SIP elements) covering each people promise with particular focus on pay and T&Cs harmonisation work & engaging with TUs. This includes medical bank and agency and nursing bank control enhancement work continuing. Some of these activities will impact morale or motivation as changes are implemented or because the prioritisation of work leaves some issues of dissatisfaction unresolved for longer than others. There is also significant work to undertake supporting some change programmes such as theatre capacity associated service and job plan changes. Focus is being placed on securing high levels of engagement with the staff survey.	**be achieved in this year, recognising the deterioration in staff positive feedback and whilst there is an understanding of the need for the enhanced control framework staff continue to regularly cite there are insufficient staff within the organisation to enable demands to be met.**
3.2	20 (no change)	Clear diagnostic work undertaken including cost centre analysis. Metrics for measurement	1. People scorecard (ops and exec) 2. LCD reporting to People Committee / Trust SDR (exec)	Clarity of scope of the LCD SI (through PFISG) and a renewed charter based on the culture	**The Executive Team has reduced confidence that the**

Risk	Score	Rationale for proposed Q3 score including link to key risks	Key assurance received in Q2 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
		established. Reports developed and discussed at executive and TMC. Plan drafted to support priority culture & OD recommendations and agreed in SIP. Commencement of work with surgery and perinatal service. Some resources identified for immediate interventions. OD and culture featured in the Big Conversation. Cohort 2 of OD skills development started. Realignment of culture governance and QSIP safety culture into a co-ordinated programme of work. Establishment of behavioural workstream and associated interventions.	3. Equalities and Inclusion reports (ops and exec) 4. WRES and WDES report (ops and exec) 5. Patient First Strategic Initiative Programme report 6. H&W steering group reporting to People Committee (exec) 7. H&S Committee Chair report (ops) 8. F2SU Guardian report (ext) 9. Guardian of Safe Working Report (ops) *No identified gaps in assurance in Q2*	plan. Conclude resourcing discussions for OD delivery. Continue to use Big Conversation and strategy development to engage organisation on its culture. Conclude the current phase of senior leadership development (with Roffey Park). Support Board and Exec team development with the procurement of a Board development programme and continuing the Exec team development. However, even with these actions there is a risk of making the target risk reduction to 15 by the year end.	**target score of 15 can be achieved in this year, recognsing the impact reflected in the risks relating to workforce, quality, performance and finance.**
4.1	20 (no change)	No change to risk score as there is continued work being undertaken which includes: 1) New standard work for review quality standards 2) 50% assurance standards to have clinical lead 3) Production Clinical assurance Framework (Trust level) 4) Develop standard work to review mortality outlier 5) NHSE Kloe 6 spec com completed. 6) CQC improvement group	1. Quality Scorecard (ops and exec) 2. Safe Staffing report (annual QGSG and People) 3. QIA reporting (ops and exec) 4. Quality risk reporting (ops / finance) 5. Learning from deaths report (ops and exec) 6. Clinical Effectiveness reporting (ops and exec) 7. Mental Health Steering Group reporting (ops) *Gaps in assurance received in Q2*	The proposed actions include • Completion and roll out of standard work for quality standards review (COEG / division) • To secure 100% assurance standards to have named clinical lead • Confirmation of National audit participation • Standard work to log all national registries / quality data returns (COEG link to IG) • CAF to be rolled out into	**The Executive Team has reduced confidence that the target score of 16 can be achieved in this year, recognising the level of CQC identified improvements that will remain outstanding by the year end**

Risk	Score	Rationale for proposed Q3 score including link to key risks	Key assurance received in Q2 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
		established – close all but one pre 2023 actions	*Spec com steering group reporting*	each Division • Spec com UHSx steering group established and work plan to be developed to review all specialist com services • Methodology to support reporting on all mortality outliers – learning and action via SDR • CQC improvement group – completion of 50% must do actions. • MSSP – 2/8 outstanding actions to be completed • SJR backlog to be completed	
4.2	20 (no change)	Whilst actions have been taken including • All divisions are commencing to report harm reviews • All sites are compliant with completion Tendable audits >70% • There has been a manual trawl Hosp Acq thrombosis there remains significant work to the completed as recognised within the single improvement plan. Also there is a need to improve divisional compliance with the Duty of Candour regulations	1. Quality Scorecard (ops and exec) 2. Maternity Scorecard (ops and exec) 3. Safe Staffing report (nursing) (exec) 4. Incident report (ops and exec) 5. DoC compliance reporting (ops and exec) 6. Medico Legal update 7. QIA reporting (ops and exec) 8. Quality risk reporting (ops 9. Harm reviews (ops) 10. MSSP report (ext) 11. Birth Rate + report (ext) 12. Learning from deaths report (ops and exec)	The proposed actions include • Harm reviews – confirm std process for documenting and confirming harm • Cancellation rebooking policy • Increase to 100% compliance with all care standards captured in Fsof C audit • NEWS / PEWS 75% (news >5) all sites • SOP for review of Hospital acq thrombosis inlc radiology agreed reporting language • Awareness of sepsis – use EPMA audit • Develop theatre ventilation action plan	**Already achieving target score BUT note this is at a significant risk score of 20**

Risk	Score	Rationale for proposed Q3 score including link to key risks	Key assurance received in Q2 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
			13. Clinical Effectiveness reporting (ops and exec) 14. Mental Health Steering Group reporting (ops) 15. Initial reports on Specialist Ventilation and Water Safety (ops and exec) *Gaps in assurance received in Q2* *Routine Specialist Ventilation Group reporting* *Routine Water Safety Group reporting* *QIA reporting*	• Evaluate the impact of continuous flow model on ED corridor care	
5.1	15 (no change)	The 'big conversation' was launched across the organisation to help to determine our vision, purpose and priorities. The 'as is' state has been discussed with the board and workshops have been held with the leadership team to determine key areas of focus and principle for our new strategy and identify the difficult decisions we will need to take to develop an effective and credible strategy and roadmap. Development of the strong case for a Sussex Cancer Centre has been refreshed with a view to increase external stakeholder support, and we continue to gain assurance from the	• Clinical Strategy (exec) 1. ICS and Collaborative Networks meeting reporting (exec) 2. CiC reporting (exec) 3. Contracting performance reporting (ops) 4. System people plan reporting (exec) 5. Annual operational plan linked to system priorities (exec). 6. 3Ts corporate project update *There were no gaps in assurance received in Q2*	The outputs from the 'big conversation' and leadership workshops will be formulated into missions and goals that will provide a draft strategic framework. We will also finalise design principles which will help us to understand the direction of travel for our sites and services at a high level. The external stakeholder engagement plan for Sussex Cancer Centre will be mobilised to maximise wider political and charitable support. We will bolster our work to look at the benefits realisation of the LMB under the Interim Efficiency	It is expected that the target score of 10 will be achieved by 31 January 2025

Risk	Score	Rationale for proposed Q3 score including link to key risks	Key assurance received in Q2 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
		NHP that our project is not under review as part of the review of the NHP portfolio. We have provided input into the ICS policy and process for service changes.		Delivery Director's leadership, as part of his work on Trust efficiency. We will also commission work on options to decompress RSCH, firstly understanding what needs to be on the site because of population needs, commissioning, clinical adjacencies etc. This will complement the ICS Major Services Review analytical work.	
5.2	20 (no change)	There has been no change to the risk profile. The risk score remains at 20 (5x4) driven by. • Core Capacity: Still insufficient to meet demand, necessitating extra-contractual work and system support to manage 78 and 65-week backlogs. The Trust will not see no over 65wk waits by end of September. • Emergency Department (ED) Performance has seen no overall improvement, although at the RSCH site in Q2 there has been an improved performance, although this is counter balanced by a deterioration in other sites such as SRH • Delayed Discharge: There	1. Operational Performance Reporting (exec) 2. Integrated Performance Reporting (exec) 3. Patient First Programme report 4. Clinical Strategy (exec) 5. ICS and Collaborative Networks meeting reporting (exec) 6. Contracting performance reporting (ops) 7. Annual operational plan linked to system priorities. (exec) 8. Capital programme reporting (ops and exec) 9. Workforce deployment reporting (ops) 10. Rightsizing Theatres Programme (ops and exec) *There were no gaps in assurance received in Q2*	The proposed actions include • 65 Week Reduction Plan: Whilst not meeting the national requirement to have no over 65wk waits the Trust will continue with its plan as agreed with through the Tier 1 oversight process. • UEC Performance Improvement Plan: A full review of these improvement plans has commenced and its recommendations will be Implemented over the quarter to enhance Emergency Department performance. • Rightsizing Theatre Capacity Programme: Continue with the implementation plan to optimize theatre usage.	**There is a risk that the target score will not be achieved although work is being undertaken to review the UEC implementation plans there is a significant degree of change needed to achieve the nationally expected performance standards. The Trust has developed an RTT improvement plan which is progressing but the shape of the Trust's patient wating list will see a significant level of demand in the second half of the**

Risk	Score	Rationale for proposed Q3 score including link to key risks	Key assurance received in Q2 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
		continues to be no significant reduction in patients who do not meet the criteria to reside, impacting overall capacity and flow. The stability of the risk score indicates ongoing challenges in balancing demand and capacity within our services.		• Length of Stay Improvement: Collaborate with SCFT and the Local Authority to reduce the number of patients who do not meet criteria to reside, improving overall capacity.	**year which presents a real challenge for the Trust**
6.1	16 (no change)	The proposed score represents the following achievements • Developing models for disaggregated CRF • Inclusion digital into RIDSG and committee • Completed appointment of div dir digital • Appointment to multiprofessional career development posts	1. Trust strategy refresh tracked via CSO and Exec 2. R&I programme reporting (ops and exec) 3. Inclusion digital into the R&I strategic steering group – development program *Gaps in assurance received in Q2* *Lack of future CRF on RSCH site* *Lack of plan for NMAP divisional leads* *Gap in digital development road map year 1-3 prior to EPR*	The key action is to determine the future location for CRF this in itself would reduce the risk to 15 Along with the development of standard reporting digital integration and compliance and the development of a dedicated risk register with respect to digital integration	It is expected that the target score of 12 will be achieved by 31 March 2025 (an updated timescale linked to the work on securing a location for the Clinical Research Facility)
6.2	20 (no change)	We have completed our digital maturity assessment and scores are currently being validated against	• Internal Audit review of Data Protection Security Toolkit	Based on our DMA and DSPT assessments, we will develop our priority improvement action	The target score is not expected to be achieved until the end

Risk	Score	Rationale for proposed Q3 score including link to key risks	Key assurance received in Q2 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
		other Trusts including Sussex system partners. Risk areas indicated include our infrastructure, workforce capacity and capability and using digital to empower patients. Information governance, sustainability and identity, and access management are considered stronger areas. We have also achieved 'standards met' against our Data Security Protection Toolkit.	• Digital Steering Group Chair's Report *There were no gaps in assurance for Q2 and the Q1 assurance gap of Digital Maturity Assessment was reported to RI&D Committee July 2025*	plan for 2024/2025. We also expect our EPR to go to the NHSE investment board and expect to progress to market testing. We anticipate business case approval for the reinstatement of our data centre.	of the year (31 March 25)

5 Conclusion

5.1 The BAF continues to record the receipt of assurances with a most prominent mix of management and executive assurance being provided, however there has been a number of externally provided assurance from Internal Audit, the Guardian Service, FFT results etc. There has been a small number of sources of expected assurance for quarter 2 which did not materialise, these are linked to Patient risk 1.1, Quality risks 4.1 and 4.2, RI&D risks 6.1, but the Executives did not feel this missing assurance was significant enough to not allow them to determine a quarter 3 score.

5.2 The respective Board Committees and the Executives will continue to oversee their allocated strategic (BAF) key risks aligned to their patient first domain.

5.3 There is an increased lack confidence that target score reductions will be achieved for a number of Strategic Risks, covering Quality, People, Culture and Performance risks and there remains the same degree of limited confidence that the financial sustainability strategy risk will achieve its 2024/25 target score reduction. Should the target risk scores for these risks not reduce this would see five of the 10 strategic risks remain scored at 20 to the year end, these covering People, Culture, Quality, Finance and Performance.

5.4 The Board needs to reflect on the current level of risk for the second half of the year.

6 Recommendations to the Board

6.1 The Board is asked to **NOTE** that the continued application of the Trust's BAF oversight processes applied by the Executives and the respective oversight Committees.

6.2 The Board is asked to **AGREE** the risk revision to the description for risk 6.1 which has been discussed and agreed by the respective oversight Committee, that being Research, Innovation and Digital Committee (*"We are unable to capitalise on research innovation and digital as drivers of transformational improvement at the Trust" to better reflect the drive for improvement.)*

6.3 The Board is asked to **AGREE** the minor risk description change for risk 6.2 again which has been discussed and agreed by the respective oversight Committee, that being Research, Innovation and Digital Committee *(add the word security within the risk description in respect of the potential impact is wider than operational and clinical performance)*

6.4 The Board is asked to **AGREE** the BAF scores for quarter 3 are reasonable based on the review undertaken by the respective Board Committees and the Board itself through the receipt and discussion of the Trust Integrated Performance Report.

6.5 The Board is asked to **DISCUSS** the reduced levels of confidence that despite the actions being taken that target risk scores can be achieved for risks 2.1, 3.1, 3.2, 4.1 and 5.2 and how this impacts on the Boards risk tolerance level and should those risk target scores be adjusted

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APPENDIX 1

BAF Summary

The table below overleaf shows by risk, their current score and their target risk score. The table shows pictorially the movement in risk between the current score for Q3 and Q2
(No change, ⟷ an increase in risk ↑ and ↓ a decrease in risk)

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	**Risk Scores**														
	2024/25 Q1			**2024/25 Q2**			**2024/25 Q3**			**2024/25 Q4**			**2024/25 Target**		
	I	**L**	**T**	**I**	**L**	**T**	**I**	**L**	**T**	**I**	**L**	**T**	**I**	**L**	**T**
1 Patient (*Oversight provided by the Patient & Quality Committee*)															
1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in overall poorer patient experience and potential for adverse reputational impact.	4	5	**20**	4	5	**20** ⟷	4	5	**20** ⟷				4	4	**16**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***								
2 Sustainability (*Oversight provided by the Finance and Performance Committee*)															
2.1 We fail to deliver the in-year financial plan; alongside the requirement to return to a breakeven run-rate by M12 2025/26 and secure medium-term sustainability	5	4	**20**	5	4	**20** ⟷	4	5	**20** ⟷				5	3	**15**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***						***At risk***		
3 People (*Oversight provided by the People and Culture Committee*)															
3.1 We are unable to recruit and retain a sufficient level of workforce if we do not have effective support for staff across the breadth of the NHS people promises (covering inclusion, health and safety, learning, recognition, teamwork, flexibility & staff voice) which adversely affects our capacity and capability to deliver services, continuous improvement and Patient First TNs.	4	3	**12**	4	3	**12** ⟷	4	4	**16** ↑				4	3	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***						***At risk***		
3.2 We will not achieve our strategic aims and realise the benefits of merger, including improving patient safety and recruiting and retaining talent unless we take action to; develop a clear strategy, invest in and prioritise focussed work on culture change from 'Board to Ward' including developing our leaders to be engaging, inclusive and empathetic, aligning sub-cultures and addressing cultural gaps and reducing cultural variation	5	4	**20**	5	4	**20** ⟷	5	4	**20** ⟷				5	3	**15**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***						***At risk***		

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4 Quality ***(Oversight provided by the Patient & Quality Committee)***														
4.1 We are unable to demonstrate compliance with regulatory and quality standards	5	4	**20**	5	4	**20** ↔	5	4	**20** ↔				4	4	**16**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***						**At risk**		
4.2 We are unable to deliver any safe and harm free care	5	4	**20**	5	4	**20** ↔	5	4	**20** ↔				5	4	**20**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***						**At target score**		
5 Systems and Partnerships ***(Oversight provided by the Finance and Performance Committee)***														
5.1 We fail to realise the benefits of merger and the strategic intention of 3Ts because we are unable to successfully develop and deliver plans to optimally configure our sites and services in a way that aligns with system partners and our ICS strategy.	5	3	**15**	5	3	**15** ↔	5	3	**15** ↔				5	2	**10**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***								
5.2 We are unable to deliver and demonstrate consistent compliance with the 24/25 operational plan and NHS constitutional standards resulting in an adverse impact on patient care and the Trust's reputation and financial position.	5	4	**20**	5	4	**20** ↔	5	4	**20** ↔				5	3	**15**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***						**At risk**		
6.Research and Innovation (Oversight provided by the Research, Innovation & Digital Committee)														
6.1 We are unable to capitalise on research innovation and digital as drivers of transformational improvement at the Trust. *(revised risk description from Q3 onwards)*	4	4	**16**	4	4	**16** ↔	4	4	**16** ↔				4	3	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***								
6.2 Our digital immaturity in our infrastructure, skill and technology threaten our security, operational and clinical performance and limit our ability to realise the benefits of digital transformation	5	4	**20**	5	4	**20** ↔	5	4	**20** ↔				5	3	**15**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***								

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Agenda Item:	13.	**Meeting:**	Trust Board in Public	**Meeting Date:**	7 November 2024
Report Title:	Perinatal				
Sponsoring Executive Director:	Maggie Davies, Chief Nurse				
Author(s):	Emma Chambers, Director of Midwifery				
Report previously considered by and date:	Quality Governance Steering Group – 16 September and 21 October 2024 Patient & Quality Committee – 24 September and 29 October 2024				

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

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

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

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

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

Regulatory / Statutory reporting requirement

Communication and Consultation:
All papers have been approved at divisional safety and quality forums

Executive Summary:

a) Perinatal Quality Surveillance report – August data.

Escalations for October meetings

- Midwifery and neonatal staffing levels are significantly affected by vacancy, maternity leave and sickness, impacting safety, service provision and staff wellbeing and morale.
- Solution not yet found for separate theatre access for planned caesareans on the Brighton site following successful pilot.
- Letter of Concern received 24 September 2024, following the RM inquest raising concerns about audit and compliance with handover of care and 'check out' processes at the end of shifts. A response is being prepared.
- Poor medical staff compliance with fetal monitoring and safeguarding training.

Celebrations for October meeting

- Further reduction in perinatal mortality rates in August.
- Smoking cessation impact (see below)
- All sites now achieve 'consultant present' ward rounds day and night (from September) – Ockenden action

b) CNST Maternity Incentive Scheme Year 6 – position paper – August data.

The scheme is on track to deliver – with 6/10 Safety Actions already business as usual.

Successes

- SA2 – provisional MSDS July data indicates the standard has been met

Escalations

- SA8 (training): obstetric trainees not being released from rotas to attend FM / skills drills training
- Large group of consultants who trained in Oct/Nov 2023, unwilling to attend earlier than Oct/Nov 2024 when out of date
- Impacts quality of MDT training across the year
- Results in last minute rush to achieve compliance
- Redeployment of specialist Midwives to support staffing challenges risks capacity to deliver improvement needed to meet MIS.

c) Joint ATAIN - Q1 2024/25

Themes at RSCH/PRH

- Inconsistencies of documentation in labour and postnatally
- Staffing constraints within the neonatal workforce at PRH and increased workload
- 2 missed cleft palate, not identified at USS

Themes at SRH/WH

- Staffing constraints potentially impacted on the length of time babies remained on SCBU (especially at SRH).
- Documentation within several areas, Maternity BadgerNet, written documentation and Evolve. Inconsistencies of documentation depending on the initial location of paediatric review leading to SCBU admission. The review team sometimes struggle to obtain all the information required

Recommendations

- Improve Neonatal staffing at PRH.
- A QI project is planned to address the number of babies being admitted due to hypoglycaemia.
- Review of documentation practices to ensure contemporaneous records are available.
- Align review processes across all four sites to ensure consistency of measurable data.
- Joint risk to be raised with CSS regarding missed clefts.

Joint Transitional Care – Q1

Themes

- Treatment with IV antibiotics was the main course of treatment across site.
- Daily neonatal reviews need to be documented in Maternal BadgerNet under the Baby postnatal record; however, it was found the location of documentation varied. This continues from last quarter.
- Delay in neonatal team reviews being performed/documented on BadgerNet due to staffing constraints or increased workload pressures on the unit.
- Several babies are admitted to NNU for short periods of observation, before being transferred back to the postnatal ward.

- Babies not being formally reviewed when it was identified that they required phototherapy.
- Poorer completion of neonatal observations at SRH and WH.
- Challenging to conduct daily ward round of TC babies at PRH.

Recommendations

- Implementation of Postnatal Theme of the Month. This will be like the new Maternity theme of the week, but focus on issues on the Postnatal ward, and will be discussed at safety huddles each day throughout the month to ensure all staff are aware. The first two themes will be around escalating concerns and the use of SBAR handovers for babies transferring between wards.
- Review and align neonatal guidance across all four hospital sites.
- Review and increase paediatric staffing capacity at PRH.
- In person paediatric review required when baby identified as requiring phototherapy.

d) Saving Babies Lives Q1 24/25

- UHSussex is now 100% compliant with the implementation tool for SBLCBv3.

Key Challenges

- There are some issues around job planning for obstetricians which makes engagement challenging and these are being addressed by the Trust.
- Scanning capacity at two of the sites remains a challenge to implementing the care bundle fully.
- Element 2: UHSussex will be able to offer more scanning pathways, however this will only cover an additional 3 risk factors to start.
- Element 4: QI work needs to focus next on a trust wide fetal monitoring guideline to ensure consistency across the 4 sites.
- Element 5: PREM7+ continues to be embedded on all four sites.
    - There are challenges relating to optimal timing of interventions due to the availability of fetal fibronectin devices.
    - Bedside resuscitation is also proving difficult due to the number of variables involved in such a huge QI project across the entire perinatal team.

Key Recommendation(s):

The Board is asked to **NOTE** these reports.

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Agenda Item:	14.	**Meeting:**	Trust Board in Public	**Meeting Date:**	7 November 2024
Report Title:	Research, Innovation and Digital Committee Chair Report to Board				
Sponsoring Non-Executive:	Jackie Cassell, Non-Executive and Committee Chair				
Author(s):	Jackie Cassell, Non-Executive and Committee Chair				
Report previously considered by:					

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

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

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	N/A	
Sustainability	N/A	
People	N/A	
Quality	N/A	
Systems and Partnerships	N/A	
Research and Innovation	Yes	Links to risk 6.1

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Research, Innovation and Digital Committee met on the 30 October and was quorate, as it was attended by two Non-Executive Directors including the Chair and at least two executives, the Chief Medical Officer was in attendance and the Chief Executive with the Chief People Officer attended in place of the Chief Strategy Officer.
In attendance at the meeting were also the Chief Information Officer, the Clinical Research Director, the Director of Operations Research and Innovation, the Managing Director of Planned Care and Cancer, the Director of Integrated Education and the Company Secretary. The Chief Strategy Officer, Commercial Director and Associate Commercial Director and the Deputy Chief Nurse (workforce & professional standards) gave apologies

The Committee **received** and **NOTED** its scheduled reports that included:

- **Research and Innovation Digital Steering Group Chair's report** The Committee received the report that introduced the areas discussed in detail at this meeting and had been aligned to areas of risk on the Board Assurance Framework (BAF) with a deep dive into workstreams, their challenges and decisions. Of particular importance were the need for a sustainable Clinical Research Facility, risks from a lack of Research Innovation in Clinical Job Plans and lack of a Joint UHSussex & ICB Research Strategy
  The committee received an update on the incomplete Research Methodologist recruitment that had led to review of the approach toward a more widely sourced model to maximise the breadth of expertise available.

The Committee welcomed the news of the successful Health Research Partners Conference in October with many attendees and external speakers and the reported enthusiasm for Health Innovation Networks. The Committee received the update around work towards launch of the NHS Sussex Health Research strategy to be followed by a system -wide delivery plan. The Committee **NOTED** the Trust's involvement in the research partnership and closely aligned with the system's ambition and a paper would be **BROUGHT BACK** to the next meeting.

- **Research Activity Report and dashboard**. The Committee **received** updates against the developed KPIs since the last meeting and discussed the work on measuring research maturity at a divisional and service level. The summary scorecard covered 28 areas linked to patient participation; efficiency and effectiveness; staff involvement and innovation. The Committee **NOTED** that the arrangements now align to pursuit of our strategic aims with the emphasis on commercial and interventional research because they bring new treatments to our patients earlier. These are now reflected in appropriate KPIs reflecting the Trust's developing portfolio and ambitions. The closure of the large low intensity study meant the Trust was as anticipated behind its breakthrough objective on patient recruitment but the Committee was **ASSURED** the Trust will achieve NIHR requirements with no adverse financial impact, and notes the revised focus on interventional and commercial studies. The Committee **NOTED** that digital maturity and in particular EPR will in due course aid identification of eligible patients for recruitment where there are currently barriers. The Committee heard about growth in the associate PI team that enables early pre-researchers to be supported by investigators and the benefits of Division lead roles delivering a significant increase in research time in job plans.

- **Research & Innovation Workstream Updates**
  The Committee **NOTED** the Report and the progression with the Strategy launch and embedding the workstreams working with Division Leads. The next area of focus is on securing engagement with the non medical workforce. The Committee had a good discussion about the significance of the South East's Clinical Trials Unit currently hosted by the Medical School and the opportunities this affords the Trust to drive its growth. The Committee received **ASSURANCE** that embedding research working with Divisional Directors was now part of normal business and heard how this was further supported through the developing workstream towards a training hub for the professional workstream and a wide range of awards and fellowships announced.

  The Communication Workstream had worked with the research engagement network with considerable success reaching underrepresented communities thanks to support from MyUHSussex Charity. The Committee was also **ASSURED** by work taking place to improve the diversity of research applications and fellowships. A noted challenge for applicants from the Trust's international staff had been examples of aspiring grant applicants but who lacked some contextual background and there was work to boost this with support workshops and further outreach. The Committee look forward to updates on this. There had been more limited progress in the innovations area and there was a lag in reporting in the absence of the Commercial lead and a resilience limitation was acknowledged. The contributions that Memoranda of Understandings currently in development can make to information sharing as an enabler for innovation was also recognised.

- **Digital Security & Protection Toolkit Update**
  The Trust is currently rated at Standards Met rating from the DPST submission in June. The Committee **NOTED** the arrangements for the new toolkit assessment in 2024/25 which requires a baseline assessment to take place in December 2024, earlier than the current arrangement and a more graded assessment is anticipated than the current ratings. The Chief Information Officer advised that there would be a requirement for clear assignment of owners accountable for outcomes. The Committee **NOTED** uncertainty how the Trust may fare under the new arrangements and governance arrangements were currently being established. An update would be **BROUGHT BACK** to the next meeting of the Committee with Actions listed with owners and any newly identified risks to reflected in Trust strategy. The Committee noted the limited capacity of the information governance team and the risk that the arrangements could require their resources to be diverted away from operational support.

- **Digital And Data Governance**
  The Committee reviewed and **NOTED** the updated outline of digital governance arrangements including the Digital Transformation Steering Group.

- **Electronic Patient Record (EPR) Programme and Projects Reports**
  The Committee heard the UHSussex EPR was going through the Pre-Market engagement stage and prospective suppliers had expressed interest with the EPR expected to be introduced in 2027. The Committee **NOTED** that further delay at national level had implications for the capital funding profile and acknowledged there could be clinical implications of delay in respect of decisions for existing system replacements. Work in the meantime to align local arrangements had been welcomed and would help to mitigate complexity. The Committee also **NOTED** and welcomed the work through the Data Quality Group to optimise in the meantime the quality of data to brought into the EPR and to improve the reporting accuracy. The work of these and other governance arrangements through the Technical Design Authority and Change Advisory Board would mean at the invitation to tender stage we will be certain of needs and can drive down costs with greater clarity on benefits.

  The Committee **NOTED** considerable stakeholder meetings contributing to the Trust's requirements and work underway to recruit evaluators. The Chief Information Officer reiterated the earlier process through which the Trust had arrived at the decision to procure a modular EPR. The Committee **NOTED** commitments sought from the Trust to be open to converging with other Trusts embarking on a similar EPR procurement and also **NOTED** that the Trusts consultancy support for EPR had been tested for value for money and extended.

- **Digital Transformation Update**
  The Committee **NOTED** the process the proposed approach taken by the Chief Information Officer (CIO) with Divisions to assessing proposals and to resource projects those which take priority. The Committee **NOTED** feedback from my last referral to the People Committee that arrangements for Chief Nursing Information Officer (CNIO) input had been reviewed but considered a matter for the Executive.

  The Committee **NOTED** change demand is significant. The Committee received an update on the arrangements through which project support is prioritised and in conjunction with change control processes there had been consideration of confirming an internal service level agreement to be addressed at the Trust Management Committee. The Committee welcomed visibility of these pressures that could compromise the Trust's digital ambitions and **NOTED** plans to mitigate them.

- **Development of Digital & Data Strategy 2025-30**
  The Committee had **NOTED** the Trust's digital maturity assessment as scores had not been released. It welcomed the current thinking around developing the Trust's Digital and Data Strategy with strong alignment to wider Trust strategy with the aim to evolve what the workplan will look like over the next 3-5 years. The Committee welcomed the paper setting out the five themes for strategic programmes grouped under: digitising heath records, enhancing experience through digital; integrating care; One Digital; and Data informed. The committee welcomed how ambitions in these areas had been articulated with areas of action and similarly for their foundational enablers. Following the next stage to map the work over the next 3-5 years, the Strategy will be **BROUGHT BACK** to the next meeting of the Committee for sign off.

  The Committee heard how the Chief Information Officer had been engaging staff and partners with this vision giving a strategic direction others can refer to. It was acknowledged that sustained engagement takes time and that the developments would impact not only IT but represent deep cultural change and so the Committee welcomed description of the communication support sought. There had been work with Division Chiefs by the Chief Clinical Information Officer to support discussions on the major themes and also the capacity challenges and enabling people to engage with it. The Committee was **ASSURED** by updates confirming the strategy vision had been shared with the broader Sussex community.

  The Committee **NOTED** that the Clinical Research Facility has allocated funding in the capital budget, and while there is currently a process under way to identify the appropriate site and scale of the facility aligned

to other developments, this is not yet resolved. A sustainable Facility is required to underpin Trust's research ambitions, and the Committee acknowledged the frustration that this is not resolved. This will need to be sequenced in coming years in line with the Trust strategy and the Trust's Single Improvement plan. The Committee was also **ASSURED** by the thoughtful ongoing consideration of suitable benchmarking opportunities with peer Trusts with similar circumstances to understand how common challenges might be overcome

The Committee reviewed the BAF risks for which it has oversight. It **AGREED**, that having regard to both the BAF summary, the Research and Innovation Strategy Delivery risks and the reports considered during the meeting, that the strategic risk score did not change by the end of quarter 2 2024/25. The BAF risk 6.1 is maintained at a score of 16 and that this risk remains fairly stated for quarter 2 2024/25 with confidence that the risk will reach its target risk score by April. The Committee **NOTED** more clarity is needed around the Clinical Research Facility and this remains on the Committee's agenda. The Committee **AGREED** the proposed risk wording changes that are presented to the Board.

BAF risk 6.2 refers to the Digital Maturity assessment and reflects considerable work to do but proposes no reduction to that score (scoring 20). The DSPT assessment has been **NOTED** to bring some element of uncertainty.

The Committee discussed whether there are research related risks not captured risks on the risk register, specifically around how the Data Centre Reinstatement is progressing with extended discussions with the Trust's connectivity provider. Proposals would be brought to the Business Case Scrutiny Panel and the Committee heard this was close to sign off and should give a stronger and more resilience network across the trust/

Key Recommendation(s):

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

The Board is asked to **NOTE** the Committee recommendation that the BAF risk 6.1 is maintained at a score of 16 and that this risk remains fairly stated for quarter 3 2024/25. There are a number of changes around the detail of the risk.

6.2 referred to the Digital Maturity assessment and reflect a considerable way to go and propose no reduction to that score (scoring 20)

Actions taken by the Committee within its Terms of Reference

The Committee received its expected reports and the assurance these reports provided as summarised above.

Items to come back to Committee / Group (Items Committee / Group keeping an eye on)

- While a routine item for the agenda, the Data Security & Protection Toolkit will be brought back in light of the new assessment format it is anticipated that an Action plan with clear ownership for outcomes and any risks with strategy implications.
- Digital developments and their impacts that can be achieved prior to the establishment of a full EPR

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

Item	Who / when
The Committee agreed to recommend to the Board that the BAF risk score of 16 for Quarter 2 for the Research and Innovation Strategic Risk 6.1 remains fairly stated and the BAF risk score of for the Digital Strategic Risk 6.2 remains fairly stated at 20.	Board November 2024

NHS
University Hospitals Sussex
NHS Foundation Trust

RESEARCH AND INNOVATION COMMITTEE CHAIR'S HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**30 October 2024**	**Chair**	Jackie Cassell	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting			
Research and Innovation Strategy Delivery			
Research & Innovation Strategy Steering Group: Chair's Report	**Presenter** Chief Medical Officer/ Clinical Research Director	**Purpose** To note	**Outcome /Action taken** Noted. .
Research Activity To include - Research Activity Report SDR Scorecard	**Presenter** Chief Medical Officer/ Clinical Research Director	**Purpose** To note	**Outcome /Action taken** Noted updated dashboard of KPIs.
Research & Innovation Workstream Updates	**Presenter** Chief Medical Officer/ Clinical Research Director	**Purpose** To note	**Outcome /Action taken** Noted.
Brighton & Sussex Health Research Partnership HRP Sussex Health & Care Research Strategy	**Presenter** Chief Medical Officer / Clinical Research Director	**Purpose** To note	**Outcome /Action taken** Noted
Innovation update	**Presenter** Clinical Research Director for Commercial lead (away	**Purpose** To Note	**Outcome /Action taken** Noted Resilience gap acknowledged
Digital			
Digital Steering Group Chair's Report	**Presenter** Chief Information Officer	**Purpose** For information and assurance	**Outcome /Action taken** Noted. Research and Digital steering groups,
Digital and Data Governance Overview	**Presenter** Chief Information Officer	**Purpose** For information	**Outcome /Action taken** Noted
Digital Maturity Assessment	**Presenter** Chief Information Officer	**Purpose** For information	**Outcome /Action taken** No DMA score update available. Noted Development of Digital & Data Strategy 2025-30. Strategy to return for Approval- Jan'25
Digital Security & Protection Toolkit Update	**Presenter** Chief Information Officer	**Purpose** For assurance	**Outcome /Action taken** Noted
Digital Transformation Updates	**Presenter** Chief Information Officer	**Purpose** For information	**Outcome /Action taken** Noted
Electronic Patient Record (EPR) Programme and Projects Reports	**Presenter** Chief Information Officer	**Purpose** For information	**Outcome /Action taken** Noted
Risk			
R&I D Extract of Board Assurance Framework for Quarter 3	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** The Committee noted there were no changes to the R&I or Digital Strategic Risks scores during quarter 2. Updates to Research Risk articulation was noted

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	15.	**Meeting:**	Trust Board in Public	**Meeting Date:**	07 November 2024
Report Title:	Patient & Quality Committee Chair report to Board				
Sponsoring Executive Director:	Lucy Bloem, Committee Non-Executive Chair				
Author(s):	Lucy Bloem, Committee Non-Executive Chair				
Report previously considered by:					

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

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

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

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

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Patient & Quality Committee meets monthly and therefore this report covers three meetings in August, September and October 2024. The meetings were quorate, attended by at least two Non-Executive Directors and two executives. In attendance at the meetings were the Chief Nurse and/or Chief Medical Officer, the Deputy Chief Nurse for Quality and the Director of Patient Experience, and the Director of Clinical Outcomes & Effectiveness. The Chief Medical Officer and the Trust's Director of Patient Safety and Learning gave apologies to the October meeting and were represented by deputies. In addition, other key personnel attended the meeting as appropriate to present specific papers including Infection Prevention and Control, Safeguarding, Pharmacy and End of Life Care.

During the quarter the Committee received its planned items including reports on medicines management, end of life care the quality scorecard, Organ Donation, the perinatal quality surveillance dashboards, Patient Safety and Duty of Candour reports as well as the Patient Experience assurance report. The delayed Quarter 1 2024/25 and Annual reports 2023/24 for Safeguarding and for Infection Prevention and Control came to the Committee in August 2024 and the committee received monthly updates on priority matters at each meeting. The Committee also received quality assurance reports, and reports from the Committee's reporting group: Quality Governance Steering Group (QGSG) as well as the reports on the respective Patient First Trust Norths and Breakthrough Objectives.

Harm Reviews

Despite progress made in many Divisions with Harm reviews, there had been a gap in assurance and the Committee had asked to understand the trajectory and standard procedures to bringing these arrangements to a sustainable part of normal business. The Committee welcomed the work led by the Deputy Chief Medical Officer that had a focus on ensuring learning focussed process. Committee **NOTED** and welcomed the update as gaining this understanding had been a concern and the plan of actions to progress this area. Specifically, the committee noted the themes that in P1 pathways referred to delays to surgery being reported where the main challenges had been around theatre capacity at the Royal Sussex County Hospital and on P2 pathways there had been challenges on a number of sites. The Committee **NOTED** improved performance by the Specialist division. The Committee **NOTED** work with the Cancer Division to define the process for their harm reviews to conclude in November. There is an **ACTION TO COME BACK** on progress against those delivery updates by December 2024.

Patient Experience

The Q2 Patient Experience Report was received. The Committee **NOTED** that based on available Friends and Family Test (FFT) data, 89% of patients responding in Q2 were satisfied that they have a good or very good experience, which was comparable to Q1 and 2023/24 however there is a continued downward trend in patient experience particularly associated with EDs and inpatients related to waiting and especially inpatient experience accessed through A&E at the Royal Sussex County Hospital. Linked to risks noted by the Committee around staffing pressures in Maternity in the Summer, this was apparent in slightly less positive friends and family feedback in Q2. The Committee **NOTED** a continued increase in the complaints trajectory and in concerns being raised via PALS. While re-directed resource have enabled improved rate of closing complaints (more closed than received), there remains a challenge that timely complaint responses did not adhere to Trust policy and complaints being outstanding for more than 60 days and beyond this greater than 6 months and there is a focus on this. However, the committee were assured on the quality of responses as the Health Service Ombudsman continues to uphold a very low rate (less than 1%) of the escalations they receive. The Committee heard about positive continuation on Welcome Standards and the patient engagement with surgery on the colorectal changes.

The Committee discussed an area of development around communication skills and linking recurrent complaint themes in this area to Medical Leadership and appraisals. The Committee also heard that there are discussions to visiting arrangements being considered in response to patient feedback but may take time to resolve challenges with clinical arrangements.

The Committee **NOTED** the Inpatient Survey report for 2023 from both our survey provider and the national findings. The Trust's ranking nationally had dropped from last year that suggested other Trusts had improved more rapidly than us but the Trust was not an outlier and scored similarly to other Trusts. The Committee **NOTED** the areas where performance was worse, in waiting times, including for a bed, length of stay, and discharge planning including family involvement triangulated with other information received by the Committee.

Patient Safety: The committee **NOTED** incident reporting per 1000 bed days had been below the national average. Falls, pressure damage, medication errors and staffing are the most prevalent of the low harm incidents. The Q1 report in October updated on Patient Safety Incident Reporting Framework activity (PSIRF) the Trust had fully transitioned from the old framework with only one legacy Serious Incident remaining open while 11 Patient Safety Incident Investigations had been raised.

The Committee **NOTED** the PSIRG group had good division representation and medical leadership input and as well as patient experience and learning from deaths representation to allow triangulation. There had been one Never Event in the reporting Quarter (Q1). The Committee **NOTED** the change to harm gradings now includes psychological harms. The Committee heard how learning themes are selected for their potential relevance of learning applicability across the Trust and welcomed news that learning summaries are being accessed by staff. Further, RLDatixIQ now captures and disseminates learning from good care.

The Q1 Duty of Candour (DoC) Report was received, and the Committee was assured by detailed compliance monitoring with the 3 elements of the candour processes. While the Trust has very high compliance for the first 2 elements but significantly lower compliance on the final element; to investigations and discussion of reports with family. We **NOTED** that growing delays across the Trust in completing reports with competing pressures may impact this and a theme of such challenges with the Divisions struggling to achieve other quality metrics. The Trust audits DoC adherence to an extraordinary degree reflecting the importance of this communication. There has been good engagement from medical staff with the PSIRF training and we heard about the newly launched e-learning for Duty of Candour and video co-produced with patient safety partners.

While we are assured the quality and safety learning infrastructure is working cohesively, but have an **ACTION** for a future item to come back to evidence for assurance how the learnings are monitored across the safety domains (Safety, Mortality & Morbidity, SJR, complaints, friends and family feedback etc.)
The committee also received a report on Inquests and prevention of future death (PDF) notices and how the learning is fed back into Divisions. The Committee also **NOTED** the impact of the continuing significant increase in the number of inquests, particularly those with a national profile, were having on staff and providers of the support being given.

Quality Assurance: The Director of Clinical Effectiveness supplied a Quality Assurance report that indicated the current status of NICE guideline reviews, Technology Appraisals, National audits participation and assurance on changed practice and quality improvement for patients, NCEPOD, Clinical guidelines GIRFT review and action plans, CQUIN delivery, Mortality reporting / Learning from Deaths; and Health Inequalities.

The committee **NOTED** that reviews of 100% of Technical Appraisals had been completed and the target of having 75% of NICE guidance reviewed and compliance assessed had been met however NICE guidelines are still outstanding for review and that lessons learnt from the process are being implemented to simplify the process.

The Committee **NOTED** the update on the arrangements for the Trust's Palliative and end of life care aligned with the Structured Judgment Reviews and progress made against the Structured Judgement Review (SJR) backlog reducing this over 600 in August to 54 by October a triage review of the cases to expediate the process and had triaged the outstanding cases month on month by the end of September and set performance of new cases to negate any future backlog emerging. The Committee credited this significant improvement. The Committee NOTED the plan to focus on next actions to better understand how deaths can be prevented with the mortality surveillance group and the experience of patients which links to end of life care. The Committee also **NOTED** the Resuscitation Group work in Q2 2024/25 was received through the report of QGSG in October 2024.

The Committee review the dashboard metrics for mortality and **NOTED** that the SHMI and HSMR had reduced in recent months but without a clear explanation for the reason.

The Clinical Outcomes and Effectiveness Scorecard development had been delayed. The Committee **NOTED** that this performance reporting gap through the Power BI capacity issue had been appropriately escalated by QGSG.

The Committee looks forward to an improved base-line with progress against a new challenging requirement of a Medical Devices Outcome registry involving any implantable device to report on national databases and this challenge will be added to risk register. The Committee heard plans are being developed and assurance will come through the divisions. There is recognised to be an ongoing theme in relation to medical devices management and the Committee continue to seek understanding of the risk in this area.

In respect of Getting it Right First Time (GIRFT) the Trust had been subject to considerable inspection and work to support that programme with steering groups and booklets to support those visits. The Committee **NOTED** the expectation improvement at pace, especially around 65 week waits. The Committee heard about fortnightly meetings on progress and monthly oversight of the 'further faster' (top 5) actions overlaid with SIP and CQC actions. The Committee looks forward to the update to Committee in December on the proposed governance for GIRFT and how other areas within GIRFT are being undertaken.

Medicines Management

The committee received a comprehensive Pharmacy and Medicines Governance Q2 2024/25 Report which identified risks, and progress with addressing previously identified gaps in compliance and assurance. The Committee **NOTED** that audits on medicine security and Controlled Drugs audits had been embedded in tendable ward level tool. Staffing pressures had been a particular challenge, and the Committee welcomed the good progress on recruitment and retention activities within the team.

Organ Donation Annual Report

Very positive progress had been **NOTED** in the report on activity up to the end of March 2024. The Committee NOTED positive reporting on the quality of donor care in Trust departments. Specialist Nurse presence has been an important improvement helped by the layout in the Louisa Martindale building. The Committee acknowledged the issue of obtaining theatre time remained significant but heard that good progress had been made. The Board are invited to receive the spotlight on Organ Donation for information.

Safeguarding

In August, the Committee received the Annual Safeguarding reports for 2023/24 (subsequently approved by Board) with Q1 2024/25 and the Q2 report in October. The Committee **NOTED** the focus on specialised Level 3 training and work taking place with Divisions to broaden uptake of this training as well to meet the 90% compliance target to reach 85% by end of November. The Committee heard how meetings are taking place with Local Authority leads and other system partners. Continue to see high emergency department attendances and ongoing discussions with NHS partners acknowledging unprecedented mental health demand. The Committee **NOTED** the increased 12h+ and 48h+ waits on our scorecard no longer showing sustained improvement on admission avoidance.

The Committee **NOTED** this is reflected on the associated risk on the Board Assurance Framework and while we **NOTED** there is good NHS partner working that had not been in place 12+ months ago, I highlight to the Board the significance of ongoing risk sharing discussions and persisting issue of vulnerable patients in a non-therapeutic space.

The Committee welcomed the maternity service development in the area of mental health. There is an **ACTION** for Safeguarding team to update and standardise their read-across associated risks in Divisions.

Care Quality Commission (CQC) action plans

The Committee reviewed the outstanding actions from previous CQC reports and further discussed the approach to the appropriate status recording. Oversight given to this area was **NOTED** and the evolution of monitoring through the revised arrangements of the Single Improvement Programme (SIP) Committee which report to the Board. The Committee **NOTED** the Trust received 28 MUST do and 11 SHOULD do actions in 2023 which have been assigned to both corporate and divisional leads. The Committee received the report compliance status for the purpose of ongoing assurance. It should be noted that there remained an action from 2021/22 for a policy on cancellation of rebooking of surgery patients.

The Committee **NOTED** the work had made progress but there were 11 overdue actions and a diagnostic taking place for areas of concern to achieve closure by April 2025, namely Medicines Management, Management of Equipment and Theatres Ventilation. The Committee **NOTED** the move to more focussed work through using working groups of the CQC steering group and the need to use the existing management groups to accelerate progress. The Committee was **ASSURED** that the steering group had been very well attended by Divisions. The Committee were updated on the outline plans to address the risks and challenges relating to CQC actions and will receive a formal update in November.
The committed noted the considerable progress made in the Fundamental Standards of Care audits that has been made in this quarter relating to a CQC action and support being given to areas lagging behind high performing areas.

Infection Prevention and Control (IPC) Quarterly Report

At the October meeting, the Committee received the Q1 IPC report. The Committee noted the Trust had remained above trajectory for eColi, Klebsiella and MRSA, however, benchmarking hospitals per 100,000 bed days the Trust compared favourably to the national average and local comparators and there are significant national rises in eColi and CDifficilie. The annual IPC report 2023/24 has since been approved by the Board.

The Committee was concerned about inconsistency in hand hygiene data between IPC observed scores and division reporting meaning assurance cannot be taken and needs to be addressed. Ventilation remains a concern and significant work in a multi-year programme is required which is why QPC made a **REFERRAL** to the Finance & Performance Committee in August to take into consideration the level of quality risks relating to ventilation systems when reviewing the Capital Programme and the agility of the capital programme to respond to these risks. Issues had meant some theatres had been unable to be used as intended so patient waits were not optimally reduced.

The Committee heard about the new 5-year National Antimicrobial strategy and **NOTED** the significance of risks of antimicrobial resistant organisms, illustrated by a local case in which the efforts of Cleaning and facilities staff were praised. Will look at what others are doing.

There is an **ACTION TO COME BACK** for issues relating to ventilation and water and for the Estates and Facilities Director to update on management actions in relation to the internal audit relating to Medical Devices which remains an outstanding action.

Perinatal

At each meeting the Committee **RECEIVED** reports in respect of the Trust's Perinatal Quality Surveillance Reports & Dashboards for all four of its maternity units, which included the Ockenden data sets within the current dashboards and this has continued to show the perinatal mortality rate sustained below the national average.

The Committee **NOTED** peri-natal mortality and brain injury rates remain below both regional and national rates. The Committee **NOTED** the contents of the reports and **APPROVED** the latest scorecards that are provided to the Board.

The Committee considered each of the dashboards across each of the domains of; learning from incidents; training; and the voice of the service user. The Committee **NOTED** it had been a challenging period operationally and that there had been clear triangulation with staff engagement and feedback. The Clinical Operating Model for the Division had been confirmed to have been funded and positions were out to advert Through receipt of reports the Committee was **ASSURED** that the Maternity Directorate continue to report Maternity and Neonatal data and engage with Maternity and Neonatal Safety Investigation team (MNSI) as required. The Committee **RECEIVED** investigation reports within the meeting pack and welcomed their inclusion as well as confirmation of full compliance with the saving babies lives care bundle.
Summer shortages in midwifery and Neonatal teams through vacancies, sickness or other leave were **NOTED**. The Division reported some gaps in shifts continued and the challenge of staff flexible working to maintaining arrangements at night. The Committee **NOTED** the Trust had received a letter of concern from NMSI on handover response and that the MNSI had been satisfied by the Trust's response.

The Committee also received the Q1 report on Avoiding term admission (ATAIN) rates which were met for Worthing and St Richards but not for RSCH and PRH and it was noted that a key factor had been estate issues impacting ability to provide transitional care on site with a primary reason for admissions to specialist care being hypoglycaemia for which there was a particular work programme in progress.
The Committee **NOTED** the list of actions to be undertaken toward compliance with an **ACTION** to come back a plan for items that will give assurance at the November meeting.

The Committee received updates on progress towards the Trust's year 6 CNST Maternity Incentive Scheme submission. Challenged staffing had given rise to challenges in training compliance, mitigated by close tracking of individuals training compliance and heard that internal audit will scrutinise evidence for sign off. The Committee received an update on the Maternity Safety Support Programme and while this has been valued support, there is a set of agreed actions for exiting the programme and the committee will **BRING BACK** an item for further discussion of the plan for doing so including theatre capacity.

Risks and Board Assurance Framework (BAF)

The Committee reviewed the Trust's key risks with the potential to impact on quality and noted those with the highest current score and their alignment to the areas that the Committee had continued to scrutinise for assurance. The Committee recognised risks scored at 25 reflected the general harm and unacceptable patient experience from prolonged crowding in emergency departments even though mitigations had meant there was not an identifiable harm coming to an individual as well as the risks to patients with mental health needs not receiving appropriate care in the Acute Hospital care setting.

In relation to risk 1.1, the Committee heard that we are unable to deliver or demonstrate a continuous and sustained improvement in patient experience, in particular due to the challenging situation arising from

crowding in the Emergency Departments and waits for treatment resulting in adverse reputational impact, and poorer patient experience. The Quarter 2 score remains at 20 as it had remained through 2023/24. There is still belief this could reach the agreed target but this was contingent on improved emergency care performance and patient experience.

The Committee had a discussion on the BAF and the respective risks it has assigned oversight, these being risks 4.1 and 4.2. The Committee reflected on the information received during the meetings in respect of these risks along with the update provided post the review by the Audit Committee. The Committee supported the continuation of both 4.1 Unable to deliver any safe and harm free care and 4.2 at 20 unable to demonstrate compliance with any regulatory and quality standards which is supported by the gaps in compliance noted in my report and updates on incident themes, harm free waiting times.
The work improving the steering group on 4.2 for oversight was **NOTED**.

The Committee also recommended that 4.1 remains at 20. The Committee **NOTED** the executives reduced confidence that the risk score could reach the 16 target by year end in light of the number of actions required. The Committee **AGREED** with the assessment this appears extremely challenging and noted the risks that underpin this, in associated people and referral to treatment performance BAF risks.
The committee noted the routine ventilation and water safety group did not report in time but do seek to report in Q3 that may be late.

The quality risk wording was noted to have been updated for 2024/25 that differentiates risks around meeting Standards from those risks around the delivery of harm free care.

Quality Governance Steering Group (QGSG) and Quality Scorecard

We have been evolving the meeting format in the quarter and reflecting confidence in the flow through the QGSG meeting, a change to the meeting order at the October meeting secured more time for direct evidence from Corporate Directors.

The reports from QGSG included divisional summaries, as well as safety and quality domain summaries plus updates against the CQC action plans. The committee **NOTED** improved monitoring of missed observations though the fundamental standards of care workstream and recognised the cohesive working between the Trust's two surgical Divisions teams to advance the work required for CQC action progress. Both the Women & Children and CSS Divisions presented directly to QPC on their Quality Compliance and challenges which has further strengthened the Board to Ward link. This has proven valuable in triangulating information from the Quality reports and understanding the particular divisional challenges.

Risks

Reflecting on the Risk Register update and division reports to the QGSG the Committee **NOTED** the top risk themes had not changed. The Committee **NOTED** that these themes particularly include Workforce, access to theatres and IT systems and recognise the importance that these risks must not become normalised.
The Committee **NOTED** these risk themes had been well triangulated in discussions covered in the Committee meeting and efforts with the associated risks in RTT and Mental Health and these are reflected in the Board Assurance Framework.

Referrals to other Committees

At the August meeting, the Patient & Quality Committee requested that the Finance & Performance Committee takes into consideration the level of quality risks relating to ventilation systems when next presented with the Capital Programme and whether sufficient funds had been made available to mitigate the risks.

At the September meeting I noted the prevalence of a lack of integrated data systems in divisional risk reporting in risks to service provision, patient safety and patient experience. The Committee requested that the Research, Innovation and Digital Committee considered how these concerns would be managed in relation to the prioritisation of system planning.
Key Recommendation(s):
The Board is asked to **NOTE** the assurances received at the Committee and the actions taken of the Committee within its terms of reference. The Board is asked to **NOTE**: - The Committee's recommendation in respect of BAF risks 1.1, 4.1 and 4.2 for which it has oversight, that the scores for the end of quarter 2 are fairly represented. The Board is also invited to **NOTE** the following item has been received and is commended to the Board: - Organ Donation Annual Report 2023/24

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**27 August 2024**	**Chair**	Lucy Bloem	**Quorate**	Yes
Meeting Date	**24 September 2024**	**Chair**	Lucy Bloem	**Quorate**	Yes
Meeting Date	**29 October 2024**	**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	**Aug**	**Sep**	**Oct**	**Presenter** Chief Medical Officer/ Dep. Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted.
Quality Dashboard (excluding Maternity) Safety, Effectiveness, Experience, Mortality	**Aug**	**Sep**	**Oct**	**Presenter** Chief Medical Officer/ Deputy Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted.
Patient Experience Report Assurance Report Q2 Quarterly Report- Oct 2024			**Oct**	**Presenter** Director Patient Experience & Engagement	**Purpose** For information	**Outcome /Action taken** Noted
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Position Paper	**Aug**	**Sep**	**Oct**	**Presenter** CNO/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Safe, Effective, Caring, Well Led and Responsive						
Patient Safety Assurance Report - Harm free care Report Counter Measure Summary - Harm Reduction Report - Inquest Monthly Report			**Oct**	**Presenter** Chief Nurse / Deputy Director Patient Safety & Learning	**Purpose** For information	**Outcome /Action taken** Noted

Infection Prevention & Control Assurance Report Annual Report 2023/24 Report Aug24 Updates Q1 Oct 2024	**Aug**	**Sep**	**Oct**	**Presenter** Director Infection, Prevention & Control	**Purpose** For assurance	**Outcome /Action taken** Noted. Annual Report to Board
CQC Update / Action Plans	**Aug**	**Sep**	**Oct**	**Presenter** Chief Nurse / Director Patient Safety & Learning	**Purpose** For information	**Outcome /Action taken** Noted
Safeguarding Adults and Children 2023/24 Annual Report and Q1 Report -Aug24 Quarter 2 2024/25 Update Reports -Oct 24	**Aug**		**Oct**	**Presenter** Chief Nurse/ Deputy Chief Nurse	**Purpose** For assurance	**Outcome /Action taken** Noted. Annual Report to Board
Divisional Spotlights: Clinical Support Services (Aug) Women, Children & Young People (Sept 24)	**Aug**	**Sep**		**Presenter** Division Director of Quality/ W&C Chief of Service and Director of Nursing	**Purpose** For information	**Outcome /Action taken** Noted
Quality Assurance Report Including Clinical Outcomes & Effectiveness Group Reports			**Oct**	**Presenter** Chief Medical Officer / Director Clinical Outcomes & Effectiveness	**Purpose** For assurance	**Outcome /Action taken** Noted
Facilities and Estates Ventilation, Water and Medical Devices updates	**Aug**			**Presenter** Chief Nurse / Director Estates and Facilities	**Purpose** For information	**Outcome /Action taken** Noted. Work started to understand scale of water safety concern across Trust
Fundamental Standards of Care update including: Blood Transfusion Group Q1 Thrombosis/VTE Group Q1	**Aug**	**Sep**	**Oct**	**Presenter** Deputy Chief Nurse	**Purpose** For assurance	**Outcome /Action taken** Noted,
Medicines Management Quarterly Report Q2 2024/25			**Oct**	**Presenter** Chief Pharmacist	**Purpose** For information	**Outcome /Action taken** Noted
Perinatal Quality Surveillance Report and Dashboards (Jun-Aug 2024 data)	**Aug**	**Sep**	**Oct**	**Presenter** Director or Midwifery / Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Maternity Claims Scorecard Q1 2024/25	**Aug**			**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted
Perinatal Mortality Review Tool (PMRT) Q1 2024/25	**Aug**			**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted
Maternity Serious Incidents Q1 2024/25			**Oct**	**Presenter** Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Foetal Wellbeing / Saving Babies Lives Review Quarterly Report			**Oct**	**Presenter** CNO/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted

Avoiding Term Admissions into Neonatal Units (ATAIN)/ Transitional Care Quarterly Report Q1 2024/25			**Oct**	**Presenter** CNO/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Risk						
Trust Risk Register relating to Patient & Quality (Summary changes between Quarterly meetings)	**Aug**	**Sep**	**Oct**	**Presenter** Chief Medical Officer / Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted
Board Assurance Framework			**Oct**	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** Agreed risks fairly stated

Actions taken by the Committee within its Terms of Reference
The Committee **AGREED** to recommend the risk score for BAF risks 1.1, 4.1 and 4.2 to the Board for quarter 3 2024/25.
The Committee received Patient Experience Quarterly Reports and the Annual Inpatient Survey
The Committee received the Infection Prevention and Control Annual Report 2023/24 and Quarterly report
The Committee received the Safeguarding Annual Report 2024/25 and Quarterly Report
The Committee received the Patient Safety Incident & Duty of Candour and Medico-Legal Quarterly Report
The Committee received the Medicines Management Quarterly Report
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)
▪ An update on Management Actions around Water and Ventilation Reports in relation to Infection Prevention & Control presented by Director of Estates following reporting to the Trust Infection Prevention and Control Committee ▪ Medical Devices Internal Audit and Management Response (November 2024) ▪ Endoscopy Accreditation (JAG) Action Plan (November 2024) ▪ Plan for Health Inequalities Reporting (Quarter 1) ▪ Reasons for decrease in SSNAP scores and challenges to be included in the Specialist Quality Review report (February 2025). ▪ Haemoncology move to Courtyard: Action plan and learning themes from the delayed move of Haematology Oncology to the Courtyard building at RSCH to be included in the next IPC or Facilities & Estates report (November 2024) ▪ Quarterly Quality Impact Assessments summary to be provided to the Committee to provide evidence and assurance of the QIA process and highlight escalations where necessary (December 2024). ▪ Update of the Committee sub-group reporting structure and oversight arrangements.
Items referred to the Board or another Committee for decision or action

Item	**Date**

The Quality Committee invites the Board to **NOTE** the following: The Committee's recommendation in respect of BAF risks 1.1, 4.1 and 4.2 for which it has oversight, that the scores for the end of quarter 1 are fairly represented. The Board is invited to note that the Organ Donation Annual Report 2023/24 has been provided separately at Item 7 on the Public Board Agenda. The Board is also invited to note that the following items have been placed on the Trust website: - Infection Prevention and Control Annual Report 2023/24 - Safeguarding Adults and Safeguarding Children Annual Report 2024/25	**Nov 2024**

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16.	**Meeting:**	Trust Board in Public	**Meeting Date:**	7 November 2024
Report Title:	People Committee Chair's Report				
Sponsoring Executive Director:	Paul Layzell, Non-Executive Director				
Author(s):	Paul Layzell, Non-Executive Director				
Report previously considered by and date:					

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

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

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

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The People and Culture Committee met on the 29 October 2024 and was quorate as the meeting was attended by at least two Non-Executive Directors and two Executives Directors. The lead executives for this Committee were in attendance at these meetings, these being the Chief People Officer and the Chief Culture and Organisational Development Officer. In attendance at these meetings were: the Director of Workforce Planning & Deployment, Director for Integrated Education, Clinical Director of Medical Education and the Associate Director of Leadership, Culture and Development. The Deputy Chief Medical Officer attended to lead on the presentation of the medical appraisal report.

At the meeting the Committee received its planned items including the reports linked to the respective Patient First True North, Breakthrough Objective, Strategic Initiatives and Corporate Projects; a presentation on the Patient First Strategic initiative, along with the updates on Cultural Programme delivery, the quarterly guardian of safe working report, medical appraisal and an update on the work being undertaken in respect of sickness absence. The Committee continued to receive the Chief People Officer's overview report drawing out the focus of the meeting's papers and the Trust People Scorecard Metrics.

The key areas of focus at the Committee 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** this report allowing it to consider the focus of the papers at the meeting and receive an overview of the Trust's people metrics. The Committee noted the key messages in the report, aligned to scorecard data and focused its attention on the dip in staff engagement, the possible drivers for the change and its alignment to the later recommendation to increase the score for strategic risk 3.1.

The Committee also noted continued focus on workforce recruitment, deployment and funding and the individual reports on medical revalidation, locally employed doctors' recruitment and deployment, sickness management and the cultural programme update.

Annual People Plan / People Promises update

The Committee **received** its scheduled update on the Trust's delivery against the Trust's People Plan covering the oversight groups for each of the respective workstreams and how these workstreams and activities link to the national people promises. The Committee discussed the breadth of the programme and the view of the Chief People Officer of the importance to have actions across each people promise area.

The Committee **provided feedback** on the structure of the report and how they wished to have highlighted the areas the Committee is being asked to consider or the specific data it is taking its assurance from.

Medical Appraisals

The Committee **took a high degree of confidence** from the reporting by the Deputy CMO for medical revalidation and appraisal on the work the Trust has done in the areas of medical appraisals, this work covering the increase in the number of appraisers, the coaching and support provided to appraiser to secure more meaningful and higher quality appraisals along with the delivery of the trajectories to meet a rate of 95% of consultants being appraised by the end of March 2025. The Committee also **noted** the work to roll out a standardised and meaningful appraisal approach to the locally employed doctors. As a result of the report and discussion the Committee was **assured** over the seriousness and focus given to the medical appraisal process and had confidence that the process is structured to deliver meaningful appraisals.

Guardian of Safe Working

The Committee **took assurance** from the report of the Guardian and through discussion with the Chief People Officer who was presenting this report on behalf of the Guardian that the reduction in exception reporting at the Royal County Site was due to improvements in the doctors rostering processes and reflected a realistic position with regard to exception reports.

Sickness Absence

The Committee **received** a report on the actions being taken to support staff to return to work and the support to managers to hold meaningful and supportive return to work meetings. The Committee **noted** the impact the rostering roll out had had on providing timely data enabling more useful return to work discussions to be had. The Committee heard that whilst there has been a focus on supporting staff and managers to consider reasonable adjustments work continues to offer a centralised resource to support local managers to understand and make such changes. The meeting **noted** the Chief People Officer's reflection that there is an increasing need to offer psychological support to staff as the national charity funded supported is reducing.

The Committee chair **noted** the correlation of the need to improve the support for reasonable adjustments with the feedback the NEDs had had within their conversations with the respective staff network chairs.

Culture Programme Update

The Committee was **updated** on the work being undertaken within this programme on the creation of the infrastructure to support the development of a healthy culture. Through the update from the Chief Culture and Organisational Development Officer the Committee was **assured** that the work on developing the tools and methodologies to bring about improvement would be tested and refined before being applied more widely through a series of improvement works commencing this quarter.

The Committee **noted** the work undertaken and the development of a cultural reference group which allows the Trust to secure feedback from a cross section of the workforce on their awareness of the work being undertaken, their perception of its effectiveness and the level of engagement with the programme in general.

Integrated education update – GMC resident doctor results

The Committee **noted** the national results provided by this survey and the alignment of the areas flagged for improvement with already established improvement plans. The Committee heard that whist a similar national survey on trainers had been undertaken at the same time the results of which had yet to reported though the organisation. The Committee **asked** that they receive assurance at a subsequent committee meeting that the areas for improvement flagged in this survey are incorporated into the Trust's improvement plans.

Equality, Diversity and Inclusion EDI

The Committee **received** its requested update post the receipt of the Trust national WRES and WDES and annual equality reporting submissions. The Committee noted the Trust's proposed plans to the address the national High Impact Actions as set out in the paper. The Committee noted that the first two years of the current EDI strategy delivery plan were focused on improving the baseline processes and that the year 3 delivery plan would be seeking a shift in focus to cover interventional improvements such as talent management.

The Committee **requested** that they receive a further update on progress with the year 3 delivery plan prior to submission and engagement with the Board.

Board Assurance Framework (BAF)

The Committee **agreed** the strategic risks for which it has oversight should see an increase in the score for risk 3.1 to a score of 16 and that the score for risk 3.2 should remain at 20. In determining this view the Committee recognised how these scores aligned to the reports received in the meeting along with the listed assurances in the BAF document itself for Quarter 2 and the actions proposed for Quarter 3. The Committee also recognised and agreed the reduced confidence that the respective risk target scores can be achieved in the send half of the year for both risks.

Referrals to other Committees

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

Key Recommendation(s):

The Board is asked to **NOTE**

The Committee recommended the Q3 scores for risks 3.1 and 3.2 which sees an increase in the risk score for risk 3.1 to 16 and the score for risk 3.2 to remain at a score of 20.

The Committee in considering the Q3 scores reflected on the reducing confidence level of the Executive and endorsed the view that reductions are likely to be made to the two People and Culture strategic risks by the end of the year and that the Board should consider this as they consider the BAF.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	29 October 2024	**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** Noted, assurance taken over alignment of performance and people risks to the BAF later on the agenda
People Plan (people promises update)	**Presenter** Chief People Officer	**Purpose** For discussion and assurance	**Outcome /Action taken** Noted, assurance taken over actions being taken within the respective workstreams to the national people promises.
Medical Appraisals Update	**Presenter** Deputy Chief Medical Officer	**Purpose** For discussion and noting of actions being taken	**Outcome /Action taken** Noted the improvement actions taken and the delivery against the established trajectories. The Committee noted the degree of confidence the Dep CMO has that the year end targets will be achieved.
Recruitment & Deployment of Locally Employed and Speciality & Specialist Doctors	**Presenter** Director of Workforce Planning	**Purpose** For discussion and noting of actions being taken	**Outcome /Action taken** Noted the work undertaken and took assurance over the work to establish a consistent and standardised set of processes to support this valuable cohort of staff. The Committee noted how the work described in the report supported the improvements recommended by internal audit in their recent review.
Guardian of Safe Working Hours Q2 report	**Presenter** Chief People Officer	**Purpose** For discussion and noting of actions being taken	**Outcome /Action taken** Assurance taken over the work taken in respect of issues raised. Noted that the reduced exception reporting was linked to improved rostering.
Sickness Absence Deep Dive	**Presenter** Chief People Officer	**Purpose** For discussion	**Outcome /Action taken** Noted and took confidence from the CPO that the focus of the work being undertaken is on supporting staff to return and remain in work.
Briefing on Patient Safety Concerns raised through People Processes	**Presenter** Chief People Officer	**Purpose** For noting	**Outcome /Action taken** Noted and agreed the process described allows the P&Q

			Committee to have confidence that the processes will flag any significant concerns. The Committee agreed to share the process with the P&Q Committee chair. The Committee noted that from information in Q1 and Q2 not significant concerns needed to be referred to the P&Q committee.
Cultural Programme Update	**Presenter** Chief Culture and Organisational Development Officer	**Purpose** For information and noting of actions being taken	**Outcome /Action taken** Noted and took confidence that the actions being taken to develop the improvement infrastructure were appropriate.
Integrated Education Update – GMC national training survey results	**Presenter** Director of Integrated Education	**Purpose** For assurance	**Outcome /Action taken** Noted the GMC resident doctor survey results, noted they remained similar to prior years and that the action plans were being developed to address issues where in the main incorporated in existing action plans rather than requiring extra action plans
New reporting for Leadership, Culture and Development programme	**Presenter** Chief People Officer	**Purpose** For noting	**Outcome /Action taken** Noted the change to the reporting oversight and the continued link to the Committee
Equality, Diversity & Inclusion report, including - Themes from 23/24 Annual Equalities Report - EDI talent mgmt, stocktake - Equalities workforce data	**Presenter** Chief People Officer	**Purpose** For information and noting of actions being taken	**Outcome /Action taken** Noted the action being taken against the key improvement areas and the High Impact Actions. The Committee agreed that further reporting on progress should continue to be reported alongside the development of the year 3 delivery plan. The Committee noted that year 1 and 2 delivery plans were about establishing the required infrastructure to allow the Trust to move forward.
Patient First Improvement Programme Update	**Presenter** Chief Operating Officer	**Purpose** For information	**Outcome /Action taken** The Committee noted the work to consolidate the programme and the examples of divisional and operational successes included in the report relating to the daily mgmt. system and local improvement projects.

Medical Workforce Systems, Update	**Presenter** Chief People Officer and Director of Workforce Planning	**Purpose** For information	**Outcome /Action taken** Noted the plan to transition this work away from a dedicated corporate project to business-as-usual processes. The Committee agreed reporting of progress of this area and in particular improvements to levels of approved job plans be reported through the CPO overview report to the Committee.
Updates from Reporting Groups - Education & Workforce Group - Joint Negotiation & Consultation Committee - Nursing & Midwifery Workforce Group	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Updates Noted and the Committee agreed there was no items for their specific action or referral.
Updates on Integrated Care System	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
Board Assurance Framework	**Presenter** Company Secretary	**Purpose** To agree	**Outcome /Action taken** Agreed to the risk scores recommended by the lead executives.

Actions taken by the Committee within its Terms of Reference
The Committee **AGREED** to share the process for assuring the Patient and Quality Committee over the timely referral of any identified patient safety concerns within the people reports, noting that in Q1 and Q2 there were no significant concerns needing referral. The Committee **AGREED** to the scores for the Strategic Risks 3.1 and 3.2 were appropriately scored, noting that strategic risk 3.1 was increased to a score of 16.
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)
The Committee agreed that it would receive in six months a further update on medical appraisals The Committee agreed it would seek assurance that the GMC Trainer Survey results are being fed into Trust improvement plans
Items referred to the Board or another Committee for decision or action
Item
The Committee agreed there were no specific items referred to another Committee for action. The Committee agreed to recommended to the Board the Q3 scores for risks 3.1 and 3.2 this seeing an increase in the risk score for risk 3.1 to 16 and the score for risk 3.2 to remain at a score of 20. The Committee in considering the Q3 scores reflected on the reducing confidence level of the Executive which they endorsed that reductions could be made to the two People and Culture strategic risks by the end of the year. The Committee agreed that the Board should consider this view as they consider the BAF and the realistic opportunity to achieve the initially set target scores.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	17.	**Meeting:**	Trust Board in Public	**Meeting Date:**	07 November 2024
Report Title:	Finance & Performance Committee Chair's report to Board				
Sponsoring Director:	Philip Hogan, Committee Non-Executive Chair				
Author(s):	Philip Hogan, Committee Non-Executive Chair				
Report previously considered by:					

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

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

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

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

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

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

The papers related to the Trust's Sustainability True North, Breakthrough Objective (productivity), Strategic Initiative (environmental sustainability) and Corporate Projects, a Quarter 2 finance report, the Efficiency Programme, the Capital Programme, Operational Performance including the performance against constitutional standards, Commercial team activities including procurement, an ICS finance update and discussion of key risks with the Board Assurance Framework. At the October meeting, the Committee received an update on the 3Ts programme.

Investment decisions were also considered and approved (subject to the Committee's delegated limits) that concerned the development of an Urgent Treatment Centre at Worthing Hospital.

True North Financial Performance Report - Quarter 2 2024/25 Financial position

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

The FPC discussed and **NOTED:**

- As at month 6 the Trust delivered a £34.9 million deficit year to date, which is £5.4 million adverse to the plan.
- The enhanced grip and control measures enacted following quarter 1 have slowed run-rate increases and there has been considerable non-recurrent items enabling the month 6 in-month outcome to be reported on plan.
- The most significant in-month and year to date drivers of the adverse position to the plan are: medical vacancies and costs of premium cover, high cost drug expenditure in excess of the block contract, lower MSK income, the net impact of unfunded change to Insulin Pump usage resulting from NICE guidance, and open escalation beds above the funded capacity.
- There is a very high risk that projected financial outcomes of the efficiency initiatives in delivery will not meet the planned improvements required to achieve the agreed (and funded) £19.5 million full year deficit. The month 6 efficiency programme under delivered by £1.5 million against plan as the phasing of the efficiency programme starts to increase through the second half of the year.
- There remains considerable focus from both system oversight and internally on the value delivered associated with the growth in staff establishment since 2019/20. The enhanced grip and control arrested the growth in whole time equivalents worked across the Trust and an increased proportion substantive staff within that. Agency costs remain below the agency ceiling but are still prevalent in hard to recruit and challenged specialities.
- The Cash position is below plan. Deficit support funding has been received in October. Cash management remains a key area of focus as the year progresses.
- The better payments practice code performance is below the target level although performance has been maintained in quarter and the FPC sought assurance local small enterprises did not suffer detriment.

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

- Work on financial improvement and recovery continued the previously reported areas:
  - Stabilising the financial position, preventing further deterioration with enhanced spend controls from July.
  - Bridging the gap in the financial position – with Trust wide cross-cutting work-streams being established which are aligned to the key drivers of our financial position; and
  - Addressing the underlying deficit - undertaken as part of the strategy development work.

- Given the level of risk to full year forecast, the Trust engaged the services of an interim Efficiency Delivery Director who has undertaken a review of further efficiency opportunities, and the October meeting received a comprehensive assessment of the opportunities available.

- The FPC **AGREED** the need for additional efficiency initiatives and **RECOMMENDED** the Board accept the proposals and discuss and agree its attitude to the enhanced levels of risk inherent in the additional proposals and agree a clear statement of 'red lines' and Trust wide position.

Capital Investment Progress Report Quarter 2

The FPC **RECEIVED** the Q2 update against the Trust's 2024/25 capital plan and the forecast outturn.

The FPC **NOTED:**

- The current programme is underspent by £6 million year to date but was **ASSURED** this is driven by timing differences and that the full £82 million funds available will be spent in year.
- One of the greatest areas of slippage relates to the Electronic Patient Record project which is subject to extensive central approvals process and remains a critical strategic project for the Trust.
- The planned expenditure exceeds the available funds by £12.7 million (forecast outturn). This overprogramming from the original plan continues to be actively managed and the FPC was ASSURED this gives the flexibility required to enable the funds to be spent.
- The risk associated to the timing risk of the delivery of the project to connect to the Worthing Heat Network that will be managed through the Capital Investment Group Monthly meetings with oversight of the Chief Financial Officer. The Director of Estates and Facilities is in discussions to manage the risks to the grant funding timescales. It was noted the project must be complete by August 2025 to meet contractual obligations.
- The Patient and Quality Committee had made a referral to the FPC to review the quality risks inherent within the capital prioritising process. The FPC was assured there is an adequate process in place although acknowledged the need for greater transparency for the coming planning period. The FPC discussed the governance arrangements through which this takes place.

ICS Update

The September and October meetings of the FPC **RECEIVED** an update on the Integrated Care System (ICS) financial position, meetings of the Strategy Committees in Common with ICS partners and the proposed system wide work to review how the system improves its services to our population in line with the national initiative to move towards more integrated care, improved prevention and primary care services, reduced health inequalities, better outcomes and a sustainable financial position.

The Committee **NOTED** the Sussex Strategy Committees in Common had last met on 22 October 2024 where it received an initial report from consultants Carnall Farrar who presented extensive data on the Sussex population health position.

Operational Performance

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

The FPC **NOTED:**

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

- Overall Trust performance against all the constitutional standards remained challenging and whilst some progress has been made against targets this has not always been sustained, The Trust was generally below national targets. However, the Trust's relative position to its NHS peers had been considerably improved.
- The Trust continues to make good and significant progress on the waiting lists – meeting it's 65 week targets in September and a reduction of some 31,000 patients on the PTL overall. This is among the biggest reductions in PTL in England.
- There are plans to improve performance and acceptance that there is still considerable work to be undertaken. The Trust is engaged with a number of Getting it Right First Time (GIRFT) Visits and planning to embed best practice such that there is an expectation of rapid improvement. There was validation that the Daily Management System work being rolled out across all the Trust's hospitals is a good initiative.

Productivity

Each meeting the FPC **RECEIVED** and discussed an updated report on the productivity breakthrough objective from the Managing Director for Planned Care and Cancer in September and Chief Operating Officer in October. The FPC **NOTED** that as of Month 6, year on year the Trust has continued to show one of the largest improvements nationally and significant improvement on the breakthrough objective and activity delivery. Considerable improvement opportunity remains and there are four specialties that require specific focus to deliver efficiently and use less premium spend. A further specialty has moved into the list of challenged areas

Each meeting the FPC **RECEIVED** updates on the Corporate Projects and **NOTED:**

Commercial Progress Report Quarter 2

The FPC **RECEIVED** a comprehensive report on the commercial activity in Q2 at the October meeting. The Update included a report on the Trust's wholly owned subsidiary, Pharm@Sea that provides outpatient pharmacy services to the RSCH and PRH sites and the Commercial Director outlined the basis for the decision she had taken to activate the option for extending Pharm@Sea's supply contract with the Trust to 2028. The FPC also **NOTED** that the Trust's shareholder representative on the Pharm@Sea's Board will become the Chair of the FPC as of 1st November 2024.

The Committee **NOTED** developments around the Trust's hospitals' staff restaurant provision and **DISCUSSED** how it can be assured these will be providing an enhanced and valued service to our staff. The Committee **NOTED** that the Commercial Director has put in place the governance to do so, including the Retail Steering Group having representation from Staff-side as well as Staff Governors.

The Committee **NOTED** the support for staff entrepreneurship to ensure patients and the Trust and its staff benefit from innovation and noted and that those multi-disciplinary arrangements report through the leadership of the Associate Commercial Director to the Research, Innovation and Digital Committee.

3Ts Progress Update

The FPC **RECEIVED** an update on the progress of stages 2 & 3 of the 3T's project. The funding envelope remains the key challenge, and the project is currently undertaking a market testing exercise designed to

work with the Contractor to agree a funding, value and project scope to meet that funding envelope. The New Hospitals Programme will return to their Investment Committee in January 2025 for confirmation of the funding envelope. In advance of this, the Trust has been working with the NHP to agree funding for an early works package to the value of £20.62m. Subject to funding agreement, these works will bring forward construction completion and help keep costs within the financial envelope.

Due to absence of the SRO and Executive Sponsor, the report to the FPC on Benefits Realisation from Stage 1 was deferred to the next meeting.

The Committee **NOTED** that the 3Ts developments were not within scope of the central review of the National Hospitals Programme and other than the funding envelope is not at risk.

The Committee **NOTED** the information behind the proposal going to Trust Board on the decision to proceed with the programme to open the Helideck on the Thomas Kemp Tower at the RSCH site. The FPC **ENDORSED** the recommendation to the Board to proceed with the works to open the Helideck.

Risks and Board Assurance Framework (BAF)

The FPC **AGREED** the reports and discussions accorded with the key risks and their linkage to its oversight of the BAF strategic risks allocated to it triangulated with the reports received. All the BAF risks it has oversight of were reviewed and considered.

Accordingly:

- the quarter 3 2023/24 scores for Sustainability (Finance) risk 2.1 should remain at 20 as indicated by the financial and efficiency reports received.
- and Performance risk 5.1 and 5.2 are fairly represented as at the end of quarter 2 and remained unchanged for quarter 3.

The Committee NOTED that the overall Trust risk profile has increased. There is reduced confidence that risks 2.1 and 5.2 will achieve their target score by year end.

Referrals to other Committees

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

Key Recommendation(s):

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

The Board is asked to **NOTE** the Committee recommendation that the BAF risks 2.1, 5.1 and 5.2 for which it has oversight, are fairly represented as at the end of quarter.

The Board is asked to **AGREE** the additional efficiency initiative proposed by the interim Efficiency Delivery Director and **DISCUSS** and **ACCEPT** the resulting inherent risks and 'red lines' to give the Executive team clear guidance as to what they can and should not do.

FINANCE & PERFORMANCE COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Date	**31 October 2024**	**Chair**	Philip Hogan	**Quorate**	Yes
Meeting Date	**26 September 2024**	**Chair**	Philip Hogan	**Quorate**	Yes
Declarations of Interest	No declarations were raised in September. During the October meeting Philip Hogan confirmed he had been nominated as Trust Shareholder representative on the Pharm@Sea Board, a wholly owned subsidiary. The Commercial Director reported during the meeting that she had agreed to activate the option to extend the Pharm@Sea supply contract from April 2025 to March 2028.				

Items received at the Committee meeting

Sustainability True North Financial Performance Report Quarter 2 2024/25 in Oct 2024 - Updates Provided in Sep 2024 for Month 5	**Sep**	**Oct**	**Presenter** Interim Chief Finance Officer	**Purpose** For assurance	**Outcome /Action taken** Noted position and significant key risks.
Efficiency & transformation Programme. Efficiency Report Quarter 1 2024/25 in Oct 2024 - Updates Provided in Sep 2024 for Month 5	**Sep**	**Oct**	**Presenter** Interim Chief Finance Officer (Sep24) /Efficiency Director (Oct24	**Purpose** To inform the committee on the update on the 2024/25 plan delivery	**Outcome /Action taken** Noted. There is considerable challenge from Month 5 given phasing of plan and £30m of target remains high risk.
Capital Investment Progress Report Update on Capital Plan for 2024/25		**Oct**	**Presenter** Director of Capital Planning	**Purpose** To update on the implementation of the 2024/25 capital plan and set out the actual position at Q2 end.	**Outcome /Action taken** Noted. There has been progress to mitigate the overprogrammed capital plan significantly The Committee NOTED the process through which planning and prioritising the plan each year takes account of quality risks re equipment/ventilation.
ICS System Update Report		**Oct**	**Presenter** Interim Chief Finance Officer/ Chair of Committee	**Purpose** For information	**Outcome /Action taken** Noted system work on financial gap, and national context and the implications for the Trust. Also update on Committees in Common
Sustainability Breakthrough Objective Productivity Updates on delivery of associated Systems & Partnership Corporate Projects ▪ Median Hour of Discharge ▪ Reducing Length of Stay	**Sep**	**Oct**	**Presenter** Managing Director - Planned Care / Managing Director Unscheduled Care	**Purpose** To inform the Committee of the productivity against 2019/20 activity at 2019/20 cost	**Outcome /Action taken** Noted. Considerable work is taking place but there are risks to pace of delivery. External reviews of work by GIRFT national team offering assurance of the Daily Management System as the suitable approach under roll out

Commercial Progress Report Q2 2024/25 including Procurement Strategy		**Oct**	**Presenter** Commercial Director	**Purpose** To inform Committee of activity undertaken by the commercial directorate and upcoming areas of opportunity	**Outcome /Action taken** Noted.
Systems & Partnership True North Operational Performance ▪ Performance Scorecard ▪ Report on Constitutional Standards		**Oct**	**Presenters** Chief Operating Officer	**Purpose** For information	**Outcome /Action taken** Noted and recognised the performance challenges which support the strategic risk score remaining at 20
Contract Award Recommendation Urgent Treatment Centre		**Oct**	**Presenter** Director of Capital and Planning / MD Unscheduled Care	**Purpose** To endorse	**Outcome /Action taken** Approved works and agreed award of associated contract. Discussed imperative to operationalise by Oct '25
Trust Risk Register relating to Finance and Performance		**Oct**	**Presenter** Company Secretary/ Chief Operating Officer/ Commercial Director	**Purpose** For information	**Outcome /Action taken** Noted that the key risks were discussed in Committee and aligned appropriately with the BAF
Board Assurance Framework		**Oct**	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** Agreed risks fairly stated. Discussed reduced confidence of reaching target risk scores 2.1 & 5.2 by year end

Actions taken by the Committee within its Terms of Reference
The Committee **AGREED** to recommend the quarter 3 score for BAF risks 2.1, and in relation to risk 5.1 and 5.2 for which it has oversight, are fairly represented as at the end of quarter 2. The Committee considered and **APPROVED** the following development and associated contract award for the Urgent Treatment Centre, Worthing. The FPC **ENDORSED** the recommendation to the Board to proceed with the works to open the Helideck
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)
Environmental Sustainability - To set a CO2 reduction target across a 3-5 year plan by December 2024. 3Ts Stage 1 Benefits Realisation.

Items referred to the Board or another Committee for decision or action	
Item	**Date**
The FPC **RECOMMENDS** that the Board **NOTE:** o The Committee considered the quarter 3 score for BAF risks 2.1, and in relation to risk 5.1 and 5.2 for which it has oversight, are fairly represented as at the end of quarter 2. o In respect of risks 2.1 and 5.2, there is reduced confidence that these will achieve their target score by year end The Board is asked to **AGREE** the additional efficiency initiative proposed by the interim Efficiency Delivery Director and **DISCUSS** and **ACCEPT** the resulting inherent risks and 'red lines' to give the Executive team clear guidance as to what they can and should not do.	**November 2024**

University Hospitals Sussex
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Agenda Item:	18.	**Meeting:**	Trust Board in Public	**Meeting Date:**	07 November 2024
Report Title:	Committee Chair's Report from Single Improvement Plan Committee meetings				
Committee Chair:	Paul Layzell – NED and SIP Committee Chair				
Author(s):	Paul Layzell – NED and SIP Committee Chair				
Report previously considered by and date:					

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

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

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

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	The SIP is to secure assurance that the Trust's systems support enhanced patient experience
Sustainability	Yes	The SIP complements the oversight of the Trust's use of resources
People	Yes	The QSIP is to secure assurance that the delivery of this programme is aligned to the Trust's people plan
Quality	Yes	The SIP is to secure assurance that the Trust's systems support the provision of high-quality care
Systems and Partnerships	Yes	The SIP is to support the provision of assurance from the Board to external stakeholders
Research and Innovation	N/A	Not directly

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

Regulatory / Statutory reporting requirement

The Trust Board has entered into a number of undertakings with NHS E and as part of these the Board has established robust oversight over the delivery of those undertakings through the dedicated Single Improvement Plan (SIP) Committee. The Trust is also required to provide assurance of the undertakings delivery and the SIP Committee is integral to flow of assurance over delivery to the Board to then engage with NHS E and the ICB.

Communication and Consultation:

The Single Improvement Steering group received the workstream updates from their meetings which supports the reporting to this Committee.

Report:

The Committee has met in each of the months of August, September and October and was quorate as it was attended by at least two non-executives, and at least two executives. In attendance at these meetings was the Programme SRO and Director of Communications.

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Single Improvement Plan delivery dashboard

The Committee received at each of its meetings the overall programme delivery dashboard and the workstream delivery scorecards.

The Committee at its August meeting requested of each of the respective Board Committee that they consider the assurance they receive that the planned actions are making a change for those metrics which have not materially changed for last 6 – 9 months. At the October meeting the Committee received feedback from the Chair of the People and Culture Committee and the Chair of the Patient and Quality Committee that at their meetings in October they did review the assurances they received and secured confidence that the plans were making a difference to key metrics. The Finance and Performance Committee was yet to meet.

The Committee in receiving the updated dashboard at its September Committee, reflected that greater clarity would be helpful to include clear delivery trajectories, to enable the Committee to undertake a more proactive review of the improvement plan construction which in turn would give confidence that the outcome improvements will be seen at the other Board Committees who have the oversight of the action outcomes and process improvements. At the October meeting the Committee reflected on the introduction of Statistical Process Control Charts and the value these had in focusing the Committees attention.

Quarter one plan refresh

The Committee at its September meeting received the quarter one plan refresh which included a high-level summary of the key actions delivered per workstream and highlights of the next quarter's key deliverables.

Improvement workstream reviews

Complementing the review of the programme delivery dashboard on a cyclical basis the Committee scheduled a **focused discussion** on a specific programme for each meeting.

The August meeting covered the Surgery Workstream. The Chief Operating Officer as Executive Lead for this workstream provided an update on the scope of the workstream and shape of the improvement programme and the key improvement activities delivered and those in train within this workstream. The improvements made included the drawing together single patent level tracking lists, the change to the colorectal surgery pathway to expedite patients waiting for surgery and those being progressed in relation to day case surgery and the wider surgery operating model. Within this update the Committee also received a summary update of progress against the prior RCS recommendations and noted their progress.

The September meeting covered the Quality Improvement Workstream. The Chef Medical Officer supported by the Chief Nurse as co Executive leads for this workstream provided an update on the progress made across the key areas of this workstream. The Committee was informed that the information supporting this update had been considered at the Patient and Quality Committee the previous day (24 Sept). The update drew out the changes to and the outcomes being achieved within three key areas of Fundamental Standards of Care oversight, systems for improving the Trust's Clinical Effectiveness processes and oversight and the continuation of the development of the divisional compliance assurance framework. The Chair of the Patient and Quality Committee confirmed that within the reporting to that Committee information on process improvements and their outcomes were being seen. The Patient and Quality Committee Chair reflected that the as had been noted by the SIP Executive Lead the need for divisional prioritisation of resource allocation was needed to sustain the improvement work and was a common focus of their Committee conversations.

The October meeting covered the Urgent and Emergency Care Workstream. The Deputy Chief Executive and Chief Operating Officer as executive lead for this workstream provided an update to the Committee on

this workstream. The Committee noted the changes brought about through this programme including a spotlight on the work undertaken at the Royal Alex Children's Hospital as well as the focus on the use of Urgent Treatment Centre capacity. The Committee reflected on the complexity and breadth of the programme and heard that the Deputy Chief Operating Officer is completing a review of the specific action plans to rationalize these were possible. The Committee noted that whilst this programme of work is focused on the Trust's actions there are complementary actions being progressed with system partners coordinated within the system winter plan. The Committee endorsed the programme's view that key to the delivery of these improvements in what is a complex arena is a clear of coherent approach to the communication of the actions and their impact and those complementary actions being taken by system partner to secure engagement with the changes required.

Programme Risk Register

The Committee **received** and **noted** at each of its meetings that the programme risk register had been reviewed at the supporting executive steering group. The Committee **noted** the actions proposed to address the risks identified relating to this programme, including the question of resourcing.

Recommendations

The Board is recommended to:-

NOTE the Committee continues to provide oversight to the delivery of the overall programme and the enhanced oversight instigated from July through dedicating time at each meeting to undertake a detailed review of one of the workstreams.

NOTE the support being provided by other Committees on the efficacy of the improvements through their respective complementary focus on key outcome metrics.

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	19.	**Meeting:**	Trust Board in Public	**Meeting Date:**	07 November 2024
Report Title:	Audit Committee Chair's Report				
Author(s):	David Curley – Audit Committee Chair				
Report previously considered by and date:					

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

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

Implications for Trust Strategic Themes and any link to BAF risks		
Patient	Yes	The Committee provides oversight of the process supporting each aspect of the BAF
Sustainability	Yes	The Committee provides oversight of the process supporting each aspect of the BAF
People	Yes	The Committee provides oversight of the process supporting each aspect of the BAF
Quality	Yes	The Committee provides oversight of the process supporting each aspect of the BAF
Systems and Partnerships	Yes	The Committee provides oversight of the process supporting each aspect of the BAF
Research and Innovation	Yes	The Committee provides oversight of the process supporting each aspect of the BAF

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

Regulatory / Statutory reporting requirement

There is a requirement to have a functioning and effective Audit Committee. The Audit Committee is established to support the Board in securing assurance over the Trust's governance, risk management and internal controls systems.

Communication and Consultation:

Report:

The Audit Committee met on the 24 October 2024 and was quorate as it was attended by Non-Executive Directors. In attendance were the Chief Governance Officer, and the Trust's Commercial Director / Interim Director of Finance and the Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members. The Chief Medical Officer attended for the relevant internal audit report in respect of SAS Doctors and the Chief Information Officer and Information Governance Officer / Data Protection Officer attended for the Data Security and Protection Toolkit report.

Risk Register and BAF reports

The Audit Committee considered, reviewed and discussed the Trust's BAF report and risk management policy compliance report. The Committee continued to be provided with assurance that the Trust's processes

underpinning the active review of the BAF have continued over quarter 2 and support the proposed quarter 3 scores to be presented to the respective oversight Committees. The Audit Committee itself reflected on the increasing level of strategic risks recognsing that there is also an increasing level of operational risks being recognised by the clinical and corporate divisions.

Through the receipt of the Internal Audit report on divisional risk management the Committee was assured over the level of improvement made and recognised this correlated with the risk management compliance report the Committee receives at each of its meetings.

The Committee agreed that complementing the review and feedback to the Board which will take place over the last week of October by each of the respective oversight committees the Audit Committee would also seek the Board in considering the BAF as a whole it considers the implication of the increasing level of strategic risk and the reducing confidence of the Executive that the initially expressed reduced target score will be achievable in the latter half of the 2024/25 year.

Internal Audit activity

The Committee noted the positive opinions on the Trust's Nurse Rostering, Divisional Risk Management and Key Financial Systems.

The Committee noted the negative assurance opinion on the Trust's design and operation of the systems of internal control in respect of the SAS Doctors Quality Governance. The Committee through the update from the Chief Medical Officer had confidence that appropriate actions are being taken to address the weakness in the application of the designed control environment. The Committee recognised that the tracking and reporting of these improvement actions would be provided initially through the People and Culture Committee.

The Committee recognised the proactive use of Internal Audit as a tool for improvement of the Trust processes for the support, deployment and recognition of this key cohort of staff.

The Committee noted that good levels of engagement continue in respect of recommendation delivery and that were deadlines are revised these did not pose significant weaknesses. The Committee noted there were just three recommendations where the deadlines had passed and sought assurance be provided ahead of the next scheduled meeting that action had been taken.

Local Counter Fraud

The Committee considered the Local Counter Fraud progress report for Quarter 2 2024/25 in relation to their work undertaken in respect of reported concerns. Through this reporting the Committee noted there were no elevated fraud risks.

The Committee received two benchmarking reports undertaken by RSM against their client base in respect of the Trust's level of Declaration of Interests returned and the number and type of Single Tender Waivers which provided confidence over the operation of the Trust's processes as in both areas the Trust benchmarked favourably.

Data Security Protection Toolkit

The Committee received the report confirming that whilst the assessment criteria had changed significantly fort this year, 2024/25, the Trust has established a process of seeking, validating and learning from the assurances being obtained against the established standards. The Committee noted that complementing the self-assessment will be an internal audit review which will report ahead of the final submission by the Trust of its declaration.

Key Recommendation(s):

The Board is specifically asked to **CONSIDER** when the BAF is discussed, the view of the Audit Committee that the overall level of current risk to the Trust's Strategic Objectives being held within the Trust remains high and this is alongside an increasing level of operational risks.

The Board is also asked to **NOTE**

- The Audit Committee's continued receipt of management assurance over the BAF and underpinning risk management processes.
- The LCFS reporting for Q2 had not identified any significant issues
- The level of positive assurance provided by Internal Audit, especially in the areas of the Trust's Key Financial Systems and Divisional Risk Management processes.

University Hospitals Sussex NHS Foundation Trust

COMMITTEE ACTIVITY HIGHLIGHT REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate
Audit Committee	24 October 2024	David Curley	**Yes**

Declarations of Interest Made

There were no declarations of interest made.

Matters received at the Committee meeting

Item	Presenter	Purpose of the paper	Action Taken
Internal Audit Reports - Activity Progress Report - Recommendation Follow Up Report - Global Risk Landscape think piece.	BDO (Internal Auditors)	For assurance over respective areas of internal control	The Committee noted the positive opinion on the Trust's Nurse Rostering, Divisional Risk Management and Key Financial Systems. The Committee noted the negative assurance opinion on the operation of the SAS Doctors Quality Governance. The Committee was informed as to the actions being taken would address the weaknesses identified noting the proactive use of Internal Audit as a tool for improvement of the Trust processes in this area. The Committee noted the Internal Auditors follow up report continued to show good levels of engagement with Internal Audit to provide evidence of action delivery or a sound rationale for any date changes. The Committee noted there were just three recommendations where the deadlines had passed and sought assurance be provided ahead of the next scheduled meeting that action had been taken.
Board Assurance Framework (BAF)	Chief Governance Officer / Company Secretary	For review and discussion to consider any referrals to other Committees for their oversight of actions and current scores.	The Committee discussed the BAF and continued to receive assurance that the underpinning processes remained in operation over quarter 2 and supported the proposed quarter 3 scores which would be scrutinised and approved by the respective oversight committees. The Committee itself reflected on the increasing level of strategic risks

			recognsing that there is also an increasing level of operational risks being recognised by the clinical and corporate divisions. The Committee agreed to request the Board in considering the BAF as a whole considers the implication of the increasing level of strategic risk and the reducing confidence of the Executive that the initially expressed reduced target score will be achievable in the latter half of the 2024/25 year.
Risk Management Policy Compliance Report	Chief Governance Officer / Deputy Company Secretary	For assurance over Trust's process.	The Committee noted the impact the Executive Led Risk Oversight Group has had on the level of risk reviews undertaken. The Committee noted the correlation between this report and the outcome of the recent Internal Audit review of divisional risk management processes showing that the divisional risk management processes where improving.
Counter Fraud Reports - Activity Progress Report - DoI Benchmarking report - Single Tender Waiver Benchmarking	RSM (LCFS)	For assurance over respective areas of internal control and for information on the Trust's fraud profile and links to LCFS work	The Committee noted the work undertaken by the counter fraud team, that there were no elevated fraud risks. The Committee in receiving the two benchmarking reports gained confidence over the operation of the Trust's processes as in both areas the Trust benchmarked favourably.
External Audit Update	GT (External Audit)	To note status of the External Audit work	The Committee noted that the 2024/25 external audit work planning had commenced and that a detailed plan would come to the next meeting.
Losses, Special Payments and Overpayments Register	Commercial Director / Interim Director of Finance	To note the report and the assurance it provides over the Trust's processes.	The Committee took assurance from the generally low level of losses and special payments. The Committee also discussed the drivers of payroll overpayments and the work being undertaken by the Trust including the engagement with the national payroll process work.
Tender Waiver Report	Commercial Director	To note the report and the assurance it	Through discussion the Committee was assured over the processes being applied to support early

		provides over the Trust's processes.	engagement by budget holders with the procurement team to support them to a better route to market. Considered the rationale for the increase in these but has confirmed by the benchmarking report this level remains low.
Data Centre update	Chief Information Officer	To note	The Committee received information on the progress with the move.
Data Protection Toolkit Progress Report	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 received the report confirming that whilst the assessment criteria had changed significantly fort this year, 2024/25, the Trust has established a process of seeking, validating and learning from the assurances being obtained against the established standards. The Committee noted that complementing the self-assessment will be an internal audit review which will report ahead of the final submission by the Trust of its declaration.
Health and Safety Committee Chairs Report	Company Secretary	Provision of information on the activity of this Committee and review of the Committee's view of the Trust's Health and Safety risks.	The Committee noted the assurance provided over the continued meeting of the H&S Committee. The Committee noted the increasing number of specific Trust wide H&S risk assessments that needed to be completed and how not having these assessments added to the overall degree of risk being held by the divisions and the Trust generally.

Actions taken by the Committee within its Terms of Reference

There were no specific actions requiring the Committee approval at this meeting.

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

There were no specific items outside those within the Committee's business plan required to return to the Committee

University Hospitals Sussex NHS Foundation Trust

Items referred to the Board or another Committee for decision or action	
Item	**Referred to**
The Committee agreed that the delivery of the improvement actions resulting from the Internal Audit Review of SAS Doctor Governance would be referred to the People and Culture Committee	P&C Committee for oversight
The Committee agreed to request specifically that as the Board considers the BAF at its meeting in November that it recognises that the overall level of current risk to the Trust's Strategic Objectives being held within the Trust remains high and this is alongside an increasing level of operational risks.	Board

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Agenda Item:	20.	**Meeting:**	Trust Board in Public	**Meeting Date:**	07 November 2024
Report Title:	UHSussex 2030: 5 Year Strategy				
Sponsoring Executive Director:	Roxanne Smith, Chief Strategy Officer				
Author(s):	Jenny Preece – Deputy Director Strategy & Planning Joe Mills – Director of Strategy				
Report previously considered by and date:	n/a				

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

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

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

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Sustainability	Yes	Development of new Trust 5 Year Strategy
People	Yes	
Patient & Quality	Yes	
Systems and Partnerships	Yes	
Research and Innovation	Yes	

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

Regulatory / Statutory reporting requirement

Communication and Consultation:

This is the first substantive public update on the Trust's 2030 Strategy Project, which was introduced at the AGM in July. It includes headlines from our engagement so far with public, partners and patients.

Executive Summary:

This report provides an update on the Strategy, messages from the Big Conversation, and next steps.

Key Recommendation(s):

For the Board to note.

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UHSussex 2030 : 5 Year Strategy

UHSussex Board in Public

Roxanne Smith, Chief Strategy Officer
Joe Mills, Director of Strategy

7 Nov 2024

Purpose

- This presentation provides an update on progress relating to the development of the UHSussex Strategy to 2030. This includes our Big Conversation with patients, partners and staff, and the ‘must dos’ and themes that will shape our strategy.
- The Board is asked to **note** this update.

The big have your conversation
Help shape our new Trust strategy

A new 5-Year Strategy & Roadmap for UHSussex

NHS University Hospitals Sussex NHS Foundation Trust

- Developing our **strategy for University Hospitals Sussex – our vision and ambitions for 2030, and road map to get there.**
- The Strategy will **build on progress since UHSussex was formed in 2021 -** understand our identity, purpose and priorities for patients, staff and our wider communities.
- **Corporate and clinical strategy –** to make the most of our many assets and strengths and develop our plans to tackle the challenges we face
- We started the '**Big Conversation'** across the organisation this summer, and it is now live with our patients, communities and partners
- To be published in **Q1 2025**. Implementation plans to ensure that the Trust is aligning its resources with its strategy and enabling each part of the organisation to create clear plans that will contribute to our 2030 strategic objectives.
- Will complement and **support the delivery of the NHS Sussex Health & Care Strategy** and those of our neighbours, and Government 10-year Plan for the NHS.

Why are we developing a new strategy now?

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- We want to deliver higher quality, faster and equitable care to patients across Sussex.
- We want to be an excellent place to work for our staff, and attract and retain more brilliant people.
- We want to deliver maximum value for the taxpayer, including benefiting from our size and scale to be as effective and efficient as possible.
- We want to contribute to our communities as an anchor institution and to work in partnership to play our role in improving health outcomes for local people.
- We want to fully contribute to, and benefit from, the Government's mission to make the NHS fit for the future.

Our Road map will build on our existing commitments, our learning from evidence and our Big Conversation, in the context of local and national strategy:

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UHSussex Clinical Strategy 2023-26

UHSussex Improvement Plan July 2024

Our Big Conversation with patients, staff and partners

Review of evidence about our current position (strengths, opportunities, weaknesses and threats) & learning from others

Improving Lives Together – NHS Sussex Health & Care Strategy

Darzi Review, and forthcoming Government 10 Year Plan for NHS

We have placed staff, patient and partner voices at the heart of strategy development. We are hearing from thousands of people to help shape the future of UHSussex.

The big conversation — have your say

Help shape the future of your local hospitals

Patient and Partner Surveys open until mid-Dec

~2500 UHSussex colleagues have joined the Big Conversation

Social Media campaign @UHSussex

4 Partner Events across Sussex

Hospital roadshows, on all our sites

Post cards or online survey promoted by our volunteers

Around 2500 of our staff have been involved in our Big Conversation so far

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A: What are you proud of?

B: What would you like UHSussex to be known for in 2030?

- Our staff are proud of their **resilience**, and how teams and colleagues **work together** to provide **care in difficult circumstances**.
- They have comments about a range of issues which can get in the way of productivity, including **digital** and **data**, **communication** and **culture**, how our **sites** look and the **facilities** available, **staff wellbeing**, and **cost of living.**
- They want us to become an organisation which is known for **excellence, innovation** and **quality** as well as building on our strong foundations of **teamwork** and **compassion**.
- They have lots of ideas about how to achieve this, and make improvements for our patients and communities, and want to be involved.

Our partners are engaged and have some clear messages for us

- Through Partnership Events in Chichester, Brighton, Worthing and Horsham, we have met representatives from **77 organisations** in Sussex.
- Our Non Executive Board Directors are also meeting our key partners Trusts, Primary Care Provider Collaborative, and Local Authorities.
- We also have a **live survey** for health and care professionals across Sussex to feed in their views.

Key messages from partners:

- Overall partners are **positive** about UHSussex and very **welcoming of the opportunity** to engage further and more regularly

They have also raised:

- A perception that UHSx tends to be **inward looking** rather than collaborative
- UHSx and partners are often 'on the same page' about their intentions to collaborate more effectively, but need to have **meaningful plans** to realise our collective ambitions
- UHSx has an important **leadership role** to ensure that partnership working delivers holistic care for those in need
- Their keen-ness that we engage in the **shift from treatment to prevention** with clarity on what that means for an acute provider in the context of growing numbers of people with long term conditions and complex needs
- The opportunity to work to join up **digital solutions and data sharing** to support collaboration
- The importance of seeing a patient **holistically**, including anything which may lead to an inequality in their care, and bringing in partners to help where required

Our engagement with members of the public is also ongoing

University Hospitals Sussex NHS Foundation Trust

Working in partnership with the ICB, we have launched **Patient & Public Surveys**.

The Surveys will run until early December. They are being promoted through: targeted communications to **members and supporters**; **ICB patient group channels**; **health and social care partner channels;** and the Trust's **digital and social media platforms**.

They will soon be available in shortened form as **postcards to complete across our sites**, with Trust volunteers encouraging members of the public to get involved. We are also working with **patient groups directly** to capture their insight, and are drawing on previous insight from patients about our services.

We have heard from nearly 400 people so far. From our early analysis, emerging messages include:

- In the main, staff are **friendly** and **professional**
- **Waiting times**, and not knowing when treatment will be received, concerns many people
- A&E / **Emergency Departments** are a particular area where negative comments have been recorded
- **Getting in contact** with the Trust can be difficult – including issues with appointment letters and follow up from treatment.

The Survey can be found here:

Your invitation to a conversation about our five-year strategy - University Hospitals Sussex NHS Foundation Trust (uhsussex.nhs.uk)

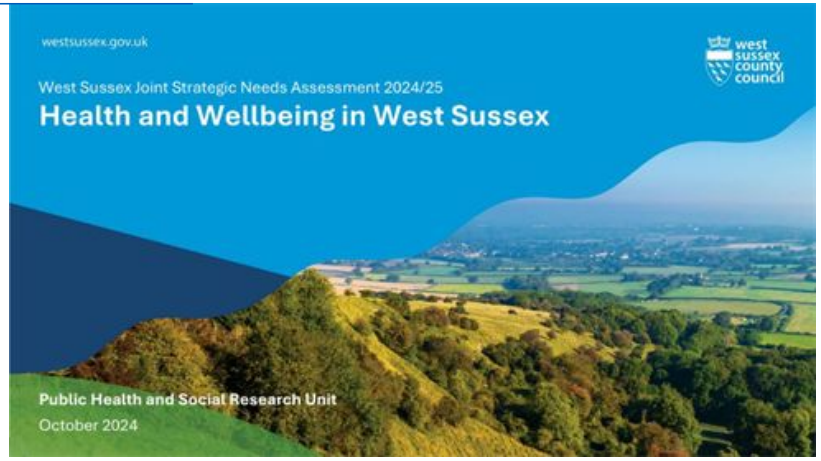
The changing needs of our population will drive our strategy

NHS
University Hospitals Sussex
NHS Foundation Trust

- We currently serve around 1.3m people across our catchment area
- We expect our population to increase by 3% by 2030
- Numbers over 85 are projected to increase by 7%
- In most areas, numbers of children will fall – Brighton has among the lowest fertility rates in the country
- We will continue to see significant social and economic inequalities

This means:

- We will see **additional demand for our services** for frailty and older people's medical and surgical needs, and for services for patients with multiple complex health needs.
- There will be some **relative decrease in demand for paediatric and maternity** services.
- We will continue to see growth in **health inequalities** in our area. There will be increasing need to:
  - ensure that **our services are inclusive, available and protected** for all with acute needs.
  - **promote public health and overcome health inequalities**,
  - improve **community, primary health and mental health care** capacity



Drawing on what we have learned so far, the Board has agreed 12 working 'must haves':

NHS
University Hospitals Sussex
NHS Foundation Trust

1. High quality, safe services for the people of Sussex
Building on our improvement plan, to secure safe and consistent standards of practice across all sites and services

2. Patients at the heart of our strategy
Improve access, quality, tackle unwarranted variation in care, adapting to meet the needs of our population and improve the way we work with patients as partners.

3. Our staff are our greatest asset
We will invest in, listen to and empower our people and cultivate a culture which lives up to our values.

4. UHSussex will be more than the sum of its parts
Using our sites and scale to develop and deliver services where the Sussex population needs them, getting full benefit from our resources and expertise, across the whole Trust

5. Our sites will have clear identities & areas of focus
Both clinical and as anchor trusts engaged with local communities and partner services, and contributing to local economic and environmental sustainability.

6. Reduce competition for capacity between planned and unplanned care
considering the role of 'cooler' sites with more capacity for high volume low complexity planned activity.

7. Build on our potential to develop our tertiary, research and educational specialisms
Setting ambitious and credible plans which will benefit patients, create opportunities for staff and generate greater income.

8. Partnership for shared goals
Develop and deliver our strategy in the context of the Sussex system, working in strategic and operational partnership to achieve shared goals for our populations

9. Prioritise digital transformation
Integrated, digital-first systems, and data that supports innovation and improvement – implemented well with strong clinical and corporate involvement.

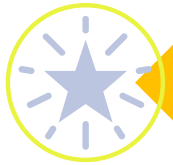
10. Be ambitious about the quality of our corporate services
Recognising their critical role in supporting the delivery of our clinical services and making UHSx a great place to work

11. Be bold in our financial planning
Living within our means, tackling waste, embracing innovation and transformation, seeking new income & using economies of scale to deliver maximum value to the taxpayer.

12. We will manage change well.
Build on our expertise in continuous improvement and increase our capacity to manage change and major transformation projects across the organisation. Changes will be planned and delivered in partnership with our staff and communities.

We have identified four ambitious, cross-cutting themes which need to be delivered:

University Hospitals Sussex NHS Foundation Trust



People *Empower & enable people to be their best*

Care *Excellent care everywhere*

Future *UHSussex: Ready for the future*

Communities *Helping our communities to thrive*

** The wording will be reviewed & iterated at key points in response to feedback*

We will also develop a new vision. Some suggestions from staff so far include:

- *"A bright horizon for all*
- *"The Hospital to receive care"*
- *"The Trust to be part of*
- *"Quality in all that we do"*

Next steps

NHS
University Hospitals Sussex
NHS Foundation Trust

- We are now starting to identify the opportunities and choices which will enable us to set out a road map to deliver our ambitions over the next five years.
- Careful prioritisation, and some difficult choices, will be required to ensure that the strategy is deliverable, affordable, and meets the changing needs of our population.
- A further update will be presented to the next Public Board on 6th February.
- Engagement with patients and partners, as well as staff, continues and will influence the decisions that are made. We will play back what we have heard when we publish the strategy in Q1 2025.

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NHS Foundation Trust

QUESTIONS?

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	21.	**Meeting:**	Trust Board in Public	**Meeting Date:**	07 November 2024
Report Title:	Company Secretary Report				
Author(s):	Company Secretary				
Report previously considered by and date:					

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

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

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

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

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

Regulatory / Statutory reporting requirement

Foundation Trusts are required to establish and maintain an effective Board and systems of governance.

Communication and Consultation:

Report:

Lead Governor

The Lead Governor's term of office came to an end at the start of October 2024. An election process was held. The outcome of the process was that Lindy Tomsett, Public Governor for Chichester was re-elected for the period of two years, noting it is a constitutional requirement that the lead governor is a public governor.

Pharm@sea Shareholder Representative

The Trust has shareholder representative on the Board of Pharm@sea and from the 1 November this representative is to be Philip Hogan one of the Trust's Non-Executives. The Trust has expressed its thanks to its former representative Dr Okorie for the diligence in which he undertook the role for the Trust.

Board Cadance

The Board has agreed that it intends to move to eight meetings a year in public. This change will be reflected in the corporate meetings calendar for 2025/26 and the Board has indicated that it should commence as soon as is practicable. We are working on the implementation of this change and expect to be able to enact this for the next quarter which would see a March 2025 Board meeting in public being added to the calendar along with the already scheduled meeting in public in February 2025.

University Hospitals Sussex
NHS Foundation Trust

Items placed on the Trust's website

Since the last meeting in public the following annual reports have been placed on the Trust's website

- 2023/24 Annual Safeguarding Report (covering both adults and children)
- 2023/24 Annual Infection, Prevention and Control Report

These reports can be found at:
https://www.uhsussex.nhs.uk/resources/safeguarding-annual-report-2023-2024/

https://www.uhsussex.nhs.uk/resources/infection-prevention-and-control-annual-report-2023-2024/

Recommendations

The Board is recommended to

NOTE the outcome of the recent Lead Governor Election

NOTE the change in shareholder representation on the Pharm@sea Board

NOTE that the placement on the website two further annual reports

NOTE the plan is to adopt the revised Board Candance from Quarter 4 of 2024/25.

SUPPORTING APPENDICES

Actual and Potential Deceased Organ Donation 1 April 2023 - 31 March 2024

NHS Blood and Transplant

University Hospitals Sussex NHS Foundation Trust

Organ Donation and Transplantation 2030: Meeting the Need

In 2023/24, from 47 consented donors the Trust facilitated 38 actual solid organ donors resulting in 93 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

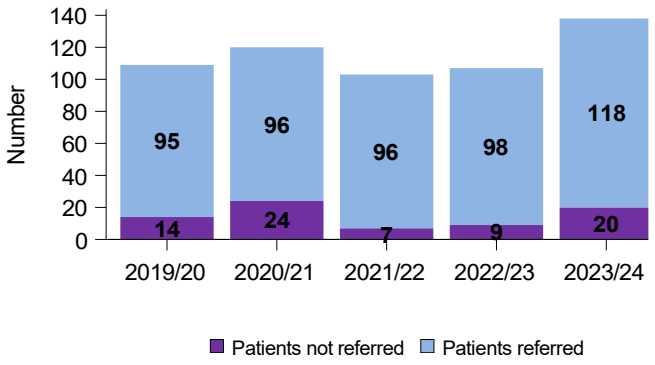
In addition to the 38 proceeding donors there were 9 consented donors that did not proceed.

Best quality of care in organ donation

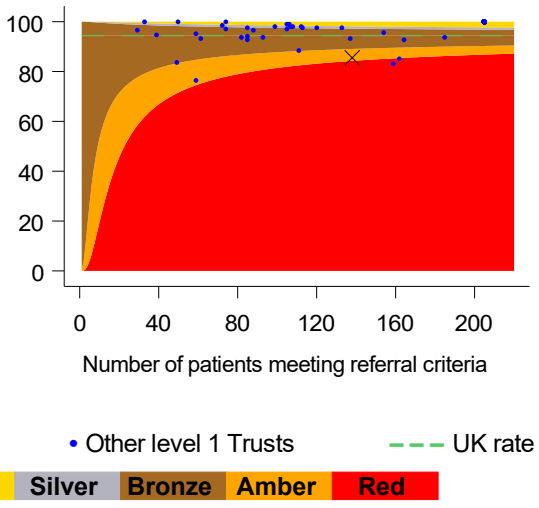
Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



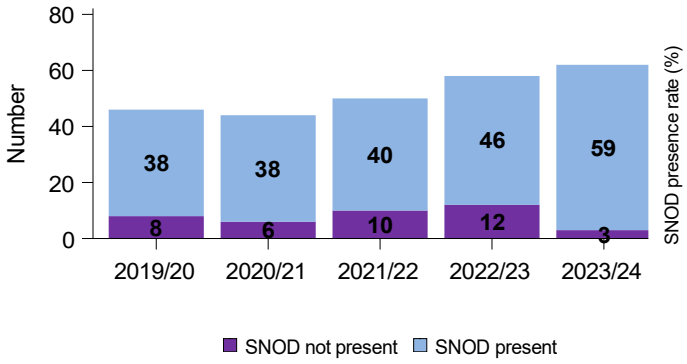
The Trust referred 118 potential organ donors during 2023/24. There were 20 occasions where potential organ donors were not referred.

When compared with UK performance, the Trust was below average (amber) for referral of potential organ donors to NHS Blood and Transplant.

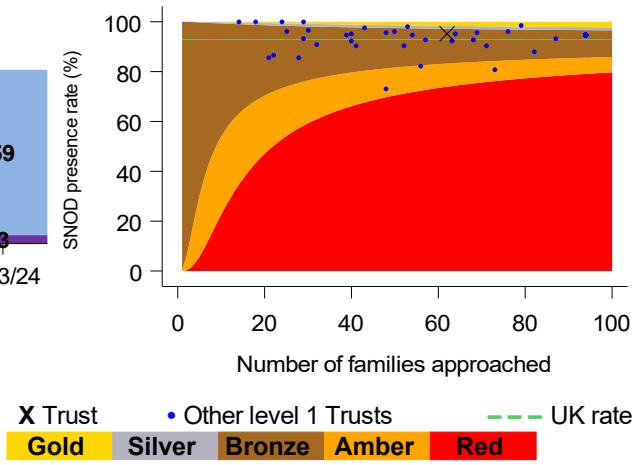
Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



A SNOD was present for 59 organ donation discussions with families during 2023/24. There were 3 occasions where a SNOD was not present.

When compared with UK performance, the Trust was average (bronze) for SNOD presence when approaching families to discuss organ donation.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South East*	UK
1 April 2023 - 31 March 2024		
Deceased donors	203	1,510
Transplants from deceased donors	445	3,723
Deaths on the transplant list	29	418
As at 31 March 2024		
Active transplant list	829	7,484
Number of NHS ODR opt-in registrations (% registered)**	4,116,544 (44%)	28,161,705 (42%)
Number of NHS ODR opt-out registrations (% registered)**	227,280 (2%)	2,577,667 (4%)

*Regions are defined using the NHS region definitions
* % registered based on population of 9.29 million, based on ONS 2021 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers, rates and comparison with UK data, 1 April 2023 - 31 March 2024

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	37	2029	108	5331	138	6911
Referred to Organ Donation Service	37	2017	88	4949	118	6522
Referral rate %	G *100%*	*99%*	A *81%*	*93%*	A *86%*	*94%*
Neurological death tested	27	1534				
Testing rate %	B *73%*	*76%*				
Eligible donors[2]	25	1426	78	3635	103	5061
Family approached	21	1259	41	1849	62	3108
Family approached and SNOD present	21	1215	38	1672	59	2887
% of approaches where SNOD present	G *100%*	*97%*	B *93%*	*90%*	B *95%*	*93%*
Consent ascertained	17	858	29	1023	46	1881
Consent rate %	B *81%*	*68%*	S *71%*	*55%*	S *74%*	*61%*
- Expressed opt in	12	533	18	637	30	1170
- Expressed opt in %	*100%*	*95%*	*100%*	*85%*	*100%*	*89%*
- Deemed Consent	4	246	10	323	14	569
- Deemed Consent %	*67%*	*58%*	*56%*	*47%*	*58%*	*51%*
- Other*	1	78	1	63	2	141
- Other %*	*100%*	*52%*	*100%*	*34%*	*100%*	*42%*
Actual donors (PDA data)	17	788	21	710	38	1499
% of consented donors that became actual donors	*100%*	*92%*	*72%*	*69%*	*83%*	*80%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

For further information, including definitions, see the latest Potential Donor Audit report and up to date metrics via our Power BI reports at:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2023 - 31 March 2024

University Hospitals Sussex NHS Foundation Trust

Table of Contents

Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report and our Power BI reports with up to date Trust metrics are available at https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2024 based on data meeting PDA criteria reported at 8 May 2024.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2023 and 31 March 2024, University Hospitals Sussex NHS Foundation Trust had 38 deceased solid organ donors, resulting in 93 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2022/23. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2023 - 31 March 2024 (1 April 2022 - 31 March 2023 for comparison)

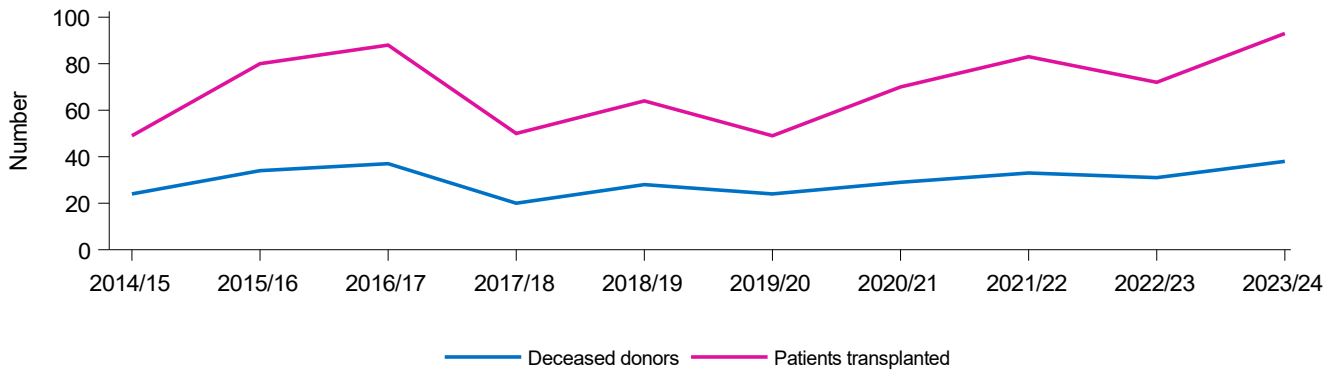
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor: Trust		Average number of organs donated per donor: UK	
DBD	17	(15)	48	(42)	3.3	(3.1)	3.6	(3.4)
DCD	21	(16)	45	(30)	2.9	(3.1)	2.9	(2.8)
DBD and DCD	38	(31)	93	(72)	3.1	(3.1)	3.2	(3.2)

In addition to the 38 proceeding donors there were 9 additional consented donors that did not proceed, all where DCD donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2023 - 31 March 2024 (1 April 2022 - 31 March 2023 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	30	(25)	1	(2)	13	(12)	3	(2)	4	(5)	0	(0)
DCD	36	(22)	1	(1)	8	(7)	1	(2)	0	(0)	0	(0)
DBD and DCD	66	(47)	2	(3)	21	(19)	4	(4)	4	(5)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2014 - 31 March 2024



2. Key Rates in Potential for Organ Donation

A summary of the key rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

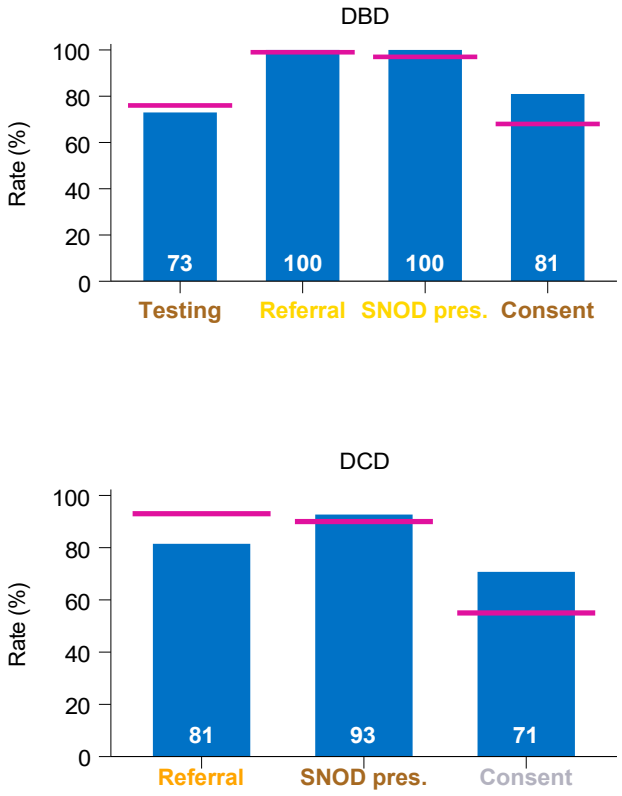
This section presents specific percentage measures of potential donation activity for University Hospitals Sussex NHS Foundation Trust.

Performance in your Trust has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2023/24 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

Note that caution should be applied when interpreting percentages based on small numbers.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2023 - 31 March 2024



Trust — UK

Gold | Silver | Bronze | Amber | Red

Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2019 - 31 March 2024

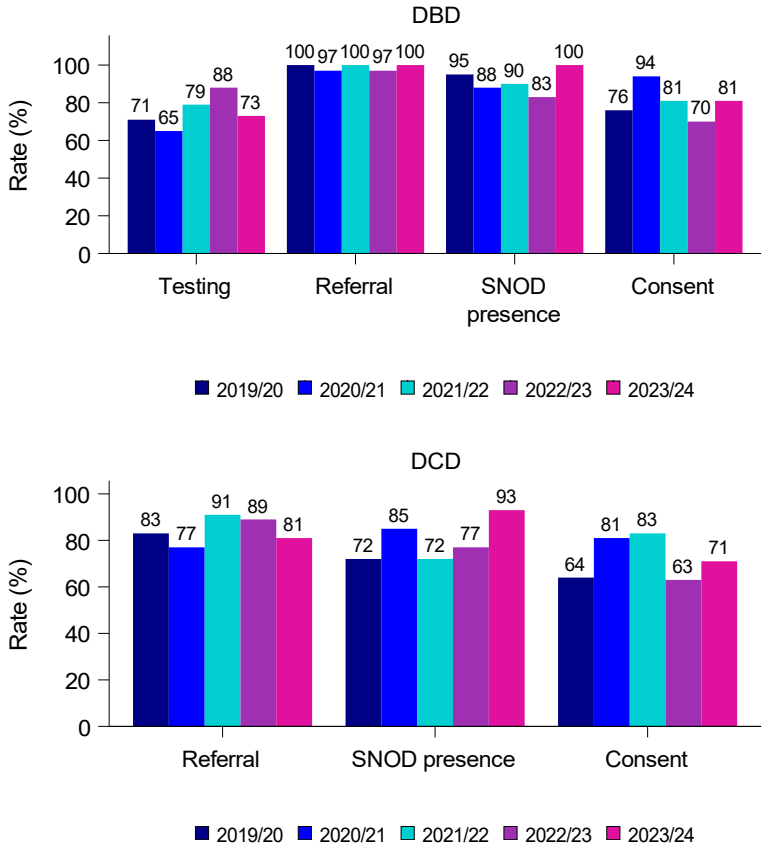


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2023 - 31 March 2024

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	37	2029	108	5331	138	6911
Referred to Organ Donation Service	37	2017	88	4949	118	6522
Referral rate %	G *100%*	*99%*	A *81%*	*93%*	A *86%*	*94%*
Neurological death tested	27	1534				
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- Other %*	*100%*	*52%*	*100%*	*34%*	*100%*	*42%*
Actual donors (PDA data)	17	788	21	710	38	1499
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[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold Silver Bronze Amber Red

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2019 - 31 March 2024

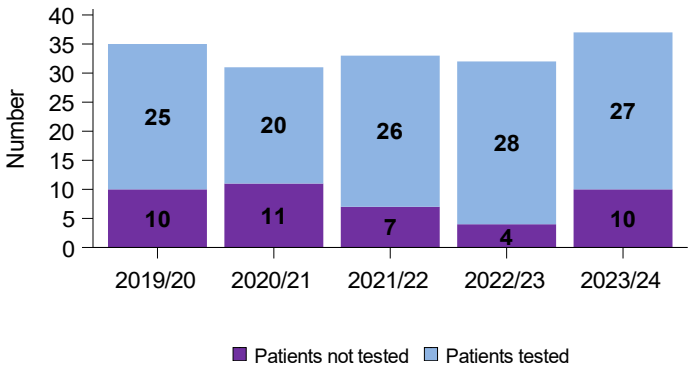


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2023 - 31 March 2024

	Trust	UK
Biochemical/endocrine abnormality	-	32
Clinical reason/Clinician's decision	3	72
Continuing effects of sedatives	-	15
Family declined donation	-	40
Family pressure not to test	-	55
Hypothermia	-	1
Inability to test all reflexes	1	20
Medical contraindication to donation	-	5
Other	1	58
Patient had previously expressed a wish not to donate	-	4
Patient haemodynamically unstable	3	151
Pressure of ICU beds	-	1
SN-OD advised that donor not suitable	1	13
Treatment withdrawn	-	20
Unknown	1	8
Total	**10**	**495**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2019 - 31 March 2024

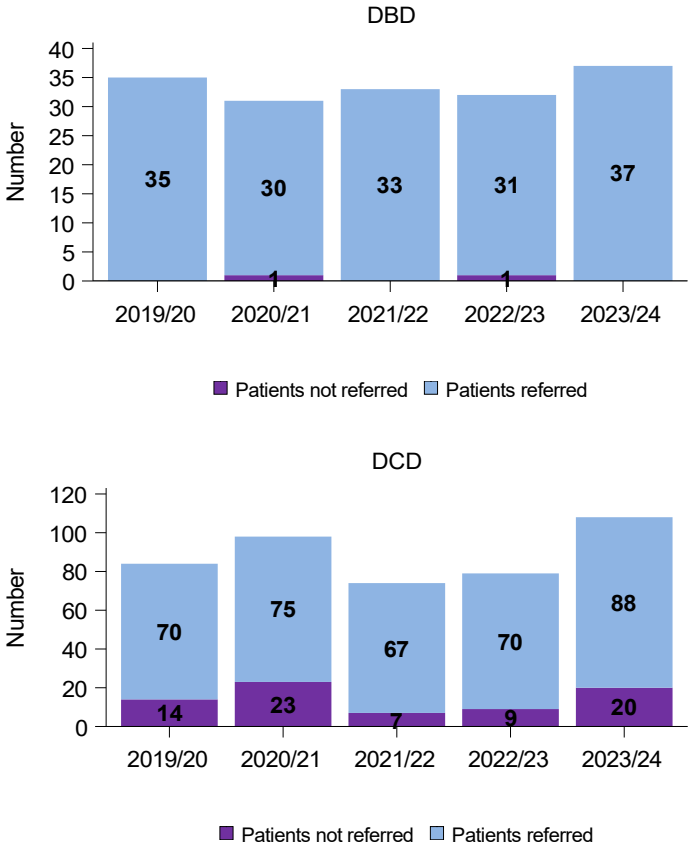


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Trust	UK	Trust	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	4
Coroner / Procurator Fiscal reason	-	1	-	-
Family declined donation following decision to remove treatment	-	-	-	9
Family declined donation prior to neurological testing	-	-	-	1
Medical contraindications	-	-	1	42
Not identified as potential donor/organ donation not considered	-	8	16	260
Other	-	1	-	9
Patient had previously expressed a wish not to donate	-	-	-	2
Pressure on ICU beds	-	-	-	5

If 'other', please contact your local SNOD or CLOD for more information, if required.

Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Reluctance to approach family	-	-	-	2
Thought to be medically unsuitable	-	-	3	42
Uncontrolled death pre referral trigger	-	2	-	6
Total	**-**	**12**	**20**	**382**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

In 2023/24 there were 79 potential donors in your Trust with an ACI reported, 69 DBD and 78 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

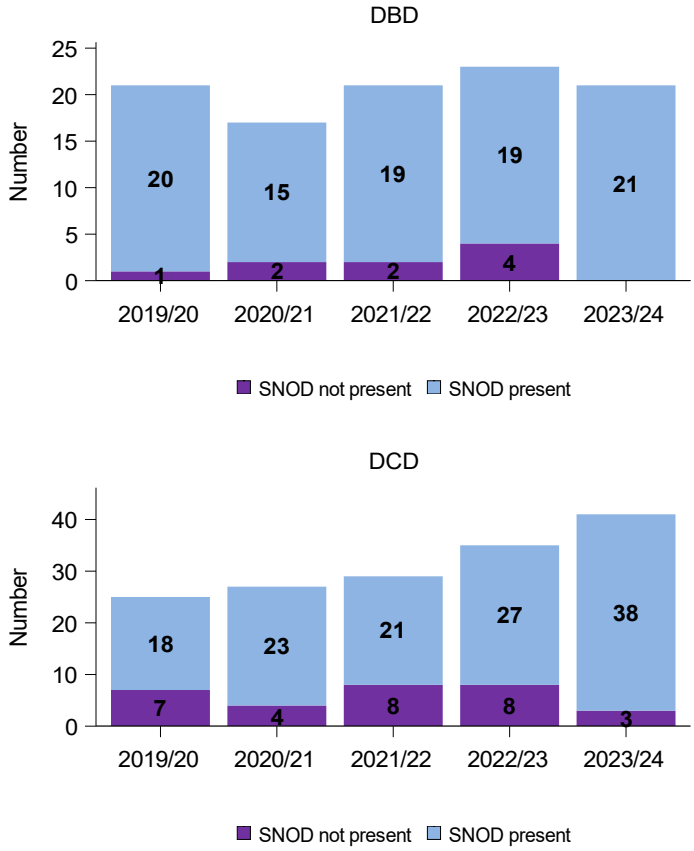
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2023/24, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 23% and 14%, respectively, compared with DBD and DCD consent/authorisation rates of 70% and 60%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known decision of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2019 - 31 March 2024



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 8 May 2024]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 8 May 2024]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 8 May 2024]

3.5 Consent

In 2023/24 the DBD and DCD consent rates in your Trust were 81% and 71%, respectively.

Figure 3.4 Number of families approached, 1 April 2019 - 31 March 2024

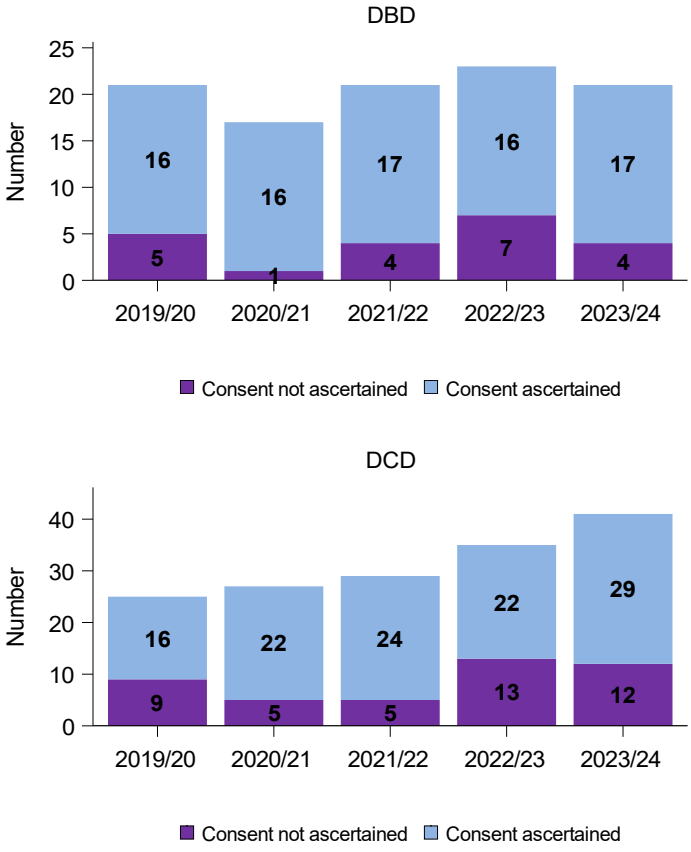


Table 3.3 Reasons given why consent was not ascertained, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Trust	UK	Trust	UK
Family believe patient's treatment may have been limited to facilitate organ donation	-	-	-	1
Family concerned other people may disapprove/be offended	-	3	-	4
Family concerned that organs may not be transplantable	-	2	-	8
Family did not believe in donation	-	5	-	9
Family did not want surgery to the body	-	42	-	57
Family divided over the decision	-	12	1	20
Family felt it was against their religious/cultural beliefs	1	49	2	28
Family felt patient had suffered enough	-	24	1	78
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	13	-	17
Family felt the length of time for the donation process was too long	-	30	1	167
Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	5	-	17

If 'other', please contact your local SNOD or CLOD for more information, if required.

Table 3.3 Reasons given why consent was not ascertained, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Family were not sure whether the patient would have agreed to donation	1	49	3	113
Other	-	24	1	57
Patient had previously expressed a wish not to donate	1	94	3	167
Patient had registered a decision to Opt Out	-	21	-	43
Strong refusal - probing not appropriate	1	25	-	39
Total	**4**	**401**	**12**	**825**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinical - Absolute contraindication to organ donation	-	3	-	5
Clinical - Considered high risk donor	-	4	-	8
Clinical - DCD clinical exclusion	-	-	-	2
Clinical - No transplantable organ	-	7	-	12
Clinical - Organs deemed medically unsuitable by recipient centres	-	17	1	58
Clinical - Organs deemed medically unsuitable on surgical inspection	-	9	-	6
Clinical - Other	-	3	-	7
Clinical - PTA post WLST	-	-	6	164
Clinical - Patient actively dying	-	4	-	7
Clinical - Patient asystolic	-	3	-	1
Clinical - Patient's general medical condition	-	1	-	6
Clinical - Positive virology	-	2	-	-
Clinical - Predicted PTA therefore not attended	-	-	-	1
Consent / Auth - Coroner/Procurator fiscal refusal	-	10	-	8
Consent / Auth - Family placed conditions on donation	-	-	-	1
Consent / Auth - NOK declined organ donation	-	1	-	-
Consent / Auth - NOK withdraw consent / authorisation	-	6	-	22
Consent / Auth - Other	-	-	-	1
Logistical - Other	-	-	1	1
Logistical - Retrieval team not available	-	-	-	1
Logistical - Unit unable to maintain patient	-	-	-	1
Total	**-**	**70**	**8**	**312**

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. Comparative Data

A comparison of performance in your Trust/Board with national data

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section compares the quality of care in the key areas of organ donation in your Trust with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Trust is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Trust, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

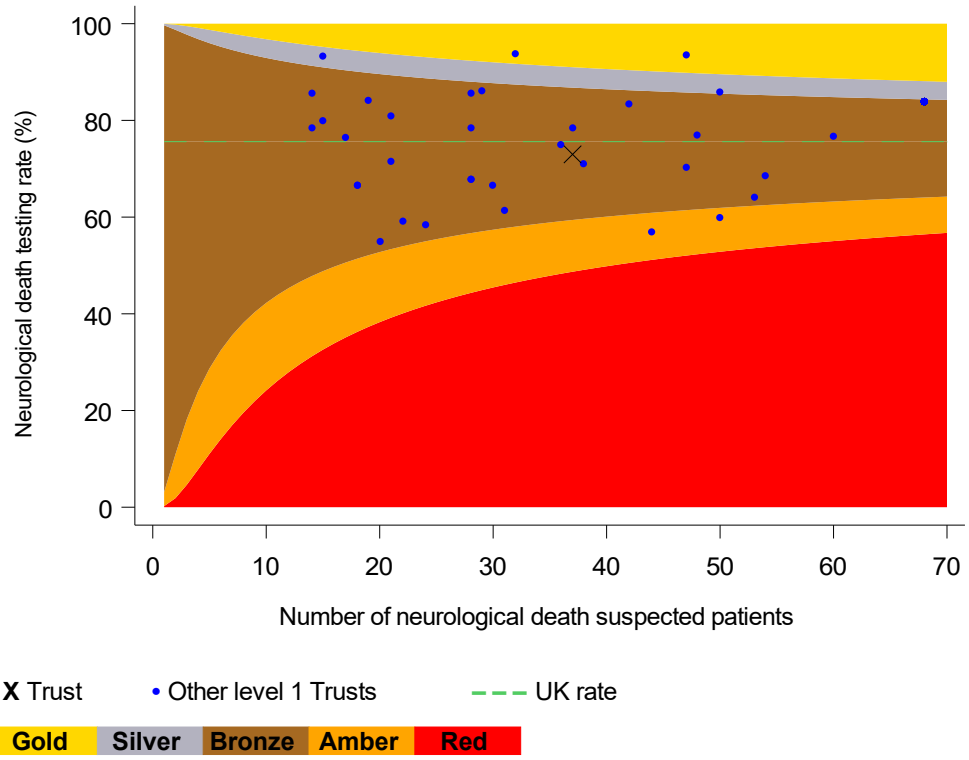
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 7.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

4.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2023 - 31 March 2024

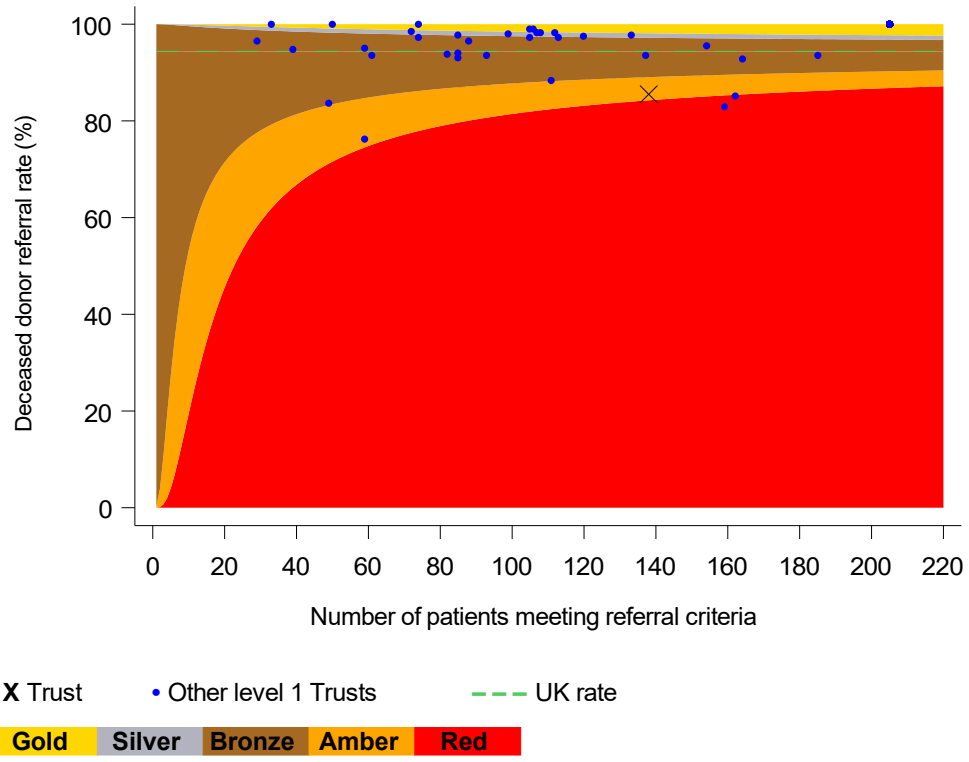


When compared with UK performance the neurological death testing rate in University Hospitals Sussex NHS Foundation Trust was average (bronze).

4.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2023 - 31 March 2024

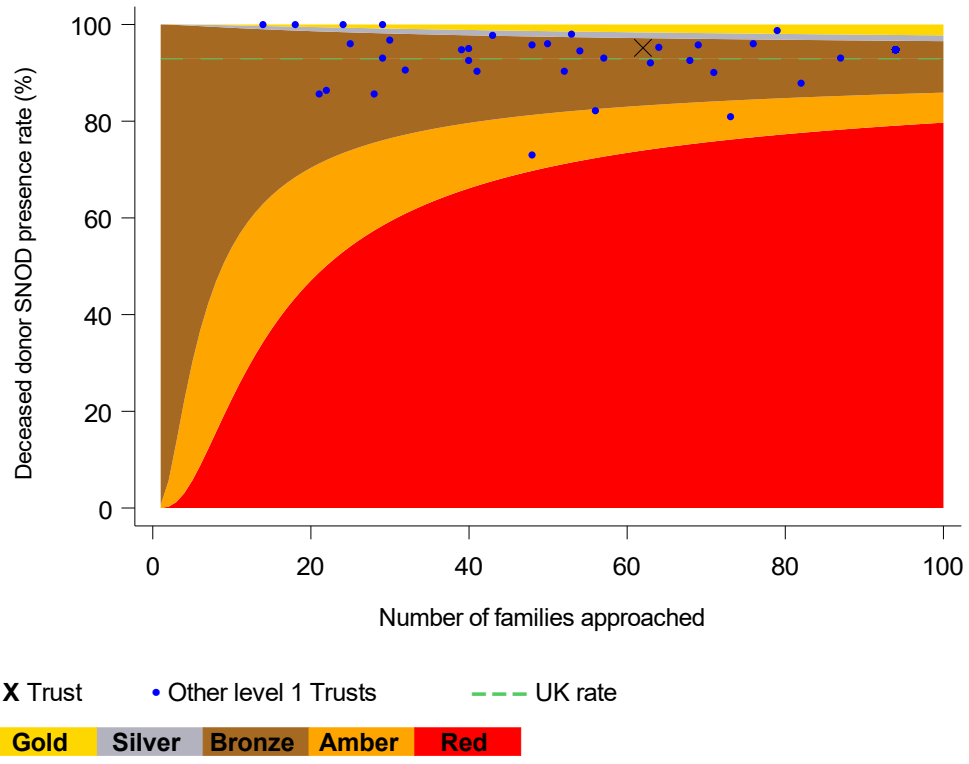


When compared with UK performance University Hospitals Sussex NHS Foundation Trust was below average (amber) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

4.3 SNOD presence

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

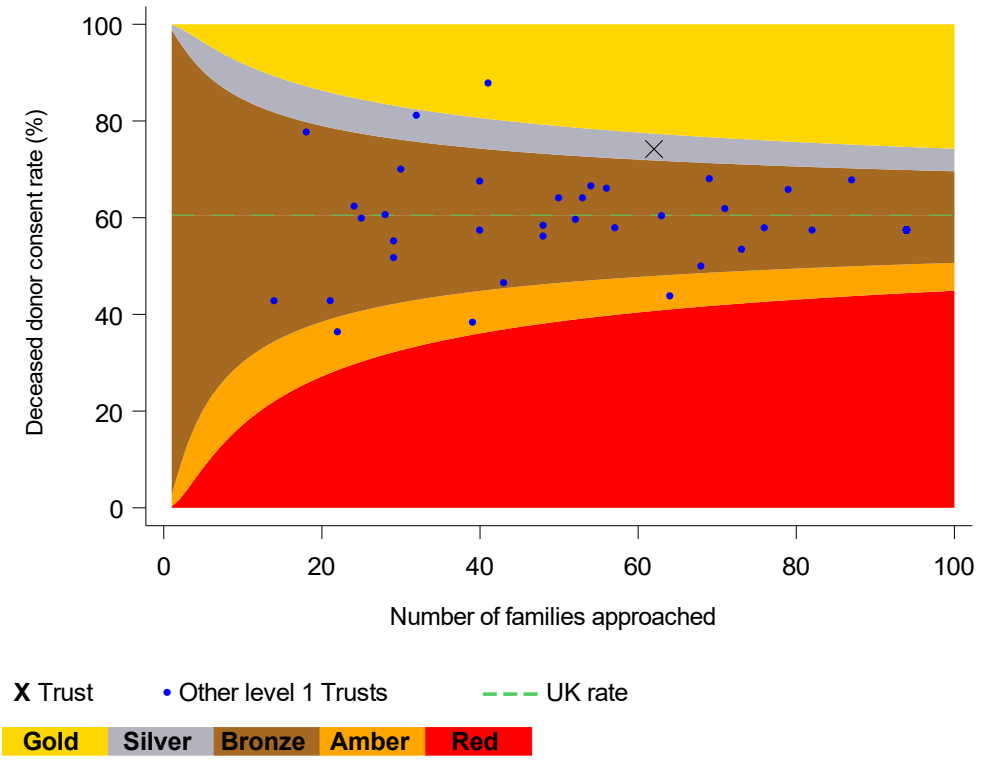
Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2023 - 31 March 2024



When compared with UK performance University Hospitals Sussex NHS Foundation Trust was average (bronze) for Specialist Nurse presence when approaching families to discuss organ donation.

4.4 Consent

Figure 4.4 Funnel plot of consent rate, 1 April 2023 - 31 March 2024



When compared with UK performance the consent rate in University Hospitals Sussex NHS Foundation Trust was good (silver).

5. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2023 - 31 March 2024

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Brighton, Royal Sussex County Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	28	21	75	28	100	20	20	17	17	100	13	76	13
ICU - cardiothoracic	0	0	-	0	-	0	0	0	0	-	0	-	0
Chichester, St Richard's Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	4	3	-	4	-	3	3	2	2	-	2	-	2
Haywards Heath, Princess Royal Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	1	0	-	1	-	0	0	0	0	-	0	-	0
Worthing, Worthing Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	4	3	-	4	-	3	2	2	2	-	2	-	2

Table 5.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2023 - 31 March 2024

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Brighton, Royal Sussex County Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	72	60	83	72	60	33	31	94	23	70	17
ICU - cardiothoracic	2	0	-	2	2	0	0	-	0	-	0
Chichester, St Richard's Hospital											
A & E	1	0	-	1	1	0	0	-	0	-	0
General ICU/HDU	16	14	88	16	8	4	3	-	3	-	2
Haywards Heath, Princess Royal Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	2	1	-	2	1	0	0	-	0	-	0
Worthing, Worthing Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	15	13	87	15	6	4	4	-	3	-	2

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for University Hospitals Sussex NHS Foundation Trust in 2023/24 there were 0 such patients. For more information regarding the Emergency Department please see Section 6.

6. Emergency Department data

A summary of key numbers for Emergency Departments

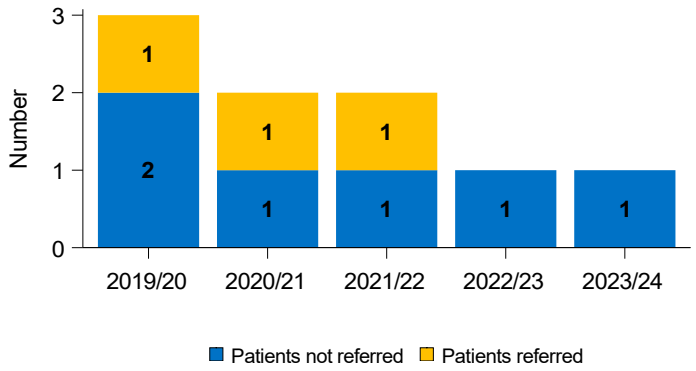
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a decision in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [4] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

6.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

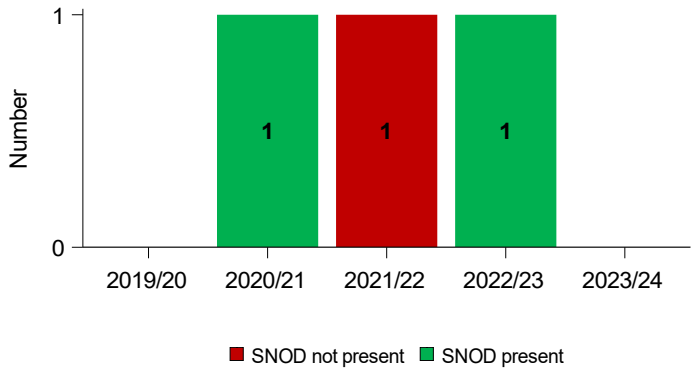
Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2019 - 31 March 2024



6.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2019 - 31 March 2024



[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 8 May 2024]

7. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

7.1 Supplementary Regional data

Table 7.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South East*	UK
1 April 2023 - 31 March 2024		
Deceased donors	203	1,510
Transplants from deceased donors	445	3,723
Deaths on the transplant list	29	418
As at 31 March 2024		
Active transplant list	829	7,484
Number of NHS ODR opt-in registrations (% registered)**	4,116,544 (44%)	28,161,705 (42%)
Number of NHS ODR opt-out registrations (% registered)**	227,280 (2%)	2,577,667 (4%)

*Regions are defined using the NHS region definitions
** % registered based on population of 9.29 million, based on ONS 2021 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

7.2 Trust/Board Level Benchmarking

University Hospitals Sussex NHS Foundation Trust has been categorised as a level 1 Trust. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 7.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 7.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more (≥ 12) proceeding donors per year	36
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	51
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	31
Level 4	3 or less (≤ 3) proceeding donors per year	39

Tables 7.3 and 7.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 7.3 National DBD key numbers and rate by Trust/Board level, 1 April 2023 - 31 March 2024

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	37	27	73	37	100	26	25	21	21	100	17	81	17
Level 1	1183	881	74	1174	99	858	814	715	682	95	483	68	451
Level 2	539	414	77	538	100	402	388	344	339	99	242	70	220
Level 3	169	138	82	167	99	138	130	119	116	97	81	68	72
Level 4	138	101	73	138	100	98	94	81	78	96	52	64	45

Table 7.4 National DCD key numbers and rate by Trust/Board level, 1 April 2023 - 31 March 2024

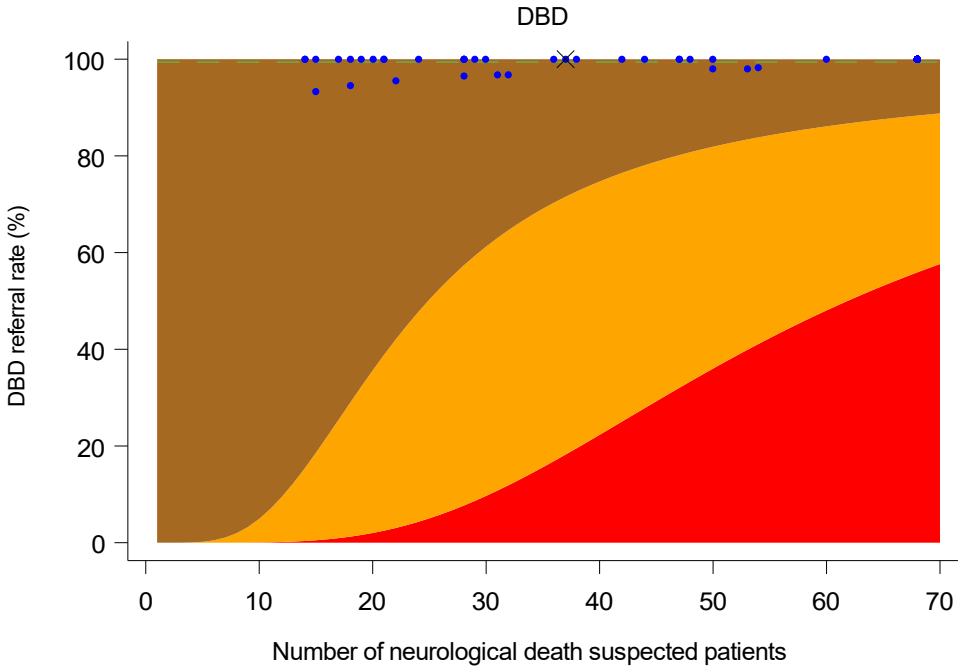
	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	108	88	81	108	78	41	38	93	29	71	21
Level 1	2735	2533	93	2669	1932	1066	965	91	590	55	430
Level 2	1532	1426	93	1494	1039	499	454	91	285	57	187
Level 3	583	547	94	559	353	167	154	92	93	56	54
Level 4	481	443	92	464	311	117	99	85	55	47	39

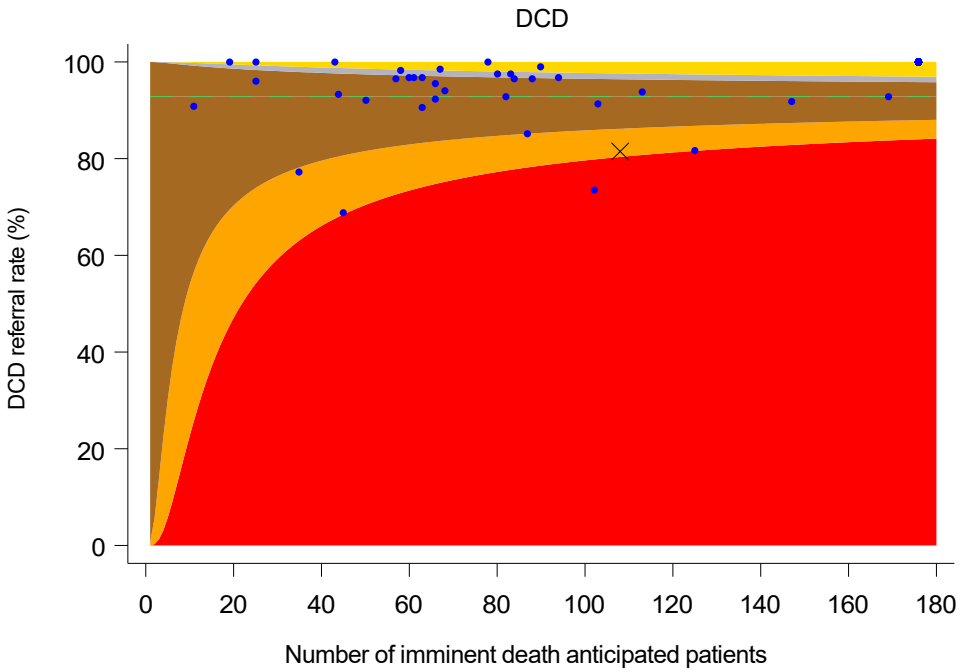
7.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Trust against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

Figure 7.1 Funnel plots of referral rates, 1 April 2023 - 31 March 2024



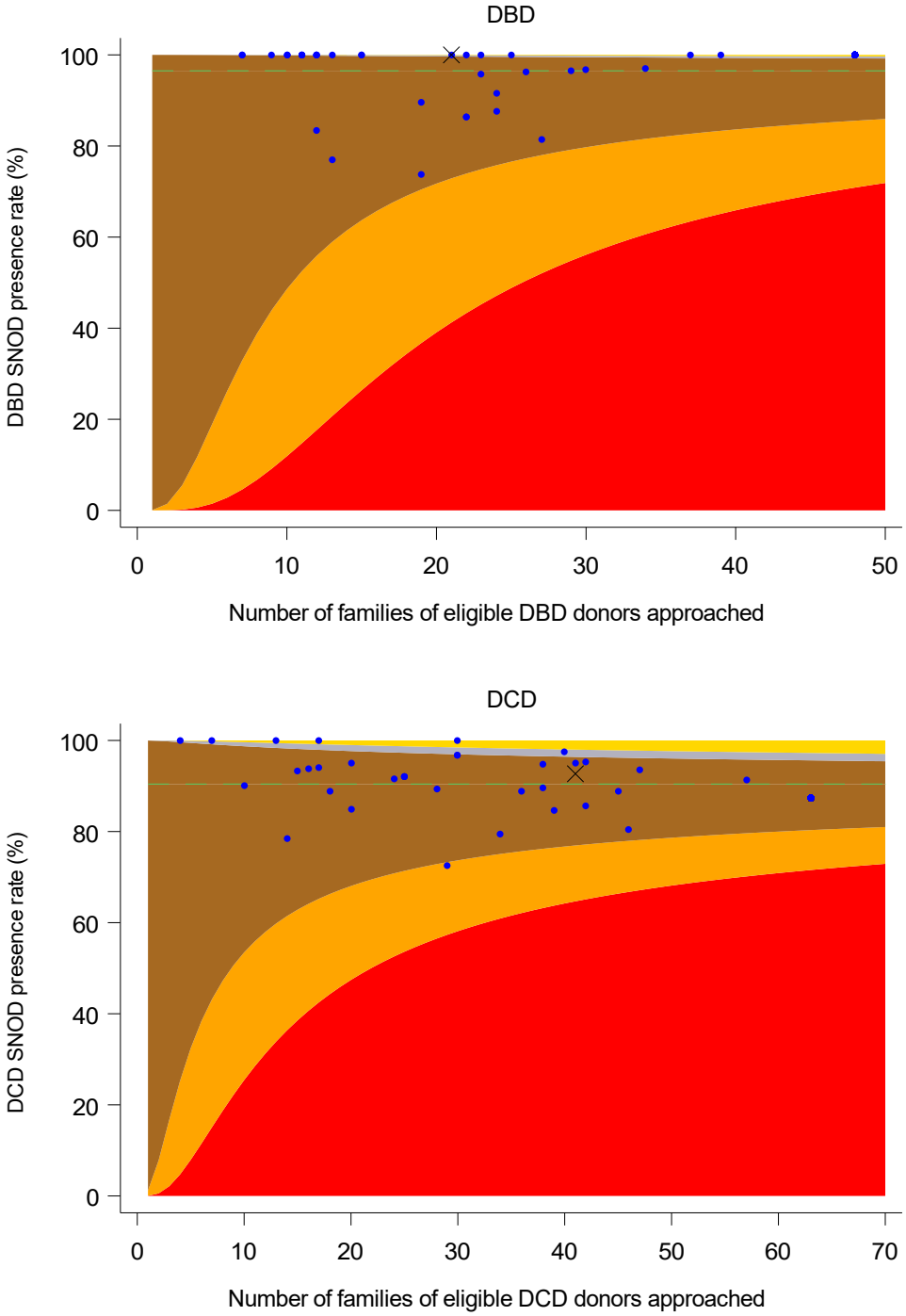


X Trust • Other level 1 Trusts – – – UK rate

Gold **Silver** **Bronze** **Amber** **Red**

When compared with UK performance University Hospitals Sussex NHS Foundation Trust was exceptional (gold) for referral of potential DBD organ donors and below average (amber) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

Figure 7.2 Funnel plots of SNOD presence rates, 1 April 2023 - 31 March 2024

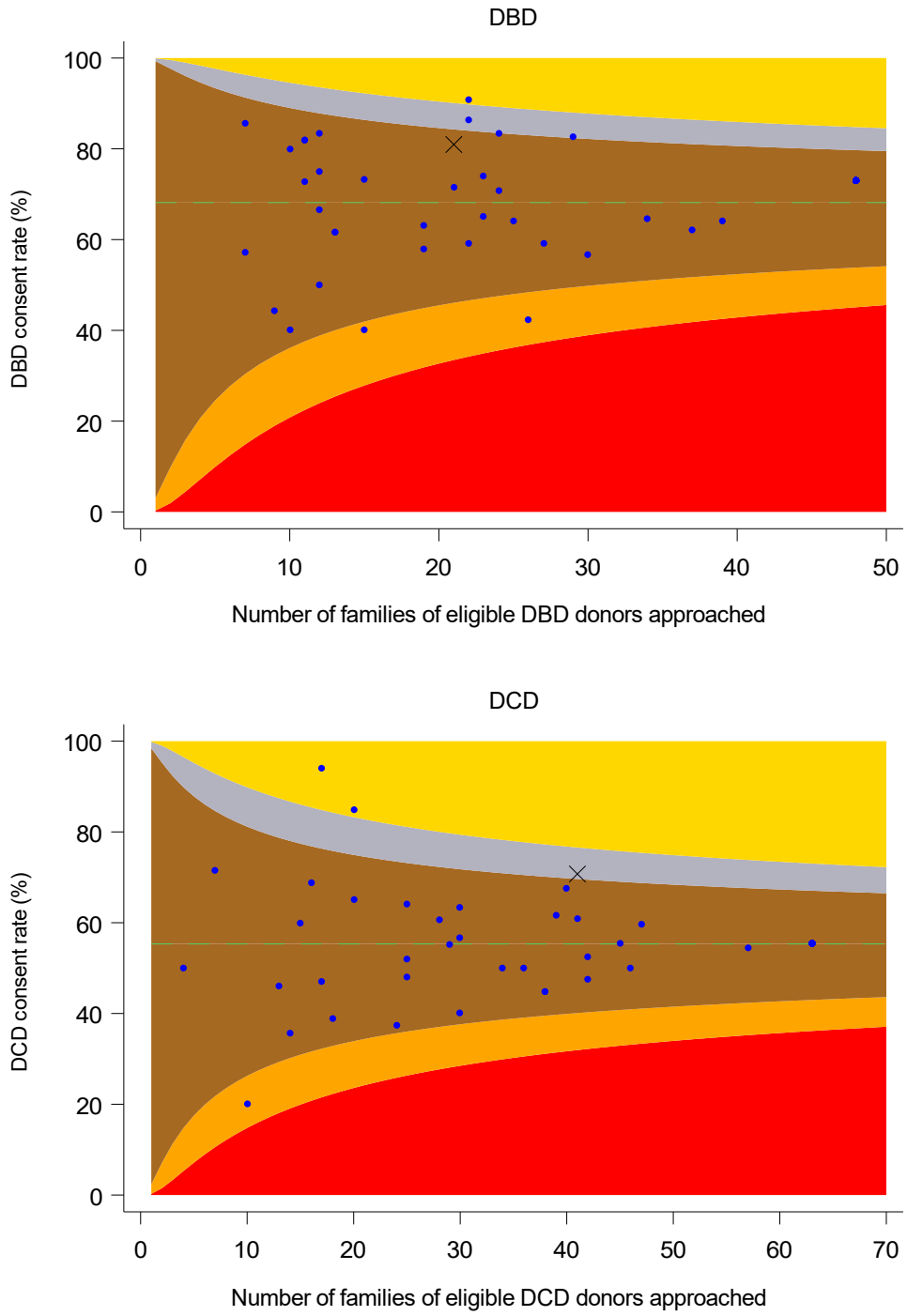


X Trust • Other level 1 Trusts – – – UK rate

Gold | Silver | Bronze | Amber | Red

When compared with UK performance University Hospitals Sussex NHS Foundation Trust was exceptional (gold) and average (bronze) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

Figure 7.3 Funnel plots of consent rates, 1 April 2023 - 31 March 2024



When compared with UK performance the consent rate in University Hospitals Sussex NHS Foundation Trust was average (bronze) and good (silver) for DBD and DCD donors, respectively.

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under (prior to 81st birthday)

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – below 37 weeks corrected gestational age'. Previously referred to as brain death
Neurological death tested	Neurological death tests performed to confirm and diagnose death
DBD referral criteria	A patient with suspected neurological death
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to Specialist Nurse – Organ Donation	A patient with suspected neurological death referred to a SNOD. A referral is the provision of information to determine organ donation suitability. NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DBD donor	A patient with suspected neurological death
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188) Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Donation decision conversation	Family of eligible DBD asked to make or support patient's organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual donors: DBD	Patients who became actual DBD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Actual donors: DCD	Patients who became actual DCD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested

Referral rate	Percentage of patients for whom neurological death was suspected who were referred to the SNOD
Donation decision conversation rate	Percentage of eligible DBD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations)
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above)

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving invasive ventilation, in whom a clinical decision to withdraw treatment has been made and a controlled death is anticipated within a time frame to allow donation to occur (as determined at time of assessment)
DCD referral criteria	A patient for whom imminent (controlled) death is anticipated following withdrawal of life sustaining treatment (as defined above)
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to SNOD	A patient for whom imminent death is anticipated who was referred to a SNOD. A referral is the provision of information to determine organ donation suitability NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DCD donor	A patient who had treatment withdrawn and imminent death was anticipated within a time frame to allow donation to occur.
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DCD donor to be assessed	A patient who had treatment withdrawn and imminent (controlled) death was anticipated, with no absolute medical contraindications to solid organ donation.
DCD exclusion criteria	DCD specific criteria determine a patient's suitability to donation when there are no absolute medical contraindications (see absolute contraindications documentation above)
DCD screening process	Process by which an organ may be screened with a local and national transplant centre to determine suitability of organs for transplantation
Medically suitable eligible DCD donor	An eligible DCD donor to be assessed considered to be medically suitable for donation (i.e. no DCD exclusions and not deemed unsuitable by the screening process)
Donation decision conversation	Family of medically suitable eligible DCD donor who were asked to make or support patient's organ donation decision - This includes clarifying an opt out decision.
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual DCD	DCD patients who became actual DCD as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Referral rate	Percentage of patients for whom imminent (controlled) death was anticipated who were referred to the SNOD

Donation decision conversation rate	Percentage of medically suitable eligible DCD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained.
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations).
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above).

Deemed Consent/Authorisation

Deemed consent applies if a person who died in Wales, Jersey or England has not expressed an organ donation decision either to opt in or opt out or nominate/appoint a representative, is aged 18 or over, has lived in the country in which they died for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed consent for a significant period before their death.

Deemed authorisation applies if a person who died in Scotland has not expressed, in writing, an organ donation decision either to opt in or opt out, is aged 16 or over, has lived in Scotland for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed authorisation for a significant period before their death. Note that, in Scotland, a patient who has verbally expressed an opt in decision is included as a deemed authorisation, whereas a patient who has verbally expressed an opt out decision is not included.

Consent/Authorisation groups

Expressed opt in	Patient had expressed an opt in decision. Opt in decisions can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England and Jersey. Verbally expressed opt in decisions are not included in Scotland
Deemed consent/authorisation	Patient meets deemed criteria specific to each nation as described above. In Scotland, this includes patients who have verbally expressed a decision to opt in
Expressed opt out	Patient had expressed an opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations
Other	Patient has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key rates in potential for organ donation	
Figure 2.1	Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below.
Figure 2.2	Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA.
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below).

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.

Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 Comparative data	
Figure 4.1	A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board, of the same level, is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The UK rate is shown on the plot as a green horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the UK rate (average performance). If a Trust/Board lies outside the 95% confidence limits, shaded silver (good performance) or amber (below average performance), this serves as an alert that the Trust/Board may have a rate that is significantly different from the UK rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the UK rate (exceptional performance), while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the UK rate (poor performance). It is important to note that differences in patient mix have not been accounted for in these plots. Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented. The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.
Figure 4.2	A funnel plot of the deceased donor referral rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.3	A funnel plot of the deceased donor SNOD presence rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.4	A funnel plot of the deceased donor consent/authorisation rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.

5 PDA data by hospital and unit	
Table 5.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 5.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

6 Emergency department data	
Figure 6.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 6.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

7 Additional data and figures	
Table 7.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. A UK comparison is also provided.
Table 7.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 7.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 7.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Figure 7.1	A funnel plot of the DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.2	A funnel plot of the DBD and DCD SNOD presence rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.3	A funnel plot of the DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.

NHS
Blood and Transplant
www.nhsbt.nhs.uk

May 2024

Dear Dr Findlay and Dr Urch,

The number of donors and transplants in the UK have continued to improve and we are returning to pre-pandemic levels. Please accept our recognition and thanks for the effort of your staff.

This letter explains how your Trust contributed to the UKs deceased donation programme.

Organ and tissue donation and transplantation activity - 2023/24

From 47 consented donors, University Hospitals Sussex NHS Foundation Trust facilitated 38 actual solid organ donors resulting in 93 patients receiving a transplant during the time period. Additionally, 43 corneas were received by NHSBT Eye Banks from your Trust.

Quality of care in organ donation - 2023/24

When compared with national data, during the time period your Trust was:

- Below average for the referral of potential organ donors
- In line with the national average for Specialist Nurse presence when approaching families to discuss organ donation

- Your Trust referred 160 patients to NHSBT's Organ Donation Services Team; 118 met the referral criteria and were included in the UK Potential Donor Audit. There were a further 20 audited patients that were not referred.
- A Specialist Nurse was present for 59 organ donation discussions with families of eligible donors. There were 3 occasions when a Specialist Nurse was absent for the donation discussion.
- In South East, 44% of the population have registered an NHSBT Organ Donor Register (ODR) opt in decision. This compares to 42% of the population nationally.

Up to date Trust metrics are always available via our Power BI reports found here:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

What we would like you to do

- Ensure your Trust supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and quality data at the Board with support from your Organ Donation Committee Chair.
- Recognise any successes your Trust has had in facilitating donation or transplantation, especially during the ongoing NHS pressures.
- An opt-in registration on the NHSBT Organ Donor Register results in the highest rates of consent, please support your Organ Donation Committee in their efforts to promote the NHSBT Organ Donor Register where possible.

Deemed Consent Legislation - England

England introduced deemed consent (Max and Keira's Law) in May 2020. In England between 20 May 2020 – 31 March 2024 there were 1812 occasions when consent was deemed from 3215 occasions where deemed consent applied.

Why it matters

In 2023/24, 445 people benefited from a solid organ transplant in the South East. However sadly, 29 people died on the transplant waiting list during this time.

Thank you once again for your vital ongoing support for donation and transplantation.

Yours sincerely,

Anthony Clarkson
Director of Organ and Tissue Donation and Transplantation
NHS Blood and Transplant

University Hospitals Sussex NHS Foundation Trust

Perinatal Quality Surveillance – Trust wide summary report – August 2024 data

Purpose

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

Background

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

The provider trust and its board, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, 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.

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

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

Risk Register

New risks added during August with a score of 16 and above:

ID	Title	Risk Register	Subtype	Current Risk Grading	Status	Location	Service
2001	Cooling system failure in bereavement suite cold room	Women & Children	Clinical	16	Closed	St Richards Hospital, Worthing Hospital	Maternity, Mortuary
Air conditioning unit has broken in the cold room of the bereavement suite on labour ward. This contravenes the Human Tissue Authority mortuary guidelines for the storage of deceased bodies This is a Single breech in statutory duty it is possible that we may have to report this to the HTA, definitely would have to if it affects a baby's condition, and the likelihood is it will. this may impact condition of the baby and render post-mortem impossible							
Risk closed 01/10/2024: The cooling system has been repaired. The risk is no longer a concern. As requested at the Divisional Risk meeting in September 2024 a new risk #2128 created regarding non- compliance with HTA regulations.							

Risk closed during August with a score of 16 and above:

ID	Title	Risk Register	Subtype	Current Risk Grading	Status	Location	Service

1971	Redeployment of specialist midwives, leads and managers and the impact upon clinical effectiveness and patient safety	Women & Children	Patient	20	Closed	St Richards Hospital, UHSussex NHS Foundation Trust, Worthing Hospital	Maternity
Due to the significant staffing issues, specialist and senior midwives are being redeployed to clinical areas. As a consequence of this there will delays in guideline management, audits, clinical incident reviews and actions from incidents impacting overall patient safety. This will also have and impact on CNST, Ockenden, SBL, CQC compliance							
This risk is a duplicate of risk #1544. It has been agreed at the Divisional Risk Meeting on 21/08/2024 that this risk is to be closed and merged with risk #1544. All information and actions have been added to risk #1544.							
1914	Ventilation certificate for the obstetric theatres at Princess Royal hospital and Royal Sussex County Hospital has expired poses a risk for infection	Obstetrics & Gynaecology	Health and Safety Requirements	16	Closed	Central Delivery Suite, Level 13 Tower	Obstetrics
The purpose of the ventilation works is to provide staff and patients with a safe and clean environment in the operating theatre. The Trust has to be able to evidence compliance with Health Technical Memorandum (HTM) annually. This is to meet Section 12 of Health Care Act. This last verified 9 and 10 Jun 2023. At that time the Trust identified a number of remedial works that we must undertake. The Estates proposal is the perform the verification over a weekend, effectively closing Labour Ward Theatres at PRH &RSCH from Fri 1800 hrs to Mon morning this weekend. In addition to this there are then 3 x weekend closures to be managed at both sites over Jun and Jul 2024. If the verification is not conducted, we risk: (1) non-compliance with Health Care Act, (2) risk of working in a theatre environment with inferior ventilation and (3) increased scrutiny with CQC and (4) costs of postponing contractors for this work.							
13.08.2024 the Theatre ventilation work has been completed.							

Escalations for October meeting

- Midwifery and neonatal staffing levels are significantly affected by vacancy, maternity leave and sickness, impacting safety, service provision and staff wellbeing and morale.
- Solution not yet found for separate theatre access for planned caesareans on the Brighton site following successful pilot.
- Letter of Concern received 24 September 2024, following the RM inquest raising concerns about audit and compliance with handover of care and 'check out' processes at the end of shifts. A response is being prepared.
- Poor medical staff compliance with fetal monitoring and safeguarding training.
- Poor engagement (26%) and concerning responses via SCORE survey, review, engagement and action plan in development. A more detailed report of findings will be available at the next committee.

Celebrations for October meeting

- Further reduction in perinatal mortality rates in August.
- Smoking cessation impact (see below)
- All sites now achieve 'consultant present' ward rounds day and night (from September)– Ockenden action

Domains

1. *Deaths and Harm*

Aug-24	Latest MBRRACE National Figure (June 2023)	South East Benchmark (June 2023)	Trust Rates	Princess Royal, Haywards Heath	Royal Sussex County Hospital, Brighton	St Richards Hospital, Chichester	Worthing Hospital, Worthing
Deaths and Harm							

12 Month Rolling Neonatal Death (NND) Rate per 1000 births	1.6	1.4	1.27	0 NNDs 12 month rolling rate is 0.89/1000	0 NNDs 12 Month rolling rate is 2.62/1000	1 NND. 12 month rolling rate is 1.37/1000	0 NNDs. 12 month rolling rate is 0/1000
12 Month Rolling Stillbirth Rate per 1000 births	3.6	3.3	1.49	0 Stillbirths 12 month rolling rate is 1.77/1000	0 Stillbirths 12 month rolling rate is 1.74/1000	0 Stillbirths 12 month rolling rate is 0.91/1000	0 Stillbirths 12 month rolling rate is 1.54/1000
12 Month Rolling Perinatal Mortality Rate per 1000 births	5.2	4.7	2.76	2.65	4.36	2.28	1.54
MNSI Referrals	n/a	n/a	0 x MNSI	0 x MNSI	0 x MNSI	0 x MNSI	0 x MNSI
Serious Incidents (SI)	n/a	n/a	0 x SI	0 x SI	0 x SI	0 x SI	0 x SI

Update: On 11th July the 2024 the MBRRACE-UK perinatal mortality surveillance, UK perinatal deaths of babies born in 2022: State of the nation report was published. State of the nation report | MBRRACE-UK (le.ac.uk)

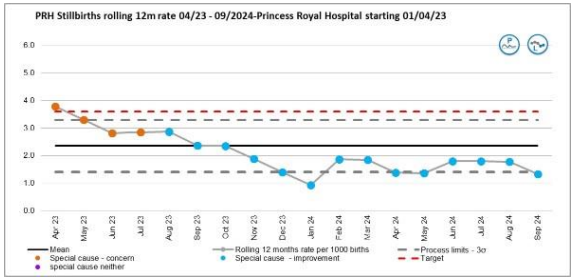
The rates using 2022 data for England were as follows:

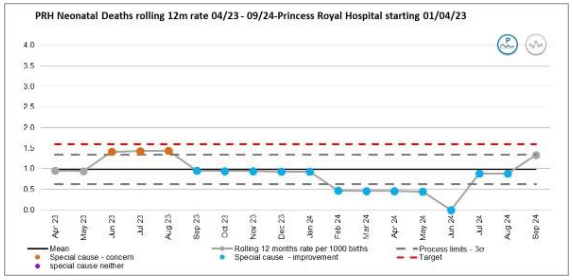
- Neonatal deaths: 1.67 per 1000 births
- Stillbirths: 3.33 per 1000 births
- Perinatal mortality: 5 per 1000 births

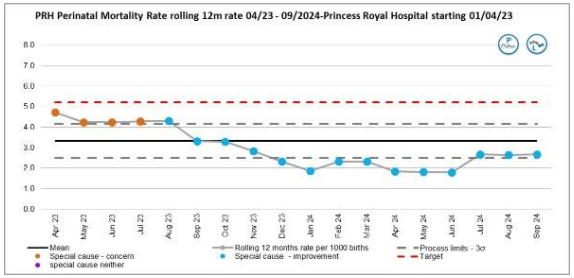
A request for more timely perinatal mortality and morbidity data has been made to the Chief Midwife for England. All Trusts report data on a monthly basis via the Perinatal Quality Surveillance Framework, yet currently, this data is not collated into a 'live' national rate, meaning that the only benchmark data available is MBRRACE benchmark data from 2022. Assurance was provided that this is being explored nationally.

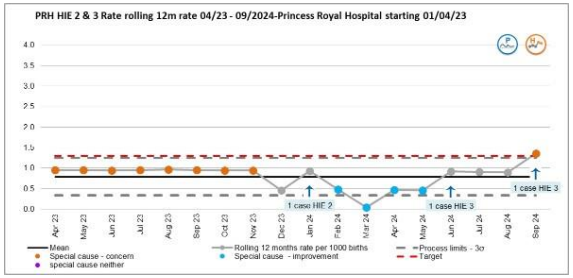
Site specific outcome data can be found below:

Princess Royal Haywards Heath – Rolling 12 month rolling rate Sept 2024



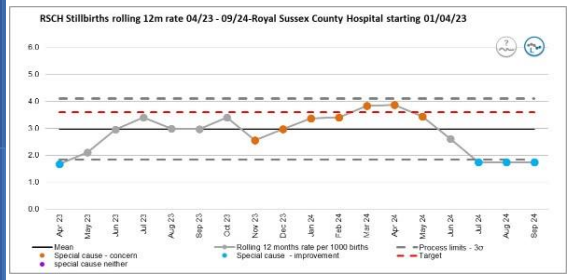


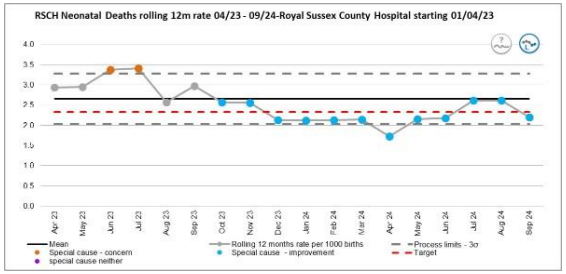


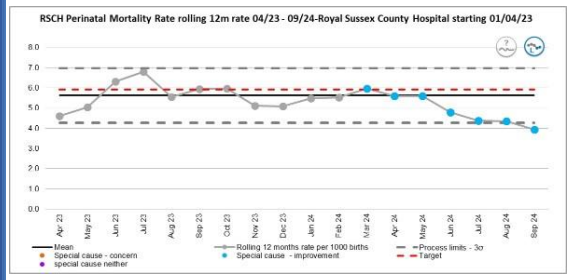


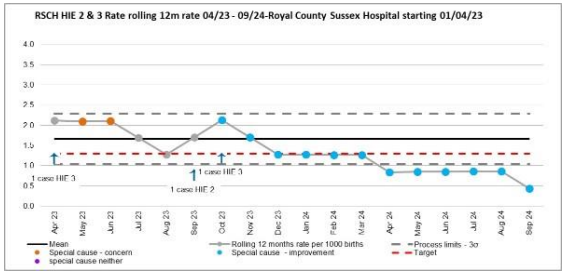
Royal Sussex County Brighton – Rolling 12 month rolling rate Sept 2024

Important - Group average neonatal death rate for services with NNICU and neonatal surgical service is 2.33/ 1000. The Perinatal Mortality rate has also been adjusted accordingly to 5.93/1000

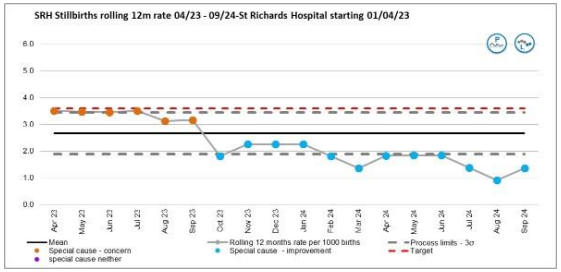


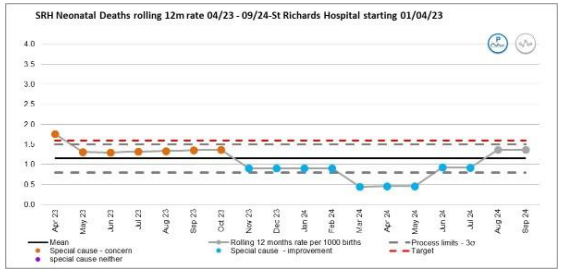


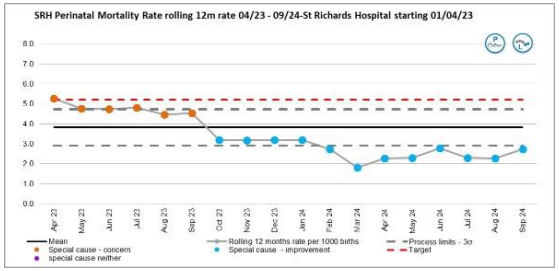


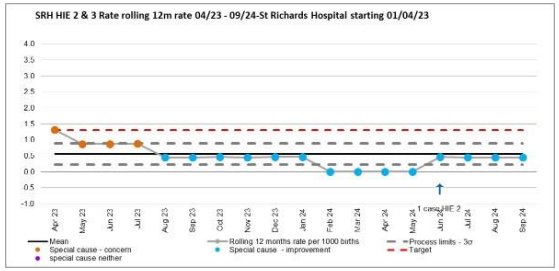


St Richards Chichester – Rolling 12 month rolling rate Sept 2024

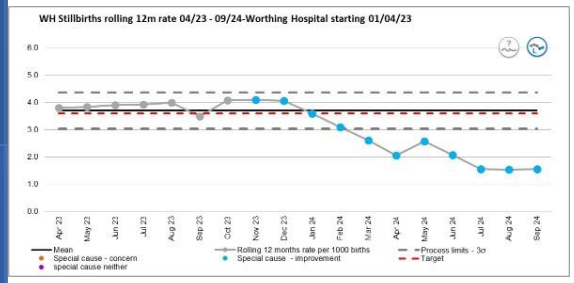


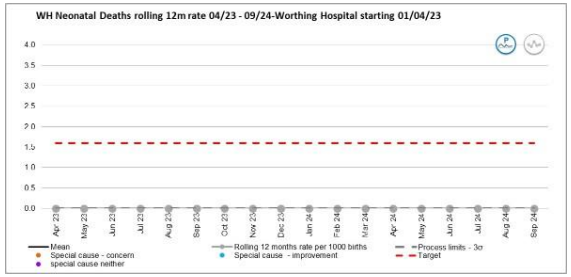


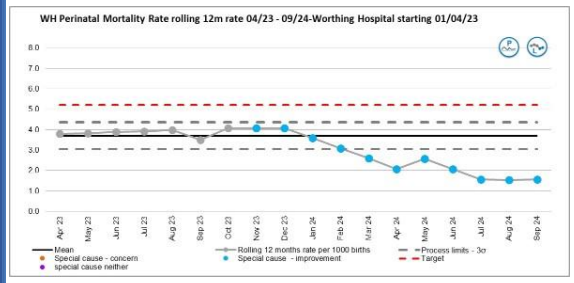


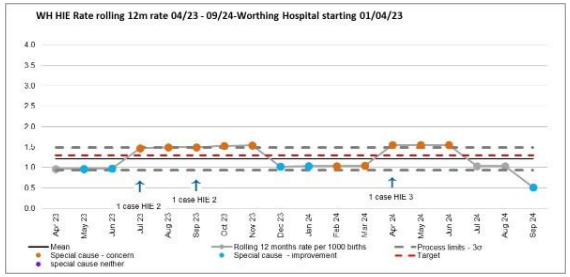


Worthing – Rolling 12 month rolling rate Sept 2024









July 2024 – Brief case details:

Neonatal deaths (NND):

One case at SRH

Stillbirths:

0 cases

Maternity and Neonatal Safety Investigation (MNSI) Referrals:

0 cases

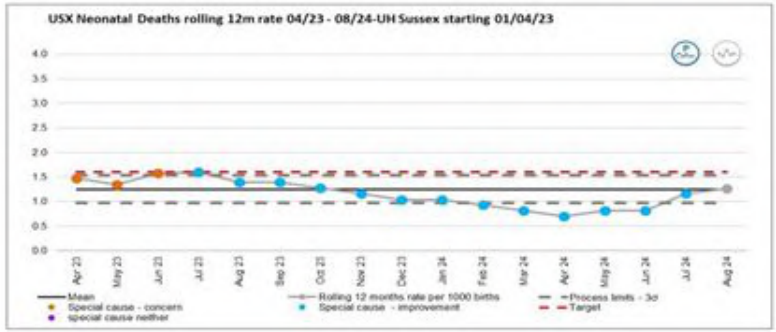
A new Patient safety incident review system Patient Safety Incident Response Framework has been introduced at UH Sussex. Details can be found here: NHS England » Patient Safety Incident Response Framework.

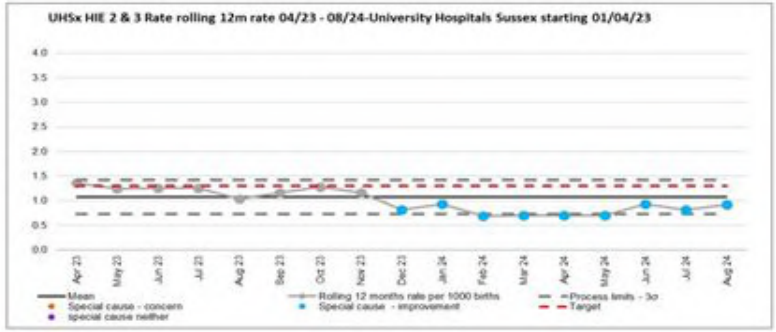
LMNS approval for the PQS Dashboard to be changed to reflect this is awaited. In the interim, the previous definitions of “Serious Incident” and “Moderate Harm” will be applied to cases.

Analysis:

Overall, the service continues to demonstrate special cause improvement in neonatal death, stillbirth and overall perinatal mortality rates as well as Hypoxic Ischemic Encephalopathy (HIE or brain injury) grades 2&3. The rates continue to remain below national rates, they are now also below the Southeast benchmark, however, the service continues to progress quality improvement actions previously outlined, which are focused on reducing poor outcomes further. These include workforce improvements, training, culture, documentation and fetal monitoring, as well as implementation of the Saving Babies Lives care bundle v3 (SBLv3) which is now fully implemented.

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





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

Health Inequalities – June 2024 outcome data (July and August data is not available at the time of reporting)

Currently the scorecard source for this data does not allow for extraction of data by site. The monthly figure as well as the annual rolling figure is presented below where available. Total births include all babies born, including those from Global Majority groups and areas of deprivation. 'Global Majority' is the terminology adopted to replace BAME – Black, Asian and minority ethnic, to increase inclusivity. There is ongoing work to improve how these data are presented to aid interpretation. Improved reporting via SPC charts has been delayed, this will commence as soon as available.

Brighton and Haywards Heath

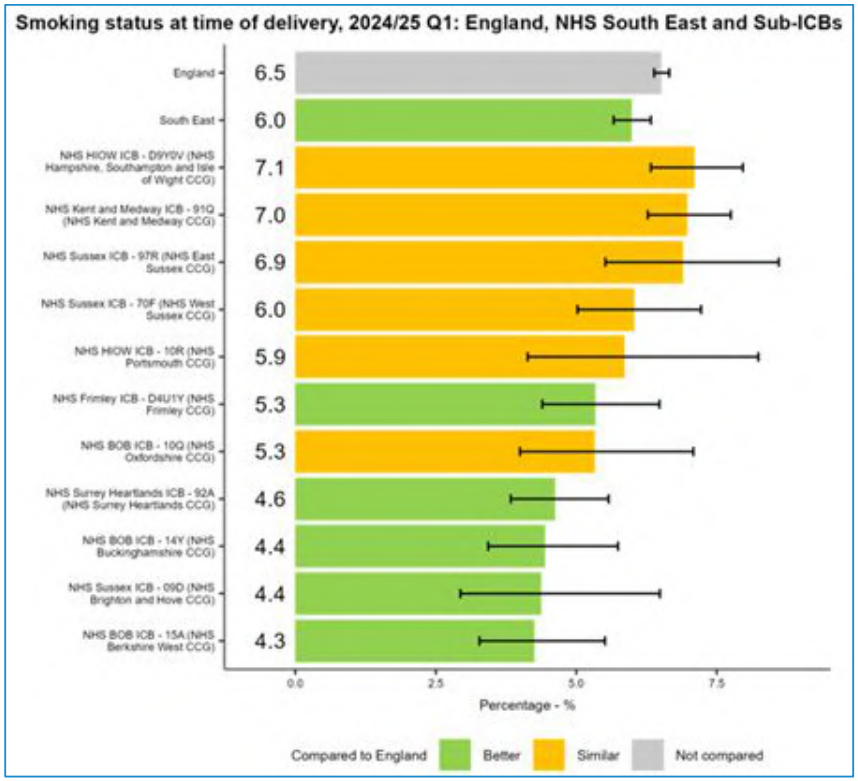
Measure	Pre-term birth <37 weeks (%)		Extreme prematurity (21+6-23+6 weeks) (%)		Stillbirth (per 1000 births)		Neonatal death (per 1000 births)		Total HIE (1,2,3) per 1000 births		Smoking at booking (%)		Smoking at birth (%)	
PRH/RSCH	**Jun-24**	**Annual**	**Jun-24**	**Annual**	**Jun-24**	**Annual**	**Jun-24**	**Annual**	**Jun-24**	**Annual**	**Jun-24**	**Annual**	**Jun-24**	**Annual**
Total births	7.04%	8.23%	0.00%	0.15%	2.82	2.27	2.82	1.07	5.67	1.78	8.31%	7.32%	6.82%	5.76%
Global majority groups	9.86%	8.40%	0.00%	0.50%	0.00	1.52	14.08	2.33	-	2.08	0.00%	1.86%	0.00%	1.80%
10% most deprived	11.76%	13.11%	0.00%	0.42%	0.00	-	0.00	0.00	0.00	5.21	28.57%	18.28%	43.75%	17.55%
20% most deprived	13.33%	11.85%	0.00%	0.21%	0.00	2.78	0.00	0.00	0.00	2.69	22.22%	16.87%	27.59%	15.10%

Worthing and Chichester

Measure	Pre-term birth <37 weeks (%)		Extreme prematurity (21+6-23+6 weeks) (%)		Stillbirth (per 1000 births)		Neonatal death (per 1000 births)		Total HIE (1,2,3) per 1000 births		Smoking at booking (%)		Smoking at birth (%)	
SRH/WH	**Jun-24**	**Annual**	**Jun-24**	**Annual**	**Jun-24**	**Annual**	**Jun-24**	**Annual**	**Jun-24**	**Annual**	**Jun-24**	**Annual**	**Jun-24**	**Annual**
Total births	8.96%	7.45%	0.30%	0.07%	0.00	1.95	2.99	0.51	3.00	1.44	9.57%	9.11%	6.34%	6.64%
Global majority groups	8.33%	7.93%	0.00%	0.00%	0.00	7.05	0.00	-	27.78	4.51	0.00%	1.38%	0.00%	1.33%
10% most deprived	0.00%	11.64%	0.00%	0.00%	0.00	10.42	0.00	27.78	0.00	0.00	0.00%	39.24%	0.00%	30.70%
20% most deprived	3.03%	10.46%	0.00%	0.00%	0.00	2.78	0.00	3.62	0.00	0.00	15.15%	21.48%	9.09%	15.91%

Analysis:

- Segmented data for neonatal deaths on LMNS scorecard at SRH/WH relates to 1 baby (10% most deprived 1/3 & 20% most deprived 1/23).
- Currently Sussex LMNS progress with achieving the HIE grades 2/3 is on track but not fully assured, focused work will continue to achieve this ambition by year end.
- Smoking cessation services continue to have a significant impact. The following chart demonstrates lower than national 'Smoking At Time Of Delivery (SATOD) rates for Sussex services, with significantly lower rates in Brighton and Hove:



Safeguarding summary

Training compliance

01/08/24 - 81%

15/08/24 - 81%

02/09/24 - 81%

15

17/09/24-78%

The Maternity Safeguarding team continue to be responsible for providing level 3 safeguarding training to all staff within maternity services on a yearly basis, this is a combination of eLearning and a face-to-face session. The key issues addressed within the Maternity face to face safeguarding training are referred to within the report.

Escalations

Maternity currently has an acute staffing crisis escalated to board level. Due to the situation all mandatory training days will be cancelled indefinitely; this is likely to continue until end November. The impact will be that staff will not receive their level 3 safeguarding training within this period. All specialist midwives have been dispatched from their usual roles to work clinically; at the current time safeguarding midwives are exempt from this.

Maternity Safety Support Programme (MSSP):

The service continues to make progress towards achieving the required exit criteria.

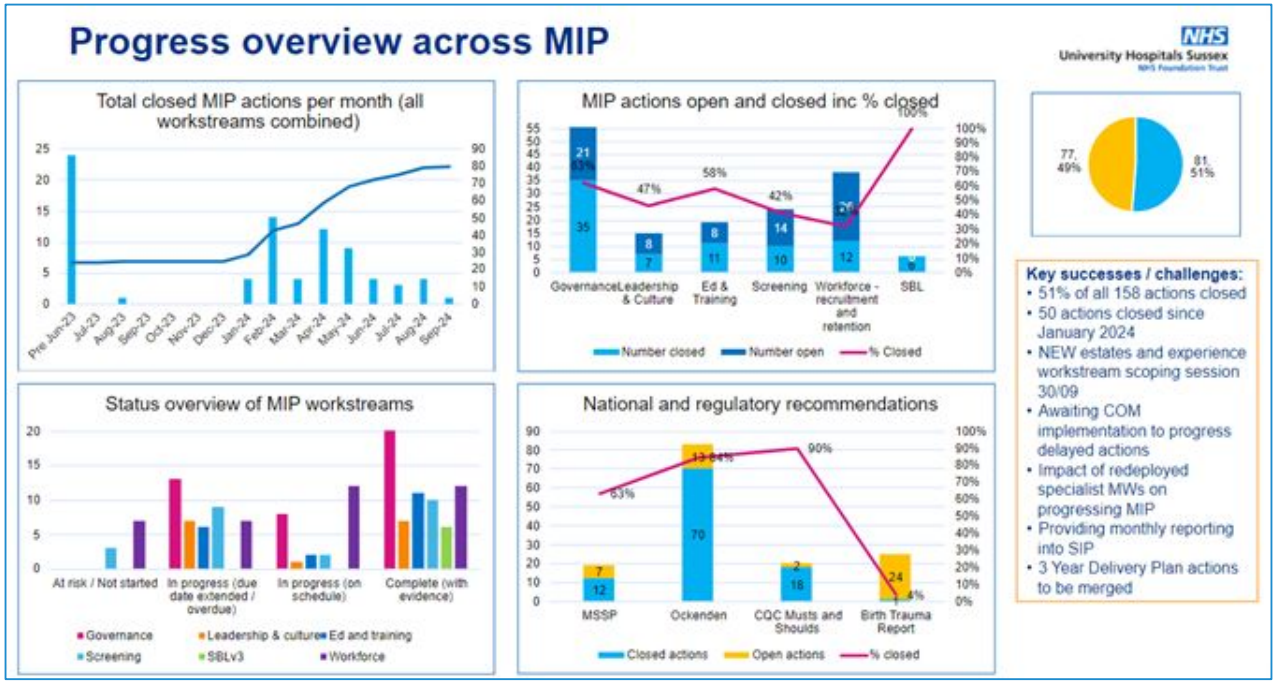
Criteria	Actions required	Estimated completion
Permanent midwifery leadership structure	Clinical Operating Model (COM) finalisation then recruitment	Q4 2024/25
Developed Perinatal leadership structure	Clinical Operating Model (COM) finalisation then recruitment	Q3-4 2024/25
Consultant job planning re leadership and governance	Clinical Operating Model (COM) finalisation then recruitment	Q3 2024/25
Maternity Governance Framework	Finalisation and ratification	Q3 2024/25
Access to separate theatre for elective caesareans on Brighton site with a view to relocation on other sites.	Successful pilot completed – negotiations with surgery underway	Q4 2024/25

Developed maternity strategy	Discussion with Chief Strategy Officer	TBC
Cross site maternity audit plan and guideline group	Central guideline group in place, audit plan in development	Q3 2024/25

Maternity Improvement Plan (MIP):

New workstreams added to Maternity Improvement Plan:

- Estates and environment
- Service user engagement



The programme risks include:

- Temporary Midwifery Leadership (permanent roles to be advertised late October)
- Redeployment of specialist midwives to support staffing challenges (ending in November)
- Awaiting recruitment into finalised COM structure to progress workstreams (job matching and planning underway)

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS):

See accompanying paper

2. Leadership and training

Aug-24	PRH		RSCH		SRH		WH	
Leadership and Training Rolling since Mar 24								
Fetal Monitoring - Midwives	80.98%	↑	74.81%	↓	95.55%	↓	88.9%	↓
Fetal Monitoring - Medical	56.69%	↓	50.58%	↑	95.21%	↑	77.5%	↓
Multi Disciplinary Skills Drills	91.51%	↑	85.71%	↑	83.90%	↓	84.6%	↓

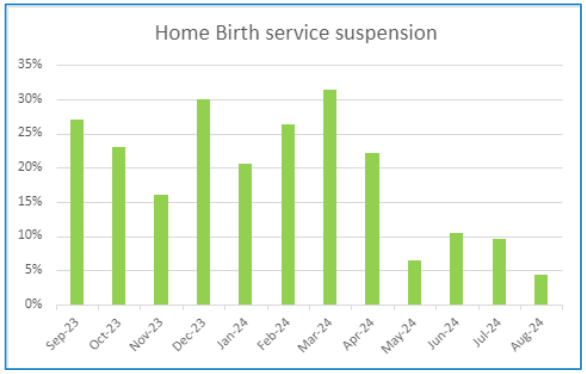
There is continued focus to achieve the required 90% compliance in all staff groups with particular focus on medial teams.

3. Voice of the User

Voice of the user	Princess Royal, Haywards Heath	Royal Sussex County Hospital, Brighton	St Richards Hospital, Chichester	Worthing Hospital, Worthing
Friend and Family Test	94.12%	94.1%	95.65%	90.00%
Complaints	0	4	0	2
Legal Claims	2	0	0	0

The service has seen an increase in legal claims submitted following cases > 2 years ago, thought to be as a result of recent media coverage. The service is developing a programme of restorative support for families affected by difficult birth experiences or poor birth outcomes while in the care of UHSx. Working with experts in the field, individual and group restorative support will be offered to families and staff involved.

Home Birth Suspensions:



The new model of care provided by the home birth team continues to result in a lower rate of suspension of the service despite the ongoing staffing issues. This provides an improved experience for our service users and the team providing this service.

4. Team feedback

Perinatal Workforce

A maternity Safety Forum was chaired by Lucy Bloem, Maternity Safety Champion NED, and Maggie Davies, executive Maternity safety Champion, on 1st October. Discussions included estates and environment concerns – the deputy director of estates attended the meeting. Also discussed was staffing, perinatal mortality rate improvements, ImproveWell, request for team to join the Maternity Improvement Plan working groups, staff survey and staff conference.

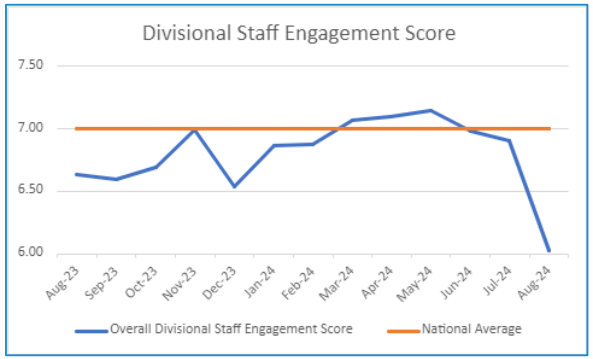
A meeting between the quadrumvirate and maternity safety champion exec and non-exec took place on 23rd September. Discussions included the access the separate theatres for planned caesareans, and a staffing update SCORE survey and cultural work.

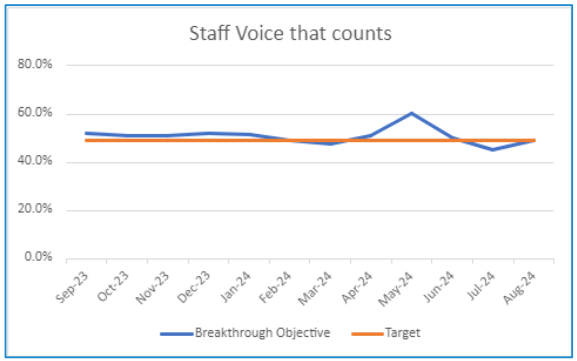
Midwifery workforce:

Please see accompanying bi-annual Perinatal workforce report

Staff Engagement:

The Staff Voice that Counts Score for the Division has dropped well below the Trust target (6.02 vs 7), analysis of the responses suggests that lack of involvement in decisions and developments fed into this response - a reduction was expected because of the conversations regarding potential reconfiguration of services in response to workforce issues in Worthing. Various methods of involvement in development such as listening events, workstream groups and the ImproveWell app, have been implemented to support clinical teams, however, uptake is only around 15%. Encouragement within staff engagement work continues, including Listening Events across the services, video messaging and service specific and Division wide newsletters. The lean and temporary leadership structure within operational, medical and nursing/ midwifery teams, impacts on the ability of leadership teams to maintain visibility and accessibility across diverse services and multiple sites. Now the Clinical Operating Model has been approved, recruitment into roles will commence in October. Improvement in these measures is expected once embedded.





The ImproveWell app is a tool to improve staff engagement and wellbeing. 137 (+8 from September) members of the team are now using the app, with 33 (+14 from September) ideas having been submitted. Ideas include:

- Ensuring specialist midwives are supported by core staff when working on a new ward
- Ensuring families and their babies on wards have more privacy by moving chairs for waiting patients away from ward doors
- Reviewing the organization of TTOs and discharges on postnatal ward.
- Increasing access to thermometers in line with other sites.

Good day and bad day word clouds

The good day measure function demonstrates that teamwork and colleagues are what makes a good day, and poor staffing impacts most on those experiencing their day as bad.

Conclusion and Recommendations:

Reducing perinatal mortality and HIE rates continue despite workforce pressures. Green shoots of recovery are evident in the midwifery and neonatal nursing workforce with reducing vacancy. Anecdotally morale is improving in response to this.
It is evident from staff engagement surveys and the SCORE survey that a very challenging summer has impacted the level of clinical team engagement and satisfaction. The leadership teams will continue to support and provide opportunities for involvement. Real focus is needed to improve medical training compliance.

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

Date: 2nd October 2024

University Hospitals Sussex
NHS Foundation Trust

Avoiding Term Admissions into Neonatal Units (ATAIN)

Quarter 1 (April, May, June 2024)

PRH, RSCH, SRH, WH

Contents

Background

ATAIN is a programme of work to reduce harm leading to avoidable admission to a neonatal unit for infants born at term gestation. The programme focuses on four key clinical areas related to term admission: respiratory conditions, hypoglycaemia, jaundice, asphyxia (perinatal hypoxia–ischaemia). These represent some of the most frequently recorded reasons for admission according to neonatal hospital admissions data and represent a significant amount of potentially avoidable harm to babies.

Furthermore, there is overwhelming evidence that separation of mother and baby at or soon after birth interrupts the normal bonding. Not only is there the potential for significant impact on maternal mental health and bonding, but also the adverse impact on successful breastfeeding.

‘Full-term’ or ‘term’ admissions include all babies born at or after 37 weeks' gestation and admitted to a neonatal unit within the first 28 days after birth

Aim

For all unplanned admissions to a neonatal unit for medical care at term a thorough and joint clinical review by the maternity and neonatal services will identify learning points to improve care provision, consider the impact service re-design might have on reducing admissions and identify avoidable harm.

- Clinical reviews, undertaken jointly by both maternity and neonatal services, should optimise understanding of potential areas of suboptimal care so that the learning and impact can be fully addressed.
- This should include considering whether the baby was admitted as a ‘safety net’ strategy because of concern for infant wellbeing on the delivery unit or the postnatal ward, or because of lack of availability of transitional care.

Regular, multidisciplinary local reviews provide understanding as to why a term baby has been admitted to the neonatal unit and for identifying possible service improvements.

Results

The National Neonatal Audit Programme (NNAP) benchmark is <5% term admissions to the Neonatal Unit. In total, at UHSussex 105 term babies were admitted to the Neonatal Unit (NNU)/ Special Care Baby Unit (SCBU) in Quarter 1.

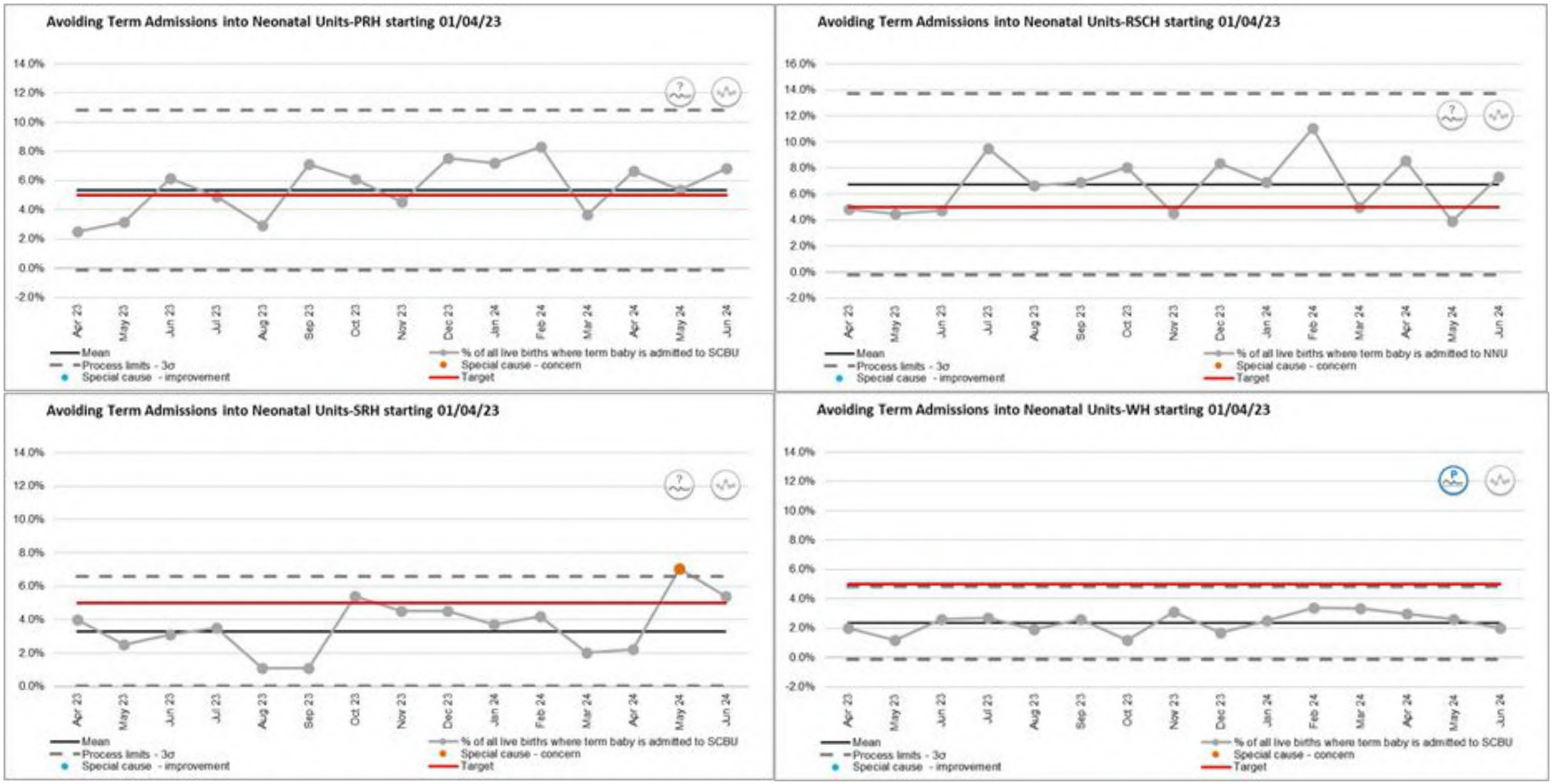
For the total of Quarter 1, the benchmark of <5% of admission to the Special Care Baby Unit was met for the duration at WH (2.2%, 2.6% & 2.9%). SRH met the benchmark in April only (2.9%, 7.0% & 5.3%). RSCH and PRH met the benchmark in May.

SPC charts of ATAIN rates show that the average ATAIN rates over 12 months from April 2023 at RSCH and PRH are above the national target, while at SRH and WH the average rates meet the national target. In Q1, there was a higher rate of admission at SRH in May, which the SPC chart has identified as special cause for concern.

Work is ongoing to determine if the same definitions are being used across the hospital sites to count their neonatal admissions to ensure consistency:
WH and SRH: Any baby that has been admitted to SCBU for over 4 hours becomes a formal admission and will be included in the ATAIN figures and review process. If baby returns to its mother in within 4 hours, it will not be counted.
PRH and RSCH: Any baby requiring admission to SCBU or NNU for any length of time is included in the review process.

Action: Clarity is being sought for what the national definition is and should be used to align data collection and reviews cross site.

SPC charts

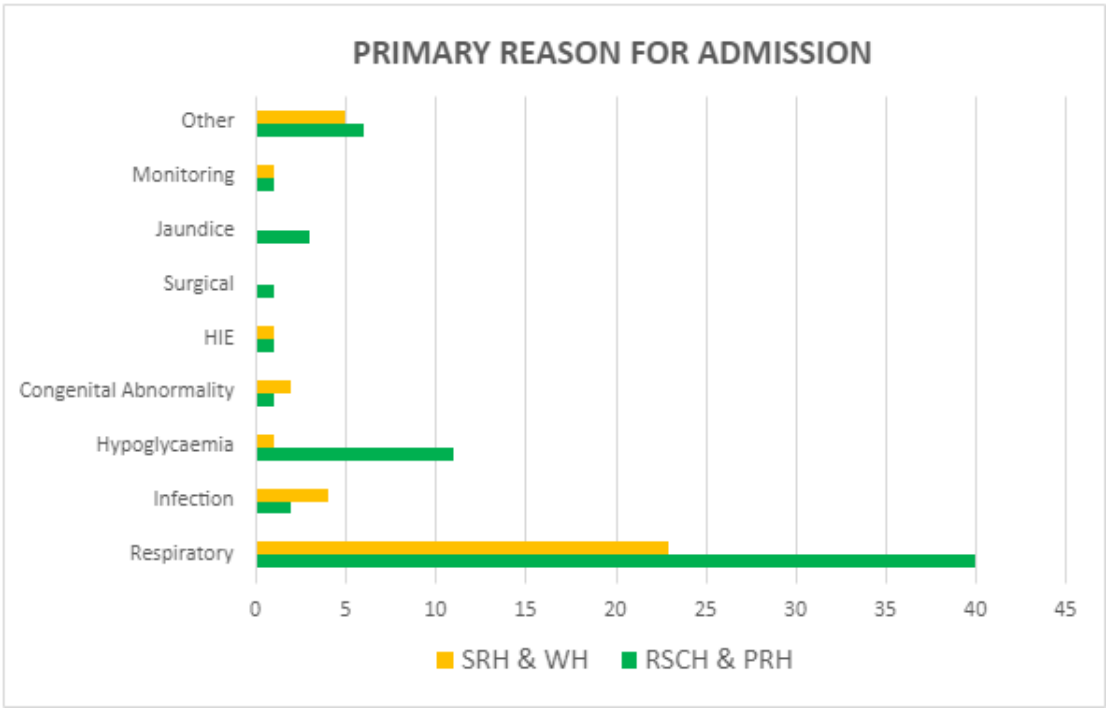

Avoiding Term Admissions into Neonatal Units-PRH starting 01/04/23
Mean
Process limits - 3σ
Special cause - improvement
% of all live births where term baby is admitted to SCBU
Special cause - concern
Target
Avoiding Term Admissions into Neonatal Units-RSCH starting 01/04/23
Mean
Process limits - 3σ
Special cause - improvement
% of all live births where term baby is admitted to NNU
Special cause - concern
Target
Avoiding Term Admissions into Neonatal Units-SRH starting 01/04/23
Mean
Process limits - 3σ
Special cause - improvement
% of all live births where term baby is admitted to SCBU
Special cause - concern
Target
Avoiding Term Admissions into Neonatal Units-WH starting 01/04/23
Mean
Process limits - 3σ
Special cause - improvement
% of all live births where term baby is admitted to SCBU
Special cause - concern
Target

In Quarter 1 there were 36 admissions to NNU from RSCH, 30 admissions to SCBU from PRH, 27 admissions to SCBU from SRH and 12 admissions to SCBU from WH which is a total of 105 term admissions to the SCBU/NNU.

For RSCH & PRH 6 were excluded. This was due to 2 AN diagnosis/plan for admission, 1 surgical, 1 undiagnosed congenital anomaly, 1 MNSI case (concealed pregnancy HIE & NND), 1 subgaleal haemorrhage as upgraded to a moderate harm that is awaiting patient safety review.

RSCH & PRH: RDS (40), Hypoglycaemia (11) Jaundice (3) Infection (2), HIE (1), Congenital (1), Monitoring (1), Surgical (1), Other (6),

SRH & WH: RDS (23), Infection (4), Hypoglycaemia (1) Congenital abnormalities (2), Cardiac (2), HIE (1) Monitoring (1) Other (5) this includes NAS scoring/social concerns/ tertiary centre input.



The majority reason for admission this quarter across all four sites was again due to respiratory support.

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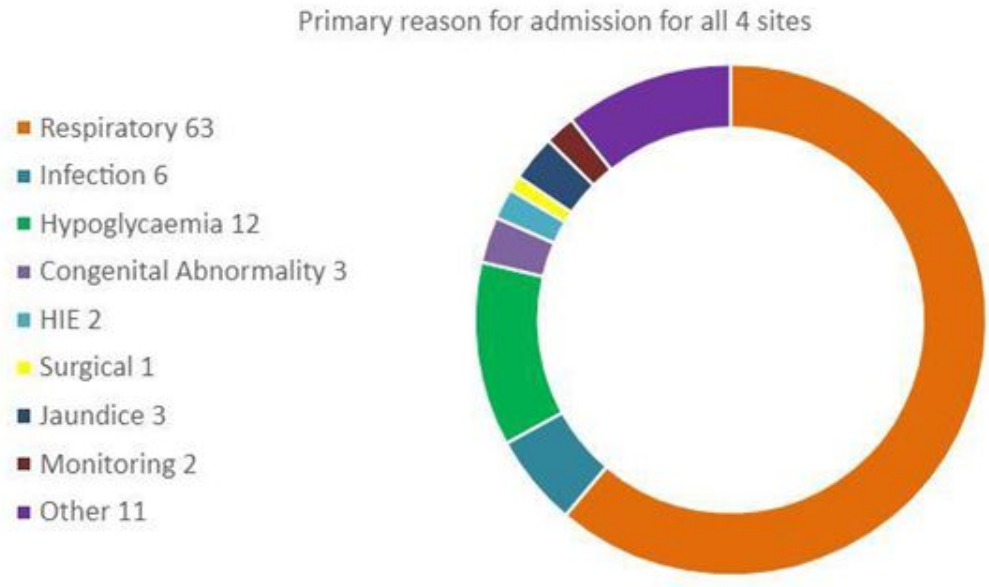
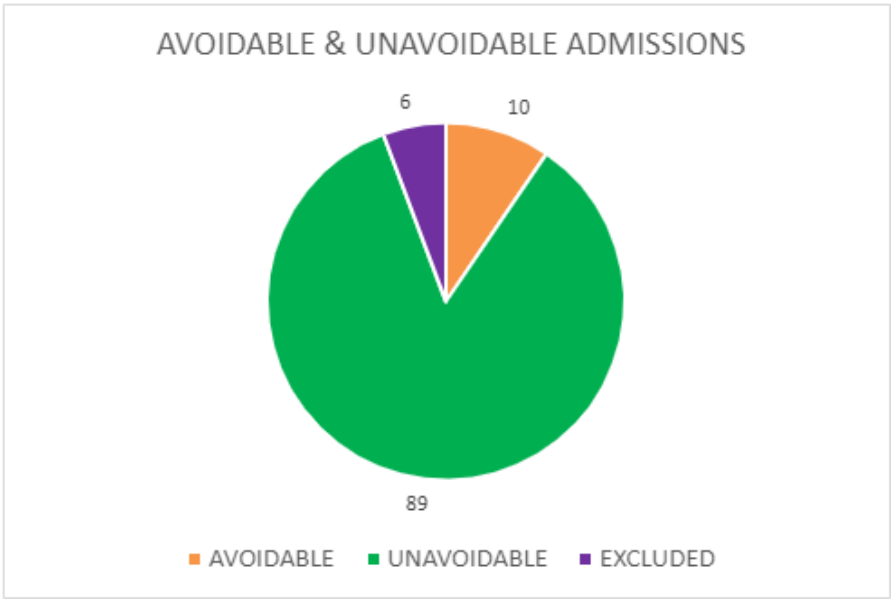


AVOIDABLE/UNAVOIDABLE

At RSCH & PRH 58 (88%) admissions to the NNU were categorised as appropriate admissions, 2 (3%) were deemed avoidable at peer review meeting, with 6 (9%) excluded. On both sites if BAPM TC was implemented 7 infants could have avoided admission to the NNU 1 at PRH 6 at RSCH.

At SRH & WH 31 (79.5%) admissions to the NNU were categorised as appropriate admissions with 8 (20.5%) were deemed potentially avoidable at the review of care.

Overall 85% (89) of admissions across all four sites were considered unavoidable with 9.5% (10 cases) considered as potentially unavoidable. 6 cases (5.5% were excluded).



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On review of the 10 avoidable admissions, the following themes were identified:

- At PRH 1 avoidable admission was for respiratory reasons, prolonged period attempting an FSE with a possible bradycardia, USS not considered prior to delivery

- At RSCH Hypoglycaemia pathway not followed with adequate feeding.

- At SRH 6 babies at were admitted for respiratory distress. 4 of these were found to have only required a short period of optiflow (mostly in air), consideration was given that potentially these babies could have been weaned off quicker minimising the period of separation of mother and baby. One baby was born in poor condition at birth however had a rapid response to resuscitation. This baby was started on IV fluids that likely delayed enteral feeding leading to admission. The other baby had 2 brief oxygen desaturations on postnatal ward but did not require any respiratory support, had a nasal gastric tube inserted with no indication identified from the review. These babies were all born during May which was known to be a particularly difficult period with staffing constraints.

- 1 baby at SRH required cooling and has been diagnosed with HIE with care issues identified on initial review, therefore this was considered avoidable. (Awaiting MNSI final report)

- 1 baby at WH was found to have a cleft palate and was admitted at the request of the Palate team for observation and feeding support. At the MDT review, it was considered that the additional monitoring that was required could have been provided within the Transitional Care pathway.

Themes identified during the ATAIN process at RSCH & PRH.

- Inconsistencies of documentation in labour and postnatally
- Staffing constraints within the neonatal workforce at PRH and increased workload
- 2 missed cleft palates, no concerns raised via USS

Themes identified at SRH & WH.

- Staffing constraints potentially impacted on the length of time babies remained on SCBU (especially at SRH).
- Documentation within several areas, Maternity BadgerNet, written documentation and Evolve. Inconsistencies of documentation depending on

the initial location of paediatric review leading to SCBU admission. The review team sometimes struggle to obtain all the information required.

Recommendations

The results of this audit are shared with the Maternity, Neonatal and Board Level Safety Champions, and used to inform QI work as part of the Transitional Care and ATAIN UHSx Steering group. Actions are tracked through the ATAIN and TC action tracker.

1. Improve Neonatal staffing at PRH.
2. A QI project is planned to address the number of babies being admitted due to hypoglycaemia.
3. Review of documentation practices to ensure contemporaneous records are available.
4. Align review processes across all four sites to ensure consistency of measurable data.

University Hospitals Sussex
NHS Foundation Trust

Transitional Care

Quarter 1 (April, May, June 2024)

PRH, RSCH, SRH, WH

Contents

Background

Neonatal Transitional Care (NTC) is defined as care additional to normal infant care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals.

Keeping mothers and babies together should be the cornerstone of newborn care. NTC supports resident mothers as primary care providers for their babies with care requirements more than normal newborn care, but who do not require care in NeoNatal Units (NNU).

Implementation of NTC has the potential to prevent thousands of admissions annually to UK neonatal units, and to provide additional support for small and/or late preterm babies and their families. NTC also helps to ensure a smooth transition to discharge home from the neonatal unit for sick or preterm babies who have spent time in a neonatal unit, often at some considerable distance from home.

NTC is multidisciplinary and should be flexible and responsive to mother and baby's physical and emotional needs as well as the rest of the family. A recent systematic review concluded that "transitional care benefits the health outcomes of moderately compromised infants and mothers in terms of de-medicalising care, improving mother and baby attachments, avoiding separation, developing parenting skills for dependent infants and raising the potential for shorter length of hospitalisation". *British Association of Perinatal Medicine (BAPM) Neonatal Transitional Care - A Framework for Practice (2017). A BAPM Framework for Practice.* Potential benefits of transitional care:

For mother and baby:

- Optimised attachment process.
- Maximal opportunities for skin-to-skin contact.
- Facilitation of baby-led feeding and establishment of breast feeding.
- Access to 24-hour practical support with feeding and /or prompt medical review if required– helping to build self-efficacy and thus confidence in parenting.
- Immediate access to skilled midwifery support for routine postnatal care.
- Family-friendly environment.
- Potentially reduced risk of hospital-acquired infection.

For maternity and neonatal services:

- Reduced length of neonatal stay.
- Improved team working within maternity and neonatal services.
- Greater parental confidence, with reduced rates of re-admission.
- Increased breast-feeding rates.
- Improved neonatal patient flow with potential for more efficient use of NNU cots.

- Additional professional opportunities for midwives.

Criteria for Neonatal Transitional Care

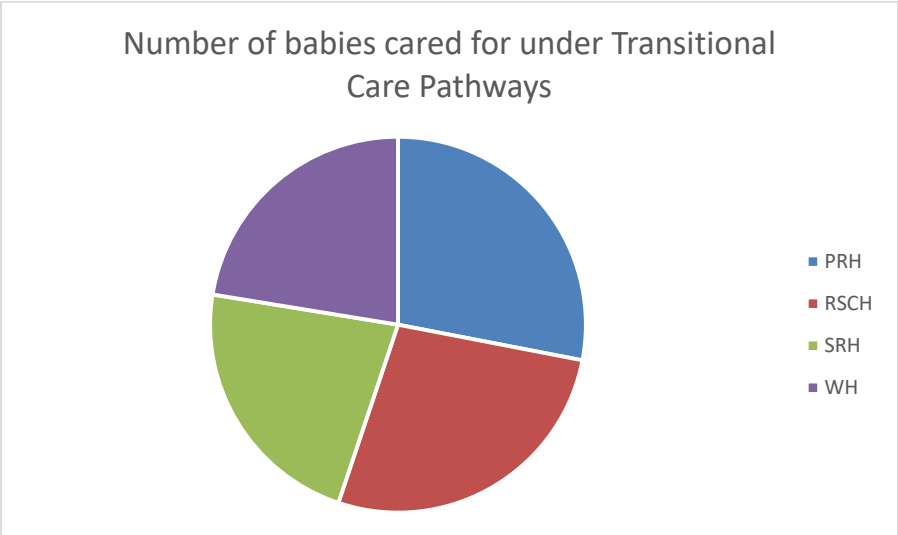
- Gestation 35-36+6 weeks at birth who do not fulfil criteria for intensive or high dependency care.
- Risk factors for sepsis requiring IV antibiotics, but clinically stable and/or stable baby who has developed (or been identified as having) risk factors for sepsis, requiring IV antibiotics
- At risk of haemolytic disease requiring immediate phototherapy or requiring phototherapy following identification on the ward or in community.
- Excessive weight loss.

Objective

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

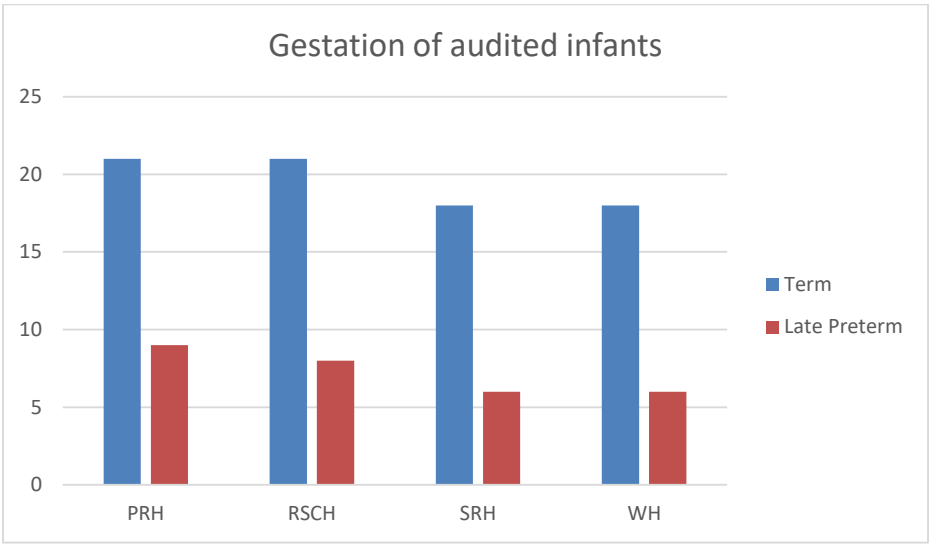
Data collection

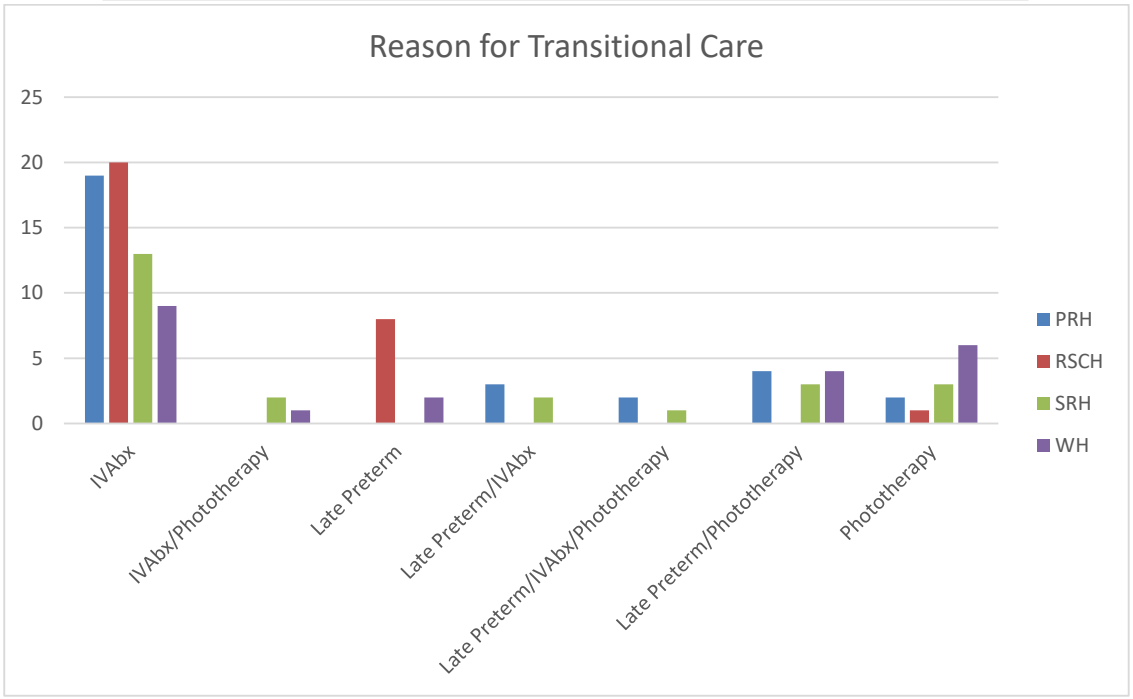
A sample of neonatal medical records of babies who met the criteria for Neonatal Transitional Care were audited between a 3-month period of April to June 2024. Infant's care pathways, via their neonatal medical records on Badgernet were audited: PRH 30 sets, RSCH 29 sets, SRH 24 sets and WH 24 sets.



Results

Most of the cases audited were term gestation neonates.





Most babies under Transitional Care, as shown in the graph above, were found in the category of receiving intravenous antibiotics for suspected sepsis. Some babies had multiple treatments during their admission.

Record of Neonatal Medical Involvement

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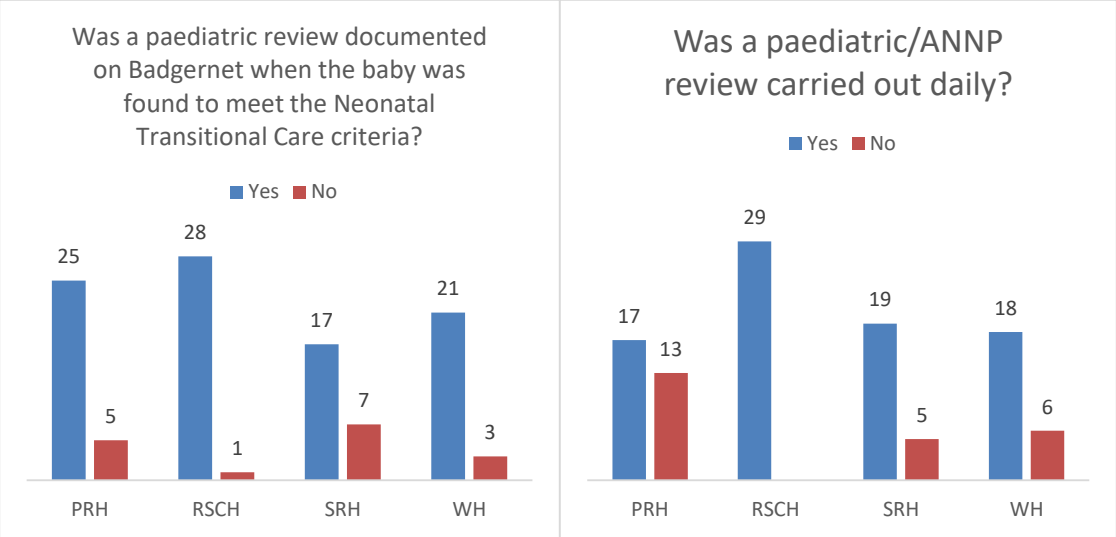
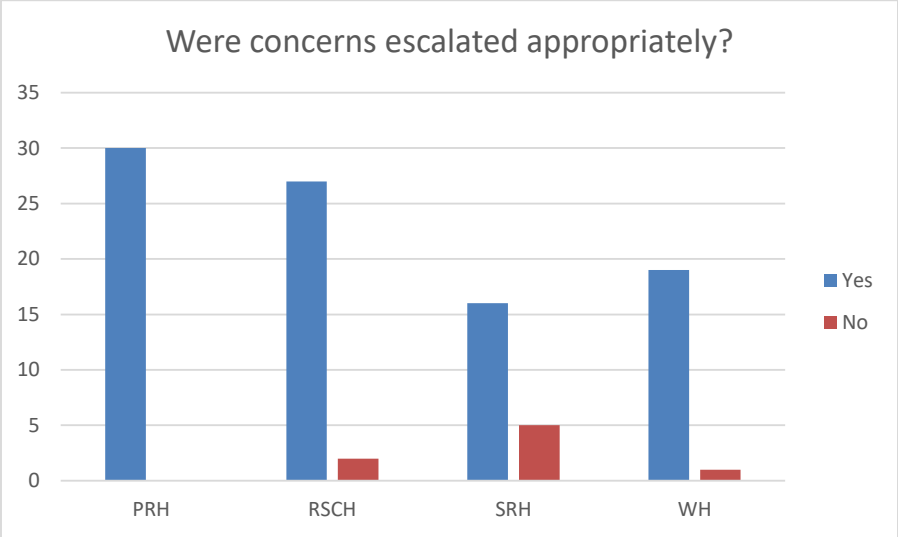
Neonatal teams should be involved in the decision making and planning of care for all babies in transitional care and should have a review each day they are under Transitional Care. Reviews should be documented within the Badgernet record.



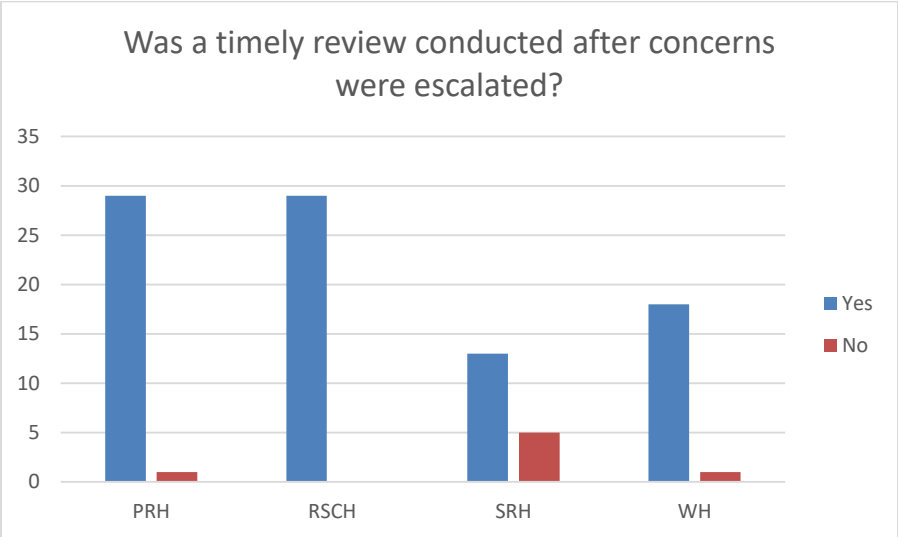
Most cases were appropriately reviewed when found to meet the Neonatal Transitional Care criteria. However, documentation of Neonatal/Paediatric reviews showed gaps in 16 cases (5 at PRH, 1 at RSCH, 7 at SRH and 3 at WH) where initial review and decision to start TC was not documented. This could be attributed to the documentation being located separately on Metavision or paper notes. However, this cannot be confirmed as this was beyond the scope of this audit. When reviewing notes, the baby's transitional care pathway was clear.

Daily reviews were documented in most cases. However, some work is required to ensure that all babies have a daily review whilst on transitional care pathways, particularly at PRH for this quarter. This is because there is 1 ANNP who covers both labour ward and the postnatal ward workload, as well as SCBU. TC babies care is overseen by both nursery nurses and midwives, who do escalate any concerns with these babies, therefore babies on Transitional Care who are clinically well will be the lowest priority. Additional paediatric support at PRH is needed in order to meet this standard.



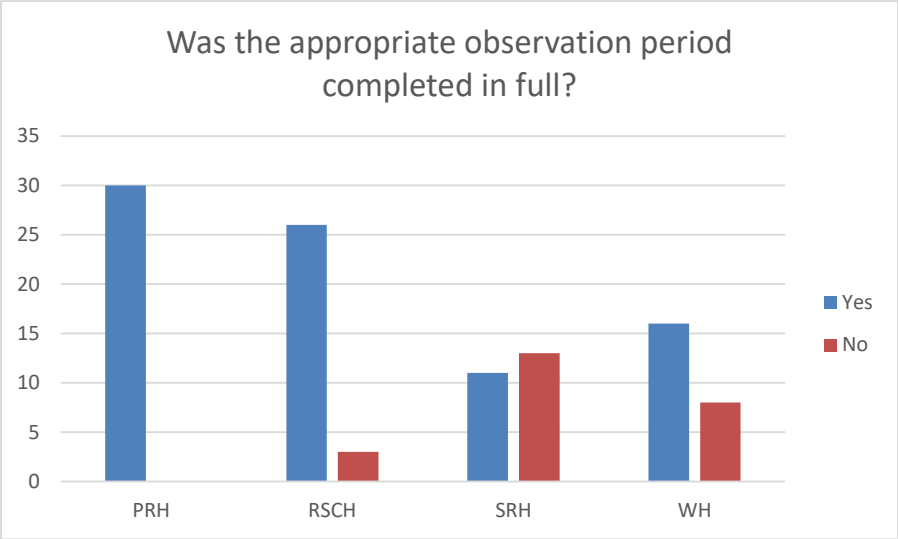
For the majority of neonates, any concerns were escalated appropriately. For those that were not:

- a baby had a high temperature at 05:25, which remained high at 06:30. There was no clear documentation of escalation, although the baby was reviewed by the paediatric team at 08:15.
- two hypoglycaemic episodes were managed appropriately with glucoboost but not escalated to the paediatric team.
- A hypoglycaemic episode in a late preterm infant of 2.3 was not identified as low (as there is a different threshold for late preterm babies at WH and SRH). The next glucose level was 1.8, which may have been prevented if the previous result had been managed.
- A low temperature was recorded but no evidence of action taken or rechecking. The baby was transferred to SCBU but it is unclear the reason for this admission from Badgernet notes. In this case it is possible the low temperature was escalated but there is no documentation to evidence this.



6

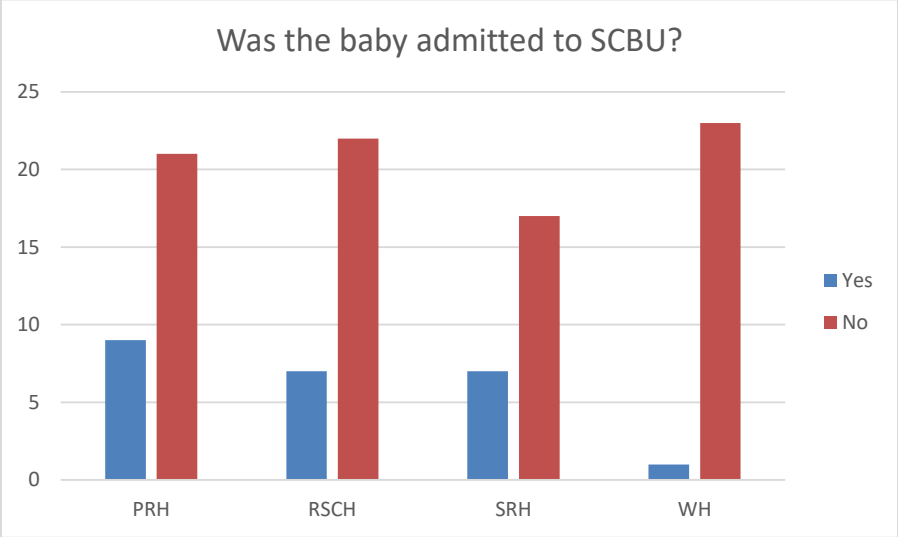
Most babies received a timely review from the neonatal team when concerns arose; this was clearly documented in the baby medical records on BadgerNet. Whilst this result is positive, acknowledgment should be given that in times of high acuity/low staffing reviews are sometimes documented later. In the cases where timely review did not occur, often management of the baby was discussed by the paediatric team, but they did not attend to physically review the baby. In this quarter this occurred most frequently when a baby was found to require phototherapy treatment. Best practice would be for the baby to be formally reviewed to undertake a full clinical exam.



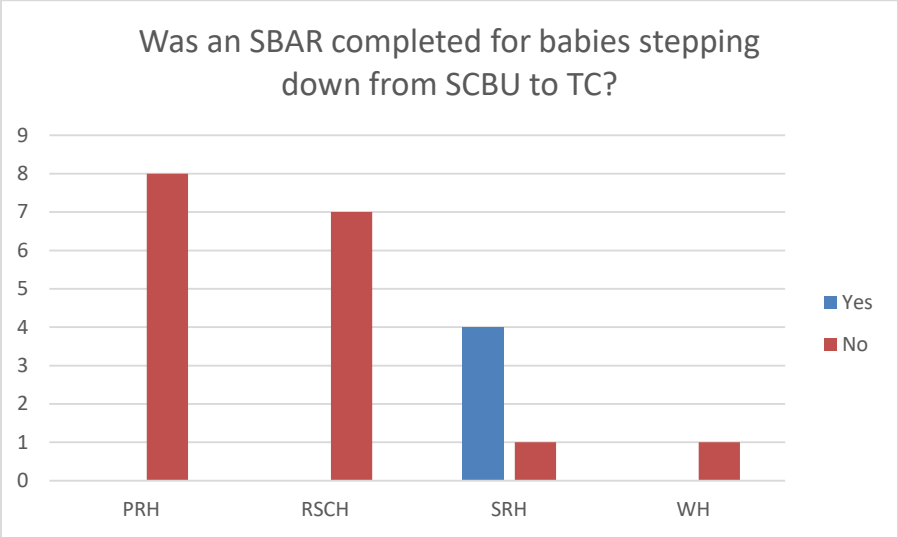
There is a significant difference between achieving the full observation period at WH and SRH compared to PRH and RSCH. On review of the guidance, there is significant difference in what is required at each site, as seen in the table below. In order to be able to directly compare each ward for this standard, these guidelines should be reviewed and aligned.

	PRH/RSCH	SRH/WH
	TC	
IV Abx	6 hourly full set observations 4 hourly random blood glucose for 24 hours >2.5mmol/L	4 hourly full set observations
Late preterm	No specific guideline, will be on hypoglycaemia pathway	3 prefeed blood glucose >2.5 30 min obs for 2 hours 4 hourly for 24 hours BD until discharge (after 72 hours)
Hypopathway	4 hourly prefeed blood glucose >2.5 mmol/L with temperature 12 hours if GDM (diet), antihypertensives, macrosomic, SSRIs 24 hours if medicated GDM	2 prefeed blood glucose ≥2.0. If both <2.5, one needs to be done on gas to confirm >2.0

Phototherapy	6 hourly temperature	4 hourly full set observations Daily weight
Non-TC		
Hypothermia	4 hourly temperature	4 hourly temperature
Sepsis obs	2 hourly for 12 hours GBS- 2 hourly for 24 hours, if had 2 doses antibiotics then normal sepsis obs	Guideline: 12 hours 2 hourly obs
NAS	4 hourly/when settled after feed	4 hourly
Meconium	Thin: 1 and 2 hours of age Thick: 1 and 2 hours of age, 2 hourly until 12 hours	Thin: 1 and 2 hours of age Thick: 1 and 2 hours of age, 2 hourly until 12 hours
Kaiser	For babies at risk, should be on 4 hourly observation for 24 hours, however this is inconsistently applied and many babies are having much more frequent observations than this.	



TC admission to NNU is shown in the graph above. This was due to several reasons including following resuscitation after birth for a period of observation, further observations while having IV antibiotics, double phototherapy and sepsis combined, and hypoglycaemia.



Audit of the use of SBAR handover tool within Badgernet is a new addition to this report. It appears to be well embedded at SRH but not at the remaining hospitals. SBARs are generally being completed, however these are on paper and not contained within Badgernet.

Themes

This audit has identified areas for improvement. Maintaining good practice is essential and in cases where escalation is required this should be undertaken through a timely Neonatal/Paediatric review. Daily Neonatal/Paediatric review should be ensured for TC babies.

Across the audit several themes were identified:

- Treatment with IV antibiotics was the main course of treatment across site.
- Daily neonatal reviews need to be documented in Maternal BadgerNet under the Baby postnatal record; however, it was found the location of documentation varied. This continues from last quarter.
- Delay in neonatal team reviews being performed/documented on BadgerNet due to staffing constraints or increased workload pressures on the unit.
- Several babies are admitted to NNU for short periods of observation, before being transferred back to the postnatal ward.
- Babies not being formally reviewed when it was identified that they required phototherapy.
- Poorer completion of neonatal observations at SRH and WH.
- Challenging to conduct daily ward round of TC babies at PRH.

Recommendations

The results of this audit are shared with the Maternity, Neonatal and Board Level Safety Champions, and used to inform QI work as part of the Transitional Care and ATAIN UHSx Steering group. Actions are tracked through the ATAIN and TC action tracker.

- Implementation of Postnatal Theme of the Month. This will be like the new Maternity theme of the week, but focus on issues on the Postnatal ward, and will be discussed at safety huddles each day throughout the month to ensure all staff are aware. The first two themes will be around escalating concerns and the use of SBAR handovers for babies transferring between wards.
- Review and align neonatal guidance across all four hospital sites.
- Review and increase paediatric staffing capacity at PRH.
- In person paediatric review required when baby identified as requiring phototherapy.

University Hospitals Sussex NHS Foundation Trust
Saving Babies Lives Quarterly report – Quarter 1 24/25

Introduction

An audit plan has been developed to continually monitor and identify areas to improve the service and outcomes relating to the care bundle. Saving babies lives (SBL) audits for quarter 1 2024/25 have been completed. The aim is to provide assurance to our Trust and the Local Maternity and Neonatal System that all six elements have been implemented. Furthermore, that where quality improvement areas are identified there is a robust plan to assess and review and changes to practice.

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

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

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

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

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

University Hospitals Sussex
NHS Foundation Trust

1.REDUCING SMOKING IN PREGNANCY

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

Smoking at time of booking: 8.27%
Smoking at time of delivery: 6.27%

Process indicators and Outcomes		Ambition	Stretch ambition	Quarter progress
CO@ booking 1a.i	94.5%	90%	95%	+1.5%
CO@36/40 1a.ii	88.8%	80%	95%	-0.2%
Asked about smoking at booking 1a.iii	100%	80%	95%	=
Asked about smoking at 36/40 1a.iv	61.3%	80%	95%	+17.5%
% of smokers where smoking status is recorded at all antenatal appointments	68.3%	Maintain	NA	+34.8%
% smokers referred to opt out service 1.b	96.3%	90%	95%	+1.3%%
% of smokers in Q1 who set a quit date 1c	51.3%	50%	60%	-4.7%
% of smokers at booking that are CO verified non smokers at 36 weeks 1d	23.1%	25%	NA	-3.9%
% of smokers who set a quit date and have a non-smoking CO verified reading at 4 weeks 1e – new process of data capture	14%	50%	60%	-49%
% of smokers where CO is recorded at all antenatal appointments 1.2	77%	Maintain	NA	-6.7%

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

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

1.9 – The SFPT have a three-hour slot on mandatory training which included processes, opt out referrals, feedback and data collection. The verbal update supported by SBL eLearning for Health package.

In Q1 528 members of staff attended their mandatory SFP update. This is 93% of staff expected to attend this day.

1.10 – All staff delivering TDT have been trained in the delivery of this. There are no new members of staff in the team in Q1.

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

INTERVENTIONS: Reducing the risk of FGR

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

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

Additional Measure		Ambition	Stretch ambition	Quarter progress
Percentage of women booked who had a risk assessment for aspirin	98.9%	80%	90%	+0.9%

The latest quarterly audit of 10 exceptions demonstrated there is work to be done in improving risk assessments and is captured in the Element two leads meeting. A working party has already been formed to support improvement efforts with the community teams.

Recommending vitamin D to all pregnant women.

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

Additional measure		Ambition	Stretch ambition	Quarter progress
Vitamin D recommended at booking as per BN report	45%	80%	90%	N/A
Vitamin D recorded as being taken	96%			-4%
Audit of all SGA babies	89%			+4%

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

INTERVENTIONS: Monitor and review risk of FGR throughout pregnancy

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

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

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

From Q4 23/24 it was evident in the data that some assessments were incomplete as per gold standard, Q1 data has evidenced similar findings. It was agreed that this would be a QI focus piece of work. This has commenced and all parties have engaged well to this point; there have been 3 main work steams identified for improvement.

1. The education needs of some community staff undertaking the assessments
2. The process for the antenatal clinic leads once referral received
3. The reassessment following combined screening

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

Scan results are not recorded on BadgerNet, meaning a full audit of uterine artery dopplers for high-risk people identified at booking is not possible. Out of 50 high risk people 44 (88%) had correctly had their scan performed at 20 weeks scan. The processes and follow up have been identified as a QI project within the leads meeting and is part of a bigger piece of work surrounding capacity. UHSussex have scanning capacity issues at Royal Sussex County and Princess Royal Hospitals. A gap analysis has been undertaken supported by the LMNS and shared with NHSE.

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

Another audit around this would support assurance; however, because SFH measurements are business as usual for the midwives and there are no themes or Datix incidents to suggest this is an issue, this will be audited again in Q2.

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

Training of fundal height measurement, both technique and referral is covered in our multidisciplinary MDT Fetal Wellbeing Day and will maintain an annual training obligation within maternity education to meet all requirements of the Core Competency Framework. 86% of midwifery and obstetric staff attended training in Q1.

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

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

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

All FGR cases both detected and undetected are reviewed by the fetal wellbeing team (SBL requires 20 undetected per year). Staff are requested to Datix all SGA cases to ensure there

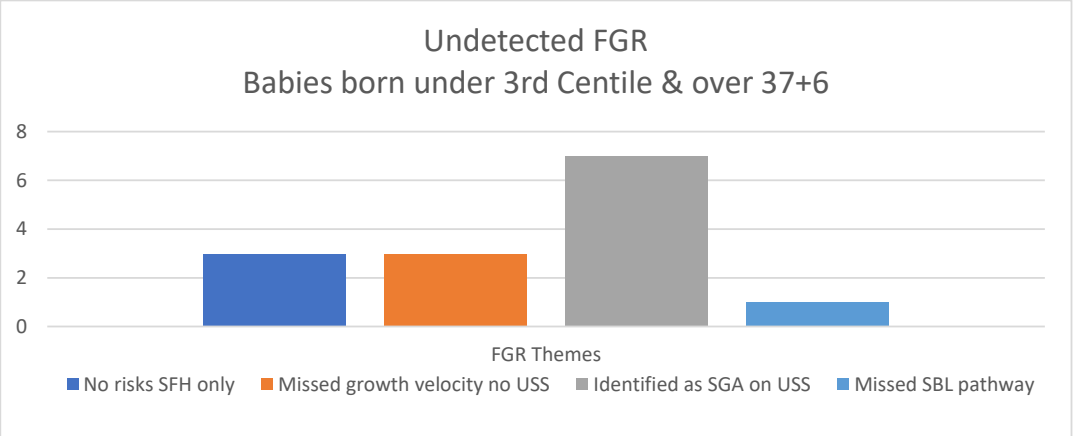
is a review of all babies under 10th centile. Reporting on BagerNet is limited due to the centiles used for reporting which are 0-0.4, 0.4-2.0 and >2-9.0, therefore a manual audit of cases is undertaken.

Outcome Indicator 2b		Ambition	Quarter progress
Numerator: Number of pregnancies where an SGA fetus is detected during the antenatal period	135	0%	-0.4%
Denominator: Total number of pregnancies submitted to MSDS	2145		
% of pregnancies where an SGA fetus is antenatally detected	6.3%		
Outcome Indicator 2d		Ambition	
Numerator: Number of babies <3rd centile >37+6	14	Review of data needed first	
Denominator: Babies born under the 3rd centile	27		
% of babies born under the 3rd centile >37+6	51.9%		

These outcome indicators are said to be a measure of effective detection and management of FGR. The ambition for 2b is unachievable if the aim is to detect and manage SGA, this will be discussed at the next assurance meeting.

13 babies were detected as FGR and delivered within the guidance of SBL = 48.1% detection rate for births < 3rd centile. (Reduction of 11.2%) 14 babies were undetected for FGR.

On review of the 14 born under the 3rd 50%, 7 FGR babies followed SBL USS growth pathway and were not identified as FGR. All were identified as SGA.



All of the babies that had serial scans and were identified at SGA were delivered as per SBL guidance for an SGA detected baby.

This data is produced in addition to SBL requirements to ensure consistency across the LMNS reporting	
Numerator: Number of pregnancies where an SGA fetus is detected during the antenatal period and born <10th centile	52
Denominator: Total number of pregnancies where a baby is born <10th centile	141
% of pregnancies where an SGA fetus is antenatally detected	36.9%

UHSussex had 141 babies born under the 10th centile. Of these babies 52 were detected antenatally.

Outcome Indicator 2e		Ambition	Quarter progress
Numerator: Number of babies >3rd centile <39+0	7	0%	-1 baby
Denominator: Babies born over 3rd centile	2115		
% of babies born above the 3rd centile <39+0	0.3% (n7)		=

The aim of this indicator is to pick up babies who are identified as being small but are not small and have been induced unnecessary. All detected SGA cases below the 3rd and 10th centile are reviewed regarding timing of induction in line with clinical guideline based on SBLCBv3 recommendations. There were no unnecessary inductions at St Richards hospital in Q1.

Process Indicator 2d. Annual data presented. Avoidable death report due in Q2. Findings will be shared in Q2.

3. RAISING AWARENESS OF REDUCED FETAL MOVEMENT (RFM)

INTERVENTIONS

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

The recommended reduced fetal movements checklist incorporated BadgerNet is used in addition to computerised Cardiotocograph (cCTG) analysis available on all sites. Audit in Q1 demonstrated the following:

There were 1615 attendances at 28 weeks and above and the results were as follows:

Process indicator 3a		Ambition	Stretch ambition	Quarter progress
Numerator: Number of women with RFM that have cCTG	1615	Maintain		-1.6%
Denominator: Number of care contacts with RFM	1696			
% of women who attend with RFM and have a cCTG	95.2			

Further analysis of the data has identified an issue with reporting on BadgerNet which has been raised on the service console. Several admissions had 'YES' ticked for is this a computerised CTG and they came up on the report as not having completed. People who were later found to be in labour appeared on the report as not having a cCTG but cCTG cannot be used in people with uterine activity

In a manual audit of 10% of notes 100% of those eligible had a cCTG

Process indicator 3b		Ambition	Stretch ambition
Numerator: Number of women with USS performed	33	Review of data needed first	
Denominator: Number of care contacts with recurrent RFM	394		
Proportion of women who attend with recurrent RFM who had an ultrasound the next working day	33/394		

This report on BadgerNet is unlikely to reflect the true number of people who have a scan following recurrent RFM because sonographers are not documenting on the MIS on all four sites. This is being looked at within the working party for element 3.

In a manual audit of 10% of recurrent RFM 82% had a USS the next working day (MON-FRI) this is a reduction from 84% from the previous quarter. Sonography continues to be a challenged area in maternity as discussed in element 2.

Completion of a checklist for those with RFM. This additional measure is no longer reported within BadgerNet and has been removed from the report. System C are working to better capture this data accurately. A manual audit of notes showed that there was a small 2% increase in RFM checklist completion this quarter.

Outcome indicator 3d		Ambition	Stretch ambition
Numerator: Number inductions before 39 weeks where the only indication is RFM	12	<5%	
Denominator: Number of inductions before 39 weeks	244		
Rate of induction when RFM is the only indication before 39 weeks	4.9%		

There appears to have been a slight rise this quarter from 3.9% in the previous quarter, there is a spread across all 4 sites and no themes identified in relation to a particular member of staff offering IOL. Care is personalised and of note, there is a rise in listening to women's concerns and offering IOL following informed and individualised discussions.

Outcome Indicator 3c. Annual data presented. Avoidable death report due in Q2. Findings will be shared in Q2.

4. EFFECTIVE FETAL MONITORING DURING LABOUR

Process and outcome indicators:

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

INTERVENTIONS

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

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

UHSussex has maintained >80% training for Midwifery staff in Q1. Work is ongoing with the service lead for medical staff to ensure fetal monitoring training is planned into staff hours and an increased robust system in place to ensure follow up for those that miss their allocated place.

New data collection has been agreed for ease of reporting on the PQS – the following data is reported as rolling compliance

Process indicator 4a		Ambition	Stretch ambition
Numerator: Number of staff with in-date annual training compliance on fetal monitoring	817	80%	90%
Denominator: Number of staff to be trained	939		
% of staff who have received training on CTG interpretation and intermittent auscultation, human factors and situational awareness	87%		

Process indicator 4b		Ambition	Stretch ambition
Numerator: Number of staff successfully completed mandatory annual competency assessment	719	85% (of the 80% in 4a)	90%
Denominator: Number of staff taking annual assessment	817		
% of staff who have successfully completed mandatory annual competency assessment	88%		

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

Additional Measures	24 Set of notes per site	Ambition	Quarter progress
Fresh eyes review hourly for CTG or 4 hourly for IA	61%	80%	-1.5
Regular (at least hourly) review of maternal and fetal wellbeing	67%	80%	-10%
Structured Risk assessment at the start of labour	92.8%	80%	-2%

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

Focus on correct classification and appropriate escalation of maternal and fetal concerns in labour showed although the reviews were carried out late in 39% of cases 96% of these were correctly classified and escalated. Often within that 39% there was documentation which reported poor staffing as a cause for lack of timely fresh eyes.

Outcome indicator 4d. Annual data presented. Avoidable death report due in Q2. Findings will be shared in Q2.

5. REDUCING PRETERM BIRTHS

INTERVENTIONS

Assess all women at booking for the risk of preterm birth and stratify to low, intermediate and high-risk pathways using the criteria in Appendix F SBLV2

Outcome indicator 5l.a		Ambition	Quarter progress
Numerator: Number of women who give birth to a singleton between 16+0 and 23+6	18	Maintain	+0.71%
Denominator: Total number of singleton births	2118		
% of births with a singleton baby giving birth between 16 and 23+6	0.85%		
Numerator: Number of women who give birth to a singleton between 24+0 and 36+6	135	Maintain	+0.2%
Denominator: Total number of singleton births	2118		
% of births with a singleton baby giving birth between 24 and 36+6	6.5%		

5.2i – Mortality to discharge in the very preterm babies. During Q1 there were 17 babies that were discharged from neonatal units who were born in the previous months under 31+6. There were no deaths prior to discharge.

5.3 - UHSussex has a dedicated preterm clinic on all 4 sites. In Q1 there were 65 people that booked with a high risk of preterm birth, 100% were referred to the clinic slots for cervical length screening by 16 weeks or as urgent if booked after this time. A 10% sample audit for compliance showed 50% were referred within the timeframe, the other 50% were referred for appointments between 16+1 and 17+6.

5.9 – There has been an issue with the procurement of fetal fibronectin (QfFN) devices and the devices secured do not give a quantitative number. This has hindered use of the QUiPP app as the other figure to input is a cervical length taken within the last 24 hours which is often not available. UHSussex acknowledge this will likely hinder optimisation as not all obstetricians can perform a bedside trans vaginal scan to assess cervical length. Current use of the app is 46%.

5.11 – Completing and following up an MSU for intermediate and high risk people has always been well embedded and a further audit will be carried out in Q2 for assurance purposes.

5.16 – UHSx have good processes embedded for involving neonatal in the discussions with parents regarding preterm birth. All preterm births are audited and will be reported as exceptions. There were no exceptions in Q1.

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

Process indicator 5a		Ambition	Stretch ambition	Quarter progress
Numerator: 1st birth <27weeks (singleton) <28 weeks (multiple) and <800g born in the same site a NICU	5	70%	85%	+3%
Denominator: Total number of 1st baby born <27 weeks<28 (multiples) and under 800g	6			
% of singleton infants less than 27 weeks, or 28 if multiples with an EFW of under 800g born in maternity services with NICU	83%			

At PRH 1 baby born at 24+5 as arrived in triage with presenting part visible therefore no time to transfer to tertiary unit (excluded from data).

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

Process indicator 5b		Ambition	Stretch ambition	Quarter progress
Numerator: Number of live births ,34+0 who receive a full course of antenatal corticosteroids within 7 days of birth	22	40%	55%	+15%
Denominator: Total number of live births before 34+0	31			
% of babies <34 weeks receiving a full dose of antenatal corticosteroids within 1 week before birth	70.9%			
% of babies where birth is more than 7 days after receiving their first course of antenatal corticosteriods	12.9%	NA		

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

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

Process indicator 5c		Ambition	Stretch ambition	Quarter progress
Numerator: number of babies born <30 weeks who receive magnesium sulphate within 24 hours prior to birth	7	80%	90%	-12.5%
Denominator: Total number of live births before 30+0	8			
% of babies born <30 weeks who receive magnesium sulphate within 24 hours prior to birth	87.5%			

At RSCH 1 baby was born in a paramedic ambulance on the way to hospital

			Ambition	Quarter progress
5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection.	Num: 7 Denom: 9	77.8%	Maintain	=
5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth.	Num: 22 Denom: 34	64.7%	50%	-21.3%
5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth.	Num: 22 Denom: 34	64.7%	65%	+3.2%
5g. Percentage of babies born below 34 weeks of gestation who receive their own mothers milk within 24 hours of birth. **2 received donor milk and 8 none within 24 hours	Num: 19 Denom: 34	55.9%	Maintain	+9.1%
Volume-Targeted Ventilation for babies born below 34 weeks' gestation who need invasive ventilation	Num: 8 Denom: 8	100%	>95%	
Caffeine For babies born below 30 weeks' gestation	Num: 8 Denom: 8	100%	>95%	
5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (1 to 9 above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation).	97/157 eligible interventions were received: 61.8%		Review Maintain	+1.5%

Women who are identified at high or intermediate risk of pre term birth at booking are not always referred within the correct timeframe to be seen in the antenatal clinic by an obstetrician. Often these women also have other risk factors, which means they are referred to a different clinic (eg maternal medicine/diabetes) which is often at a later gestation.

Q1 has seen an overall decreased percentage of babies receiving MGSo4, however it is important to acknowledge the small number of babies, 7/8 babies did have the intervention.

There has been a drop in compliance with optimal cord clamping with a reduction of 7.6%, however UHSussex remains above the ambition for 50%. The QI identified for this element

alongside PREM7+ which would support temperature and optimal cord clamping is bedside resuscitation, this feels like a huge piece of work across 4 sites and a level 3 NICU as well as three SCBU units. Discussions are ongoing in efforts to involve all stakeholders in the perinatal team needed for this.

Outcome indicator 5k. Annual data presented. Avoidable death report due in Q2. Findings will be shared in Q2.

6. Management of Diabetes in Pregnancy

INTERVENTIONS

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

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

Outcome indicator 6g		Ambition	Stretch ambition	Quarter progress
Numerator: number of pregnant women with type 1 and type 2 diabetes that have HbA1c measured between 24+0 and 30+0 weeks.	12	80%	>95%	+9%
Denominator: Number of women with type 1 and type 2 diabetes	15			
% of women with type 1 or type 2 diabetes that have their HbA1c measured at the start of the 3rd trimester	80%			

One person couldn't be tested for HbA1c due to haemoglobin variant so have been excluded from the data. Compliance has improved greatly in the past year. The need to test the HbA1c is slowly becoming better embedded.

CONCLUSION

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

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

Element 2, there is good progress with looking at the quality of risk assessments and identifying QI. With a midwife sonographer now qualified, UHSussex will be able to offer more scanning pathways, however this will only cover an additional 3 risk factors to start.

Element 4, QI work needs to focus next on a trust wide fetal monitoring guideline to ensure consistency across the 4 sites. Utilising BadgerNet to optimise record keeping is also a theme in this quarter. It is planned that this work will be lead via the lead's meetings held monthly.

Element 5, PREM7+ continues to be embedded on all four sites. There are challenges relating to optimal timing of interventions due to the availability of fetal fibronectin devices. Bedside resuscitation is also proving difficult due to the number of variables involved in such a huge QI project across the entire perinatal team.

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UHSussex ACTION PLAN

Element	Element description	Intervention reference	Action	Lead	Timeline	RAG
2	Fetal growth restriction	2.7	Uterine Artery Doppler audit required from obstetrics lead at WH/SRH	Fetal Wellbeing Consultant Obstetrician Lead	June	
		Outcome indicator 2a	Risk assessment Quality	Fetal wellbeing MW	Oct	
		Digital BP	Further planning needed to embed digital BP recording	HoM/Transformation	Dec 24	
		2.14	FGR/SGA Guideline re-written for 4 sites, Awaiting CDAG approval	Governance Lead	June	
3	Reduced Fetal Movements	NA	Develop the 4C's QI 1. Computerised CTGs, 2. Checklist completed, 3. Care plan documentation, 4. Communicating RFM information	Transformation Lead MAU/Triage leads	Oct	
4	Fetal monitoring in Labour	4c	Timely fresh eyes and systematic reviews audit under required ambition, work with fetal wellbeing leads to establish barriers	Transformation Lead	Oct	
		NA	Alignment of auditing to reduce variation	Fetal wellbeing leads	Q2 Data	
5	Pre-term birth	5e 5f	Bedside resuscitation – commence perinatal discussion to start with LSCS. Preterm birth obs leads, Neonatal obs leads, labour ward leads	Transformation Lead, I/P matrons	Oct	

Action Plan from LMNS assurance meeting

Action No.	Date of Meeting	Action detail	Description	Action owner	Due Date	Update	Action status - RAG rating	Date Complete	Admin Notes
7	22/03/2024	Babies < the 3rd centile born > 37+6 weeks gestation not detected antenatally as SGA	SH, MJ to have an internal discussion with the audit team	SH/MJ	01/07/2024	2024.06.21: LS updated: conversation ongoing around the complex issue, identification of babies in the category	Progressing		
10	22/03/2024	BadgerNet push notifications	LJ to report to the Group following the review of BadgerNet push notifications around the reduced fetal movement leaflet.	LS	01/10/2024	2024.06.21: BadgerNet releases the notifications 4 times during pregnancy; work is ongoing around getting the notifications acknowledged, social media usage etc.	Progressing		review following meeting information shared
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	01/10/2024	2024.06.21: BE-Business case is in development, report in Q2 2024/25	Progressing		
20	21/06/2024	Quit date reporting	LS to link with NHS Sussex Tobacco Leads and ESHT stop smoking midwives to align practice around reporting quit dates met.	LS	01/10/2024		Progressing		
21	21/06/2024	Scan statistics	LJ to link in with the sonography task and finish to ascertain the full impact including the total numbers of growth scans being declined due to capacity.	LJ	01/10/2024		Progressing		
22	21/06/2024	Training- scan interpretation	LS to enquire whether there is need for further training for midwives around interpreting 3rd trimester scans to support current SOP application.	LS	01/10/2024		Progressing		
23	21/06/2024	Digital BP monitoring guidance	LJ to follow up the escalation with the regional safety team around digital BP monitoring guidance changes.	LJ	01/10/2024		Progressing		
24	21/06/2024	SPC chart utilisation	LS and JD to link around utilising SPC charts for Intervention 2.18.	LS/JD	01/10/2024		Progressing		
25	21/06/2024	Ouf of hours scans	BE to discuss how on-call sonography can support with out of hours scans for reduced fetal movements.	BE	01/10/2024		Progressing		
26	21/06/2024	Hourly fresh eyes	LJ/LS to explore national guidance on the parameters for the hourly fresh eyes, how many minutes following the hour etc.	LJ/LS	01/10/2024		Progressing		
27	21/06/2024	Element 5 support	BE/LS to explore Element 5 support following the Transformation midwives' role ending in September 2024.	BE/LS	01/10/2024		Progressing		
28	21/06/2024	Quarterly audit processes	LJ, LS, SMc and JC to meet around the quarterly audit processes.	LJ/LS/ SMc/JC	01/10/2024		Progressing		
29	21/06/2024	SBL at LMNS QSF	LJ to revise the LMNS QSF agenda to receive implementing SBL as an item every 6 months.	LJ	01/10/2024		Progressing		