



University Hospitals Sussex

NHS Foundation Trust

Meeting of the Board of Directors

10:00 to 14:00 on Thursday 4 September 2024

Washington Suite Boardroom, Level 2, Worthing Hospital, Lyndhurst Road, Worthing

AGENDA – MEETING IN PUBLIC

Item:1	Time: 10:00	Welcome and Apologies for Absence <i>Apologies:</i>	<i>To note</i>	Verbal	Presenter: Philippa Slinger
		Confirmation of Quoracy To note	<i>To agree</i>	Verbal	Presenter: Philippa Slinger

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.

Item:2	10:00	Declarations of Interests	<i>To note</i>	Verbal	Presenter: All
Item:3	10:00	Minutes of UHSussex Board Meeting held on 05 June 2025	<i>To approve</i>	Enclosure	Presenter: Philippa Slinger
Item:4	10:05	Matters Arising from the Minutes	<i>None</i>	Verbal	Presenter: Philippa Slinger
Item:5	10:05	Questions from the public To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	<i>To respond</i>	Verbal	Presenter: Philippa Slinger
Item:6	10:25	Patient Story	<i>To note</i>	Verbal	Presenter: Dr Maggie Davies
Item:7	10:40	Report from Chief Executive	<i>To receive and note overview of the Trust's activities</i>	Enclosure	Presenter: Dr Andy Heeps

STRATEGY

Item:8	11:00	Excellent Care Everywhere - OneUHSussex	<i>To discuss</i>	Enclosure	Presenter: Dr Andy Heeps

DELIVERY

Item:9	11:25	Integrated Performance Report	<i>To receive and note</i>	Enclosure	Presenter: Dr Andy Heeps
		• Chief Executive's Introduction • Patient • People • Sustainability (financial performance) • Quality • Systems and Partnerships • Research and Innovation • National Oversight Framework			
Item:10	12:00	<i>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.</i>			
	12:30	5-minute Break			
Item:11	12:35	Maternity Assurance Report	<i>To note</i>	Enclosure	Presenter: Emma Chambers
Item:12	12:50	Board Assurance Framework	<i>To approve</i>	Enclosure	Presenter: Glen Palethorpe

ASSURANCE REPORTS FROM COMMITTEES**Escalated Items Only:**

Item:13	13:05	Report from the Research, Innovation & Digital Strategy Assurance Committee including Research and Innovation - from the meeting held on the 30 July 2025	<i>To note assurance from Committee and action recommendations from the Committee</i>	Enclosure	Presenter: Prof. Jackie Cassell
Item:14	13:10	Report from Patient & Quality Assurance Committee - from the meetings held on the 24 June and 29 July 2025 (See appendices)	<i>To note assurance from Committee and action recommendations from the Committee and approve appendices</i>	Enclosure	Presenter: Lucy Bloem
Item:15	13:20	Report from People & Culture Assurance Committee - from the meetings held on the 27 May, and 29 July 2025	<i>To note assurance from Committee and action recommendations</i>	Enclosure	Presenter: Prof. Paul Layzell

(See appendices)*ns from the
Committee and
approve
appendices*

Item:16	13:30	Report from Finance & Performance Assurance Committee - from the meetings held on the 29 May, 26 June and 31 July 2025	<i>To note assurance from Committee and action recommendations from the Committee</i>	Enclosure	Presenter: Philip Hogan
Item:17	13:35	Report from Strategy & Major Projects Assurance Committee - from the meetings held on the 31 July 2025 including:	<i>To note assurance from Committee and action recommendations from the Committee</i>	Enclosure	Presenter: Prof. Paul Layzell
Item:18	13:40	Report from Audit Committee - from the meeting held on the 22 July 2025 including report from Committee Chair (See <i>appendices</i>)	<i>To note assurance from Committee and action recommendations from the Committee and approve appendices</i>	Enclosure	Presenter: Philip Hogan

COMPLIANCE

Item:19	13:45	Company Secretary Report	<i>For information only</i>	Enclosure	Presenter: Glen Palethorpe

OTHER

Item:20	14:00	Any Other Business	<i>To receive any notified urgent business and action</i>	Verbal	Presenter: Philippa Slinger
Item:21	14:00	Date and time of next meeting: The next meeting in public of the Board of Directors is scheduled to take place at 10.00 on Thursday 13 November 2025 in Worthing. To resolve to move to into private session <i>The Board now needs to move to a private session due to the confidential nature of the business to be transacted</i>		Verbal	Presenter: Philippa Slinger

Supporting Appendices

Item:11	Maternity Assurance	<i>Perinatal Quality Surveillance ATAIN & Transitional Care Perinatal Mortality Review Tool</i>	<i>To receive and note</i>

Item:14	Patient & Quality Assurance Committee	<i>Annual Reports:</i> - <i>Mortality & Learning from Deaths Report 2024-25</i> - <i>End of Life Care Report 2024-25</i> - <i>Patient Safety & Duty of Candour Report 2024-25</i> - <i>Patient Experience Report 2024-25</i> - <i>Safeguarding Children & Adults Report 2024-25</i>	<i>To receive and approve annual reports for publication to the Trust website</i>
Item:15	People & Culture Assurance Committee	<i>Annual Reports:</i> - <i>Freedom to Speak Up 2024-25</i> - <i>Guardian of Safeworking 2024-25</i> - <i>Annual Workforce Equality Report 2024-25</i>	<i>To receive and approve annual reports for publication to the Trust website.</i>
Item:18	Audit Committee	<i>Annual Audit Committee Report 2024-25</i>	<i>To receive and note</i>

Minutes



Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 05 June 2025, held in the Washington Suite Boardroom, Worthing Hospital, Lyndhurst Road, Worthing and via Microsoft Teams Live Broadcast.

Present:

Philippa Slinger	Chair
Lucy Bloem	Non-Executive Director
Professor Jackie Cassell	Non-Executive Director
Professor Gordon Ferns	Non-Executive Director
Philip Hogan	Non-Executive Director
Bindesh Shah	Non-Executive Director
Dr George Findlay	Chief Executive
Dr Maggie Davies	Chief Nurse
David Grantham	Chief People Officer
Nigel Kee	Chief Operating Officer
Jonathan Reid	Chief Financial Officer
Roxanne Smith	Chief Strategy Officer
Professor Catherine (Katie) Urch	Chief Medical Officer

In Attendance:

Glen Palethorpe	Company Secretary
Dr Sarah Westwell	Chief of Service – Cancer (Item 5 only)
Dominic Clarke	Deputy Managing Director & Divisional Director of Operations – Cancer (Item 5 only)
Dr Anna Olsson-Brown	Clinical Director (Item 5 only)
Bill Shay	Patient (Item 5 only)
Tamsin James	Board and Committees Manager (Minutes)
Catherine Bridger	Board and Committees Manager (Production)

TB/06/25/1 WELCOME AND APOLOGIES FOR ABSENCE ACTION

- 1.1 The Chair welcomed all those present to the meeting.
- 1.2 There were apologies for absence received Dr Andy Heeps, Professor Paul Layzell and David Curley. It was noted that Wayne Orr was observing the meeting on the livestream but as was unable to participate his apology was taken.
- 1.3 The Chair acknowledged that Sandi Drewett had left the role of Chief of Culture & Organisational Development but remained with the Trust supporting the cultural improvement programme. The Chair thanked Sandi for her work and engagement as a Board member. It was also shared by the Chair that the meeting today was David Curley's last meeting in Public as he was leaving his role as Non-Executive Director on the 30 June 2025 after the Audit Committee receiving the 2024/25 final accounts and annual report. The Chair thanked David for his dedication to the Audit Committee Chair role.

TB/06/25/2 DECLARATIONS OF INTERESTS

- 2.1 There were no interests declared.

TB/06/25/3 MINUTES OF THE MEETING HELD ON 08 MAY 2025

- 3.1 The Board received the minutes of the meeting held on 08 May 2025.
- 3.2 The minutes of the meeting held on 08 May 2025 were **APPROVED** as a correct record.

TB/06/25/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

- 4.1 There were no formal matters arising.

TB/06/25/5 SERVICE PRESENTATION - CANCER

- 5.1 The Board welcomed the Cancer Services team; Sarah Westwell, Chief of Service; Dominic Clarke, Divisional Director of Operations; and Dr Anna Olssen, Clinical Director, and paid a special welcome to Mr Bill Shay, who has Cancer and is a patient of the Trust who was attending the meeting to share his experience of his care received at UHSussex since his Stage 4 melanoma skin cancer diagnosis in 2015.
- 5.2 Sarah Westwell began by highlighting the significant progress made by the Division since its formulation on merger on the delivery of the performance standards, the current challenges facing the service, and a clear vision for the future of cancer care across Sussex. Outlining how demands on cancer services continue to rise, because of increasing incidences of cancer, with more patients being referred with suspected cancer and more people being diagnosed with cancer. Sarah also described a rise in the numbers of patients living many years with treatable but enduring cancer which is a testament to the advances in Cancer treatment over the years.
- 5.3 Sarah continued to share that UHSussex receives the second largest number of urgent suspected cancer referrals nationally, and some services, such as breast, are the largest in the country; and the key objective for the division was to provide rapid diagnosis, particularly as up to 93% of referred patients do not have cancer and required prompt confirmation.
- 5.4 Dominic Clarke outlined the focus on improving services by improving access to radiotherapy and systemic anti-cancer therapies with key opportunities in digitisation and AI automation, reducing health inequalities, and expanding personalised care.
- 5.5 Sarah advised that the division's continuing focus remained on improving patient outcomes, delivering consistent, compassionate, individualised care, sustaining operational improvements, increasing early diagnosis rates, and reducing treatment variation and inequity of access. Anna Olsson-Brown also outlined the aim to drive innovation and research and further develop services and teams. With continued support, the Cancer Division aimed to become a leading regional cancer centre supported by strong collaboration with partners, including the Surrey and Sussex Cancer Alliance (SSCA), Sussex Integrated Care Board (ICB), NHS England (NHSE), and various charitable organisations.
- 5.6 Dominic highlighted the national cancer waiting times demonstrate the improvements made over the recent years. The 28-day Faster Diagnosis standard improved from 51% in September 2023 to 80% in March 2025. The 62-day Referral to Treatment target also rose from 54% in September 2023 to 68.9% in March 2025. These improvements are notable given the high patient volume managed by the Trust. As a result, the Trust transitioned from Tier 1 for Cancer in October 2023 to Tier 2 from April 2025.

- 5.7 Bill Shay provided a valuable patient perspective by sharing his experience of care received at UHSussex since his stage 4 melanoma skin cancer diagnosis in 2015. Since then he'd remained under the care of Dr Westwell and had since become a Macmillan volunteer, helping those with their more recent diagnosis. Bill's story emphasised how cancer care was increasingly becoming a long-term, manageable condition rather than being exclusively focused on cure.
- 5.8 George Findlay shared his thoughts on the diagnostic and imaging challenges and the scale of improvements underway with colleagues from Clinical Support Services to alleviate the clinical pressures that will improve responsiveness.
- 5.9 Gordon Ferns asked for clarity of the reporting line for paediatric oncology, Anna Olsson-Brown explained that the team that specialises in oncology are part of Women & Children's services. Anna added that there is a strong interface with the Teenage and Young Adult population, and the team works collaboratively with paediatrics through joint pathways and internal delivery models. There was a further discussion relating to workforce improvements, particularly in the recruitment of academic oncologists, which remained a long-term goal.
- 5.10 Lucy Bloem thanked the team for their inspiring presentation and expressed from a patient experience perspective there would be a strong desire to understand what happens next in their pathway, particularly regarding the challenges from an administrative and clerical support. From a patient perspective, she asked what steps could be taken and what support was required from leadership to support this. Sarah emphasised the strain on administrative teams and linked it to the need for advancing digital solutions, especially in clinic scheduling and appointment management. Delays in scanning contributed significantly to appointment backlogs, causing distress for patients. Sarah also mentioned the potential of AI in dictation and documentation, suggesting that tools capable of generating letters from consultations could halve processing time and streamline workflows rationalising the structure for consistency and efficiency.
- 5.11 The Board shared their thanks to the Cancer services team, and to Bill Shay for his valuable insight.
- 5.12 The Board **NOTED** the update.

TB/06/25/6 QUESTIONS FROM MEMBERS OF THE PUBLIC

- 6.1 The Chair acknowledged that the Board had received five questions in total from two members of the Public, Ms Sharma and Katie Fowler, in advance of the meeting and shared thanks to these members of public for their submission.
- 6.2 Glen Palethorpe shared a detailed response to Ms Sharma's points raised and both Maggie Davies and Professor Katie Urch firstly shared their sincere condolences to Katie Fowler and went on to answer the points raised.
- 6.3 The Board **NOTED** the questions received by the members of the public and agreed that the detailed responses would be provided individually to those who raised the questions.

TB/06/25/7 CHIEF EXECUTIVES REPORT

- 7.1 George Findlay shared that there were three areas to highlight from his report this month, these being Maternity Services, the Sussex Cancer Centre, and Research & Innovation.

- 7.2 George began by sharing the progress made by our maternity services and their work with the Maternity Safety Support Programme, outlined within the letter attached as an appendix. The letter informs the Trust that the lead for the programme, and national maternity improvement advisor, had all confirmed their support for services to move to the next phase of the programme, with a view to exiting completely later this year. The Board shared their thanks to the maternity teams for their hard work and dedication to reach this milestone, and this welcome news comes as Trust awaited the reports from the Care Quality Commission, following their most recent inspection of maternity services.
- 7.3 George expressed that the Trust's plans to improve cancer care for people across Sussex had taken a big step forward with the approval of planning permission for the new Sussex Cancer Centre, which would be built on the grounds of the old Barry Building at the Royal Sussex County Hospital in Brighton.
- 7.4 George added that the new Sussex Cancer Centre would be a base for a new regional cancer research partnership that would shape the future of treatment and give cancer patients access to cutting-edge clinical trials. It will also increase the Trust's potential to expand and develop new research and innovation opportunities for both patients and staff. This is central to strategic development and growth as a Trust. In support of the research discussions, the Chair advised that it had been agreed to hold a board development session this year focusing on Research Innovation and Digital.
- 7.5 The Board reflected on cybersecurity discussions held at the previous Board meeting around the digital spectrum and heard that cybersecurity remained a significant risk on our risk register, along with the challenges across the NHS to stay ahead, as threats continued to evolve. Rox Smith supported the update explaining that the Trust was in a strong position, supported by the audited Data Security and Protection Toolkit (DSPT) which is heavily focused on digital security, and Nigel Kee added that the Trust remained compliant with Emergency Preparedness, Resilience and Response (EPRR) standards, which in themselves covered elements of cyber-attack preparedness.
- 7.6 The Board **NOTED** the Chief Executive report.

TB/06/25/8 2025/2026 OPERATIONAL AND FINANCIAL DELIVERY PLAN

- 8.1 Jonathan Reid provided a detailed update on the financial and operational plan for 2025/26, explaining that since January, the team had worked diligently on preparing comprehensive financial papers that outlined the financial, operational, and delivery plans which had previously been received by the Board for review and approval. Jonathan noted the challenge presented by the national NHS performance and financial requirements; however, the plan remained straightforward in its production and despite the high demand on services had been constructed to adhere to national guidance. As summarised within the paper, Jonathan explained that the focus remained on delivering access and performance standards, providing an overarching response to current pressures. Jonathan stated that the performance plan was structured for full delivery of national standards, with the sole exception of RTT (Referral to Treatment) targets. Despite challenges from national and regional teams, the infrastructure delivery and completion rate was at 55%, and intended to attain 60% in 2026/27, and maintain full compliance with diagnostics standards.
- 8.2 Jonathan explained that the Trust had worked closely with NHS Sussex and NHS England to agree a funding settlement which reflected local and national priorities, given pressures on expenditure, and the underlying run-rate on the

exit from 2024/25, the Trust had an efficiency requirement of £108.9m, and delivery arrangements for efficiency, including the undertaking Quality Impact Assessments noting this process itself continued to be strengthened to support this level of efficiency ambition.

- 8.3 Jonathan stated that in support of the ambitious financial plan, Divisional and Corporate budgets had been reset and a new framework for financial accountability and management implemented, alongside a strengthening of the overall performance management arrangements across the Trust.
- 8.4 The Trust operating plan was being supported by a detailed Trust wide workforce plan, that was being supported by a robust system of controls over workforce and is being closely monitored by the Finance & Performance Assurance Committee, to ensure that the Workforce Strategy is delivered, including key plans in respect of Education, Workforce Development, Culture and Equalities performance.
- 8.5 Jonathan explained that the next key milestone for the Trust would be the end of Quarter 1 where the Board would receive an update on performance against key standards and the stretched financial ambition, as well as receiving confirmation from the Finance and Performance Assurance Committee on the development of the Efficiency and Productivity Programme. At this point, the Board would consider whether remediation actions were required. It was highlighted that at the end of Month 1, the Trust was delivering slightly ahead of its baseline plan.
- 8.6 The Board further discussed the role of Quality Impact Assessments being applied to the efficiency programme and stressed the need for robust assurance of its execution, ensuring the refreshed process triangulated with the operational and divisional plan requirements. It was agreed that further updates would be presented through the Patient & Quality Assurance Committee for continued oversight.
- 8.7 The Board **NOTED** the confirmed and final Financial and Operating Plan for 2025/26 and the associated arrangements to ensure Board oversight and support delivery.

TB/06/25/9 OTHER BUSINESS

- 9.1 There were no further items for discussion.

TB/06/25/10 DATE OF NEXT MEETING

- 10.1 It was noted that the next meeting of the Board of Directors in Public was scheduled to take place at **10.00** on **Thursday 04 September 2025 in Worthing**

Tamsin James
Board & Committees Manager
June 2025

Signed as a correct record of the meeting.

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

Agenda Item:	7.	Meeting:	Trust Board in Public	Meeting Date:	4 September 2025	
Report Title:	Chief Executive's Report					
Sponsoring Executive Director:	Andy Heeps, Interim Chief Executive					
Author(s):	Andy Heeps, Interim Chief Executive					
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only		
	N/A	Yes	Yes	N/A		
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)		
	N/A	N/A	N/A	N/A		
Regulatory Reporting Requirement		No statutory requirement. This is a standing Chief Executive's report to the Board, providing updates on key national, regional and local issues relevant to the Trust's performance and strategy.				
Summary of the report describing What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i> So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i> What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s) being made)</i>		This report provides the Board with an overview of key national, regional and local developments affecting UHSussex. It highlights the findings of the developmental Well-Led review, updates on elective recovery, urgent and emergency care pressures, maternity safety, the launch of the new Trust strategy, and wider system changes.				
Recommendation <i>(linked to What Next section)</i>		The Board is asked to: 1. Note the updates set out in the Chief Executive's Report. 2. Consider the implications of national, regional and system developments for UHSussex. 3. Seek assurance that risks are being managed appropriately, with further detail to be provided through the relevant Committees where required				
Assurance / Scrutiny route already undertaken <i>(please explain where matter previously considered, and assurance provided)</i>		This is the Chief Executive's standing report and is presented directly to the Board. Where specific issues require deeper assurance, these are considered through the relevant Board Committees (e.g. People & Culture Assurance Committee for workforce and culture; Patient & Quality Assurance Committee for safety and maternity).				
Link to Trust Strategy <i>(note which theme)</i>	Patients	People	Future	Communities	One UHSussex	Culture
	Yes / N/A	Yes / N/A	Yes / N/A	Yes / N/A	Yes / N/A	Yes / N/A
Link to annual delivery plan	Delivery of the Annual Delivery Plan depends on the organisational culture, leadership and governance foundations described in this report. The Well-Led review response, elective recovery, urgent and emergency care plans, and maternity safety improvements are all critical enablers for achieving delivery plan milestones.					
Link to BAF (explain which BAF risks this	This report relates to several BAF strategic risks, in particular:					

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

CHIEF EXECUTIVE'S REPORT

This is my first report to the Trust Board as Interim Chief Executive. Alongside updates from across our hospitals, I also want to provide some wider context for the Board's discussions by highlighting recent national and regional developments that are relevant to our plans and performance. I also want to take this opportunity to thank Dr George Findlay for his leadership of UHSussex as Chief Executive over the past three years. George has guided the Trust through a period of significant challenge and change, including the recovery from the pandemic and the development of our new strategy. We wish him well for the future.

Headlines

The developmental Well-Led review by Niche Health and Social Care Consulting has been an important and challenging moment for UHSussex. While it recognised some areas of progress, it also gave clear and sometimes difficult feedback about our governance, our culture and the way we lead. Many of the themes reflect what our own staff have been telling us for some time, particularly about the need for greater consistency, openness and inclusion. If we do not respond with honesty and pace, there is a real risk to the confidence of our people, partners and regulators. I set out our proposed next steps in a paper to this Board meeting.

We continue to face the challenge of long elective waiting lists. While overall numbers are reducing, we must double down our focus on the longest-waiting patients. We know from complaints that long waits are a consistent and distressing theme, and tackling this is a root cause of patient dissatisfaction. Nationally, it has been confirmed that UHSussex remains under tier 1 oversight for elective care, tier 2 for urgent and emergency care and cancer, and not under oversight for diagnostics. This underlines both the importance of our elective recovery work and the expectation that we continue to demonstrate progress.

Urgent and emergency care remains under sustained pressure, particularly at peak times. Ambulance handover times are improving but continue to be variable at Brighton, and we continue to use continuous flow to mitigate against corridor care. These issues will remain a significant risk through winter, despite significant new investment in urgent care facilities across our sites which I outline below.

Finally, the Sussex healthcare system continues to develop plans to move more follow-up care from hospitals into local community services, in line with the ambitions of the 10-Year Health Plan. This is the right direction for patients and consistent with government policy, but we need to be clear about the implications for our own activity, income and the potential for stranded costs.

National Policy and Regulation

NHS Oversight Framework 2025/26

NHS England has published its revised Oversight Framework for 2025/26. This introduces a five-tier segmentation model for trusts, ranging from the highest performing to the most challenged, with performance judged across access, safety, workforce, finance and productivity. Deficits will cap the score an organisation can achieve, and segmentation data will be published quarterly. High-performing trusts will gain greater autonomy, while those in lower tiers will be drawn into the new Provider Improvement Programme with targeted national

support. Given our financial position and anticipated competency assessment, UHSussex is likely to be placed in segment 4. This will bring additional external scrutiny, but also structured support, and reinforces the importance of demonstrating visible progress against the key metrics where we are being held to account.

National Maternity and Neonatal Review

An urgent independent investigation into maternity and neonatal care has been launched nationally, to be led by Baroness Amos. Up to ten trusts will be examined in depth, with a focus on culture, behaviours and outcomes. The Secretary of State has already referred publicly to families in Sussex who have experienced tragedy, and some of those families have met with the review Chair. While no trusts have been not been formally named as one of the trusts to be investigated, we recognise the importance of this process and, if included, we will work openly and fully with the review team and act swiftly on their findings.

In parallel, we continue to work with the NHS England Maternity Safety Support Programme, which has visited all four of our maternity units and provided initial feedback. Their recommendations are being incorporated into our maternity safety plan as we strengthen how we listen to women, families and staff, and ensure that improvements in safety, culture and experience are embedded.

We are clear that the lessons from both the national review and the support programme will not only shape our own improvement journey, but also contribute to national learning across the NHS.

Urgent and Emergency Care Plan

A new national plan for urgent and emergency care has been published, setting stretching targets for performance but giving providers greater flexibility in how improvements are achieved. For UHSussex, our ability to respond will be strengthened significantly over the coming weeks as new facilities open across our hospitals. These include a new Same Day Emergency Care Unit at St Richard's, an Urgent Treatment Centre at Worthing, and both an Acute Medical Unit and a Same Day Emergency Care Unit at the Royal Sussex County Hospital. Together, these developments represent part of a multi-million pound capital investment in urgent care across the Trust. They will expand our capacity, improve patient flow, and ensure we are better prepared for the pressures of winter.

Dash Patient Safety Review

A national review led by Penny Dash has called for a fundamental rebalancing of how patient safety is managed across the NHS. It highlights that while oversight and regulation are necessary, an over-reliance on process and reporting can unintentionally disempower clinical teams and reduce focus on outcomes that matter to patients. The review recommends a stronger emphasis on empowering frontline teams, valuing patient and family experience, embedding learning from incidents, and creating the right culture for safety rather than relying solely on compliance measures.

As part of our governance review linked to our refreshed Operating Model, we will be aligning our approach with the Dash recommendations. This will include cross-checking our Patient Safety Incident Response Framework themes, and ensuring that divisional board meetings move beyond process compliance to closed-loop learning, where changes can be tracked and

tested until improvement is demonstrated. We will also strengthen how we listen to patients and families when harm occurs, so that their voices directly shape our safety improvement priorities.

This direction of travel is consistent with the findings of the recent Well-Led review, which highlighted the need for stronger staff voice, more inclusive leadership behaviours, and a culture where speaking up leads to visible change. By bringing these strands together, we can build a safety culture that is both open and accountable, and where improvement is owned and driven by those closest to patients.

Regional and ICB Update

Future ICB arrangements

Nationally, NHS England has set out the expectation that Integrated Care Boards (ICBs) will reduce their running costs to £18.76 per head of population, supported by a new Model ICB Blueprint which defines the core functions of future ICBs. For Sussex, this has significant implications: the current annual cost base of £74.7m could not be delivered safely within the reduced allocation on a standalone footprint.

Following detailed work at the Sussex ICB Board in May, and in parallel at Surrey Heartlands, both Boards agreed that a joint model offered the safest and most sustainable way forward. A plan was submitted to NHS England on 30 May setting out an approach for collaboration between Sussex and Surrey, retaining separate Integrated Care Partnerships in each geography to ensure focus on local population health. On 24 June NHS England confirmed acceptance of the proposed new boundaries, with Surrey Heath and Farnham returning from the Frimley system to Surrey. On 3 July, ministerial support was confirmed for the creation of a new Surrey and Sussex ICB from 1 April 2026.

NHS Sussex Draft Commissioning Intentions

Sussex ICB has published its draft commissioning intentions for 2025/26, setting out how services will be planned and funded across the county. The intentions signal a continued shift towards prevention, community-based and digitally enabled models of care, with greater emphasis on neighbourhood teams, urgent and emergency care reform, rehabilitation and management of long-term conditions. For UHSussex, this direction of travel aligns with our own strategy, but it also presents risks if activity is displaced from hospital settings without clear financial transparency or mitigation of stranded costs.

The provider collaborative is now considering how best to respond to the commissioning intentions, ensuring that the approach is coordinated, needs-led and sustainable. We are working collaboratively with partners across Sussex to model the impact of these changes, understand the financial consequences, and design pathways that are both clinically effective and operationally viable.

There will also need to be further clarity from the ICB on the commissioning form these intentions will take — whether through an alliance model or a lead provider model. Each approach has significant implications for UHSussex in terms of accountability, risk, and the way we organise care. The Board will need to return to this question at a future point once the ICB has set out its direction more clearly.

NHS Sussex Chair

In May, Stephen Lightfoot announced that he will not be seeking reappointment as Chair of NHS Sussex and will conclude his term in September 2025. Stephen has played an important role in leading the ICB through its first years, and we are grateful for his partnership with UHSussex during that time.

Sussex Health and Care Research Strategy

The county's first five-year research strategy has now been published, setting out ambitions to enhance patient care, address local health priorities, and foster a culture of continuous improvement across Sussex. Research is also a central theme of our new UHSussex strategy, and we will play a key role in delivering the ambitions of this plan alongside our academic and system partners.

RSV Vaccination Campaign

More than 375,000 RSV vaccinations have been delivered to vulnerable people across the South East over the summer. This campaign should help reduce pressure on our emergency departments and paediatric services during the winter months. We have actively supported the communications effort to maximise uptake across our communities.

Leadership changes at Surrey and Sussex Healthcare NHS Trust

I welcome the appointment of Andrew Hines as the new Chief Executive at Surrey and Sussex Healthcare NHS Trust (SASH), who will take up post in the autumn following the retirement of Angela Stevenson after 37 years in the NHS. Andrew joins from Barts Health, where he has led the development of their group operating model, and earlier in his career worked at SASH. I would like to take this opportunity to thank Angela for her long service and for her partnership in recent years as we have worked closely together across the Sussex system.

University Hospitals Sussex

UHSussex Strategy

We are preparing to publish our new Trust strategy, Excellent Care Everywhere, on 1 October. The strategy sets out our vision for the next five years and beyond, focusing on how we will deliver better, faster and fairer care, support our people, and strengthen our role in the Sussex health and care system. Over the past year we have engaged widely with staff, patients, partners and communities, and their feedback has helped shape the final plan. Publication will be an important milestone in setting a clear and shared direction for UHSussex, and in building the culture and behaviours we need to succeed.

CQC inspections

The Care Quality Commission published its assessment of children's and young people's services at Worthing Hospital, based on an inspection in June 2024. The services were rated Good overall. Inspectors highlighted the safety culture and the kindness of our staff, while also noting the need to strengthen staffing levels and reduce waiting times. The full report can be found at <https://www.cqc.org.uk/location/RYP18/reports/LAP-01134/services-for-children-and-young-people>

We are awaiting confirmation of publication dates for the CQC's inspection reports into maternity services at Worthing and the Royal Sussex County Hospital, and for the emergency department at the Royal Sussex County Hospital, which were carried out earlier this year.

The CQC also undertook its scheduled Well-Led inspection of the Trust in July, and we are awaiting publication of the report.

Fire Safety compliance

Since the last Board meeting, the Trust has received formal correspondence from West Sussex Fire and Rescue Service following site inspections at St Richard's Hospital, the Princess Royal, and the Sussex Orthopaedic Treatment Centre. At St Richard's, an Enforcement Notice has been issued requiring improvements in fire safety arrangements, risk assessments, staff training and equipment maintenance, with these improvements to be made by February 2026. At the Princess Royal and Orthopaedic Centre sites, letters of fire safety matters were issued, highlighting issues relating to maintaining clear escape routes, maintenance of alarms, emergency lighting and fire doors, and staff training. The Trust is acting promptly to address the issues within all three documents from the Fire Service noting there is no immediate risk to patients or staff.

Work is already underway to address these requirements through our estates, fire safety and clinical teams, with external assurance being sought where appropriate on their delivery. Progress will be monitored through the Trust's health and safety committee and reported back to the Board to provide assurance that risks are being managed.

STAR Awards

We recently held our annual STAR Awards, celebrating the achievements of colleagues across UHSussex. More than 1,200 nominations were received from staff, patients and members of the public, reflecting the pride people feel in the care we provide. The winners and finalists showcased the compassion, innovation and commitment that exist across our teams.

Media coverage

Since the last Board meeting, UHSussex has attracted positive coverage for several important stories, including progress on the new Acute Stroke Centre at St Richard's, a pioneering trial of a gonorrhoea vaccination, the launch of the Sussex Research Strategy, and the award of a National Quality Mark for our preceptorship programmes. At the same time, we have continued to handle significant media interest in sensitive issues, including inquests, complaints, waiting times, George Findlay's departure as chief executive, the ongoing police investigation into general surgery and neurosurgery in Brighton between 2015–21 (Operation Bramber), and the national maternity review.

Andy Heeps
Interim Chief Executive
September 2025

Agenda Item:	8.	Meeting:	Trust Board in Public	Meeting Date:	4 September 2025
Report Title:	Building One UHSussex: Our Response to the Developmental Well Led Review				
Sponsoring Executive Director:	Andy Heeps, Interim Chief Executive				
Author(s):	Andy Heeps, Interim Chief Executive				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only	
	N/A	Yes	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement		This report sets out our response to the developmental Well Led review published in July 2025. While there is no formal statutory reporting requirement, the Board has accepted all 22 recommendations and will monitor delivery closely. Progress will also be shared with NHS England through our usual reporting arrangements.			
Summary of the report describing What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i> So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i> What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s) being made)</i>		In July 2025, Niche Health and Social Care Consulting published its developmental well led review of University Hospitals Sussex. The review recognised progress in key areas, including cancer, maternity and elective recovery, improved partnership working, and greater stability in the executive team. However, it also highlighted deep challenges in leadership, culture and governance. Staff described low psychological safety, tolerance of poor behaviours, and a “parent–child” style of leadership, alongside a lack of clarity in governance and inconsistent recognition of voices beyond medicine. The Board accepts the findings in full. We are sorry that colleagues and patients have experienced the behaviours and culture described in the report. Our response is at the heart of the Trust’s future and is aligned with our new Excellent Care Everywhere 2030 strategy. This time, culture and leadership will not sit alongside “business as usual” but will be everyone’s business. We have structured our response around four interlinked pillars, each led by an executive director: Behaviours and Culture – co-design of a new Values and Behaviours Framework with staff, launching in October, embedded in recruitment, appraisal, recognition and Freedom to Speak Up processes. Leadership Development – a new leadership programme for all levels, strengthening nursing and AHP voices, embedding 360° feedback, and clarifying expectations of leaders. Structure and Governance – redesign of the Clinical Operating Model with Tricordant, governance review, refreshed Board Assurance Framework, and consistent divisional governance. Policy, Process and Systems – refresh of the Patient First improvement system aligned with NHS Impact, rollout of the Daily Management System, review and simplification of HR policies, and stronger quality assurance of efficiency schemes. Progress will be measured through staff surveys, culture heat maps, Freedom to Speak Up data, patient experience, workforce metrics and a new composite culture measure. Oversight will sit with the Board, with the Interim Chief Executive as Senior Responsible Officer and each pillar led by an executive.			

Recommendation <i>(linked to What Next section)</i>	The Board is asked to: Note the findings of the Niche developmental Well Led review of UHSussex, published in July 2025. Approve the Trust's response framework, structured around four pillars: - Behaviours and Culture - Leadership Development - Structure and Governance - Policy, Process and Systems Endorse the Board's acceptance of all 22 recommendations in full, with oversight arrangements led by the Interim Chief Executive as Senior Responsible Officer and executive leads for each pillar. Agree that progress will be reported at each Board meeting for the first six months, before transitioning to committee oversight with integrated Board assurance.					
Assurance / Scrutiny route already undertaken <i>(please explain where matter previously considered, and assurance provided)</i>	This is the first time the Board has considered the Trust's response to the developmental Well Led review. Progress will be reported to the Board monthly for the first six months to provide direct assurance, before oversight is embedded into the relevant Board committees with the Board retaining overall accountability.					
Link to Trust Strategy <i>(note which theme)</i>	Patients Yes	People Yes	Future Yes	Communities Yes	One UHSussex Yes	Culture Yes
Link to annual delivery plan	Successful delivery of the Annual Delivery Plan is dependent on creating a healthy culture, clear leadership and effective governance. The response to the developmental Well Led review provides the foundation for this by setting the standards of behaviour, leadership capability, and structural clarity needed for sustained improvement. Without progress on these areas, the ambitions in the Annual Delivery Plan cannot be achieved consistently.					
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	The response to the developmental Well Led review has a direct bearing on several BAF strategic risks. In particular: Risk 2 – Culture (current score 16, target 12): The review findings align directly with this risk. Delivery of the four-pillar response is expected to strengthen controls and assurance, supporting a reduction in score over time. Committees have already questioned whether this risk should remain at 20 until improvement is evidenced, underlining the importance of the work. Risk 3 – Workforce (current score 12, target 12): Leadership development, clearer behaviours and fairer HR policies will support retention and staff experience, sustaining assurance at the target score. Risk 11 – Change Capacity (current score 16, target 12): Embedding new governance, leadership and improvement systems will increase organisational capacity for change and strengthen assurance over the medium term. Risks 6, 7 and 9 – Operational configuration, Research/Innovation, and Digital (scores 15–20): Progress on governance, leadership and improvement capability will provide stronger foundations to mitigate these risks, though assurance is currently limited. Overall, the Well Led response is a central control for the BAF culture and workforce risks, with knock-on benefits for change capacity, governance, and improvement risks. The impact is expected to be a strengthening of the assurance profile in 2025/26 , with movement in risk scores dependent on sustained delivery.					
Link to CQC domain	Safe N/A	Caring N/A	Effective N/A	Responsive N/A	Well-led Yes	Use of Resources N/A

Other impacts	Equality and Diversity (if yes has HEIA completed)	Environmental	Legal	External Registrations (if yes please indicate which)
	Yes (No)	N/A	N/A	Yes – CQC, NHS England License



Building One UHSussex: Our Response to the Developmental Well Led Review

Introduction

In July 2025, Niche Health and Social Care Consulting published its developmental well led review of University Hospitals Sussex. The review looked at leadership, governance and culture, and made 22 recommendations for improvement. We published the report in its entirety on our website on 31 July 2025.

The report was a challenging but important read. It recognised progress in areas such as cancer, maternity and elective performance, stronger partnership working, and greater stability in the executive team. But it also found that we remain much to do, with feedback that portrayed a divided organisation, with inconsistent behaviours, weak governance arrangements, and cultural norms in places that do not always support a safe and inclusive workplace.

Staff told reviewers they did not always feel safe to speak up, and described a “parent and child” style of leadership. They highlighted the disproportionate influence of medical voices and said that nursing, allied health professionals and managers are not always heard as strongly. Others have further reflected that their voices – including allied health professionals, clinical scientists and facilities staff – were not fully present in the report, but nonetheless feel silenced in our culture. At the same time, the review also heard examples of supportive teams, strong local leadership and staff who are proud of the care they provide. Niche noted improvements in operational performance, and described cautious optimism among staff and partners that change is possible. The report noted that many staff continue to have confidence in their leaders and feel positive about the direction of the Trust, even if this is not yet consistent everywhere. Our task now is to build on those strengths while tackling the areas where people still feel unheard or undervalued.

The Board accepts the review in full. We are sorry that colleagues and patients have experienced the behaviours and culture described in the report. It is clear that we have not always created the environment our staff need or the consistency of leadership our patients deserve. Our response is at the heart of the Trust’s future. Previous attempts to run culture work in parallel with “business as usual” have not succeeded. This time must be different: it is everyone’s business.

To underline this, as Interim Chief Executive, I am the Senior Responsible Officer for our response, with each of the four pillars led by an executive director.

Findings and Themes

Niche’s review concluded that progress has been held back by:

- division between our east and west legacy organisations
- tolerance of poor behaviours and incivility
- low psychological safety, with many staff afraid to speak up
- leadership that can feel paternalistic
- governance arrangements that lack clarity and consistency

The 22 recommendations cover culture, leadership, governance and improvement. They have been aligned with our *Excellent Care Everywhere* strategy (launching October 2025) and will be delivered through four linked pillars.

Response Framework – Four Pillars

The Board has agreed a response structured around four interlinked pillars: Behaviours and Culture, Leadership Development, Structure and Governance, and Policy, Process and Systems. Each pillar responds directly to the findings of the review.

This update shows progress already made, and sets out the next steps.

1. Behaviours and Culture

Niche highlighted that UHSussex does not yet have a single culture, and that poor behaviours and low psychological safety are too common. Staff told the reviewers about experiences of incivility, exclusion and fear of speaking up. We recognise that these voices must be heard and respected. It is about acknowledging those experiences honestly and then building the culture we want to see.

We have already begun to respond. We have commissioned SilverMaple, a consultancy with deep experience of cultural change in the NHS, to work with us to create a new UHSussex Values and Behaviours Framework. We have started engaging with staff and will run co-design workshops through September to ensure that this framework is shaped by those who work here every day.

We will launch the new framework in October along with our new strategy. It will set out clear standards for every member of staff and every leader. We will embed those standards into recruitment, appraisal, Freedom to Speak Up and recognition processes, so they become part of daily working life rather than a statement on paper. We will make it clear that incivility, exclusion and discrimination have no place in UHSussex, and we will back that up with a training programme to help our staff and leaders feel confident in tackling poor behaviour when they see it. We will also develop a single measure of culture so that progress can be tracked openly and consistently over time.

This work links directly to the *Culture and People* theme of the new strategy. Staff experience is central to excellent care, and this framework will underpin our ambition to make UHSussex one of the best places to work in the NHS.

2. Leadership Development

Niche described leadership in UHSussex as too often paternalistic, with unclear clinical leadership roles and professional voices beyond medicine not fully heard. We have already taken important steps to address this. We have introduced 360-degree feedback for the Board and executive team, and this has been used in this year's appraisal round. We have launched the first Senior Leadership Group leadership development programme, bringing senior leaders together across sites and professions. We have also begun to talk more openly at senior leadership meetings about the leadership behaviours we want to see.

We will now build on this by launching the Excellent Care Everywhere Leadership Programme later this year, aligned to the new behaviours framework. This programme will clarify what we expect of leaders at every level. It will strengthen the voice of all clinical leaders, and it will

ensure that nursing and allied health professional voices are equal partners with medical leadership. We will create clearer succession planning and career pathways so that people can see how they can progress within UHSussex. And we will make sure we learn from and spread the success of our best teams so that excellence is not confined to pockets but becomes the norm.

This work is at the heart of the strategy's *Leadership* ambition: building capable, compassionate and inclusive leaders throughout the organisation and making leadership development part of how we run the Trust day to day.

3. Structure and Governance

Niche found that our Clinical Operating Model is too complex, divisional governance inconsistent, and that our Board assurance arrangements need to be reset. We have acted quickly. We had already commissioned Tricordant, specialists in NHS organisational design, to work with us on a new Clinical Operating Model through a multiprofessional design group. A digital twin of the Trust is being created to allow us to test different options and benchmark our functions. At the same time, we have commissioned a governance review led by Leanne McLean, an experienced former chief nurse, who is reporting on how we can strengthen our governance, accountability and assurance.

We will complete the new Clinical Operating Model by early 2026. This will simplify accountabilities and balance leadership between medicine, nursing and management. We will standardise divisional governance so that it is consistent and reliable across the organisation. We will refresh the Board Assurance Framework to reflect our new priorities and provide clearer oversight. And we will strengthen our presence in system forums so that UHSussex is represented effectively and contributes with confidence.

This pillar connects directly to the strategy's ambition of being *One UHSussex* — a single organisation with clear accountability, streamlined governance and joined-up decision making.

4. Policy, Process and Systems

Niche reported that the Patient First improvement system, while once successful, has lost momentum and now divides opinion. It also noted that many of our policies and systems do not consistently support our values. We have already started to address this. The Daily Management System is being rolled out across our wards, giving teams more visibility of pressures and enabling frontline problem solving. Recruitment is underway for a Director of Improvement and Organisational Development, with strong external candidates expressing interest, to lead the work at scale across the organisation.

On HR issues, we will undertake a comprehensive review of our people policies and processes. Repeatedly our staff told Niche that these are seen as inconsistent or overly complicated, and staff have told us they do not always feel fair or transparent. We will test those policies against our values, simplifying where we can, and making sure they support leaders to act consistently and staff to feel treated with respect. This includes policies on performance, capability, grievance and dignity at work, which will be reframed to reinforce the behaviours we expect and to encourage early resolution rather than escalation.

We will also refresh our improvement system, aligning it with NHS Impact and making it a practical system that staff can trust and use. And we will strengthen the way we test the quality impact of efficiency schemes, so that financial pressures do not compromise patient care.

This work underpins the strategy's *Improvement and Innovation* theme. It commits us to a consistent approach to improvement, where staff at every level are supported to solve problems, make changes and deliver better care every day.

Measuring Progress

Measuring culture is not straightforward. Culture is lived in daily experiences, and no single number can capture it fully. At the same time, it is important that we hold ourselves to account and are able to show whether the changes we are making are making a difference.

We will therefore use a combination of measures to track progress. This will include:

- Results from the NHS Staff Survey and local pulse surveys, which tell us how staff feel about their workplace.
- Culture heat maps and feedback from focus groups, which give a more detailed picture of where change is happening and where more support is needed.
- Information from our Freedom to Speak Up service, including the number and type of concerns raised and how quickly they are resolved.
- Patient experience data, because the way staff feel at work is closely linked to the quality of care patients receive.
- Trends in retention, sickness absence and disciplinary cases, which reflect whether people feel valued and supported.

Alongside these indicators, we will learn from other organisations, inside and outside the NHS, that have been through significant cultural change to learn what has worked for them and how progress can be demonstrated in a way that is meaningful. Our aim is to create a composite culture measure which combines these sources into a simple, visible picture for the Board, our staff and the public.

This will never be perfect, but it will give us a clear way of seeing whether we are moving in the right direction and whether staff and patients are feeling the difference.

Oversight and Accountability

This work is led by the whole Board. The Interim Chief Executive is the Senior Responsible Officer. Each pillar has an executive lead. For the first six months, progress will be reported at every Board meeting. Thereafter, committees will take on elements of oversight but the Board will retain an integrated view.

Conclusion

The developmental well led review is a turning point for UHSussex. The Board accepts its findings in full, and we are sorry that colleagues and patients have experienced the behaviours and culture described in the report. We know that in the past we have not always created the environment our staff need or the consistency of leadership our patients deserve.

We now have a clear plan, supported by external expertise and aligned with our new *Excellent Care Everywhere* strategy. But we also recognise that trust will not be rebuilt through words or plans alone. What matters is what our people see and feel every day.

This is not about diminishing or disputing the voices that Niche heard. Those accounts were real and must be respected. But our task now is to build on that feedback and to focus on creating the culture we want to see: One UHSussex where staff feel respected, supported and able to thrive, and where patients experience safe, consistent and compassionate care.

This will not be quick or easy. But by listening carefully, learning openly and holding ourselves to account, we will take the steps needed to build a stronger, more inclusive and more effective organisation for the future.

Recommendations

The Board is asked to:

1. **Note** the findings of the Niche developmental Well Led review of UHSussex, published in July 2025.
2. **Approve** the Trust's response framework, structured around four pillars:
 - Behaviours and Culture
 - Leadership Development
 - Structure and Governance
 - Policy, Process and Systems
3. **Endorse** the Board's acceptance of all 22 recommendations in full, with oversight arrangements led by the Interim Chief Executive as Senior Responsible Officer and executive leads for each pillar.
4. **Agree** that progress will be reported at each Board meeting for the first six months, before transitioning to committee oversight with integrated Board assurance.

Andy Heeps
Interim Chief Executive
September 2025

Appendix: Recommendations, Grouping and Executive Leads

High Impact and Urgent – address immediately

Rec	Pillar	Action	Lead Exec	Strategic Link
1	Behaviours and Culture	Values and Behaviours Framework launched in October, embedded in recruitment, appraisal and recognition	Chief Strategy Officer (with Chief People Officer)	Supports the strategy's <i>Culture and People</i> theme, making clear that staff experience and behaviour are at the heart of excellent care
4	Behaviours and Culture	Staff stories, culture heat maps and composite measure reported to Board	Chief People Officer	Strengthens assurance under <i>Culture and People</i> by making culture as visible as quality and finance
6	Leadership Development	Leadership programme with clear expectations for senior leaders	Chief Strategy Officer (with CPO)	Supports <i>Leadership ambition</i> , focusing on the senior leadership community as role models
8	Leadership Development	Review of clinical leadership model to strengthen authority and nursing voice	Chief Medical Officer / Chief Nurse / CSO	Advances <i>One UHSussex</i> by ensuring balance across medical, nursing and managerial voices
20	Policy and Systems	Refresh Patient First aligned with NHS Impact	Chief Strategy Officer	Delivers <i>Improvement and Innovation</i> , providing a single approach to continuous improvement
21	Behaviours and Culture	Shared definition of safety including psychological safety	Chief People Officer (with CSO)	Links to <i>Culture and People</i> , broadening our definition of safety to include staff confidence and voice

High Impact but Needs Development

Rec	Pillar	Action	Lead Exec	Strategic Link
18	Leadership Development	Develop new co production framework with Healthwatch and patient forums	Chief Strategy Officer	Supports the strategy's focus on <i>Better and Fairer Care</i> by putting patients and communities at the centre of change
19	Structure and Governance	Bi annual cross system strategy sessions	Chief Executive	Connects to <i>Partnerships and Communities</i> , ensuring UHSussex plays a strong system role

“Just Do It”

Rec	Pillar	Action	Lead Exec	Strategic Link
3	Structure and Governance	Ensure October strategy reflects Niche findings	Chief Strategy Officer	Ensures alignment between Niche and <i>One UHSussex</i> from the outset
7	Leadership Development	Spread learning from areas with proven success	Chief Strategy Officer	Embeds <i>Improvement and Innovation</i> by scaling proven success
10	Behaviours and Culture	Board discussion and visible campaign on discrimination and respect	Chief People Officer	Part of <i>Culture and People</i> , showing visible action on inclusion
11	Structure and Governance	Committee terms of reference updated through governance review	Company Secretary	Strengthens <i>One UHSussex</i> governance by clarifying accountability
14	Structure and Governance	QIA oversight for efficiency schemes	Chief Finance Officer/CMO/CN	Supports <i>Better and Faster Care</i> by linking efficiency to safety and quality

Work Underway

Rec	Pillar	Action	Lead Exec	Strategic Link
2	Structure and Governance	Delivery plans under development	Chief Strategy Officer	Ensures that all strategy workstreams translate into practical delivery under <i>One UHSussex</i>
5	Leadership Development	360 feedback in place for Board and execs	Chief Executive	Part of the <i>Leadership ambition</i> , embedding accountability at the top
9	Policy and Systems	HR and OD benchmarking underway	Chief Strategy Officer / Chief People Officer	Underpins <i>Culture and People</i> by ensuring resourcing is comparable to peers
12	Structure and Governance	Tricordant design group and digital twin in place	Chief Strategy Officer	Core to <i>One UHSussex</i> , redesigning the Clinical Operating Model
13	Structure and Governance	Divisional governance alignment underway	CMO / Chief Nurse	Brings divisional teams into a single model under <i>One UHSussex</i>
15	Structure and Governance	Refresh of Board Assurance Framework	Company Secretary	Improves Board oversight as part of <i>One UHSussex</i> governance
16	Policy and Systems	Digital roadmap aligned with new TOM	Chief Strategy Officer	Connects to <i>Improvement and Innovation</i> by making digital integral to the TOM
17	Structure and Governance	Divisional Accountability Meetings now in place	Chief Operating Officer	Delivers <i>One UHSussex</i> operational oversight
22	Policy and Systems	Reconfirm Green Plan commitments	Chief Finance Officer / CSO	Links to <i>Sustainability</i> as part of our long term strategy

Agenda Item:	9.	Meeting:	Trust Board in Public	Meeting Date:	4 September 2025	
Report Title:	Integrated Performance Report - Quarter 2					
Sponsoring Executive Director:	Andy Heeps, Interim Chief Executive					
Author(s):	Various Executives					
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance		For discussion	For Information only	
	N/A	N/A		Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality		Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A		N/A	N/A	
Regulatory Reporting Requirement	The Board is expected to receive routine reporting on the Trust's performance.					
Summary	This report provides the Board with an overview and headlines of the Trust's performance for quarter 2. This report is aligned to the patient first domains and will be adjusted to align to the Trust's strategy delivery plan once launched.					
Recommendation <i>(linked to What Next section)</i>	The Board is asked to NOTE and DISCUSS this report.					
Assurance / Scrutiny route already undertaken <i>(please explain where matter previously considered, and assurance provided)</i>	This is the standing report and is presented directly to the Board, however specific elements of performance have been scrutinised via the relevant Board Committees.					
Link to Trust Strategy <i>(note which theme)</i>	Patients	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan	This report provides a summary overview of the delivery of the Trust's annual plan					
Link to BAF <i>(explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)</i>	This report relates to several BAF strategic risks, covering people, quality, performance and finance.					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	Yes	Yes	Yes	Yes	Yes	Yes
Other impacts	Equality and Diversity <i>(if yes has HEIA completed)</i>		Environmental		Legal	External Registrations <i>(if yes please indicate which)</i>
	N/A		N/A		N/A	N/A

Integrated Performance Report

June 2025

Chief Executive Summary

Please see enclosed the performance report for University Sussex Hospitals. It shows our performance to June 2025 and sets out the progress we are making to deliver the Trust's 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 1 more than 40,000 patients provided feedback on the care they received within the Trust. 90.5% of those patients were satisfied that they had a good or very good experience in quarter 1, above our target of 90%. This is comparable to the previous quarter in 24/25. This is in contrast to complaints received which was 17% higher than the number received in Q4, relating to appointments, missed communications and difficulties in contacting clinical specialties.

From a quality perspective, there was a slight deterioration in the SHMI mortality rate within expected range to end March. The fall rate fell in May to 4.19. With respect to Harm caused within our care, since the implementation of DCIQ, incident reporting has increased by 16%, this is a positive sign of a learning and safety culture. The latest reported month has seen a rise and stabilisation of increased reporting, particularly for low harm events, which represent 98% of actual harm reported.

Trust performance against the constitutional access measures remained challenged in Q1 2025/26, but there has been notable improvement across all areas.

UHSX remains in Tier 1 as part of the NHSE oversight framework for RTT but - following the Trust's progress with recovering performance - cancer was stepped down to Tier 2 oversight and the Trust is no longer subject to additional oversight for diagnostics. The Trust remains in Tier 2 for emergency performance.

RTT incomplete performance has improved ahead of plan, as has the proportion of the waiting list over with over 52-week waits. No 104-week waits were reported in Q1, and 78-week waits were reduced to just 20 in June. The overall RTT waiting list reduced in June compared to March, and was lowest it has been for over three years. Less progress was made with reducing 65-week waits, which increased in April and May, but reduced to 580 in June; this is lower than April but higher than March.

Cancer performance reduced in both the 28-day 'faster diagnosis' standard (FDS) and 62-day cancer waiting time standards in April and May compared to March, but both are markedly improved year-on-year. June has seen recovery in 28-day standard (78%). The backlog of over 62-day prospective waits increased compared to March but remains below the 352 'fair shares' target set by NHS England. UHSX has moved from Tier 1 to Tier 2 in recognition of progress made and relative performance.

Diagnostics performance continued to improve in Q1 reaching 12.1%, and is now better than at any point since the Covid-19 pandemic. The total Diagnostic waiting list and backlog both reduced and the Trust's performance is now better than the national and regional median position. UHSX has been moved out of the Tiered oversight process for diagnostics.

A&E performance (including Minor Injury Units and Walk In Centres) was 72.9% in Jun-25, which was an improvement compared to both March and the same period 12 months ago. Average waiting times in ED improved and there were fewer stays of longer than 12 hours. Ambulance handover performance improved, with fewer 60-minute delays and shorter waits to handover on average. UHSX - along with system partners - remains subject to Tier 2 oversight for UEC performance.

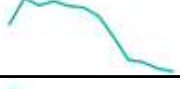
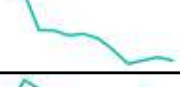
Q1 has predominantly seen a steady state maintained across the People metrics. The exceptions to this are the vacancy levels, which increased in April with the expansion of some establishments to reflect actual (outturn) staffing usage and 25/26 requirements. There is ongoing recruitment to these roles which is slowly reducing the vacancy level and some key cohorts of staff will join in Q2.

There has also been a gradual reduction in sickness absence figures higher than might be expected just by seasonal variation, reflecting focussed work on this. Work is ongoing preparing the Trust's winter vaccination programme. Appraisal rates have maintained a slow improvement to 83% and the Divisions have committed to achieving the target of 90% by the end of Q2 at the latest. There is a need to pay attention to corporate areas. Medical appraisal has been a focus of activity and, barring legitimate exclusions is at 100%, so very significant progress. There is confidence that STAM levels will be maintained above 90% this year, supported by the 'passporting' now encouraged across the NHS.

The Trust is using more staff than planned in its 2025-26 workforce plan, reflected in higher than budgeted staffing costs. To mitigate this vacancy controls and expenditure controls remain in place. There is focussed work with the areas overspending on staff.

The Trust submitted a revised breakeven financial plan for 2025/26; the YTD plan at M03 is for a £13.10m deficit. The actual deficit is £12.62m, which is £0.48m favourable to plan. Efficiency delivery of £12.85m is £5.02m favourable to plan. The position includes non-recurrent slippage against agreed cost pressure funding. The cash position is £3.81m, £1.39m favourable to plan. Capital expenditure is £2.69m above plan, with expenditure of £30.09m against a plan of £27.40m. This reflects timing differences and forecast outturn is in line with plan.

The Trust leadership continues to prioritise patient safety and staff well-being during seasonal pressures. There are positive movements in a number of key operational metrics in planned care, cancer and diagnostics which will continue to be a key part of the Trust's focus into quarter 2.

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	91.5%	90.0%	
P	People	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	6.23	7.06	
S	Sustainability	Financial Stability - Variance from breakeven plan YTD	-480k	0k	
Q	Quality	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	104.9	100.0	
Q	Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	713		
SP	Systems & Partnerships	A&E and Emergency flow - % treated and admitted/discharged within 4 hours	72.9%	78.0%	
SP	Systems & Partnerships	Cancer - To achieve the 62 day standard (All referrals - National standard revised Oct 2023)	60.21%	70.00%	
SP	Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	20	0	
SP	Systems & Partnerships	RTT Elective care - >=65 Weeks	580	0	
SP	Systems & Partnerships	A&E and Emergency flow - Hour of discharge median will be 10am to 10.59am (home for lunch) (Trust Level)	14:51	11:00	
RI	Research & Innovation	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	43	35	



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

Patient First Domain

The UHSx ambition is for patients to have excellent care everywhere. One method of tracking patient reported experience over time is using the friends and family test (FFT). Based on available FFT data, the significant majority of patients – more than 90% in quarter 1 of 2025/26 were satisfied that they have a good or very good experience, based on more than 30,000 responses. This is comparable to the previous four quarters with an improving trajectory.

Surveys are distributed for inpatients, outpatients, maternity and the emergency departments, in line with national requirements. Trust-wide ED average positive reported experience at c85% is trending above the national average (latest national data published by NHSE 80% in January 2025). Patient reported experience of EDs closely aligns to 4-hour performance. The improving trajectory is noted as relating to waiting times in EDs, reduced corridor care and attentive, kind care with comments from patients indicating positive reports of the compassion and attentiveness of the staff.

Inpatient reported experience, with 93% of patients reporting their care as good or very good, remains slightly below the national average of 95%, with the exception of at PRH. However, this is mainly due to how the data is collected with some parts of the emergency floor – including EACU and AAU - included in inpatient data, with this confounding the result slightly downward as patients provide a lower score when they have experienced longer waits. Overall outpatient reported experience is 96.5% - above the national average of 94%. Maternity patient experience is just above national averages at 94%.

The most prevalent theme in negative reviews is waiting, in particular for care and treatment in EDs, or for a bed, staff attitude and issues with appointments, such as delays and cancellations. As such, there is a correlation between our patient true north and urgent care performance, in particular the 4-hour standard.

Other themes in negative experiences include appointment cancellations, staff attitude and behaviour, inpatient care and discharge. Our fundamental standards of care programme is raising inpatient care standards through audits on handwashing, falls, patient experience and nutrition, amongst others. A new visiting policy has been implemented to support improved inpatient experience, and to improve the engagement of families.

A summit was held to evaluate the insights from 2024/25 and improvement opportunities identified which are feeding into the delivery plans for the new strategy, and into the new Patient Experience Plan for 2025-2030.

The patient voice remains influential in service changes, both through analysing patient feedback data and direct engagement of patients, including in Q1 through Healthwatch enter and views.

True North

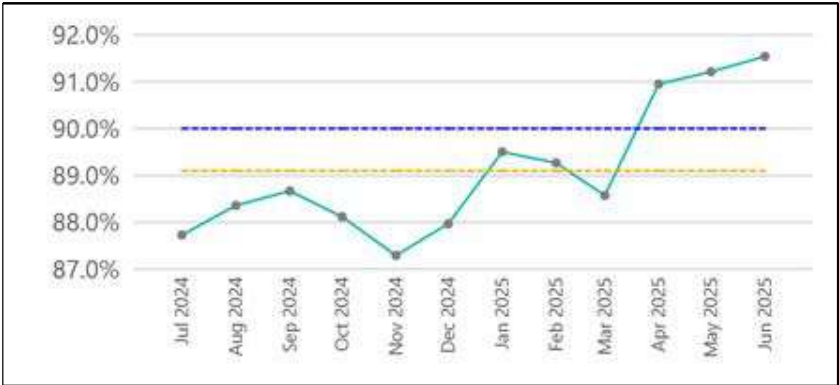
Metric: Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
87.7%	88.4%	88.7%	88.1%	87.3%	88.0%	89.5%	89.3%	88.6%	91.0%	91.2%	91.5%

Overview

The Friends and Family Test (FFT) involves a survey being distributed to ask patients to rate their care on a scale of very good (1) to very poor (5) and to give a reason for their score. The survey is grouped into four touchpoints – ED, maternity, inpatients and outpatients.

Based on available FFT data, the significant majority of patients (over 90% at the end of Q1 2025/26) are satisfied that they have a good or very good experience, based on more than 30,000 responses. This is comparable to the last four quarters with an improving trajectory over 6 data points.



What the chart tells us

Overall, Trust FFT positive rating exceeded 90% in quarter. Trust-wide ED average positive reported experience is above the national average (last reported in January 2025) and improving, with fewer patients making negative references to corridor care in Q1. Patient reported experience of ED closely aligns to 4-hour performance. Maternity services rated above 90% for all sites. Average inpatient positivity was 92.5% against a national average of 95% and outpatients averaged 96% against a national average of 94%.

The most prevalent theme in negative reviews is 'waiting' and the most prevalent themes in positive reviews are the care and kindness from staff.

Intervention and Planned Impact

Emergency department improvements are overseen by F&P breakthrough objectives with ED performance correlating with patient reported experience. Urgent and emergency care improvement plans are now in place with the aim of reducing 4 hour and 12 hour waits, and ambulance handover times.

To improve inpatient care, patient experience audits are being undertaken on the wards to identify concerns early for resolution as part of the fundamental standards of care programme. Changes to the visiting policy are supporting improved family engagement and is being evaluated.

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 and will be included in the new patient experience plan, aligned to the new Trust Strategy. As such, the key risks to patient reported experience via FFT are ED performance and care and communication by clinical staff.

Watch Metrics for Patient

Metric	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Patient experience - Number of complaints	121	126	143	113	106	107	138	154	172	170	164	159
Patient experience - Total open formal complaints	374	352	343	316	304	294	322	340	369	385	422	391

People

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

Patient First Domain

Q1 has predominantly seen a steady state maintained across the People metrics. The exceptions to this are the vacancy levels, which increased in April with the expansion of some establishments to reflect actual (outturn) staffing usage and 25/26 requirements. There is ongoing recruitment to these roles which is slowly reducing the vacancy level and some key cohorts of staff will join in Q2.

There has also been gradual reduction in sickness absence figures higher than might be expected just by seasonal variation, reflecting focussed work on this. Work is ongoing preparing the Trust's winter vaccination programme. Appraisal rates have maintained a slow improvement to 83% and the Divisions have committed to achieving the target of 90% by the end of Q2 at the latest. There is a need to pay attention to corporate areas. Medical appraisal has been a focus of activity and, barring legitimate exclusions is at 100%, so very significant progress. There is confidence that STAM levels will be maintained above 90% this year, supported by the 'passporting' now encouraged across the NHS.

The Trust is using more staff than planned in its 2025-26 workforce plan, reflected in higher than budgeted staffing costs. To mitigate this vacancy controls and expenditure controls remain in place. There is focussed work with the areas overspending on staff.

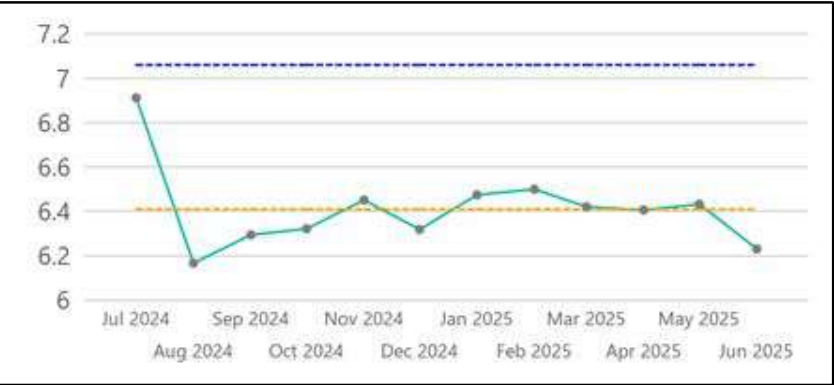
True North

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
6.91	6.17	6.29	6.32	6.45	6.32	6.47	6.50	6.42	6.41	6.43	6.23

Overview

No Data



What the chart tells us

The first quarter of the 2025-26 year has remained below the national average staff engagement score, ending with a score of 6.23 (out of 10) in June 2025 (Q1 score range: 6.41 to 6.23). This is compared to our 7.09 score in June 2024 when the Trust had achieved the target in the first quarter of the year and then declined to a score of below 7.0 from July 2024 onwards.

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

Intervention and Planned Impact

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

The entirety of planned People Directorate work will be mapped against all Ambitions comprising the 2025-30 Trust Strategy in a matrix to demonstrate that our People work will support delivery of Ambitions across the Trust Strategy, including the People Ambition, and improvements in associated KPIs and Staff Survey results.

Risks/Mitigations

Many competing demands on Divisional leadership teams' time may detract from delivery of staff engagement action plans. HRBPs have developed plans with Divisions with a focus on the top 5 key high impact actions for 2025-26 to make delivery simpler.

Improved clarity about the future of the Trust following development of the 2025-30 Trust Strategy with a wide range of stakeholders.

Development of the 2025-26 People Plan aligned to the new Trust Strategy to ensure that sufficient focus and improvement effort is made corporately towards each of the People Promises and Staff Survey.

Delivery of the 2025-26 Trust's Business and Workforce Plan is challenging and therefore effective communication about the necessary changes is critical.

Driver

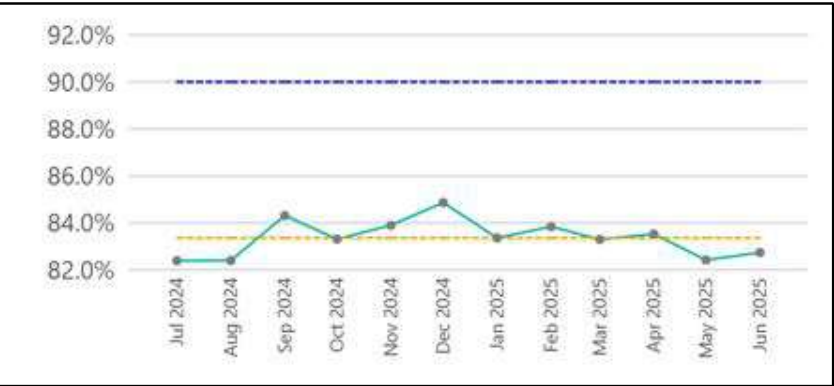
Metric: Training & development - Appraisals completed

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
82.4%	82.4%	84.3%	83.3%	83.9%	84.9%	83.4%	83.8%	83.3%	83.5%	82.4%	82.7%

Overview

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

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



What the chart tells us

The Trust Non-Medical Appraisal rate rose slightly from 81.1% in May 2025 to 81.4% in June 2025. Although this remains below the 90% target, compliance has been consistently above 81.0% since March 2024.

By Division, compliance ranges from 87.1% in Surgery (RSCH & PRH) and 87.1% in CFO Division, to 58.6% in CEO Division. (CPO Division is reporting 44.3% compliance – this includes Trust Volunteers, who should not be included and if removed, bring compliance to c. 77%). 9 Divisions improved their performance in June 2025 (CEO Division by +15.8% points); 7 Divisions worsened their position (by -6.3% points in Deputy CEO Division).

By Staff Group, all groups are above 80.0% compliance other than Admin. & Clerical (79.9%), Additional Clinical Services (77.2%) and Healthcare Scientists (74.5%). Healthcare Scientists have lowest compliance rate, and saw a fall in June 2025 (by 3.2% points).

Intervention and Planned Impact

HRBPs are continuing to support Divisional Management Teams to support uptake and identify variances at Cost Centre level.

Compliance in some Corporate Services (although smaller numbers of staff) and among Healthcare Scientists remains a persistent challenge, and lower compliance among Admin. & Clerical staff (79.9%) a missed opportunity.

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

Risks/Mitigations

Given the positive association between appraisal, engagement, experience and outcomes, the risk of underperformance against the appraisal metric are to those metrics as well as compliance with staff and regulators' expectations.

Performance of some Corporate Divisions (although numbers are relatively smaller, so less impact on overall Trust compliance rate) represents a missed opportunity for role modelling.

Mitigations are as set out in Interventions – continued focus by Divisional and Corporate Management Teams, supported by HR Business Partners, with targeted support at Cost Centre manager level.

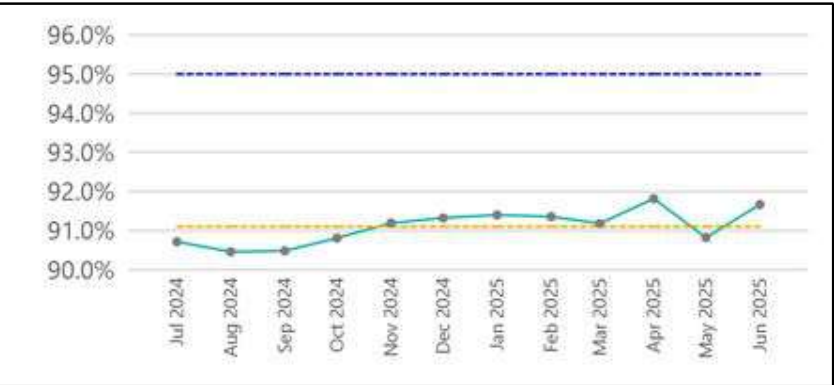
Driver

Metric: Training & development - STAM Weighted Average

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
90.7%	90.5%	90.5%	90.8%	91.2%	91.3%	91.4%	91.4%	91.2%	91.8%	90.8%	91.7%

Overview

UHSussex has set a target for all Statutory and Mandatory (STAM) training to have a compliance rate of 90%. The report shows the breakdown of the STAM weighted average (i.e. the average level of compliance across STAM subjects). This training is important in ensuring the safety of patients, staff and the public Some of it is a regulatory or statutory requirement.



What the chart tells us

The UHSussex STAM compliance rate continues to be strong, with a rate of 91.7% in June, and rates of over 90% for twelve months in a row.

Compliance rates for Medical staff continue to be a bit of an outlier but are rising and now stand at 84.7% (the ninth month in a row within the 80% range), all other groups are compliant above 90%.

Divisionally, only two are below the 90% compliance rate (Chief Executive, and Chief People Officer) although both in the range of 80-89%.

Intervention and Planned Impact

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

Resus training continues to underperform (83.3%) but this has been addressed through being less rigid in approach i.e. you can now undertake the practical before theory which has seen better sign up and attendance rates are slowly starting to rise. We are now looking at delivering some training in situ in departments or as part of wider simulation training.

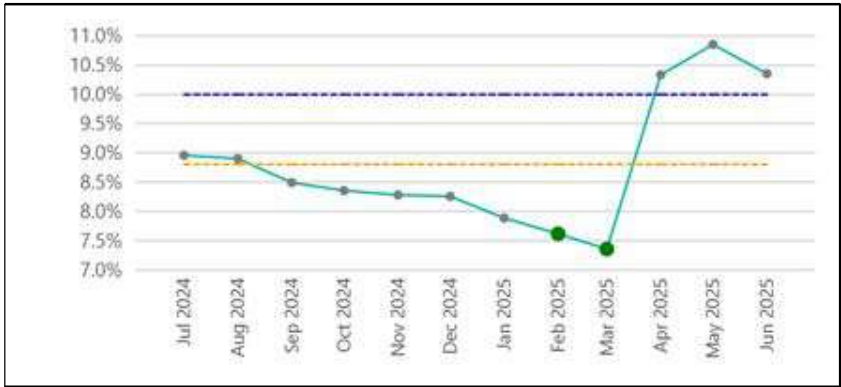
Risks/Mitigations

The MOU for the new STAM passporting process came into effect on 1st May 2025. This aims to provide smoother passporting of STAM from other NHSE MOU signatories, which will reduce time needed to repeat training each time they move, and therefore should keep compliance rates at a good level and reduce the burden of undertaking training on the individual and the service. This will be especially beneficial for new starters and those who rotate. Currently, staff will continue to complete ABLS and M&H (Clinical) to ensure equipment training is completed. Since 1st May, the number of new starters who have passporting STAM training has increased by 70%.

Oliver McGowan Part 2 training remains a risk as the ICB are still yet to commission a provider to enable this training.

Driver											
Metric: Workforce capacity - Vacancy Factor (Substantive contracted FTE) - monthly											
Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
9.0%	8.9%	8.5%	8.4%	8.3%	8.3%	7.9%	7.6%	7.4%	10.3%	10.9%	10.4%

Overview
The vacancy rate expresses, as a percentage of the Trust's overall budgeted establishment in month, the proportion of posts that are vacant. Ensuring that the Trust has sufficient substantive staff to deliver high standards of patient care is essential. A lack of staff may also impact engagement and morale. There is a focus on clinical staff and ensuring that there are adequate medical and nursing staff employed to maintain fill rates whilst recognising that bank and agency will compliment the permanent workforce where required to maintain safe staffing levels.



What the chart tells us

The Trust's budgeted establishment is 17,974 wte (increase of 833 wte from prior year). There are 16,113 wte staff in post (increase of 467 wte from prior year and an increase of 115 in Q1). The Trust currently has 1,862 wte vacancies, an increase of 367 wte in the past year resulting in a vacancy rate of 10.4%.

There has been a significant investment in substantive budgeted establishment in Q1 by 678 wte including the N&M workforce.

Vacancy rates by Staff Group show high rates within Clinical Support (15.0%), AHPs (17.8%), Healthcare Science (15.6%) and Registered Nursing (10.7%). If vacancies are considered by wte, the highest vacancies remain within the N&M workforce (568 wte).

Vacancies for HCAs increased as part of additional funding, however, reduced by 1.2% between M2/M3, currently at 15.8%. There is a similar trend for band 5 RNs following investment with a marginal reduction of vacancies between M2/M3, currently at 13.2%.

Intervention and Planned Impact

Candidate attraction strategy has been developed including:

Programme of RN and HCA recruitment events.

‘Civvy street’ editorial and advert targeting service leavers.

RCNI recruitment event for qualified nurses - 5th September 2025.

Health & Social Care Job Show - 17th & 18th October 2025.

British Forces Resettlement event - 18th September 2025.

LinkedIn recruiter license for direct sourcing for hard to recruit roles.

Continue to partner with Job Centre Plus and work coaches to support local recruitment and promote the organisation as an anchor institution.

Recruitment newspaper (Sussex - 44 sites - 22,000 copies + 5,000 copies for NHS sites) – circa September publication with a focus on EDI/values/local recruitment.

Risks/Mitigations

Change of sponsorship rules impacting on band 3 HCA posts – previous experience considered to agree starting salary i.e. to meet minimum salary threshold.

RN labour supply in the SE of England - rolling open days and assessment events.

Shortage of some medical specialities - application of enhanced medical remuneration package and support for divisions regarding role design and job planning.

Driver

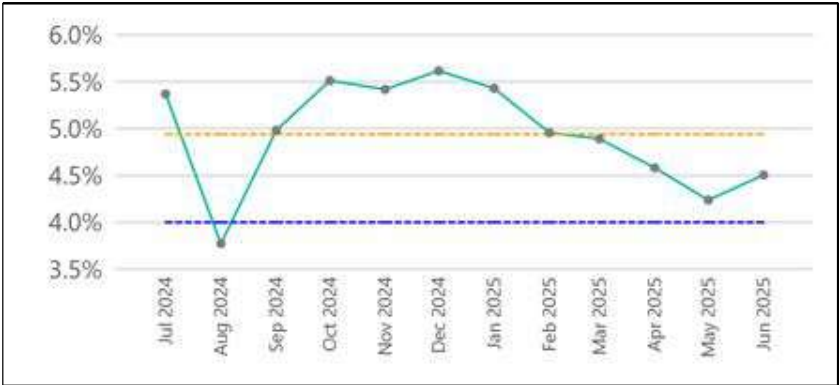
Metric: Workforce efficiency - Absence Sickness in month

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
5.4%	3.8%	5.0%	5.5%	5.4%	5.6%	5.4%	5.0%	4.9%	4.6%	4.2%	4.5%

Overview

High sickness rates impact on staff health and wellbeing, staffing levels, patient continuity of service, morale and resourcing costs.

The measure shows the percentage of the Trust’s WTE budgeted staff absent in the month.



What the chart tells us

Although the in month figure for June (4.5%) was higher than May the overall sickness trend is showing improvement. The last 3 months figures from April to June have been the best 3 month set of figures for over a year. This is not just a seasonal reflection as we saw May at 4.2% (4.9% in May 24) and June at 4.5% (4.9% in June 24).

In May 2025 there were 6 clinical divisions with an in month figure at or below the Trust target of 4% with another two at 4.1%.

When examining the 12-month rates by staff group, Clinical Support (10.2%) and Estates & Ancillary (8.7%) remain the primary areas of concern.

Intervention and Planned Impact

A dedicated team in HR support the management of long term sickness absence and more recently have taken on short term absence. This is working better for managers who have one point of contact for their support and cases. The team is supporting work in the 72 hotspot areas identified in the N&M workstream.

The team has recently been granted two additional resources for sick months that have now been in post for a month. They are focused on 4 Divisions and being able to give dedicated time to identified areas. This will shortly be supplemented by additional resources in the staff psychological services..

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

Review of Occupational health services internally and with the ICB.

A specific current focus is on the improved recording and management of medics absence.

The MH action plan is being implemented..

Risks/Mitigations

A detailed action plan to reduce absence in 25-26 has been developed.

Additional temporary resources within HR to support managers in specific areas are showing good early signs of having a positive impact. Additional resources in the Staff Psychological Support Service due by end August will add to this. The new sickness absence plan will be monitored with Divisions through the fortnightly Operational Delivery Group meetings.

Further governance arrangements are in place to both monitor sickness absence with daily absence information being shared and to control the impact on services e.g. ensuring safe staffing levels are in place whilst controlling costs.

Watch Metrics for People

Metric	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Turnover (12 month)	7.2%	7.1%	6.9%	6.9%	7.5%	6.8%	6.8%	6.8%	6.7%	6.7%	6.6%	6.5%
Workforce capacity - FTE Budgeted	17162	17239	17310	17366	17347	17261	17265	17271	17269	17825	17955	17974
Workforce capacity - FTE Substantive contracted	15624	15704	15840	15914	15910	15835	15903	15955	15998	15982	16006	16113
Workforce capacity - FTE Substantive contracted variance from Budget	1538	1535	1470	1452	1437	1426	1362	1316	1271	1842	1949	1862
Workforce capacity - Number of leavers	116	169	105	113	195	107	95	100	113	82	71	78
Workforce capacity - Number of Starters	142	488	253	241	148	99	207	191	165	198	133	153
Workforce efficiency - Absence 12 month sickness rate	5.4%	5.2%	5.4%	5.4%	5.4%	5.4%	5.4%	5.4%	5.3%	5.3%	5.2%	5.2%
Workforce efficiency - Absence Total in month.	15.9%	13.9%	15.7%	16.5%	16.5%	16.1%	16.2%	15.7%	15.6%	15.2%	14.8%	15.2%

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 our 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.		

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%.

True North											
Metric: Safety - Reduction of 5% in preventable harm - UHSx approved											
Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
583	594	546	738	581	535	612	652	643	730	635	713

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%.

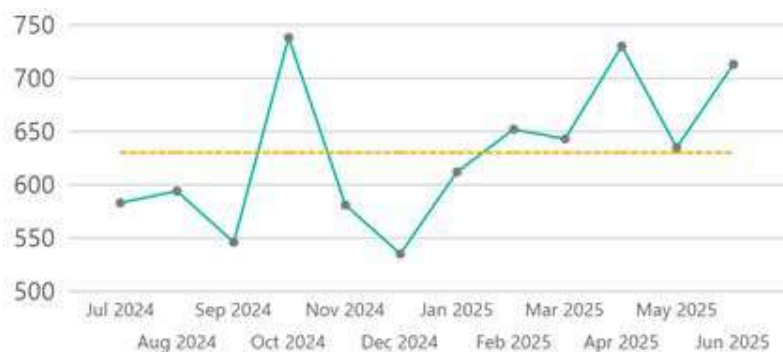
The submitted monthly incident report & harm grading (in actual numbers) for the quality scorecard via DCIQ (as graded by the reporter) requires a review, investigation and assessment for accuracy by the investigating managers. Due to capacity and or complexity, this can often take time (longer than the in-month reporting period) so in numbers, the reported (predicted in month) harm versus the final actual harm graded by the NHSE *Learning From Patient Safety Events* system (LFPSE) definition- has significant variation.

The quarterly reports provide the ratified and more accurate data on actual harms in numbers. In addition LFPSE has published revised harm criteria and the training for this update is now available in in conjunction with the Duty of Candour training on IRIS.

Therefore for the monthly reporting cycle for the quality scorecard, True North, QGSG and Quality Committee reports, in order to present ratified data we will now be reporting one month in arrears. So for July, we will provide a more accurate picture of approved harms from incidents reporting per 1000 beddays for May. This follows the same methodology as FFT.

The NHS England Learning from Patient Safety Incidents (LFPSE) has released the first Q4 report since implementation in 2024. This replaces the previous benchmarking from the National Reporting and Learning System (NRLS).

The report demonstrates the reporting rate per 1000 bed days within the acute, mental health and specialist healthcare. There was variation in recording rates across different types of NHS trusts. Recording rates (per 1,000 bed days) ranged from 7 to 130 incidents in acute trusts. UHSussex rated as 77/116 reporting acute Trust, however this score was within the main average reporting cohort and not identified as an outlier as low reporting.



What the chart tells us

May evidenced a sustained trend in the rise and stability of the month-on-incident reporting. (3356 reported in May) and a sustained rate in the reporting of low harm (622/635) = 98% of actual harm**). The highest percentage of reported patient safety incidents are graded as no harm/near miss (81%). Actual harm (low/moderate and severe/death) account for 19% of all reported incidents.

The Women's and Children's Divisions evidenced the most sustained rate of reporting per 1000 beddays (73.80). PRH are the highest site with a reporting rate of 56.19 per 1000 beddays.

Intervention and Planned Impact

Highest trends noted as pressure damage, moisture damage, falls, security related incidents and medication error/stock discrepancy. These themes are managed via the following improvement programmes: fundamental standards of care programme, the reducing violence and aggression work programme and the medicines safety group.

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; themes trends and patient stories are presented at the Trust Patient Safety Group.

DCIQ and Duty of Candour suite of training materials and videos now available on IRIS. Duty of Candour compliance is recorded as 92% a very positive increase from 25/24 reporting.

Risks/Mitigations

Evidence based learning through various training packages (e.g. HSIB silver investigations training), the majority of our learning response leads need to be socialised to this new approach to safety. Therefore, as part of our PSIRP and the launch for PSIRF, we have launched a complete suite of training for learning response leads and those investigating incidents.

The aim for the organisation is to be (1) more proportionate in its decision making based upon safety science principles, (2) provide more rapid investigations for incidents to gain learning quicker and communicate to families quicker, (3) engage with staff and provide restorative support, and (4) ensure civility for staff through just culture.

More investigative tools have been used, with 5 different investigation tools used in 2024-2025 compared to just 2 in 2022-2023.

The Patient Safety Team have trained 216 learning response leads in a 2-day training course on safety science, human factors, and investigatory science.

Since the implementation of DCIQ, in actual numbers, incident reporting has increased by 18%, this is a positive sign of a learning and safety culture.

The Trust has not seen an increase in harm across this year, so this identifies we are investigating more lower harmed incidents which allows heightened understanding more of the safety concerns/themes which are not solely driven by harm grading of incidents.

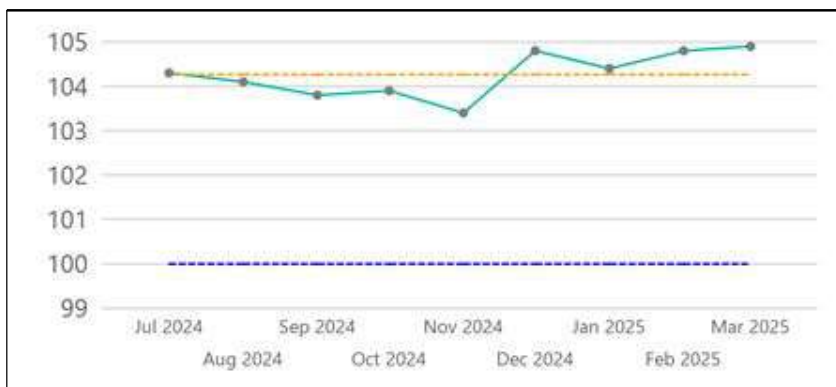
True North

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
104.3	104.1	103.8	103.9	103.4	104.8	104.4	104.8	104.9

Overview

The SHMI (Summary Hospital-level Mortality Indicator) is a measure used in to monitor mortality. The SHMI gives an indication of whether the number of deaths in a hospital is higher or lower than expected, based on the types of patients they treat. It does this by comparing the actual number of patients who die following hospital treatment (either during their stay or within 30 days of discharge) with the number expected to die. The expected number of deaths is calculated using a statistical model that predicts the number of deaths we would expect for a given group of patients, the case mix model used to calculate the expected number of deaths is based on the patients age, gender, primary diagnosis, comorbidities, admission method and socioeconomic factors (like deprivation index)



What the chart tells us

The SHMI for UHSx is 104.91 (April 2024 - March 2025). This result is not an outlier using 95% over-dispersed funnel plot limits, but it is an outlier based on the stricter 95% Poisson method.
 The In-hospital SHMI is 106.89.
 The Out-of-Hospital SHMI is 100.69.
 The SHMI at PRH, RSCH, Worthing and St Richards are all within the expected confidence limits, this is despite the SHMI at RSCH 114.06.

Intervention and Planned Impact

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

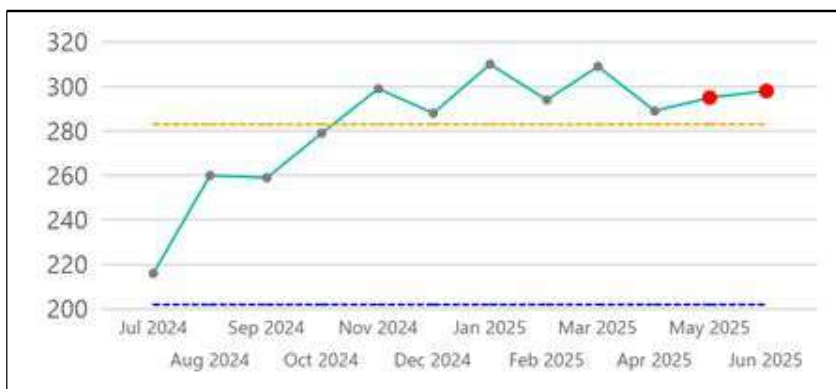
Risks/Mitigations
There are several risks or limitations in using the SHMI. There is a risk that a high SHMI may be assumed to be poor care, however, it should be noted that SHMI is a statistical measure and not a direct quality indicator. Consequently, it should be used alongside other quality indicators like SJR and audit. The SHMI may also be impacted by clinical coding which may misclassifying diagnoses or comorbidities, this will impact on the number of expected deaths. In addition, the SHMI model adjusts for case mix but not all clinical complexity (e.g. severity of illness, frailty), this may mean hospitals treating sicker or more complex patients may appear to have worse outcomes. Finally, SHMI does not adjust for palliative care coding, therefore hospitals with more palliative patients may appear to have higher mortality.

Breakthrough

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
216	260	259	279	299	288	310	294	309	289	295	298

Overview



What the chart tells us

There has been a slight increase in the number of falls between April (289) and May (295). Please note 76% of falls resulted in no harm
 UHSussex Falls Rate per 1,000 bed days May 2025 = 4.19 Average rolling year 4.30. Target 4.2, Please note 76% of falls resulted in no harm
 Overall, Trust data is tracking along the mean average and within the upper control limit, for both the number of falls and the number of falls per 1,000 bed days.
 Moderate harm and above falls since April 2024 have not identified pattern or trend currently.

Intervention and Planned Impact

The use of patients' own footwear is being promoted widely - a poster has been developed in collaboration with podiatry to encourage relatives to provide from home patients normal own footwear. Research has found that this will reduce the number of falls within hospital settings.

Compliance with the Falls Patient Track Risk assessment has increase from 45% to 82% over the last twelve months. The impact of this is that any actual or potential risk factors for falls prevention are identified in a timely manner.

The post-falls proforma has been refreshed and agreed. This will ensure a standardised approach to both nursing and medical assessment post fall and identify actual / potential contributory factors.

A thematic review has been completed for falls with severe/fatal harm. The results of this review have been shared and did not identify any recurrent themes / trends.

HFC intranet page has been updated with current documents, post-falls pathways, posters for clinical areas, patient leaflets and educational resources to support the delivery of falls prevention strategies. The falls policy has been updated and approved.

Risks/Mitigations

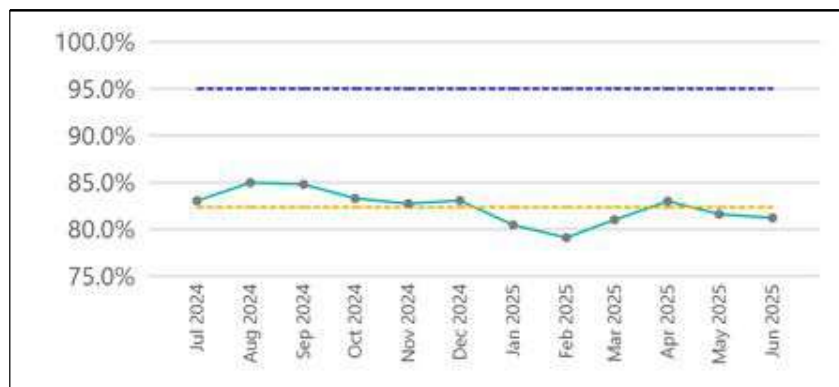
Driver

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
83.0%	85.0%	84.8%	83.3%	82.7%	83.1%	80.5%	79.1%	81.0%	83.0%	81.6%	81.2%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Care Hours Per Patient Per Day (CHPPD) trust wide has seen a gradual increase from 7.0 in December 23 to 8.9 in June 25. In the model hospital data published in April 25 the trust has moved into mid quartile 3 for registered nurses and remained quartile 1 for care staff.



What the chart tells us

The chart shows the fill rate % for care staff for the day shifts each month. The fill rate has improved from 80.5% in January to 81.2% in June 25. Despite the investment of 177 WTE HCA's trust wide increase the vacancy rate from 8.0 in May 25 to 15.8% in June 25, the overall fill rate has not significantly deteriorated it did peak at 83% in April 25.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce that is appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and reporting the associated workforce, with subgroups focusing on agency reduction, recruitment, retention, safe care, roster optimising and sickness management.

The Deputy Chief Nurse (DCN) for Workforce along with the clinical workforce team undertook establishment reviews using the safer nursing care tool (SNCT) for all inpatient areas in the January 25. Following the Establishment reviews 177 WTE HCA's were added to establish across the trust a combination of substantiating temporary workforce as part of budget setting and investment in ward areas where the team were under resourced mainly at St Richards hospital. The SNCT audits were repeated in May for all inpatient areas and emergency department followed by establishment reviews in specialist areas including critical care and theatres. This data is triangulated with CHPPD and quality metric for each department. A full report was submitted to board in May as part of workforce safeguards governance, and update will be due back at board in November 25.

As part of the establishment restacking there is a commitment to exit agency in non-specialist areas and in this financial year there is an efficiency target of 40% agency reduction. Enhanced controls have been introduced with Divisional Director of Nursing approval for additional duties where establishment has been increased. The divisions meet the DCN for workforce weekly as part of the steering group governance to monitor and challenge usage and the effectiveness of enhanced controls.

Risks/Mitigations

There are currently 15.8% Band 3 care staff vacancies an increase from 7.5% in June 25 following the investment in establishment. Significant recruitment is underway to fill all the substantive band 3 positions and with less reliance on temporary staffing the fill rate will improve in the autumn. From the 1st of April we have transitioned band 2 HCAs into Band 3 posts to align with the national job profiles. We will continue to recruit HCA's that are new to care but they will only remain a band 2 for 6 months while they undertake further training and complete their care certification. We continue to have a robust recruitment calendar attracting band 2 and band 3's. Recruitment of all band 3 Maternity Support Worker (MSW) has been centralised which has allowed a more robust recruitment pipeline and allowed us to create a waiting list for some areas.

The turnover is currently 7.5% for Health care Assistants across UHSussex, the recent work rebanding the HCA workforce should positively impact HCA retention further.

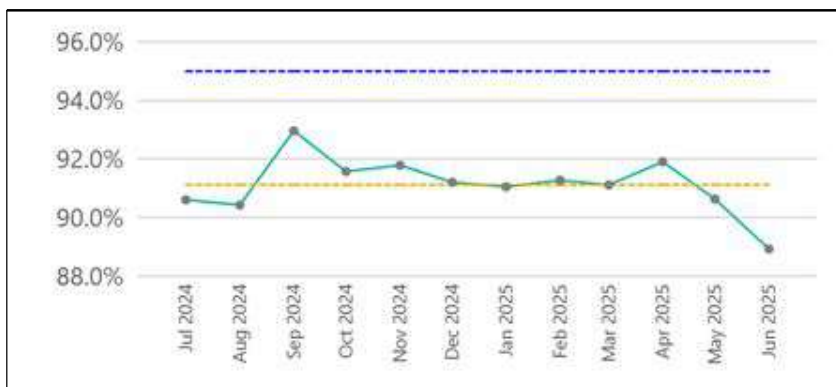
Driver

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
90.6%	90.4%	93.0%	91.6%	91.8%	91.2%	91.0%	91.3%	91.1%	91.9%	90.6%	88.9%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Care Hours Per Patient Per Day (CHPPD) trust wide has seen a gradual increase from 7.0 in December 23 to 8.9 in June 25. In the model hospital data published in April 25 the trust has moved into mid quartile 3 for registered nurses and remained quartile 1 for care staff.



What the chart tells us

The chart shows the fill rate % for care staff for the night shifts each month. The fill rate at night is better than the day at 88.9% and has deteriorated slightly from 91% in January 25.

Intervention and Planned Impact

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

Risks/Mitigations

There are currently 15.8% Band 3 care staff vacancies an increase from 7.5% in June 25 following the investment in establishment. Significant recruitment is underway to fill all the substantive band 3 positions and with less reliance on temporary staffing the fill rate will improve in the autumn. From the 1st of April we have transitioned band 2 HCAs into Band 3 posts to align with the national job profiles. We will continue to recruit HCA's that are new to care but they will only remain a band 2 for 6 months while they undertake further training and complete their care certification. We continue to have a robust recruitment calendar attracting band 2 and band 3's. Recruitment of all band 3 Maternity Support Worker (MSW) has been centralised which has allowed a more robust recruitment pipeline and allowed us to create a waiting list for some areas.

The turnover is currently 7.5% for Health care Assistants across UHSussex, the recent work rebanding the HCA workforce should positively impact HCA retention further.

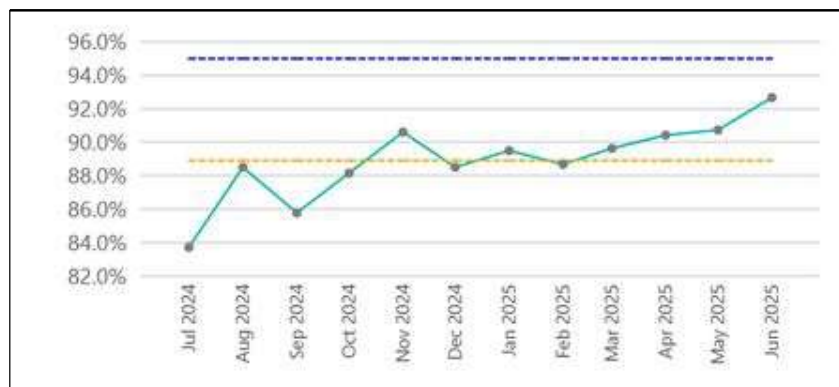
Driver

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
83.7%	88.5%	85.8%	88.2%	90.6%	88.5%	89.5%	88.7%	89.6%	90.4%	90.7%	92.7%

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). Care Hours Per Patient Per Day (CHPPD) trust wide has seen a gradual increase from 7.0 in December 23 to 8.9 in June 25. In the model hospital data published in April 25 the trust has moved into mid quartile 3 for registered nurses and remained quartile 1 for care staff.



What the chart tells us

The chart shows the fill rate % for Registered Nurses/Midwives for the day shifts each month. Registered Nurses/Midwives fill rate has seen an increasing trend since June 24 is currently 92.7% in June 25. The fill rate has improved on all sites in June and is consistent with the recruitment to substantive vacancies for band 5 nurses. The vacancy rate has increased to 13.4% due to the increase in establishment following the establishment reviews and investment. Despite this increase in vacancy rate the fill rate for registered staff has continued to improve as substantive staff are onboarded.

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, with subgroups focusing on agency reduction, recruitment, retention, safe care, roster optimising and sickness management.

The Deputy Chief Nurse (DCN) for Workforce along with the clinical workforce team undertook establishment reviews using the safer nursing care tool (SNCT) for all inpatient areas in the January 25. Following the Establishment reviews 244 WTE RN were added to establish across the trust a combination of substantiating temporary workforce as part of budget setting and investment in ward areas where the team were under resourced mainly at St Richards hospital. The SNCT audits were repeated in May for all inpatient areas and emergency department followed by establishment reviews in specialist areas including critical care and theatres. This data is triangulated with CHPPD and quality metric for each department. A full report was submitted to board in May as part of workforce safeguards governance, and update will be due back at board in November 25.

As part of the establishment restacking there is a commitment to exit agency in non-specialist areas and in this financial year there is an efficiency target of 40% agency reduction. Enhanced controls have been introduced with Divisional Director of Nursing approval for additional duties where establishment has been increased. The divisions meet the DCN for workforce weekly as part of the steering group governance to monitor and challenge usage and the effectiveness of enhanced controls.

Risks/Mitigations

There are currently 13.4% Band 5 Registered Nurse vacancies which is an increase from 8.5% (March 25) for Band 5 nurses, this is directly linked to the increase in the substantive establishment. Notably, there has been a significant focus on domestic recruitment during the 2024/2025. Through focused engagement with our student nurses and midwives, we have seen an increase in students joining the workforce. There are 153 newly qualified nurses and midwives joining the establishment between August and October 25. Our proactive recruitment strategies have effectively secured newly qualified nurses from universities across England. With the changes in the SIFE requirements (Supporting information from employers) has seen an increase in applicants who have an international qualification and are already resident in the UK. Furthermore, we have welcomed 17 Register Nurse Degree apprenticeship in 2025 and a further 25 qualify in July 2025. 32 students nursing associates completed their training during the 2024/2025 period, joining the workforce as registrants. Our aim is to commence training for 50 student nursing associates between Sept 2025 and Feb 2026 as part of our focus on growing our own and developing our Heath Care assistant (HCA) workforce.

Turnover of 3.6% for band 5 and band 6 registrants. The impact of this is that there is an improvement to fill absence and escalation shifts.

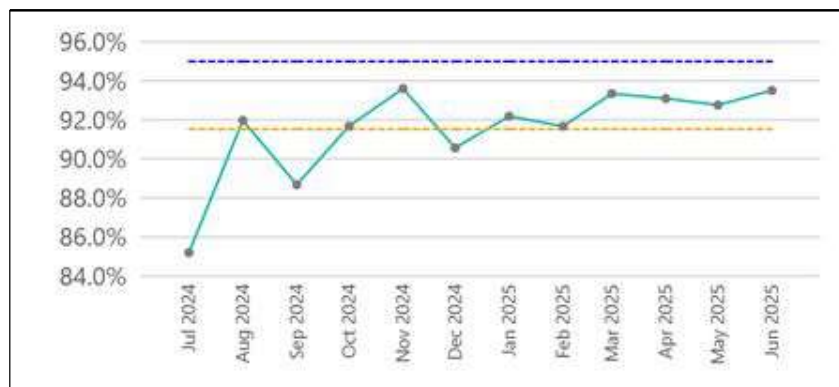
Driver

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
85.2%	92.0%	88.7%	91.7%	93.6%	90.6%	92.2%	91.7%	93.4%	93.1%	92.8%	93.5%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Care Hours Per Patient Per Day (CHPPD) trust wide has seen a gradual increase from 7.0 in December 23 to 8.9 in June 25. In the model hospital data published in April 25 the trust has moved into mid quartile 3 for registered nurses and remained quartile 1 for care staff.



What the chart tells us

The chart shows the fill rate % for Registered Nurses/Midwives for the night shifts each month. Registered Nurses/Midwives fill rate has seen an increasing trend since June 24. The fill rate has improved on all sites in June and is consistent with the recruitment to substantive vacancies for band 5 nurses. The fill rate is above 90% on all sites, the trust average is 93.5%. The vacancy rate has increased to 13.4% due to the increase in establishment following the establishment reviews and investment. Despite this increase in vacancy rate the fill rate for registered staff has continued to improve as substantive staff are onboarded.

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, with subgroups focusing on agency reduction, recruitment, retention, safe care, roster optimising and sickness management.

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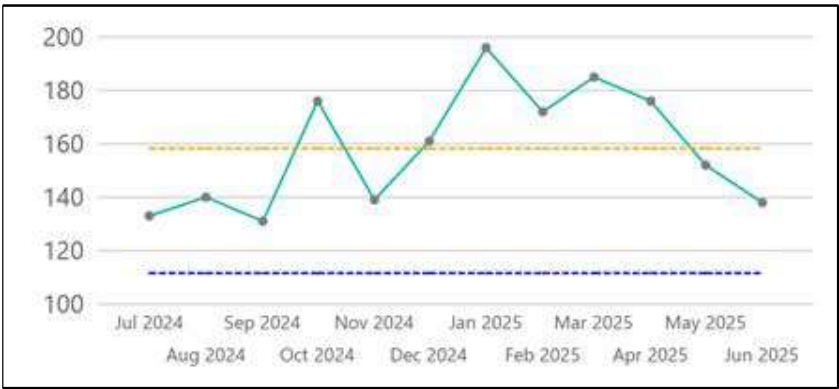
Driver

Metric: Safety - Grade 2+ pressure ulcers

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
133	140	131	176	139	161	196	172	185	176	152	138

Overview

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



What the chart tells us

HAPD –The number of category two HAPU has reducing since March 2025 from 185 to 138. The is equates to a rolling rate of category two HAPU per 1000 bed days of 2.72 which has reduced from 3.02. pressure
A thematic review for HAPU category two and above has been undertaken which has not identified any patterns or trends at this time

Intervention and Planned Impact

Purpose T risk assessment being completed on time is currently at 82.0% across the Trust. This has improved from May 79%. The impact of this is that any actual or potential risk factors for pressure damage prevention are identified in a timely manner.

There has been a decrease in category two HAPU since March 2025 185 – June 135. With HAPU Category 2 pressure being the most prevalent category.

There has been an increase in MASD reported in May and the Harm Free Care Team and Essity will be providing education / training to ensure that appropriate continence products are available for all wards. There will be an initial focus at WH-SRH where moisture related issues particularly relayed to continence issue have been reported (for example sacral and groin damage associated with loose stools or inadequate pad changes).

A mattress audit and replacement programme has been completed at RSCH, PRH. At St Richards and Worthing Hospital this will be completed by the end of August 2025. Further audits are scheduled over the next 12 months as part of a rolling inspection/ replacement plan

The TVN team has now commenced an in-person teaching and education across UHSussex which has been well attended and evaluated

Risks/Mitigations

The FSoC pressure damage working group has now combined with the continence group and a programme of work crafted as it is recognised that effective management of continence positively impact skin integrity.

The PD risk assessments and intentional rounding charts have now been standardised and embedded across UHSussex.

The Divisions have been driving up improvement opportunities by focusing on the top themes such as completing pressure damage and nutritional risk assessments on time to allow earlier identification of actual potential issues. This will be monitored via NQAG and FSoC PSG.

Weekly harm free care meeting chaired by the HON for Harm Free Care to discuss all category two and above HAPU.

Watch Metrics for Quality

Metric	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Clinical outcomes/effectiveness - Timeliness of observations against targets (NEWS2)	69.2%	70.2%	72.0%	73.5%	74.7%	73.1%	72.9%	74.3%	75.7%	77.3%	78.3%	78.2%
HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	12	14	24	23	15	25	20	11	15	11	14	20
HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	24	18	26	25	16	14	17	24	22	14	20	21
HCAI - Number of hospital attributable Klebsiella species cases (HOHA/COHA)	6	9	6	8	6	4	4	5	3	5	5	8
HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)		1					1					1
HCAI - Number of hospital attributable MSSA bacteraemia cases (HOHA/COHA)	8	6	8	12	13	13	12	8	12	7	4	7
HCAI - Number of hospital attributable Pseudomonas cases (HOHA/COHA)	3	5	1	4	4	3	6	1	4	6	5	4
Safety - % of Deaths with Comfort Obs in Place	74.6%	76.6%	77.2%	76.4%	69.8%	72.8%	80.2%	73.6%	74.5%	72.5%	78.6%	76.9%
Safety - Total moderate, severe or death incidents	93	89	106	77	97	97	109	83	106	96	85	100

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	

Patient First Domain

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

NHS Constitutional access standards:

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

Performance remained challenged in Q1 2025/26, but there has been notable improvement across all areas.

UHSX remains in Tier 1 as part of the NHSE oversight framework for RTT but - following the Trust's progress with recovering performance - cancer has been stepped down to Tier 2 oversight and the Trust is no longer subject to additional oversight for diagnostics. The Trust remains in Tier 2 for emergency performance.

RTT incomplete performance has improved ahead of plan, as has the proportion of the waiting list over with over 52-week waits. No 104-week waits were reported in Q1, and 78-week waits were reduced to just 20 in June. The overall RTT waiting list reduced in June compared to March, and was lowest it has been for over three years. Less progress was made with reducing 65-week waits, which increased in April and May, but reduced to 580 in June; this is lower than April but higher than March.

Cancer performance reduced in both the 28-day 'faster diagnosis' standard (FDS) and 62-day cancer waiting time standards in April and May compared to March, but both are markedly improved year-on-year. June has seen recovery in 28-day standard (78%). The backlog of over 62-day prospective waits increased compared to March but remains below the 352 'fair shares' target set by NHS England. UHSX

has moved from Tier 1 to Tier 2 in recognition of progress made and relative performance.

Diagnostics performance continued to improve in Q1 reaching 12.1%, and is now better than at any point since the Covid-19 pandemic. The total Diagnostic waiting list and backlog both reduced and the Trust's performance is now better than the national and regional median position. UHSX has been moved out of the Tiered oversight process for diagnostics.

A&E performance (including Minor Injury Units and Walk In Centres) was 72.9% in Jun-25, which was an improvement compared to both March and the same period 12 months ago. Average waiting times in ED improved and there were fewer stays of longer than 12 hours. Ambulance handover performance improved, with fewer 60-minute delays and shorter waits to handover on average. UHSX – along with system partners - remains subject to Tier 2 oversight for UEC performance.

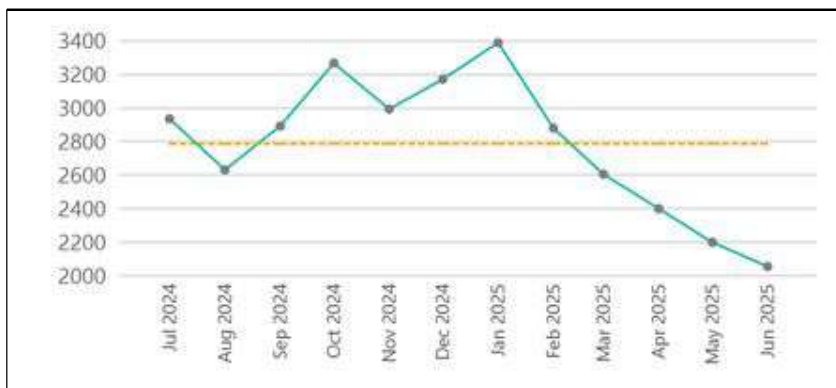
True North

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
2936	2632	2893	3268	2994	3172	3390	2881	2606	2400	2200	2055

Overview

Long waits in an Emergency Department are associated with increased patient harm, including poorer outcomes and a higher risk of mortality. Extended stays in ED, particularly those exceeding 12 hours, correlate with a higher likelihood of adverse events even after the patient has left ED.



What the chart tells us

12-hour waits in ED continued to improve in Q1, with 2055 such waits in June. This is the lowest since August 2023 and a 30% reduction compared with June last year. RSCH continues to be the most challenged site, with a 20% reduction in their monthly number; there was over 50% reduction in 12-hour waits at SRH.

Intervention and Planned Impact

Continuous flow throughout the day is receiving intense focus to ensure early morning movement out of ED on all sites has resulted in less patients being held in ED corridors. While this means that more patients are moved to the wards where they wait until a patient is discharged or the patient being discharged that day is sat out and the admitted patient placed in the vacated bed space, it spreads the risk across the hospital and creates impetus for discharges. The use of the discharge lounge is being tightly managed to ensure more patients move there sooner in the day thereby freeing up space earlier in the wards. Continuing focus is required to ensure early morning beds allocated do not drop off, particularly in RSCH.

Risks/Mitigations

The risk is that continuous flow does not happen and slows the flow out of ED. This is being operationally monitored by the Hospital leadership teams via Site Practitioners to ensure that continuous flow happens and that MoCs are liaising with their wards to ensure that the early movement required is achieved.

Numbers through the Discharge Lounge are increasingly monitored as well as the continuous flow approach where the expectation is that transfers are mapped and maintained through the day.

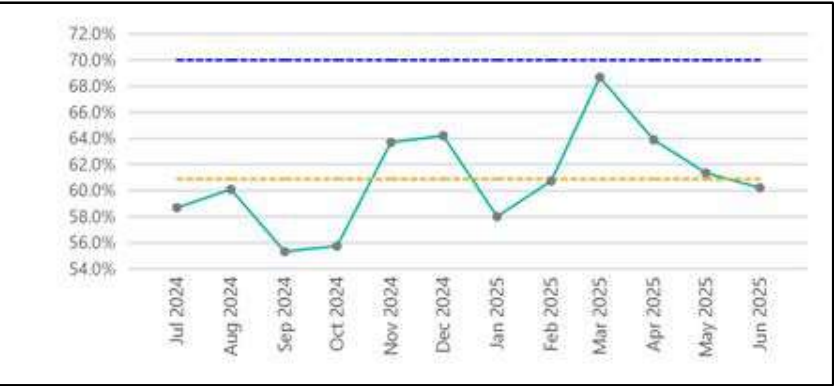
True North

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
58.69%	60.09%	55.32%	55.74%	63.69%	64.20%	58.00%	60.73%	68.68%	63.89%	61.34%	60.21%

Overview

Cancer 62-day performance is a constitutional standard, with a target of 85% of patients to be referred and commence first definitive treatment within 62 days. Please note that the constitutional standard changed in Oct-23 to include patients from all referral sources, having previously covered only urgent GP referral only. UHSX has committed to improving performance to 75% by Mar-26, 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.

May-25 performance was 61.3%, compared to 63.9% in Apr-25 (and national standard of 85% and 70% target).

Intervention and Planned Impact

The trust has developed recovery plans for each challenged tumour-site. These are being overseen through enhanced governance led by the Deputy MD (Cancer) and supported by the Surrey and Sussex Cancer Alliance. Tumour site plans are focused on improving diagnostic and treatment capacity, shortening the front of the pathway and reducing the backlog. NHS England has move the Trust from 'Tier 1' to 'Tier 2' oversight, following improvements made with cancer waits. The Trust has been awarded additional financial support by NHS England to recover cancer performance as part of the 'Tier 2' regime.



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 2 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.

Resident Doctor industrial action has disrupted planned care and cancer capacity in July. The mandate for further action runs to January 2026 and there is risk that other staff groups also decide to strike.

Breakthrough

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

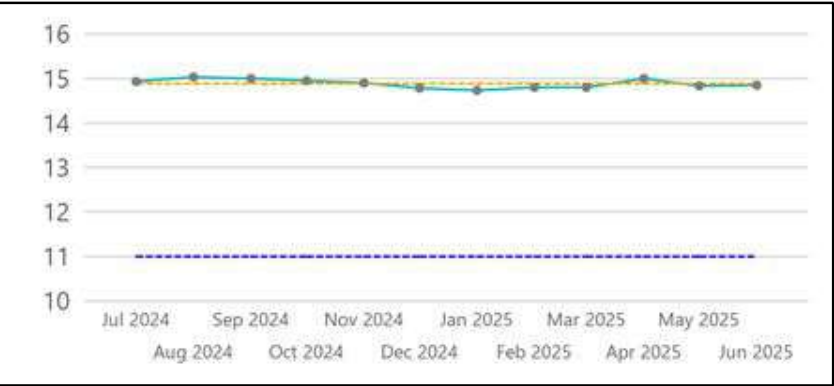
Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
14:56	15:02	15:00	14:57	14:54	14:47	14:44	14:48	14:48	15:00	14:50	14:51

Overview

Hospitals that discharge patients earlier in the day see a smoother flow of care. This helps free up beds faster, reduces waiting times for incoming patients, and makes transitions home or to other care services more coordinated.

Efficient discharge also eases hospital operations. It relieves pressure on emergency departments by creating space more quickly and helps staff manage tasks across the day without overwhelming late afternoon workloads.

Using the median discharge hour instead of the average provides a more reliable measure of how things typically run. It avoids distortion from unusually late discharges and offers a fairer way to assess and improve hospital performance



What the chart tells us

There has been no significant change in the MHD and the aim of before 11am is not being achieved. Median actual time of discharge has been 14:50 and 14:51 for May and June respectively. Performance for this will be improved by the SAFER and Discharge work in Buckets 2 and 3 of the UEC improvement programme.

Intervention and Planned Impact

Monitoring of the MHD has transferred from an SRO BO project to a metric being monitored at divisional SDR with metric oversight via the UEC Improvement Board. Greater divisional ownership of this metric is required although it is recognised that increased focus of senior clinical resource (via appropriate job-planning and support to focus on appropriate activities) is also required for consultant colleagues. In line with these changes, and with support from their Medical and Nursing clinical leads, Divisions will be expected to drive improvements in Discharge planning and timeliness.

Risks/Mitigations

Conclusion of BO objective, with accountability transferred to the divisions as this is where the focus is required to effect change.

While accountability has transferred to the divisions as this is where the focus is required to effect change, the Trust-appointed discharge Lead will oversee progress on a Pan-trust basis.. The MHD is discussed monthly at the newly-formed DAMs (Divisional Accountability Meetings) which will assist in providing exec oversight into action plans to produce an earlier discharge time overall.

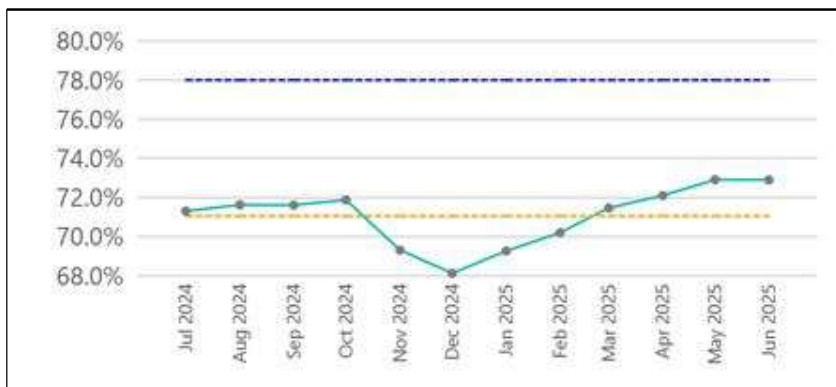
Driver

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
71.3%	71.6%	71.6%	71.9%	69.3%	68.1%	69.3%	70.2%	71.5%	72.1%	72.9%	72.9%

Overview

Being treated quickly in A&E is important both for clinical outcomes and for patient experience, as delays in care for people arriving in A&E have been associated with increased mortality and illness. The four-hour standard in A&E measures the time it takes for patients to be admitted, transferred, or discharged from the emergency department. The constitutional standard is that at least 95% leave ED within four hours of arrival. The 2025/26 Operating Plan framework requires providers to improve performance to at least 78% by March 2026.



What the chart tells us

No Data

Intervention and Planned Impact

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

Risks/Mitigations

No Data

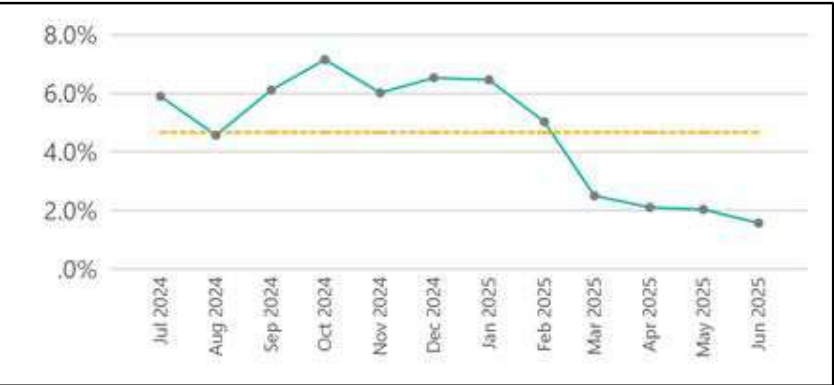
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Metric: A&E and Emergency flow - Ambulance Handovers > 60 minutes

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
5.9%	4.6%	6.1%	7.2%	6.0%	6.5%	6.5%	5.0%	2.5%	2.1%	2.0%	1.6%

Overview

National guidance states that patients arriving at an emergency department by ambulance must be handed over to the care of A&E staff within 15 minutes. Prolonged handover delays of 60 minutes or longer are therefore a key patient safety issue, as ambulances waiting to handover at a hospital are not available to respond to a potentially life-saving emergency call. Long ambulance waits also put further pressure on the system. For example, those waiting for an ambulance may call the emergency services to find out where the ambulance is, placing further demand on operators to answer more calls.



What the chart tells us

60 minute handovers also fell to 1.5% from 2.0% in May-25 and from 6.9% in Jun-24. This is the lowest % 60 min handovers at UHSX since Apr-21. There were 0 breaches at Worthing Hospital.

Intervention and Planned Impact

The continuation of continuous flow and fit to sit has increasingly enabled ED to provide space in Ambulance arrival areas area to offload patients in an increasingly timely way. There is an increased awareness of the requirement to not hold ambulances and escalate within the team when waits are increasing to implement an immediate action plan to allow for offloading. Fit2Sit is increasingly expected and delivered, particularly at times of surge.

Risks/Mitigations

Department crowding from poor use of F2F and timely transfer out of EDs. These methods will continue to be promoted in order to achieve optimum space in EDs in order to provide continuing safe care.

Driver

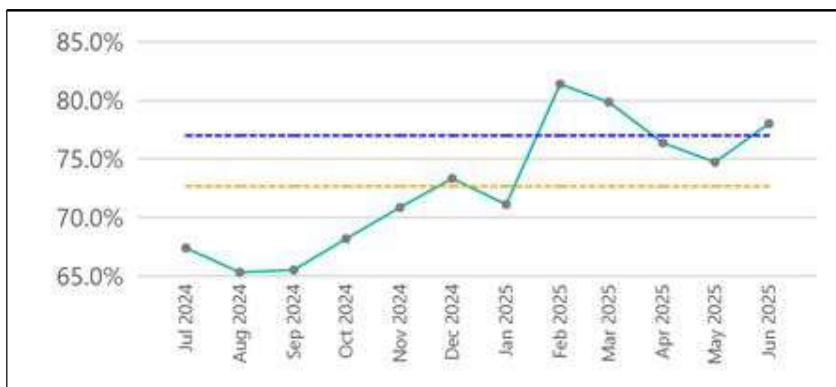
Metric: Cancer - 28 day faster diagnosis standard

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
67.40%	65.32%	65.52%	68.19%	70.86%	73.34%	71.12%	81.39%	79.85%	76.38%	74.73%	78.02%

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 80% target for 2025/26.

UHSX has committed to achievement of 80% by March 2025, in line with national planning guidance ask.



What the chart tells us

FDS performance deteriorated in May-25 to 74.7% from 76.5% in Apr-25, however, there has been a large year-on-year improvement. This is below the 80% target

Intervention and Planned Impact

The FDS performance is 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.
- UGI performance is currently affected by delayed endoscopic and radiological diagnostics.
- Urology performance is mainly affected by delays to biopsy and OP capacity.

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

NHS England has placed the Trust into its 'Tier 2' regime, having previously been 'Tier 1'. This is in recognition of the progress made with improvement.



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.

Driver

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

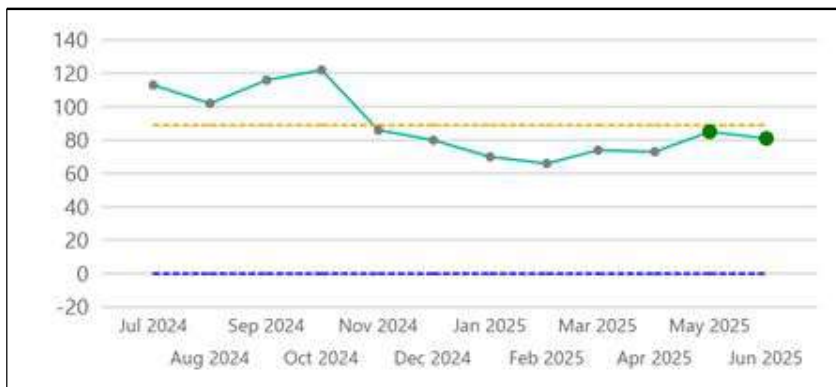
Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
113	102	116	122	86	80	70	66	74	73	85	81

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 decrease in over 104-day waits from 85 in May-25 to 81 in Jun-25, but this remains low compared to the historical position and has been kept stable at a low level.

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 Deputy MD (Cancer) and supported by the Surrey and Sussex Cancer Alliance.

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. Resident Doctor industrial action has further disrupted planned care capacity. The mandate for further action runs to January 2026 and there is risk that other staff groups also decide to strike.

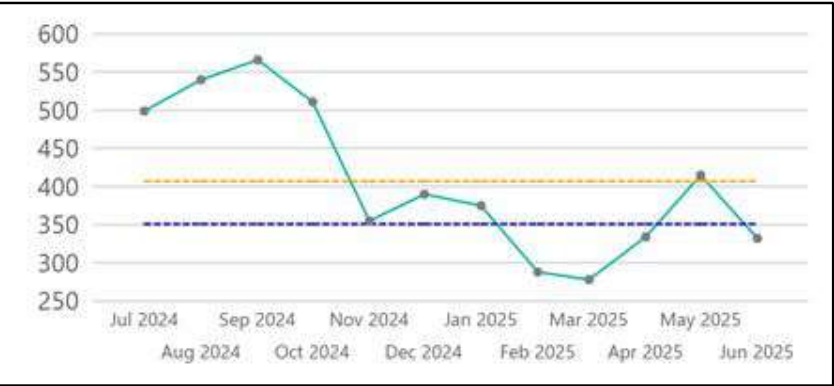
Driver

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
499	540	566	511	355	390	375	288	278	334	415	332

Overview

The NHS operating framework 25/26 requires Trusts to improve 62-day performance to 75% by Mar-25. To deliver this, UHSX has to maintain a backlog below its 'fair share' target of 351.



What the chart tells us

62-day prospective waits decreased from 415 in May-25 to 332 in Jun-25. This is below the fair shares target set by NHS England.

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 Deputy MD (Cancer) and supported by the Surrey and Sussex Cancer Alliance.

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 Two funding for diagnostic capacity.

Resident Doctor industrial action has further disrupted planned care and cancer capacity. The mandate for further action runs to January 2026 and there is risk that other staff groups also decide to strike.

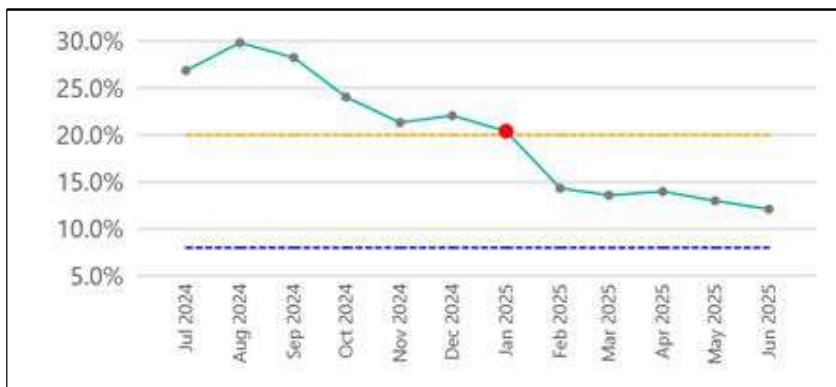
Driver

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
26.9%	29.8%	28.2%	24.0%	21.3%	22.1%	20.4%	14.3%	13.6%	14.0%	13.0%	12.1%

Overview

Diagnostics are an important element of elective care for patient care and are an essential part of decision-making towards definitive treatment. Performance is measured using the 'DM01' standard, which tracks waits across 15 diagnostic tests, ranging from imaging modalities, to physiological measurement, to endoscopic investigations. The 2025/6 operating framework does not include an ambition for DM01, but UHSX is aiming for no more than 5% of over 6-week waits by end March-26.



What the chart tells us

UHSX achieved 12.1% in Jun-25 against the DM01 standard. This was the Trust's best reported performance since the Covid pandemic.

Intervention and Planned Impact

Targeted recovery plans - with support from ICB - have been agreed for each of the most challenged modalities.
Delivery of plans being overseen weekly through 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.
Specialist diagnostic capacity, such as for cardiac imaging and enhanced sedation endoscopy, is limited, and reliant on fragile workforce.
Resident Doctor industrial action may further disrupt capacity. The mandate for further action runs to January 2026 and there is risk that other staff groups also decide to strike.

Driver

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
416	641	579	615	575	561	490	316	119	97	44	20

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 has committed to eliminating waits of 78 weeks in 2025/26.



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 Jun-25 there were just 20 patients waiting over 78 weeks, an improvement from 44 in Feb-25. This is lowest the Trust has reported since the Covid-19 pandemic.

Intervention and Planned Impact

Enhanced governance with weekly oversight by COO and MD (planned care and cancer) of 78ww cohort plus 10 longest waits in each division. The Trust also has fortnightly meetings with CEO and NHS executive to oversee progress as part of 'Tier 1' regime.

Risks/Mitigations

No Data

Driver

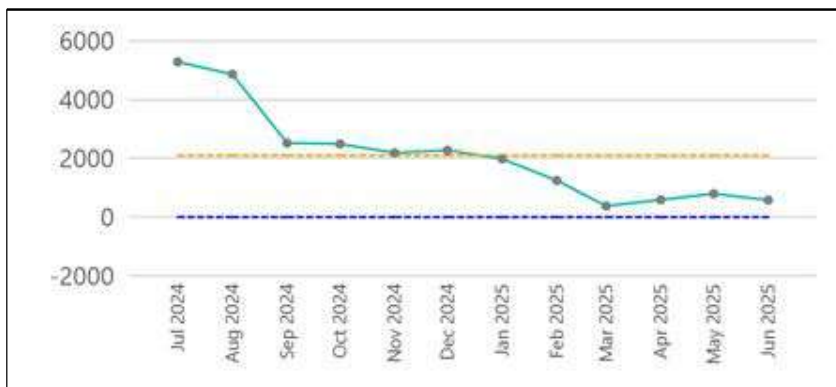
Metric: RTT Elective care - ≥ 65 Weeks

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
5288	4866	2525	2492	2189	2278	1982	1251	377	590	795	580

Overview

Elective waiting times are a key constitutional target. Elective Waiting times materially increased as a result of the covid pandemic. UHSX did not achieve 24/25 objective to reach zero, and is expected by NHS England to deliver this in 25/26.

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 795 in May-25 to 580 in Apr-25. This was the second lowest total for the Trust since the Covid pandemic.

Intervention and Planned Impact

UHSX plan to reach zero for H2 includes the following key actions:

1. Divisional specialty-level plans were set to reduce 61-week waits in Q1, and this supported a big reduction in the risk of 65ww tip-ins in July. This approach is continuing in Q2, but with trajectories now focused on reducing 58-week waits by September (which is expected to further reduce the risk cohort for Q3). Over the remainder of the year, the focus will shift down the waiting list each quarter as the Trust moves attention from 65ww to 52ww.
2. Full-pathway transfers - which were paused by ICB in May - will restart in Q2. These are patients transferred at first appointment (and therefore from lower down the waiting list), so will not immediately impact 65ww numbers but will help de-risk the Mar-26 position.
3. UHSX activity plan includes a further increase in patients being treated predominantly through improved productivity. UHSX continues to be supported by the national Getting It Right First Time team to achieve this.
4. The 65ww risk is greatest in a small number of specialties: ENT, OMFS, Ophthalmology, Dermatology, General surgical specialties (ie UGI/LGI/GS) and T&O. Specialty-specific interventions have been agreed for each of these.

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. Resident Doctor industrial action has further disrupted planned care capacity. The mandate for further action runs to January 2026 and there is risk that other staff groups also decide to strike.

Driver

Metric: RTT Elective care - 18 Week Performance

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
44.16%	43.07%	44.47%	46.35%	47.91%	48.20%	48.19%	47.97%	48.92%	50.27%	50.92%	51.30%

Overview

Under Referral to Treatment (RTT) incomplete pathways constitutional target, 92% of patients should be waiting under 18 weeks to commence first definitive treatment following GP or consultant referral. Incomplete performance was affected by Covid-19 pandemic due to a reduction in capacity in order to treat covid patients, which led to growth in the RTT backlog and total waiting list. Reducing long waiters (104+, 78+ and 65+ week waits) had superseded the 18-week target as acute Trusts looked to tackle the very longest waits as part of staged recovery to reduced waits for elective care. However, in 25/26 Trusts have been asked to improve 'RTT incomplete' performance to 60%. UHSX was not able to agree a compliant plan, due to the cost to the system of the additional activity required. The Trust's plan delivers 55% incomplete performance.



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 51.3% in Jun-25, an improvement on May-25 (50.8%) and the best performance in over 24 months.

Intervention and Planned Impact

Key actions include:

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

Risks/Mitigations

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.

Resident Doctor industrial action has further disrupted planned care capacity. The mandate for further action runs to January 2026 and there is risk that other staff groups also decide to strike.

Financial constraints limit the amount of activity that can be delivered outside of plain time.

Watch Metrics for Systems & Partnerships

Metric	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
A&E and Emergency flow - % Patients with a 21+ day length of stay	8.8%	8.1%	8.2%	8.3%	8.0%	8.6%	8.5%	8.4%	8.7%	8.8%	8.3%	8.4%
A&E and Emergency flow - A&E 4 Hour Breaches	10696	10020	9924	10388	11249	11547	10739	9743	10812	10181	10386	10094
A&E and Emergency flow - A&E Attendances	37275	35313	34959	36935	36662	36228	34941	32699	37894	36493	38341	37247
A&E and Emergency flow - Ambulance Handovers	7380	7444	7387	7719	7681	7643	7722	6794	7487	7399	7700	7564
A&E and Emergency flow - Ambulance Handovers - % Under 15 mins	51.1%	55.2%	49.4%	47.7%	48.2%	46.0%	45.1%	49.8%	52.6%	55.5%	58.8%	58.9%
A&E and Emergency flow - Average LOS (Excl LOS 0)	7.8	7.5	7.6	7.3	7.2	7.7	7.8	7.4	7.6	7.5	7.4	7.6
A&E and Emergency flow - Bed Occupancy	1782	1766	1802	1819	1837	1788	1887	1955	1892	1887	1887	1852
A&E and Emergency flow - Emergency Admissions > 1 LOS	5479	5478	5491	5813	5704	5684	5786	5103	5585	5552	5790	5548
A&E and Emergency flow - Mean Waiting Time	325	310	329	348	353	362	374	352	315	302	294	288
A&E and Emergency flow - Time to treatment in ED (Median time to treatment mins)	70	67	68	64	67	94	95	101	101	97	97	99
A&E and Emergency flow - Time to Triage in ED - % seen within 15 mins	62.5%	66.7%	62.1%	62.1%	61.2%	61.2%	61.0%	64.4%	64.7%	68.6%	72.0%	71.0%
Cancer - Two week rule performance	66.2%	62.8%	67.3%	72.6%	70.7%	83.9%	85.9%	93.8%	89.5%	84.6%	87.5%	78.9%
Diagnostics - 6 week backlog	5481	6044	5645	4895	4118	4135	3704	2679	2464	2452	2339	2169
Diagnostics - Activity	39960	35950	37660	56778	41707	36485	40439	37528	40736	38438	40149	41083
Diagnostics - Waiting List size	19127	19095	18688	19130	18285	17861	17526	18028	17528	17178	17484	17441
Elective care - Activity compared to 2019/20	105.9%	106.9%	105.7%	112.1%	110.4%	113.2%	110.0%	113.4%	149.7%	118.2%	124.6%	119.4%
RTT Elective care - >= 52 Weeks	15052	14168	10976	9965	9200	8278	7848	7437	6923	6925	6826	5860
RTT Elective care - >104 Weeks (NHSi Criteria)	4	2	4	6	6	6	8	5	4	0	0	0
RTT Elective care - Clock Starts	20716	17698	17468	20540	18977	17157	21547	18690	19576	21205	20582	22171
RTT Elective care - Clock Stops	24053	20976	22814	25072	23236	19764	23415	21490	22711	20412	21484	22881
RTT Elective care - Waiting list size	133732	130232	123868	119791	117899	121127	118530	114850	114131	115225	112989	113130

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

Patient First Domain

Data for Quarter 1 of 2025-26 for Acute Trust ranking in terms of total recruitment to studies on the NIHR portfolio. The Trust currently stands at 43rd putting it outside of the top 20% of recruiting Acute Trusts over the past 12 months (a rank of 27 or above would put a trust in the top 20%).

Our annual ranking for patient recruitment and number of recruiting studies has been consistent for the last 3 years with a top 20% position achieved in respect of studies open each year. However, our relative position for patient recruitment year on year is partially outside our control. The data is heavily skewed due to recruitment to large observational or screening studies that often recruit at a single site. The Trust performs better, standing at 27th when only looking at the number of interventional (treatment) study recruits which sits at 341 against a median of 439 for the top 28 Trusts.

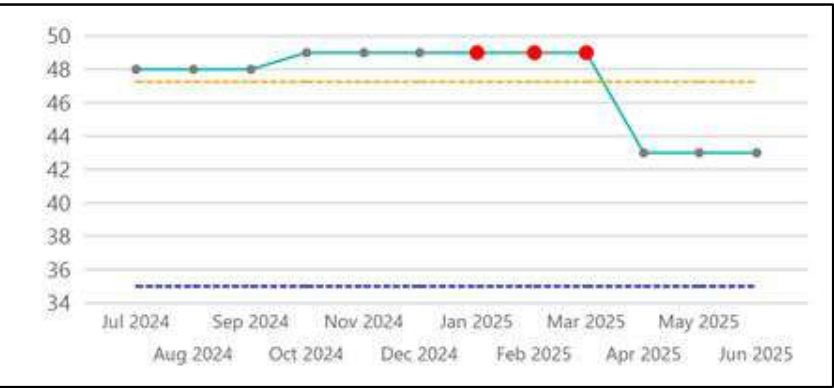
True North

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

Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
48	48	48	49	49	49	49	49	49	43	43	43

Overview

Research and Innovation drive continuous quality improvement in healthcare however a relatively small proportion of staff and patients participate in high quality research studies. Participating in research improves patients’ satisfaction with clinical care and patients are missing out on this benefit. Participation in high quality research studies results in better treatments, as well as improved diagnosis, prevention, care and quality of life for our patients and their families.



What the chart tells us

This chart shows the 12-month rolling Acute Trust ranking in terms of total recruitment to studies on the NIHR portfolio. The Trust currently stands at 43rd (June 2025) putting it outside the top 20% of recruiting Acute Trusts over the past 12 months (a rank of 27 or above would put a trust in the top 20%).

Our annual ranking for patient recruitment and number of recruiting studies has been consistent for the last 3 years with a top 20% position achieved in respect of studies open each year. However, our relative position for patient recruitment year on year is partially outside our control. The data is heavily skewed due to recruitment to large observational or screening studies that often recruit at a single site. The Trust performs better, standing at 27th when only looking at the number of interventional (treatment) study recruits which sits at 341 against a median of 439 for the top 28 Trusts.

Intervention and Planned Impact

Portfolio horizon scanning

Our delivery teams, working with Divisional Directors of Research and specialty leads, continually review available studies that offer potential benefit and are feasible to run across the Trust. In addition, our new NIHR Sussex Commercial Research Delivery Centre (CRDC), actively seeks commercial partnerships and provides a fast and efficient clinical trials delivery infrastructure working across clinical pathways and settings, enabling a hub and spoke model of commercial research delivery promoting research participation and inclusion.

The Trust is developing research and innovation in line with the R&I Strategy. The UHS Future 2030 strategy reflects the strategic potential of R&I to drive transformations of services and care at UH Sussex.

Strategic development of R&I

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

- **Major Capital Project to develop clinical research facilities** securing the reprovision of the Clinical Research Facility in the LMB and clinical research facilities at PRH and WH sites to a high quality and accreditable standard to deliver the Trust's R&I ambition.
- **Delivering the new NIHR Sussex Commercial Research Delivery Centre** (CDRC), this will be a centre of excellence, offering additional commercial research delivery capacity to existing health and care organisations in Sussex.
- **R+I workforce development and workforce model** transformation of research-specialist workforce models of research delivery (hub and spoke, agile teams).
- **Streamlining study set up and delivery** to ensure efficient delivery of clinical trials in line with DHSC performance expectations.
- **Developing embedded workforce research capacity** including medical PAs for research, NMAHP advanced practitioner job planned research time and increased workforce research capability through training and placement opportunities.
- **Development of Joint Clinical Academic Departments** establishing research-driven centres of excellence.
- **Development of our Research Leaders** through the MyUHSussex Fellowship programme, NIHR and other external fellowship opportunities and increasing participation in NIHR Associate PI scheme.
- **Further development of the Health & Care Research Partnership** supporting regional research growth and opportunity through shared research infrastructure, capacity building and collaboration with regional partner organisations.
- **Further development of Sussex Patient and Community Involvement and Engagement in Research** – supporting the sustainability and development of the Sussex Research Engagement Network (REN) to widening participation and inclusion in research.

Risks/Mitigations

The UHS Future 2030 strategy reflects the strategic potential of R&I to drive transformations of services and care at UH Sussex.

Securing estates for the reprovision of the Clinical Research Facility to a high quality and accreditable standard is the key risk to delivering the Trusts R&I ambition. Existing clinical research facilities are not adequate to support the breadth and scale of trust wide participation in research needed to achieve our strategic ambition. This is now a major capital project.

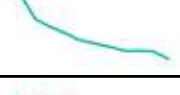
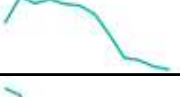
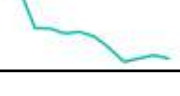
Workforce and service department capacity to deliver research is also a risk to the delivery of the Trust's research ambition – detailed work with Divisional Directors for Research will help to better clarify the risks and mitigations for each division and support services. Job planning guidance for research PAs has been agreed and disseminated.

A lack of integration of UH Sussex Research and Innovation with wider Sussex health and care systems and universities is also a risk to the delivery of our R&I ambition. We must continue to drive the success of the Sussex Health and Care Research Partnership working with partners across the Integrated Care System and academic partners to build research which addresses the needs of our population and patients and develops our future research leaders, investing in shared infrastructure such as the Clinical Trials Unit, Training Hub, and Joint Clinical Research Office.



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	6.23	7.06	
Sustainability	Financial Stability - Variance from breakeven plan YTD	-480k	0k	
Quality	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	104.9	100.0	
Quality	HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	20	2	
Quality	HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	21	5	
Quality	HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)	1	0	
Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	713		
Systems & Partnerships	Cancer - 28 day faster diagnosis standard	78.02%	77.00%	
Systems & Partnerships	RTT Elective care - >= 52 Weeks	5860	12500	
Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	20	0	
Systems & Partnerships	RTT Elective care - >=65 Weeks	580	0	

Systems & Partnerships	RTT Elective care - > 104 Weeks (NHSi Criteria)	0	0	
Systems & Partnerships	Cancer - Number of patients waiting over 62 days for treatment	332	351	
Systems & Partnerships	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	2055		

Oversight Metric Summary

Current segmentation

The Trust has been informed that it will be placed indicatively within Segment 4 of the revised National Oversight Framework (NOF). The revised framework now contains five segments from best performing segment 1 to those requiring mandated support segment 5.

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

Drivers of the segmentation

During Q1 the Trust has continued to focus on Emergency Care, Cancer and Planned Care delivery. The Trust remains within Tier 1 oversight for Planned Care performance having exited Tier 1 for cancer performance and remains in Tier 2 oversight for Emergency Care performance seeing enhanced performance oversight continue with NHS E. The Trust whilst continuing to make significant progress in reducing its overall RTT waiting list numbers and meeting its planned care performance plan did not achieve zero patients waiting over 65 weeks and in respect of emergency care performance the Trust has not made the performance gains it expected to within the quarter. The Trust however, continues to reflect good cancer faster diagnostic performance.

The Trust met its financial plan for the quarter but does recognise the degree of risk in achieving a break even position by the year end. Oversight of the Trust's efficiency and productivity improvement plan is subject to regular review at the monthly Finance and Performance Assurance Committee alongside the regular meetings with the ICB.

The Board Assurance Framework, as reported to the Board shows a predicted continued level on elevated strategic risks for many of its 11 against the Trust Strategic Ambitions.

Implications of this segmentation

As the Trust is not in segment 5 of the revised framework it does not find itself in receipt of mandated support. Segment 4 however does allow the Trust to continue to have access to external advice and support where appropriate.

Actions being taken to move from segment 4

The Trust's developed Strategy sets out the Trust's ambitions over the next 5 years to 2030. As these ambitions are translated into the respective annual delivery plans these seek to move the Trust forward to provide excellent care everywhere and lift the Trust from segment 4. However the Trust recognises it has much to do especially in the area of culture and the Trust remains with a small number of undertakings on its Licence with NHS England in respect of operational performance and finance and given the elevated degree of risk Trust does not expect to exit segment 4 in the first part of 2025/26.

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

Agenda Item:	11.	Meeting:	Trust Board in Public	Meeting Date:	04 September 2025
Report Title:	Maternity Assurance Reports				
Sponsoring Executive Director:	Maggie Davies, Chief Nurse				
Author(s):	Stephanie White, Head of Divisional Quality and Safety WCYP Emma Chambers, Director of Midwifery				
Purpose of the report: (indicate as appropriate)	For Decision	For Assurance	For discussion	For Information only	
	N/A	Yes	Yes	N/A	
Reason for not being taken in public (indicate as appropriate)	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	Yes / N/A	Yes / N/A	Yes / N/A	Yes / N/A	
Regulatory Reporting Requirement					
Summary of the report describing What (summary of current position / issue & why it matters and evidence to support that position etc) So What (provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these) What Next (summary of intended action and benefits supporting the choices and recommendation(s) being made)					
PQS (reporting May data) <u>What:</u> The Ockenden enquiry concluded that there needs to be more direct Board oversight of Maternity. A suggested dashboard was produced by NHSE/1 which we have adapted for use at University Hospitals Sussex Trust and tested via Quality Board. <u>So What:</u> Escalations for July meeting • Rapid independent investigation into maternity and neonatal services announced by Wes Streeting, Secretary of State for Health and Social Care on 23rd June. UHSussex named as one of the 'most concerning' units in the country. To date, no further information about the process is known. • Exit from Maternity Safety Support Programme delayed because of the above. • Impact on service user confidence and staff wellbeing and morale considerable, especially those involved in the cases of the family lobby group. • 'Outlier alert' letter received from National Maternity and Perinatal Audit (NMPA) raising concern regarding 3rd and 4th degree tear rates in 2023. Improvement work had been completed over the last 2 years as this high rate had been identified internally. Improvements were seen, however, the current 3rd and 4th degree tear rates at PRH are showing cause for concerns, immediate improvement actions in place. Celebrations for July meeting • 2 full-day weekday lists plus ad hoc weekend lists running at in LMB at RSCH for planned caesareans, interim solution. • 2 team members nominated for Trust Star Awards by families were shortlisted. The Worthing team who provided bereavement care to a family won the Worthing Hospital Hero award. <u>What Next:</u> The impact of the announcement of the Secretary of State on service users, staff and the leadership team cannot be underestimated. Information regarding the ongoing inquiry process is needed to enable to service to provide appropriate support to these groups. The service is committed to transparency, service user engagement and co-production, and continuous improvement. ATAIN – reporting Q3 data <u>What:</u> In 2017, NHS England identified that over 20% of admissions of full-term babies into neonatal units (NNU) could have been avoided. By providing services and staffing models that keep birthing people and their babies together, we can reduce the harm caused by separation.					

So What:

- The benchmark of <5% of admission to the Special Care Baby Unit was met for the duration at WH (1.7%, 0% & 2.1%) and for SRH (3.4%, 2.5%, 4.1%).
- PRH and RSCH did not meet the benchmark for any month during Quarter 3 (PRH 5.91%, 6.51%, 5.42%, RSCH 6.67%, 7.53%, 5.38%).
- There were 36 admissions to NNU from RSCH, 29 admissions from PRH, 18 admissions from SRH and 6 admissions from WH which is a total of 89 term admissions to the SCBU/NNU. The majority reason for admission this quarter across all four sites was again due to respiratory support.
- Overall, 89.9% (80) of admissions across all four sites were considered unavoidable with appropriate management with 10.1% (9) considered as potentially avoidable. This is an increase of 2.5% (from 7.6%) when compared to Q2.

What Next:

- RSCH & PRH: Although all admissions were deemed appropriate, there is currently a QI project underway to provide a decision-making tool to support practitioners in an aim to reduce term admissions to TMBU for RDS.
- SRH: Escalation occurred due to undiagnosed cleft/PRS further to abnormal scanning after fetal medicine escalation did not occur.

Transitional Care – reporting Q3 data

What:

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

So What:

- Treatment with IV antibiotics was the main course of treatment across site.
- Daily neonatal reviews being documented has improved since the last quarter especially at PRH.
- Delay in neonatal team reviews being performed/documented on BadgerNet may be due to staffing constraints or increased workload pressures on the unit.
- Poorer completion of neonatal observations at WH.
- Lack of documented SBARs continues to be a theme when babies are stepping down from special care.

What Next:

- Implementation of Postnatal Theme of the Month. This will be a 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. This still needs to be implemented and is the focus of the new year.
- QI project across all four sites focussing on neonatal care with a focus on hypoglycaemia, feeding and SBAR
- Review and align neonatal guidance across all four hospital sites.
- Review and increase neonatal staffing capacity at PRH.
- Review of current data collection to have more in depth understanding of why observations are not completed in full, reviews are not timely, and escalations do not occur so that this can inform future practice & learning

Review of current data collection to look at how this audit can inform & support the further development of Transitional Care Services at UH Sussex

Perinatal Mortality Review Tool - reporting Q4 (24/25) data
What:

The aim of the Perinatal Mortality Review Tool (PMRT) programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units. This report will identify any themes and the consequent action plans. The report will evidence the required standards outlined below from CNST Year 6.

So What:
Key

	Standard met for PMRT & CNST
	Not applicable for CNST but 'to be met' for PMRT
	Standard required for PMRT & CNST 'to be met'
	Standard not met for PMRT & CNST
	Not applicable for PMRT & CNST

PMRT Number	Site	Surveillance and Notification (Standard A)	Parents Perspective Sought (Standard B)	Published report (Standard C)	Grading of care
96274	RSCH	Met	Met	Met	B, A, A.
95823	RSCH	Met	Met	Met	A, A.
96023	RSCH	Met	Met	Met	B, A, C.
96448	PRH	Met	Met	Met	A, A.
96416	RSCH	Met	Met	Met	A, A, B.
96229	PRH	Met	Met	Met	A, B.
96716	PRH	Met	Met	Not yet met	B, B, A. B, B, B.

Summary

The action plans from the individual PMRT reviews are added to the Quality & Safety Action Tracker and monitored through this forum across all four sites.

What Next:
Recommendations:

- Joint PMRT meeting across the 4 sites.
- Placenta histology should be carried out by a perinatal pathologist.
- Review of patient information given to families with a Preterm rupture of membranes diagnosis.

CNST Maternity Incentive Scheme (MIS) overview
What:

Year 7 was published 2nd April 2024. Submission is due by 3rd March 2026. [MIS-Year-6-guidance.pdf \(resolution.nhs.uk\)](#)

So What:

What have we done to prepare?

- COM leadership now in place and job planning underway to enable more medical engagement in delivery of MIS CNST.
- Many of the safety actions are business as usual processes

What Next:

Barriers to address in the year

- SA3 (Transitional Care) - the Trust is required to demonstrate progress against the BAPM Transitional Care Implementation action plan from years 5 and 6 of the scheme.

	- Most actions to implement this service require changes to estates across all 4 sites, making progress difficult to evidence. - SA8 (training) - medical trainee training requires constant focus to ensure 90% compliance.					
Recommendation (linked to What Next section)	<i>The Board is asked to NOTE the Maternity Assurance Reports</i>					
Assurance / Scrutiny route already undertaken (please explain where matter previously considered, and assurance provided)	Quality Governance Steering Group Patient & Quality Assurance Committee					
Link to Trust Strategy (note which theme)	Care Yes / N/A	People Yes / N/A	Future Yes / N/A	Communities Yes / N/A	One UHSussex Yes / N/A	Culture Yes / N/A
Link to annual delivery plan						
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)						
Link to CQC domain	Safe Yes / N/A	Caring Yes / N/A	Effective Yes / N/A	Responsive Yes / N/A	Well-led Yes / N/A	Use of Resources Yes / N/A
Other impacts	Equality and Diversity (if yes has HEIA completed) Yes / N/A (Yes / No)		Environmental Yes / N/A	Legal Yes / N/A	External Registrations (if yes please indicate which) Yes / N/A	

Agenda Item:	12.	Meeting:	Trust Board in Public	Meeting Date:	4 September 2025
Report Title:	Board Assurance Framework report Q2				
Executive Sponsor	Andy Heeps – Interim Chief Executive				
Author(s):	Glen Palethorpe – Company Secretary				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only	
	Yes	Yes	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement		NHS organisations are required to have effective risk management processes and are expected to have in place and effective Board Assurance Framework covering their Strategic risks			
Summary of the report describing What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i>		<i>The Board at its meeting in June agreed the opening 11 Strategic Risks that make up the BAF, noting their alignment to the Trust's new strategic ambitions. Each strategic risk has an allocated Executive lead and oversight Committee.</i> <i>The respective lead Executives have updated the BAF in respect of their review of the assurances received in quarter 1 allowing them to provide a look back and look forward summary in support of their proposed quarter 2 scores.</i> <i>The Audit Committee in its meeting in July were assured over the continuing underpinning processes for the executive oversight and update of the BAF.</i> <i>Each allocated oversight Committee considered their element of the BAF and with the exception of 2 risks agreed with the executives view that the reports and assurance received in quarter 1 did not support any change to the quarter 2 scores.</i> <i>The Research, Innovation and Digital Assurance Committee referred the research and innovation risk to review both in terms of its description and relative score.</i> <i>The People and Culture Assurance Committee whilst agreeing there should be no reduction in the score for the culture risks requested the Board re-evaluate the score, that of 16, given the significance of this risk to the achievement of the Trust's strategy.</i>			
So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i>		<i>The Board can take assurance over the underpinning BAF oversight processes.</i> <i>The Board is asked to note the recommendations of the respective committees that there should be no reduction in any of the strategic risk scores for quarter 2 and that the committees had confidence that the target scores could be achieved by the year end.</i> <i>The Board can take confidence that each of the Board Committees have confidence that the stated target scores can be achieved by the year end, noting for two strategic risks they are at their target score already.</i>			

What Next (summary of intended action and benefits supporting the choices and recommendation(s)being made)	In respect of the request from the People and Culture Assurance Committee the Board is asked to consider the relative score of risk 2 relating to culture and determine if 16 was a reasonable score for quarter 1 or if it should have been in fact scored at 20 and thus remain at 20 for quarter 2 (with the proportionate change to the target score). The Board should note that following the comments at the Research, Innovation and Digital Assurance Committee the Board is asked to confirm the risk description for strategic risk 7 “We are unable to realise the benefits of transformation via research and innovation integration programs” is clear and aligned to the causes of the risk and is distinct to the digital strategic risk which references innovation or suggest any adjustment and to similar to strategic risk 2 is the relative score of this risk appropriate when considered against the other 10 strategic risks						
Recommendation (linked to What Next section)	The Board should consider the risk description for risk 7 We are unable to realise the benefits of transformation via research and innovation integration programs to be sure is it clear given the question asked in the Research, Innovation and Digital Assurance Committee The Board is asked to agree the Quarter 2 scores for the 11 Strategic risks, having regard for the specific requests from - the People and Culture Assurance Committee to reconsider the scoring of risk 2 relating to culture and its relative score to the other strategic risks, and should this risk have been scored at 20 for quarter 1 and thus remain at this level for quarter 2 - and the Research and Innovation Assurance Committee to reconsider the score of risk 7 and should this have been lower than 20 in quarter 1 and thus for quarter 2 remain at that score, when compared to the other risks scoring 20 The Board should also note that the each of the Board Committees have confidence that the stated target scores can be achieved by the year end, noting for two strategic risks they are at their target score already.						
Assurance / Scrutiny route already undertaken (please explain where matter previously considered, and assurance provided)	The Audit Committee considered the underpinning processes at its meeting in July Each of the respective oversight committees considered their element of the BAF at there meetings at the end of July.						
Link to Trust Strategy (note which theme)	Patient Yes	People Yes	Future Yes	Communities Yes	One UHSussex Yes	Culture Yes	
Link to annual delivery plan	The BAF provides a mechanism to consider the strategic risks to the strategy achievement and thus the delivery of the annual delivery plan.						
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	This report cover all BAF risks						
Link to CQC domain	Patients Yes	Caring Yes	Effective Yes	Responsive Yes	Well-led Yes	Use of Resources Yes	



Other impacts	Equality and Diversity (if yes has HEIA completed)	Environmental	Legal	External Registrations (if yes please indicate which)
	N/A	N/A	Yes	The Trust is expected to have an effective BAF aligned to its strategic risks



2025/26 Board Assurance Framework Report

1 Introduction

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

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

2 BAF Structure

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

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

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

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

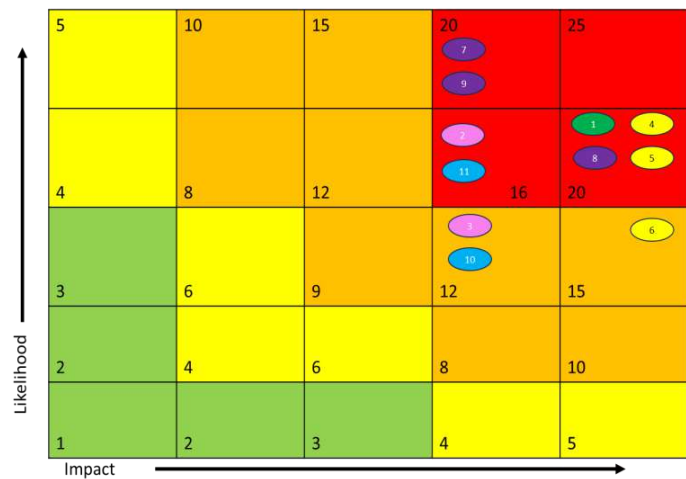
3 BAF summary

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

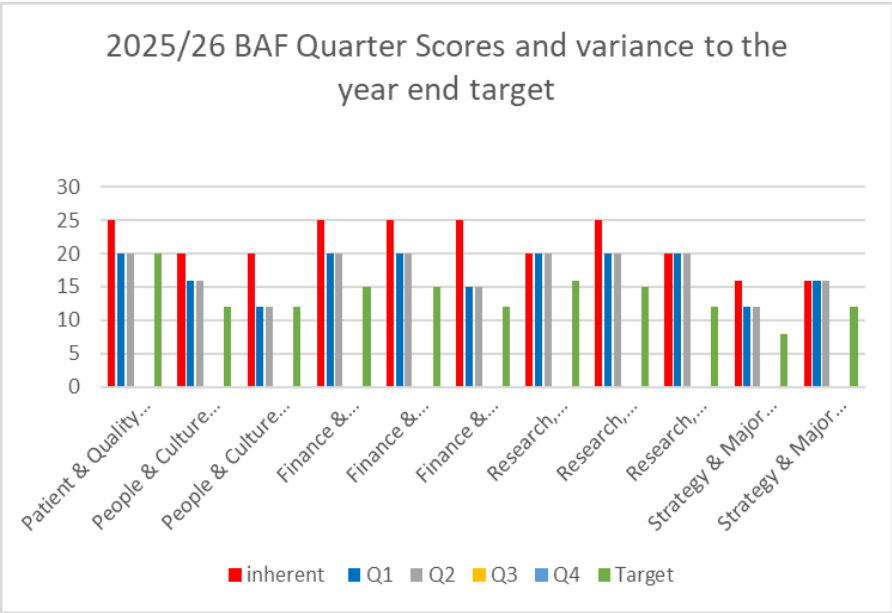
3.2 The proposed quarter 2 BAF sees no change to the opening Q1 scores and continues to shows two risks which are deemed to remain at their 2025/26 target scores one being quality at a score of 20 where the BAF reflects that we are not able to reduce this risk across the year and workforce where the risk has reduced from an uncontrolled risk to a score of 12 which would be maintained across the year.

3.3 There are three risks where the current controlled score remains at the same level as the inherent score, these being for research and digital innovation both scoring 20 and developing sufficient change resource which is scoring a 16. The Executives, however, do expect a reduction over the year for these three risks.

Strategic Risk Pictorial Summary



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



3.7 The summary BAF is attached at appendix 1.

4 BAF Quarter 2 Committee Review of the BAF

4.1 Each Committee met in July as planned and reviewed their allocated elements of the BAF and they each agreed with the Executive recommended score with two elements the individual Committee referred to the Board to consider, one relates to Research and Innovation risk score and one relates to the Culture risk score with the question as to are these scores reasonable in relation to scores of the other Strategic Risks.

4.2 The Committee’s each considered their allocated risks target score and remained confident that these could be achieved by the year end.

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

4.3.1 Patient and Quality Assurance Committee

The Committee agreed that for the patient and quality strategic risk, the score should not change, recognising that whilst the actions are progressing the score would not change for the year.

4.3.2 People and Culture Assurance Committee

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

The Committee however, whilst agreeing that the reports it received and the detail within the BAF did not support a reduction in the strategic risk relating to Culture, the Committee requested that the Board consider the relative score of this risk at 16, when compared to the others for quarter 2 are scoring 20 with a view that this risk score should have been scored at 20 for Q1 and thus would be 20 for Q2.

4.3.3 Finance and Performance Assurance Committee

The Committee agreed that for each of the three risks it has assigned oversight for, that the reports received over quarter 1 supported that the risk scores should not reduce in quarter 2. The Committee reflected on the delivery plans and that these as they are delivered over the next two quarters would support the reduction to the respective target scores by the year end.

The Committee noted that the formal assurance reports from the Trust's Estates Improvement Group but were informed that the Group had met and a formal assurance report would be provided from quarter 2 onwards.

4.3.4 Research, Innovation and Digital Assurance Committee

The Committee when it considered the research and innovation strategic risk 7, "We are unable to realise the benefits of transformation via research and innovation integration programs" asked that this description be reviewed to ensure it was clearly articulating the risk. The lead executive feels this description as approved by the Board is clear and is clearly distinct to the digital risk that also refers to innovation and reflects the causes *lack of infrastructure (environment and staffing); lack of governance and infrastructure to implement innovations ; lack of investment in pan Trust digital unification* and that the effects of this risk are that *the Trust transformation programme does not delivery to time and resources and the Trust fails to realise the opportunities to achieve productivity gains*

The Committee whilst agreeing that for strategic risk 7 the score should not reduce in quarter 2, the Committee did note the score of 20 seems high when compared to the other strategic risks scoring 20 within the other domains so asked that the Board when considering the BAF as a whole consider the relative score of this risk and should this risk be lower at a 16 with a consequent reduction in the target score to 12 by the year end.

The Committee agreed that for the other two risks it has assigned oversight for, that the reports received over quarter 1 supported that the risk scores should not reduce in quarter 2. The Committee reflected on the delivery plans and that these as they are delivered over

the next two quarters would support the reduction to the respective target scores by the year end.

4.3.5 Strategy and Major Projects Assurance Committee

The Committee when it considered each of its two allocated risks agreed that the reports received over quarter 1 supported that the risk scores should not reduce in quarter 2.

4.3.5 Audit Committee

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

5 Conclusion

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

5.2 The Board is asked to **CONSIDER** for strategic risk 2 *We do not develop a culture that supports the delivery of the Trust's mission of excellent care everywhere* its relative score given its significance to the successful delivery of the Trust's Strategy, with a view that this risk should have been scored at 20 (impact of 5 and likely hood of 4) from Quarter 1 and thus remain at a 20 for Quarter 2 and that the year end target score would be 15 (impact 5 and likelihood of 3) .

5.3 The Board is asked to **CONSIDER** the working of strategic risk 7 "*We are unable to realise the benefits of transformation via research and innovation integration programs*" is clear.

5.4 The Board is asked to **CONSIDER** the score for strategic risk 7 *We are unable to realise the benefits of transformation via research and innovation integration programs* is appropriate at 20 given the other risks scoring 20 and if this score should have been scored at 16 for Q1 (impact 4 and likelihood 4) or even 12 (impact 3 and likelihood 4) and thus remain at this score for Q2 with a consequent reduction in the target score to either 12 or 9.

5.5 The Board is asked **AGREE** the quarter 2 scores, noting the support for these scores by the relevant oversight committees, except for risk 2 and 7 where the Board was asked to specifically consider their scores when comparing these to the other strategic risk scores.

APPENDIX 1

BAF Summary

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

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	Risk Scores																	
	Inherent (uncontrolled)			2025/26 Q1			2025/26 Q2			2025/26 Q3			2025/26 Q4			2025/26 Target		
	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
Oversight provided by the Patient & Quality Assurance Committee																		
Risk 1 We are unable to maintain safe effective and compliant care.	5	5	25	5	4	20	5	4	20							5	4	20
Assessed strength of control				Some weaknesses			Some weaknesses									no change expected		
Oversight provided by the People & Culture Assurance Committee																		
Risk 2 We do not develop a culture that supports the delivery of the Trust's mission of excellent care everywhere	5	4	20		4	4	16	4	4	16						3	4	12
Assessed strength of control				Some weaknesses			Some weaknesses											
Risk 3 We do not attract, develop and retain enough people with the right skills, values and behaviours to deliver our ambitions	5	4	20		3	4	12	3	4	12						3	4	12
Assessed strength of control				Some weaknesses			Some weaknesses									no change expected		
Oversight provided by the Finance and Performance Assurance Committee																		
Risk 4 We are unable to progress towards medium-term financial sustainability, driven by a failure to deliver the in-year financial plan and/or actions to return to a break-even run rate by M12 2026/27 along with national funding realignment away from Sussex ICB	5	5	25		5	4	20	5	4	20						5	3	15
Assessed strength of control				Some weaknesses			Some weaknesses											
Risk 5 We are unable to maintain the condition of our non digital infrastructure or support the required capital investments to deliver our strategic ambitions	5	5	25		5	4	20	5	4	20						5	3	15
Assessed strength of control				Some weaknesses			Some weaknesses											
Risk 6 We are unable to configure our services and sites to	5	5	25	5	3	15	5	3	15							4	3	12

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

Agenda Item:	13.	Meeting:	Trust Board in Public	Meeting Date:	04 September 2025
Report Title:	Research, Innovation and Digital Assurance Committee Chair's Report				
Author(s):	Jackie Cassell – NED & Committee Chair				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For Discussion	For Information only	
	N/A	Yes	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement					
Summary of the report describing					
What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i>		<i>The report provides information over the business undertaken at the Research, Innovation and Digital Assurance Committee in July 2025.</i>			
		<i>The Committee meeting was quorate and received its scheduled business.</i>			
So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i>		<i>The Board can take assurance from the oversight provided by this Committee over the domains of research, innovation and digital specifically over the quality and safety of research studies undertaken over the prior year, the design of the digital resource prioritisation tool and the collaborative approach being taken to incorporate digital in the Trust's business continuity plans.</i>			
		<i>The Board can also take confidence that through the work to develop the research delivery workstreams that the Committee will through that regular reporting be able to provide assurance on the delivery against the Trust research strategic ambitions.</i>			
What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s)being made)</i>		<i>The Board can receive the BAF with confidence knowing that the content and score for strategic risks 7, 8 and 9 have been scrutinised by the Research, Innovation and Digital Assurance Committee. This oversight has confirmed that there is sufficient difference to retains a separate risk for the delivery of the benefits from research from the other risk in respect of capitalising the digital agenda as a driver for transformational improvement.</i>			
Recommendation <i>(linked to What Next section)</i>		The Board is asked to NOTE The Committee was quorate and considered all the expected reports in line with its schedule of business The Committee's assurance over the digital and research and innovation domains The Committee's recommendation that strategic risks 7 and 9 should remain separate The Committee's recommendation that a review is undertaken of the description and score of strategic risk 7. The Committee's recommendation that the risk scores for risks 8 and 9 should remain unchanged from the quarter 1 score.			

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

Research, Innovation and Digital Assurance Committee Chair's Report

The Research, Innovation and Digital Assurance Committee met on the 30 July 2025 and was quorate with 2 NEDs and 2 Executives including the Chief Strategy Officer as the lead executive for the Committee being present. The Committee received all its planned business. In attendance were also the Chief Information Officer, the Clinical Director of Research & Innovation, and the Clinical Medical Officer from Kent Surrey and Sussex Health Innovation Network. For the respective items the Trust's Data Protection Officer, and the Head of Programmes & Projects (IT) attended the meeting.

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

Digital

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

Digital Business Continuity

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

Digital Workplan

The Committee **received** an update on the digital projects being undertaken across the Trust and **noted** the breadth of the projects being supported. The Committee expressed their thanks for the work undertaken to develop a clear project prioritisation process which allows a structured process to be applied to the allocation of the IT resources.

Data Security and Protection Toolkit

The Committee **received** the report confirming that whilst the assessment criteria had changed significantly for this year, 2024/25, the Trust made its submission on time. The Committee **noted** that the Trust's submission and action plan had been accepted resulting in the Trust being assessed by NHS E as working towards standards met. The Committee was **provided** with confidence that the improvement plan has an achievable delivery timescale of December 2025 and **endorsed** the focus on corporate records management and asset management as these are the key areas that when addressed would deliver the improvement plan.

AI developments

The Committee **received** an update on the opportunities for the use of AI within the Trust and the work undertaken to establish effective oversight governance arrangements of their use. The Committee **noted** that the draft principles of the AI framework policy will come back to the Committee with a further update on AI opportunities. Through the discussion the Health Innovation Kent, Surrey and Sussex offered the Trust the opportunity to discuss what others

within Kent, Surrey and Sussex have done to implement AI in the space of ambient voice technology.

Research and Innovation

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

Research workstream update

The Committee **received** the report providing information on the developed research workstreams which have been realigned to the Trust's strategy to enable effective oversight to be provided in respect of the delivery of the Trust's research ambitions. The Committee **discussed** the development of the 'to 2030' milestone and KPIs and the baseline assessments undertaken that will allow robust tracking of delivery to occur.

The Committee was provided with an update against these workstreams and **endorsed** this workstream structure will enable the Committee to provide assurance to the Board on the Trust's delivery of the research ambitions.

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

Clinical Research Development and the Commercial Research Development Centre

The Committee **noted** the work being undertaken to progress the development of a clinical research hub and spoke development with this project being part of the Trust's major project portfolio. The Committee also **noted** the opening of the Commercial Research Development Centre and the positive performance against the set KPIs within the first few months of operation.

Research quality and safety annual report

The Committee through this report took **assurance** over the quality assurance process applied in respect of Trust sponsored and hosted studies, as the reported performance gave confidence that the Trust's research activity is being undertaken safely

Research Annual review

The Committee **recognised** the easy-to-read research annual review document that had been created by the research team and **endorsed** this be placed on the Trust website as it provided a handy guide to the public as to the breadth of research activity the Trust and patients are involved in.

BAF

The Committee **scrutinised** its allocated element of the Board Assurance Framework relating to strategic risks 7, 8 and 9. The Committee **agreed** that there was sufficient differentiation between the drivers of risk 7 (research innovation) and 9 (digital innovation) to maintain them as separate risks. The Committee asked that a review be undertaken as to the risk description for risk 7 to better describe the research risk along with a review as to the relative score of this risk when compared to the other BAF strategic risks. The Committee agreed that the recommended scores for risk 8 and 9 were appropriate.

Referrals to other Committees

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

Appendix 1**COMMITTEE HIGHLIGHTS REPORT TO BOARD**

Meeting Details					
Meeting Date	30 July 2025	Chair	Jackie Cassell	Quorate	Yes
Declarations of Interest	No declarations were raised				
Items received at the Committee meeting					
Item	Presenter	Purpose of the paper	Action Taken		
Research, Innovation and Digital Steering Group Chair's report	Chief Strategy Officer	To provide context for the papers being considered at the meeting	The Committee noted this report and how the work of the steering committee supported the flow of performance and assurance reports to the Committee.		
Digital					
AI progress update	Chief Information Officer	To provide information on developments	The Committee noted the update which described the work being undertaken by the Trust as it assesses the opportunities AI can bring and the oversight governance arrangements that have been established. The Committee was informed that the draft principles of the AI framework policy will come back to the Committee with a further update on AI opportunities. The Health Innovation Kent, Surrey and Sussex offered the Trust the opportunity to discuss what others have done to implement the AI in the space in ambient voice technology.		
Digital Business Continuity report	Chief Information Officer	To provide assurance over the Trust's processes	The Committee received the report and noted the work being undertaken in respect to enhancing the Trust's business continuity processes to include digital system recovery. The Committee noted that work was being undertaken		

			collaboratively between the divisions and IT.
Digital Workplan update	Head of Programmes & Projects (IT).	To provide assurance over the allocation of resources	The Committee received an update on the digital programme work across the breadth of projects being supported. The Committee noted the developed prioritisation tool.
Data Security and Protection Toolkit 2024/25	Chief Information Officer and Information Governance Manager / Data Protection Officer	To provide assurance over the process to achieve standards met	The Committee noted that the Trust made its required submission supported by an improvement plan which has been accepted and approved by NHS E which sees the Trust as moving to standards met. The Committee endorsed the focus on corporate records management and asset management being the main areas that when addressed would deliver the improvement plan.
Electronic Patient Record Programme and Electronic Document Management System Projects Reports	Chief Information Officer	To provide assurance over the Trust's processes	The Committee was updated on the process being followed for the procurement of the new EPR system, noting the Trust was at the supplier assessment stage. The Committee also noted the roll out of the EDMS across the Trust bringing a standardisation to the management of these records.
Research & Innovation			
Research & Innovation Workstreams update	Clinical Director of Research & Innovation	To provide information on the workstream activity since the last meeting	The Committee received the report describing the workstreams that have been established to the Trust's research ambition. The Committee noted the developed delivery milestones and KPIs to achieve the 2030 ambitions Then there is a milestone / kpis over the years to 2030 and recognises the enabling activities

Research Estates Update – provision of regional research hub	Clinical Director of Research & Innovation	To provide information on this initiative	The Committee noted that this project forms part of the Trust's major project portfolio and noted the update provided on the work being undertaken to develop the hub and spoke model. The Committee also noted the significant opportunity the work with SPFT offers to establish a research hub in Haywards Health.
Commercial Research Development Centre milestone report	Clinical Director of Research & Innovation	To provide information on this initiative	The Committee noted the delivery against the established KPIs for the centre since becoming operational in the last quarter.
Quarter 1 Research Performance Report	Clinical Director of Research & Innovation	To provide information on the Trust Activity	The Committee noted the report
Research Annual Quality and Safety Report	Clinical Director of Research & Innovation	To provide assurance of research quality assurance processes	The Committee took assurance over the quality assurance process applied in respect of Trust sponsored and hosted studies and the performance reported give confidence that the research activity is being undertaken safely.
Brighton and Sussex Health Research Partnership Report	Clinical Director of Research & Innovation	To provide information on the Trust Activity	The Committee noted the reported activity over the last 12 months
Research & Innovation Annual review	Clinical Director of Research & Innovation	For information	The Committee supported the placing of this easy-to-read review of the Trust's research activity for 2024/25 on the Trust's website.
Risk			
Research, Innovation and Digital key risk registers	Chief Medical Officer and Chief Strategy Officer	To enable the Committee to consider their allocated elements of the BAF	The Committee utilised this report when considering their allocated element of the Trust's BAF. In considering these reports the Committee noted the correlation between these risks and the reports received across the meeting.

Board Framework	Assurance	Company Secretary	To review and recommend to the Board the scores for strategic risks 7, 8 and 9	The Committee considered the relevant segments of the BAF and alongside the reports received at the meeting agreed with the executives view of the risk scores. The Committee agreed that there was sufficient differentiation between the drivers of risk 7 (research innovation) and 9 (digital innovation) to maintain them as separate risks. The Committee asked that a review be undertaken as to the risk description for risk 7 to better describe the research risk along with a review as the relative score of this risk when compared to the other BAF strategic risks. The Committee agreed with the recommended scores for risk 8 and 9 (no change from the quarter 1 scores)

Agenda Item:	14.	Meeting:	Trust Board in Public	Meeting Date:	4 September 2025
Report Title:	Patient & Quality Assurance Committee Chair's Report				
Author(s):	Lucy Bloem, Non-Executive Director, Chair of Patient & Quality Assurance Committee				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only	
	Yes	Yes	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement					
Summary of the report describing What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i>	The report provides information over the business undertaken and the Patient and Quality Committee in June and July 2025.				
	The Committee meeting was quorate at each of these meetings and received its scheduled business with the exception of the Estates Improvement Group report which was agreed would be presented at the September Committee meeting.				
	The Board can take assurance through the work of the Committee that focus is being provided to the areas of patient safety, quality of services and patient experience including the processes supporting the reporting of patient quality and safety KPIs. The Committee endorsed the planned actions to iteratively improve the quality scorecard with the extension of the use of statistical process charts.				
	The Committee in line with its Terms of Reference took the following actions - Considered and agreed to recommend to the Board • the 2024/25 Mortality and Learning from Deaths Annual Report • the 2024/25 Patient Safety Annual Report • the 2024/25 Patient Experience Annual Report • the 2024/25 Palliative and End of Life Care Report				
	The Committee referred to Executive following presentation of the Estates Improvement Plan and Terms of Reference of the newly convened Estates Improvement Group on the need for clear governance and a risk-based prioritised plan which details timeframe, cost and clarity of scope that makes best use of resources. 'Business as usual' resourcing alongside the support needed to develop the improvement plan was also escalated.				
So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i>	The Committee also requested information on the barriers and plans to achieve the one element of CNST year 7 in order to support the Board in determining the risk of any non-achievement.				
	The Committee had a discussion on the development of Trust's Quality Impact Assessment process and how the development of this process would support and enhance the safety culture of the Trust.				
	The Committee also considered the Quality Impact Assessment of inconsistent divisional quality governance resourcing levels to support compliance and recognised that the work the Trust is undertaking on its trust operating model and				
What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s) being made)</i>					

	that the Committee would be taking a keen interest in how the designed Trust Operating Model reduces this risk. The Board can receive the BAF with confidence that the content and score for strategic risk 1 has been scrutinised by the Patient and Quality Assurance Committee. The Board can receive the respective annual reports for approval having confidence these have been considered and where appropriate adjusted for feedback provided.					
Recommendation <i>(linked to What Next section)</i>	The Board is asked to NOTE - The Committee was quorate and considered all the expected reports in line with its schedule of business; - The Committee's assurance over the Trust's processes for patient quality and experience especially in respect of the pursuit of learning from reported incidents and complaints; - That the Committee acknowledges that the Trust Operating Model work will be looking to address the reported QIA risk in respect of inconsistent divisional quality assurance resources; and - The Committee's recommendation of the score for their allocated element of the BAF, strategic risk 1 which is the score remains at the target score of 20. The Board is asked to APPROVE, based on recommendations from the Committee - The 2024/25 Patient Experience Annual Report - The 2024/25 Mortality and Learning from Deaths Annual Report - The 2024/25 Patient Experience Annual Report - The 2024/25 Palliative and End of Life Care Report Subsequent to the Committee meeting in July the Chair reviewed the 2024/25 Safeguarding Annual Report and recommended this to the Board for APPROVAL					
Assurance / Scrutiny route already undertaken						
Link to Trust Strategy (note which theme)	Patients	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	N/A	Yes	Yes	Yes
Link to annual delivery plan	No specific link					
Link to BAF	No specific link					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	Yes	Yes	Yes	Yes	Yes	Yes
Other impacts	Equality and Diversity (if yes has HEIA completed)		Environmental		Legal	
	N/A		N/A		N/A	

Patient and Quality Assurance Committee Chair's Report

The Patient and Quality Assurance Committee met in the months of June and July and was quorate at each meeting, with attendance by at least two NEDs and two Executives and the relevant directors. At each meeting the Committee received the majority of its planned business which included reports on Patient Safety and Duty of Candour, Maternity Reports, Clinical Outcomes including learning from deaths, Infection Prevention & Control, Patient Experience and quality scorecards including the perinatal quality surveillance. The Committee also received reports from the Quality Governance Steering Group (QGSG) and reports from the Committee's reporting groups for information. The exception was that the formal Estates Improvement Group report was not received at the July meeting, but it was agreed that this item would be presented to the Committee's next meeting in September.

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

Patient Safety

The Committee received a number of reports in respect of this domain over the quarter. In July the Committee received the 2025/26 Quarter 1 report in respect of incident reporting, duty of candour compliance and the fundamental standards of care process outcomes along with the 2024/25 annual reports relating to Patient Safety and a thematic learning review in relation inpatient falls.

The Committee was **assured** over the underlying incident processes in respect of learning from each incident within the patient safety incident response framework. The Committee **noted** that the Patient Safety Incident Review Group continues to provide oversight of reported moderate and severe harms and through this oversight are engaging with the divisions in respect of emerging issues including the risk of lost to follow up appointments and increasing demands for mental health care within an emergency setting. The Committee noted an increasing backlog in closing incidents. As Chair I attended the Patient Safety Incident Response Group in June as part of gaining first hand assurance complementing the reports the Committee receives.

Across the quarter there has been an increase in incident reporting per 1000 bed days showing the continuation of the Trust's drive for seeking opportunities for enhancing its learning culture. The Committee **noted** the reported rates place the Trust as average in the recently released national reporting framework and that this an improvement in reporting levels for the Trust since the introduction of Datix in 2021/22.

The Committee **noted** the reported Duty of Candour (DoC) compliance rate has increased across the quarter to 92%, with the main issue being with the timely sharing of investigation outcomes with families. The Committee **discussed** the challenges with this element of the DoC and noted that the current Trust Operating Model work is reflective of the need to enhance the standardisation of divisional processes.

The Committee discussed the reported never events in quarter 1 of 2025/26 and were informed that whilst there were no common issues within these, there is to be a more detailed review of these incidents recorded including those reported in the prior year which will be reported to a future committee meeting.

The Committee, through the receipt and discussion of the Patient Safety Annual Report, reflected on the introduction of the PSIRF across the Trust and the Committee took **assurance** over the oversight governance design and their focus on the learning for Trust. The Committee **noted** that work is to be undertaken to seek assurance that the identified learning is embedded within the respective processes through processes such as clinical or management audits.

The Committee also **considered** the processes for learning from inquests and settled claims and was **assured** over the designed process in these areas.

The Committee **discussed** the outcomes of the Fundamental Standards of Care (FSoc) KPI quarterly report at its meeting in July, noting over the previous year the levels of undertaking these audits has increased. The Committee **noted** the process developments that have been made by divisions based on the FSoc audit outcomes. The Committee **discussed** over the forthcoming year the focus of this work needs to move to providing assurance over outcome now that the level of audit activity has increased to provide useful level of data. The Committee also heard that the current roll-out of the Daily Management System through which presents a further opportunity for the wards to consider the audit outcomes.

The Committee **received** at its May meeting a quality impact assessment in respect of the gap of standardised level of divisional quality resources. The meeting **noted** that the work on the Trust's Operating Model will support the addressing of this gap as it considers the balance between central and divisional resources.

Safeguarding

The Committee received the quarter 1 report s, recognising that work is needed to secure the level of compliance with the required training targets in level 3 training. The Committee recognised the importance of the training sought a detailed update at its next meeting on the barriers to the achievement of the training targets with a consideration of the required actions to make the necessary sustainable improvements. The Committee discussed the delayed discharge risks described in the report and the continued engagement with the local authorities and SPFT to work collaboratively to reduce these delays.

The Committee **noted** the overall positive assurance provided by a recent internal report in respect of the Trust's processes for compliance with the mental health act.

Infection Prevention and Control

The Committee **received** at the June meeting a report covering Infection Prevention and Control which containing the validated performance data from Q4 2024-25 across main infection types. The report contained the full years data for these infection types with the Committee **discussing** the actions being taken for those that exceeded the expected

trajectories. The Committee also **noted** that the interventions previously discussed as committee had resulted in reduction of the levels of Surgical Site Infection (SSI) rates

The Committee **reviewed** the IPC Board Assurance Framework and **noted** that this that will form part of the Trust IP&C Annual Report to be reported to a subsequent Committee meeting. The Committee was provided with an update on the actions in respect of the areas declared as non-compliant, with the delayed recruitment of mask fit testers commencing. The Committee **agreed** that the framework report through the gap analysis would allow a prioritised improvement plan to be developed for 2025/26 which would be incorporated in the annual report to be presented to a future committee meeting.

Maternity

The Committee at its July meeting **received** expected suite of maternity performance and assurance papers, including the Perinatal Quality Surveillance Reports & Dashboards; ATAIN performance report, Perinatal Mortality Review tool assurance report, Maternity Incident report along with a report on the Trust CNST year 7 position and the maternity governance framework.

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

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

The Committee **noted** through the ATAIN performance report the continued focus on learning from these admissions and the work being undertaken to continue to prevent wherever possible such avoidable admissions including a quality improvement project in relation to term admissions for respiratory distress syndrome.

In Committee **received** the Maternity Serious Incident Report for quarter 1 in its July meeting and was **assured** the serious incidents had been investigated fully and lessons learnt across the Trust and this work was aligned to the Trust's patient safety incident response framework. The Committee noted the planned thematic reviews and the assurance over learning these will provide. It also noted the Q4 24/25 Maternity Claims Scorecard.

The Committee **received** updates on progress towards the Trust's year 7 CNST Maternity Incentive Scheme submission and discussed the areas of risk. The Committee made a **request** that a detailed paper articulating the specific barriers to comply with the specific standard on transitional care and the options to address these within this year.

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

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

Quality Assurance

At the July meeting the Director of Clinical Effectiveness **presented** the learning from deaths annual report. The Committee **recognised** the messages within the report have been reported within the quarterly reports it had received over the year with the quarter 4 report presented to the May Committee meeting. The meeting **discussed** the report and how the analysis from 24/25 was driving the improvement priorities for the current year. The Committee **provided** a small number of comments on the report seeking to bring clarity and context to some of the reported charts through the reference to population demographics. The Committee **agreed** this report subject to the agreed changes should be presented to the Board.

At both at the June and July meetings the Committee **noted** that there were no SJRs which were over 60 days from referral. The Committee at its July meeting discussed the process by which learning from these reviews was shared

The Committee **received** a wider clinical outcomes and effectiveness update report and discussed the level of outstanding GIRFT assessments and whilst it was understood there were some resource constraints should the work programme be aligned to the Trust's wider productivity improvement plan to enable the Trust to be assured that these productivity changes are matched to the GIRFT further faster programme recommendations. The Committee was assured that through the revised QIA process all such changes consider GIRFT assessments.

Upon receipt of the Q4 Clinical Outcomes and Effectiveness report the Committee **reflected** on the progress across the breadth of this area that had been achieved over the past year and whilst there remain, sometimes significant gaps in compliance, for example in clinical documentation there is a clear understanding of the gap, and both plans and governance in place to address these. The Committee **noted** the reported position seeing the NICE Guidance review backlog had reduced significantly with 95% of guidance and 100% of technology appraisals reviewed within the 90 day target.

Patient Experience

At the June Committee meeting the 2024/25 Quarter 4 Patient Experience Report was **received**, with the 2025/26 Quarter 1 Patient Experience Report and Trust's 2024/25 Patient Experience Annual Report being received at the July meeting.

The Committee **requested** that the Patient Experience Annual report should be presented to the Board for its information.

The Committee **noted** an increase in complaints in Q1 to 494, the highest number received and alongside this that the highest number complaints had been able to be closed in the same quarter. It is also noted the upward trajectory of patient satisfaction with 92% of patients reporting a good or very good experience. The Committee **noted** the progress made in closing complaints more timely and utilising information to become more proactive to improve communication where issues are identified to prevent a need for a formal complaint to be raised. The Committee noted that many complaints were about poor communications whilst patients were waiting not just for treatment but for information on results and follow up appointments.

The Committee **discussed** the actions being taken and supported by PALS to make improvements based on patient feedback along with how the Friends and Family Test feedback is used by divisions and corporately to drive change,

QSGS chairs report

The Committee at both its June and July meetings **received** a report from the QSGS chair providing assurance over the work of that group and the focus that group brings over divisional patient safety, quality and patient experience.

The Committee **discussed** the alignment of the chairs report with the reports received across the meetings.

Quality Impact Assessments

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

Care Quality Commission (CQC) action plans

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

The Committee was assured over the process being applied to track the delivery of these actions and that a number of actions were now being tracked through business as usual processes overseen by other Board Committees. The Committee noted the pressure the tracking of all these actions including those absorbed into the business as usual process places on the central team but recognised that the target operating model for corporate services need to be able to provide a sustainable solution for compliance oversight.

Facilities and Estates

The Committee **noted** the update from the Director of Facilities and Estates and discussed the developing terms of reference for the 'Estates Improvement Group' (EIG) and agreed that this group should report to this Committee and QSGS.

Through the updates provided on the work of the water safety group and the specialist ventilation group the Committee recognised the progress made with an increase in compliance on ventilation and a Trust-wide devices asset register, but there remains a significant maintenance back-log in all aspects of the estate and the refurbishment requirements. The Committee **asked** for a fully costed resourcing and delivery plan for estates improvement over the next 5 years to come back to the Committee alongside the quarterly report from EIG.

In response to the quality impact of the risks and issues that are being identified relating to facilities and estates, the Committee welcomed the regular attendance of the Chief Finance Officer as executive lead for Estates had continued.

Divisional Deep Dives

As part of the rolling programme of service engagement with the Committee, at the June meeting the Committee **received** a deep dive into **Cancer Division's** successes, challenges, risks and opportunities.

The Committee was able to **note** that the division had established a clear and defined governance structure. There had been an increase in complaints linked to delays for treatment and the interlinkage with other Directorates on which the division is dependent was recognised. Delays in radiotherapy had been a result of machinery and recruitment challenges however the Trust had been supported Sussex Cancer Alliance and had been tried to be proactive in communicating the issues and delays to patients.

While regulatory requirements were met it was **noted** that there is inconsistency in the extent of guideline adoption across the division's specialities. The Committee was **assured** over the Divisional adoption of the Trust's Fundamental Standards of Care Audits.

Risk registers

The Committee **noted** the correlation between the highly scored patient quality, safety and experience risks and the reports and discussions had at the meeting and utilised these when it considered the allocated segment of the BAF. The Committee discussed the work that is needed to bring greater clarity and consistency to the reported risks, noting that a number where issues and not risks and that there continued to be an increase in the overall number of recorded risks partly driven by a disaggregation of previously recorded risks. The Committee also discussed the cultural change work that would need to support the fundamental review of each risk register to move from the now established risk reporting to risk review and management recognising that the focus on risk reporting was required in the early years of the Datix roll out.

Board Assurance Framework

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

Following the review of the BAF itself and the reports received at the Committee in July they agreed with the recommendation that despite the improved understanding of the respective challenges and developed action plans given the time these actions will take to provide robust assurance that no change should be made from the quarter 1 score of 20 noting that this score is the target score for the whole year.

Referrals to other Committees

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

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	24 June 2025	Chair	Lucy Bloem	Quorate	Yes
Declarations of Interest	No declarations were raised				
Items received at the Committee meeting					
Focus, Operation and Priorities of the Committee					
QGSG reports	Presenter Chief Medical Officer/ Dep. Chief Medical Officer	Purpose For information	Outcome /Action taken Noted and assurance taken over the work of QGSG		
Quality Dashboard (excl Maternity) Safety, Mortality Effectiveness, Experience,	Presenter Chief Medical Officer	Purpose For information	Outcome /Action taken Noted		
Patient Experience Assurance Report Q4	Presenter Director Patient Experience & Engagement	Purpose For information	Outcome /Action taken Noted and assurance taken over the process for learning from complaints		
Patient Safety					
Patient Safety Assurance Report Q4 2024/25	Presenter Chief Nurse / Deputy Director Patient Safety & Learning	Purpose For information	Outcome /Action taken Noted and assurance taken over the process for investigations and learning		
Infection Prevention & Control Update Report	Presenter Director Infection, Prevention & Control	Purpose For assurance	Outcome /Action taken Noted the IPC BAF		
Quality Assurance Report Including Clinical Outcomes & Effectiveness Group Reports Q4 2024/25 report including Mortality & Learning from Deaths Q4 2024/25 report	Presenter Chief Medical Officer/Director of Clinical Outcomes & Effectiveness	Purpose For assurance	Outcome /Action taken Noted and assurance taken over the processes for improving the Trust compliance. Also assurance taken over the review and learning from deaths		
Quality Annual Account 2024/25 (final draft)	Presenter Chief Medical Officer/Director of Clinical Outcomes & Effectiveness	Purpose For approval	Outcome /Action taken Commended for Board approval		

Facilities & Estates- Water. Ventilation, Medical Devices Compliance update reports including Estates Improvement Group (EIG) ToR.	Presenter Director of Estates and Facilities / Chief Finance Officer	Purpose For information	Outcome/Action taken Noted Improvement Plan, Ventilation Plan & and Ventilation Safety Group Chair report, Safe Water Group Chair report, Medical Equipment Improvement Plan, Agreed EIG ToR update & cross ref CQC Action Plan.
Quality Impact Assessment Report in respect of divisional quality resourcing	Presenter Chief Medical Officer / Chief Finance Officer	Purpose For discussion	Outcome /Action taken The Committee noted the risk identified through inconsistent resourcing
Division Spotlight/ deep dive from the Cancer Division	Presenter Division Director of Nursing (Cancer)	Purpose For assurance	Outcome /Action taken Noted
National Maternity Inquiry Update	Presenter Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted
Maternity PSIRF Q1 25/26 report	Presenter CNO/ Director of Midwifery / Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted and assured over the process for investigation and learning
Risk			
Trust Risk Register relating to Patient & Quality Summary of changes only, between Quarterly meetings	Presenter Chief Medical Officer / Chief Nurse	Purpose For information	Outcome /Action taken Noted the register changes

Meeting Details					
Meeting Date	29 July 2025	Chair	Lucy Bloem	Quorate	Yes
Declarations of Interest	No declarations were raised				
Items received at the Committee meeting					
Patient Safety					
Quarter 1 Patient Safety Incident & Duty of Candor report	Presenter Director of Patient Safety	Purpose For assurance	Outcome /Action taken Noted and assured over the investigation and learning processes		
2024/25 Patient Safety Annual Report	Presenter Director of Patient Safety	Purpose For information	Outcome /Action taken Noted.		

2024/25 Medico-legal annual report and report to June 2025	Presenter Director of Patient Safety	Purpose For assurance	Outcome /Action taken Noted the learning processes
Fundamental Standards of Care quarterly report	Presenter Deputy Chief Nurse (Quality)	Purpose For assurance	Outcome /Action taken Noted and assured of the audit processes
Thematic Review of inpatient falls	Presenter Deputy Chief Nurse (Quality)	Purpose For assurance	Outcome /Action taken Noted the process for applying the learning
Clinical Outcomes & Effectiveness quarter 1 report	Presenter Director of Clinical Outcomes and Effectiveness	Purpose For Assurance	Outcome /Action taken Noted and assured over the compliance processes
Mortality and Learning from Deaths quarter 1 report	Presenter Director of Clinical Outcomes and Effectiveness	Purpose For Assurance	Outcome /Action taken Noted the process for review, investigation and learning
Safeguarding quarter 1 report	Presenter Associate Director of Nursing Safeguarding	Purpose For Assurance	Outcome /Action taken Noted the activity update.
Infection Prevention and Control report to June 2025	Presenter Associate Director of Infection Prevention and Control	Purpose For assurance	Outcome /Action taken Noted the activity update.
Patient Experience			
Patient Experience Assurance Report Quarter 1 report	Presenter Director Patient Experience & Engagement	Purpose For assurance	Outcome /Action taken Noted and assured over the learning processes
2024/25 Patient Experience Assurance Annual Report	Presenter Director Patient Experience & Engagement	Purpose For information	Outcome /Action taken Noted
Maternity			
National Maternity Inquiry Update	Presenter Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted
Maternity Governance Framework	Presenter Director or Midwifery / Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted
Perinatal Quality Surveillance Report and Dashboards Q4 2024/25	Presenter Director or Midwifery / Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted and assured over the performance
ATAIN/Transitional Care Q3 24/25	Presenter Director of Midwifery/ Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted and assured over the review of these cases
Maternity Claims Scorecard Q4 2024/25	Presenter Director of Midwifery	Purpose For information	Outcome /Action taken Noted

Perinatal Mortality Review Tool (PMRT) Q4 2024/25	Presenter Director of Midwifery/ Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted and assured over the performance
Maternity PSIRF Q1 25/26	Presenter CNO/ Director of Midwifery/ Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted and assured over the process for review, investigation and learning
CNST Maternity Incentive Scheme Year 7 – update	Presenter Chief of Women & Children Service	Purpose For information	Outcome /Action taken Noted the current position
Reporting Group			
QGSG Chair's assurance report, including quality scorecards, divisional summary reports and quality domain summary reports	Presenter Chief Medical Officer	Purpose For assurance	Outcome /Action taken Noted
CQC action tracking			
CQC Update / Action Plans	Presenter Chief Nurse/ Director of Patient Safety & Learning	Purpose For information	Outcome /Action taken Noted and assured over the process for tracking actions
Risk			
Patient and Quality Risk Report	Presenter Chief Nurse/ Director of Patient Safety & Learning	Purpose For information	Outcome /Action taken The Committee noted these
Board Assurance Framework	Presenter Chief Nurse/ Director of Patient Safety & Learning	Purpose For information	Outcome /Action taken The Committee reviewed its allocated segments and agreed with and recommended the proposed score for risk 1 to the Board

Agenda Item:	15	Meeting:	Trust Board in Public	Meeting Date:	4 September 2025
Report Title:	People & Culture Committee Chair's Report				
Author(s):	Paul Layzell – NED & Committee Chair				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For Discussion	For Information only	
	Yes	Yes	N/A	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances <i>(please detail)</i>	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement					
Summary of the report describing What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i> So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i>	<i>The report provides information over the business undertaken and the People and Culture Committee in May and July 2025.</i>				
	<i>The Committee meeting was quorate at each of these meetings and received its scheduled business with the exception of the divisional presentation by Facilities and Estates in May which was deferred to later in year, likely to be October 2025.</i>				
	<i>The Board can take assurance through the work of the Committee that focus is being provided to the areas of culture and workforce including the processes supporting the reporting of workforce KPIs. The Committee endorsed the planned actions to iteratively improve the People scorecard and for this scorecard to be expanded to include cultural metrics and asked through the Strategy and Major Projects Committee that a summary mapping of all the various work contributing to cultural change is developed to support with the cultural scorecard development</i>				
	<i>The Committee in accordance with its Terms of Reference took the following actions</i> - <i>Approved the Trust data submission to NHS E in respect of Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) in support of their national publication</i> - <i>Agreed the draft of the Trust's Education Plan for 2025-30 noting that the final document would be adjusted based on the feedback from the Committee.</i> - <i>Provided feedback on the Annual Workforce Equality Report to enhance the thematic analysis and the triangulation of this work with feedback incorporated within the Well Led development review report.</i> - <i>Recommended for approval at the Board the Annual Medical Appraisal and Revalidation declaration.</i>				
	<i>The Board should note that the Committee requested sight of a of a longer-term workforce plan aligned to the Trust's Strategy and the outcome of the Trust Operating Model review in order to understand plans to mitigate risks identified to the longer term recruitment and retention of staff.</i>				
What Next <i>(summary of intended action and benefits supporting the choices and</i>	<i>The Board can receive the BAF with confidence that the content and score for strategic risks 2 and 3 have been scrutinised by the People and Culture Assurance Committee.</i>				

recommendation(s)being made)	The Board can also be assured that the referred Annual Workforce Equality Report and annual Medical Appraisal and Revalidation declaration for approval has been subject to review and in relation to the annual report comments allowing it to include a more rounded analysis supporting the 2025/26 priorities.					
Recommendation (linked to What Next section)	The Board is asked to NOTE - the Committee met and received the expected assurance reports - the Committee endorsed the work being undertaken to revise the people and culture scorecard - the actions taken by the Committee in respect of the scrutiny and approval of the Trust's WRES and WDES data submission - The Committee's recommendation of the scores for their allocated elements of the BAF, strategic risks 2 and 3, noting that the Committee recommended no change to risk 3 (workforce) but an increase to risk 2 (culture). - The Annual Medical Appraisal and Revalidation declaration was submitted in accordance with the required timetable The Board is asked to APPROVE, based on recommendations from the Committee - The Annual Workforce Equality report subject to the changes discussed at the Committee -					
Assurance / Scrutiny route already undertaken (please explain where matter previously considered, and assurance provided)	A number of items presented to the Committee had been considered by the Committees reporting groups.					
Link to Trust Strategy (note which theme)	Care Yes	People Yes	Future Yes	Communities Yes	One UHSussex Yes	Culture Yes
Link to annual delivery plan	The People and Culture Committee provides oversight of the Trust's delivery of many aspects that link to the delivery of the Trust's annual plan, not least the Trust's people promises, workforce wellbeing, training and development					
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	The Committee has oversight for the allocated people related strategic risks					
Link to CQC domain	Safe Yes	Caring N/A	Effective N/A	Responsive N/A	Well-led Yes	Use of Resources N/A
Other impacts	Equality and Diversity (if yes has HEIA completed)		Environmental		Legal	
	N/A		N/A		Yes	
					The Trust is required to maintain an effective council of governors (FT Code of Governance / FT Licence)	

People and Culture Committee Chair's Report

The People and Culture Committee met on the 26 May and on the 29 July 2025. The Committee was quorate at both meetings as was attended by at least two Non-Executive Directors and two Executives Directors. In attendance at these meetings were the respective report presenters including the Director of Workforce Planning & Deployment, Director of Human Resources, Director for Integrated Education, and the Associate Director of Leadership, Culture and Development.

At the May meeting the Committee received its planned items including the 2025/26 Workforce Plan, the Trust's Annual Workforce Equality Standards Report for 2024/25, the Trust's employee relations annual report for 2024/25, an update on the Trust's cultural programme and the Trust's education and learning plan.

At the July meeting the Committee again received its planned items including the Cultural Programme Update, the People Plan update, the Annual Workforce Equality Report and EDI workforce inclusion plan, reports from both the Freedom to Speak up Guardian and the Guardian of Safe Working Hours, Medical Appraisal and Revalidation annual report and Job Planning update.

The key areas of focus for the Committee at its May and July meetings 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 at both meetings continued to **receive** a report from the Chief People Officer providing a high-level summary of the work undertaken across the Trust within the people domain. The report also allowed the Committee to consider the focus of the papers being presented to the meeting and receive an overview of the Trust's people metrics scorecard. At its May meeting the Committee **endorsed** the planned iterative improvements to the People Scorecard and the planned inclusion of Cultural metrics for the second half of the year reporting.

The Committee **discussed** the need for the development of a longer-term workforce plan aligned to the Trust's Strategy and the outcome of the Trust Operating Model review in order to develop appropriate longer-term recruitment and staff development plans along with plans to mitigate risks identified to the longer term recruitment and retention of staff.

Workforce Resourcing Plan in support of the Trust's People Plan for 2025/26

The Committee in May **received** a report on the Trust's resourcing plan to support the Trust's people plan for 2025/26. The Committee discussed the developed resourcing plan and noted that this plan's costs were incorporated within the Trust approved financial plan. The Committee recognised the ambition within the Trust's workforce plan and took **assurance** over the alignment of the described support to each of the crucial areas of recruitment and workforce deployment, across clinical (medical, nursing, healthcare assistants and allied health professionals) and support staff.

The Committee **welcomed** the work to develop a delivery scorecard for the Committee utilising the already established divisional reporting.

2025/26 People Plan update

In the July meeting the Committee **received** its scheduled update report providing an update on the 15 improvement projects showing how these align to each of the 7 people promises within the agreed 2025/26 people plan. The Committee noted that two projects have been paused to ensure they align to the Trust's Strategy launch and the work on the developing Trust Operating Model. The Committee acknowledged how its committee's scheduled business is structured to receive assurance over the people plan delivery.

The Committee noted the progress reported within this report and the correlation to the specific reports covering culture and OD, integrated education, workforce inclusion, health and wellbeing.

Workforce Equality Standards Annual Report 2024/25

The Committee in May **received** the Trust's annual report on the workforce race equality standards (WRES) and the workforce disability equality standards (WDES). The Committee discussed those areas where the data showed some improvement and the actions being planned in those areas where no improvement had been made. The Committee was reassured that the respective staff groups were being engaged with to formulate improvement actions and that these would be clearer in the annual equality reports that is scheduled to be presented for Board approval later in the year after review by this Committee at its July meeting.

The Committee **agreed** to the submission of the Trust's required WRES and WDES data to NHS E in line with national reporting requirements.

Annual Equality Report

At its July meeting the Committee **received** the Trust's wider Annual Equality Report noting this incorporated the WRES and WDES data considered at its May meeting. The Committee **noted** that the report had been structured with a section on each of the 6 equality act protected characteristics with further sections covering the Trust's workforce groups.

The Committee **considered** the improvements achieved over the previous year, giving confidence that that Trust's plans are making a difference although with more work to do.

The Committee **considered** the determined priorities for 2025/26 and provided comments on the analysis provided in the report and that provided through other sources including the Well Led development review. It was **agreed** by the Chief People Officer that the report would be adjusted to include a thematic narrative that links the analysis across the detailed protected characteristics to the priorities for 2025/26.

The Committee **recommended**, following the adjustments agreed to in the meeting, this report to the Trust Board for approval of its publication.

2025/26 Workforce Inclusion Plan

The Committee at its July meeting **received** the Workforce Inclusion Plan complementing the Annual Workforce Equality Report. The Committee **noted** that its structure focuses on seven key strategic areas of focus each designed to address the priorities from the Trust Workforce Equality Annual Report, the high impact actions identified nationally in this area

along with the comments made in the 2023/24 Internal Audit developmental review on the EDI.

The Committee discussed the processes established for the oversight and assurance of delivery through the Workforce Inclusion Steering Group, along with progress being reported transparently within a dedicated internal inclusion dashboard. The Committee was **assured** over these establishes oversight processes and along with noting the interlinkage between this work and that within the Culture and OD workplans. The Committee **recommended** this work be linked to the Strategy and the Strategy Delivery commitments to a common language to be used as well as allowing a consistent tracking of the priority work across the Trust.

Culture Programme

At both meetings the Committee continued to **receive** a report on the culture programme. The report and update provided by the Chief Culture and Organisational Development Consultant and the Director of Integrated Education who is the workstream SRO provided **assurance** that the delivery against each of the six workstreams was on track. The Committee also **noted** the continued work on ensuring programmes of change incorporate cultural and organisational development support.

The Committee **discussed** at its June meeting the draft of the cultural anchor statement developed to tether this programme of work to that of the Trust's strategy delivery plan. The Committee **agreed** the value of the development of this statement, recognising that cultural change will take time to permeate through the organisation.

At the July meeting the Committee **noted** the move of focus for year 2 on developing the infrastructure to support change incorporating the learning from the success from the previous year. The Committee **agreed** the value of having developed measures to track the success of the plan given the breadth of work to be achieved through this plan and monitoring the delivery of the expected impact of the level of investment being committed to by the Trust. The Committee also noted that further work is needed to map these cultural interventions to the strategy delivery plan and the revised structures that result from the work on the Trust Operating Model.

The Committee requested that through the Strategy and Major Projects Committee that a summary mapping of all the various work contributing to cultural change is developed to support with the cultural scorecard development.

Freedom to Speak Up Guardian and Guardian of Safe Working Hours reports

The Committee at its July meeting **received** reports from the two guardians, these being the Freedom to Speak Up Guardian annual report and the quarter 1 Guardian of Safe Working Hours report. Both reports provided **assurance** to the Committee over the continued effectiveness of the underpinning processes.

The Committee **discussed** the matters raised by both Guardian's reports and **noted** the actions planned to be taken especially in respect of staff engagement to address the reported feedback that some staff still believe there is little value in speaking up. In respect of the Freedom to Speak Up Guardian's annual report the Guardian provided information that the issues raised at the Trust are not dissimilar to others the guardian service sees and there were no serious patient safety concerns that had not been addressed when referred on.

The Committee **agreed** the Freedom to Speak Up Guardian annual report should be shared with the Board for their information.

Medical Revalidation and Appraisal Report

The Committee at its July meeting **considered** the Trust's medical revalidation and appraisal annual report and based on the discussion **agreed** that the annual declaration should be made by the Board for submission in accordance with the required timelines.

Trust Education Plan

The Committee in **receiving** the Trust's education for 2025-30 was **assured** over its alignment with the delivery of the Trust's Strategy to 2030 and that it had taken into account national, system and local developments. The Committee was also **assured** over the management oversight arrangements established for the delivery of the plan seven main objectives.

The Committee **provided feedback** on elements of the plan in terms of clarity of some elements linked to patient education work to enable them to live well and how this work both supports staff to excel in their current roles but also allow them to develop skills to enable them to move between roles in support of their personal and career development.

The Committee **endorsed** management's plan to create a delivery scorecard to enable both the management groups to track delivery and provide assurance to the Committee of its delivery.

Risk registers

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

Board Assurance Framework

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

Following the review of the BAF itself and the reports received at the Committee in July they **agreed** with the recommendation to make no change from the quarter 1 score of risk 3 in relation to workforce but **agreed** based on the reports received and the discussions to recommend to the board that risk 2 relating to culture should be higher, thus a score of 20. The Committee felt a higher score was supported by the breadth of actions still to be completed and the impact of the current culture on the inability to reduce some of the other risks within the BAF.

Referrals to other Committees

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

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	27 May 2025	Chair	Paul Layzell	Quorate	Yes
Declarations of Interest	No declarations were raised				
Items received at the Committee meeting					
People Performance Overview including People Scorecard	Presenter Chief People Officer	Purpose For discussion and assurance	Outcome /Action taken The Committee utilised the overview to bring focus to the meeting. Noted the recorded performance showing a broadly stable level of performance across the broad range of indicators. The Committee endorsed the planned iterative improvements to the People Scorecard and the planned inclusion of Cultural metrics.		
Resourcing plan in support of the workforce plan for 2025/26	Presenter Director of Human Resources Operations	Purpose For discussion and assurance	Outcome /Action taken The Committee discussed the developed resourcing plan to support the delivery of the Trust’s workforce (people) plan. The committee took assurance over the alignment of the support to each of the crucial areas of recruitment and workforce deployment, across clinical (medical, nursing, healthcare assistants and allied health professionals) and support staff. The Committee welcomed the work to develop a delivery scorecard for the Committee utilising the already established divisional reporting		
Workforce Equality Standards Report 2024/5	Presenter Associate Director, Leadership, OD & Engagement	Purpose For discussion	Outcome /Action taken The Committee received the Trust’s annual report on the workforce race equality standards (WRES) and the		

			workforce disability equality standards (WDES). The Committee agreed to the submission of the Trust's required WRES and WDES data to NHS E in line with national reporting requirements.
Employee Relations Annual Report 2024/25	Presenter Director of Human Resources Management	Purpose For discussion and assurance	Outcome /Action taken The Committee received the annual report. The Committee in discussing the report endorsed the work being proposed to support middle managers in this area and the additional oversight step added to seek to reduce the length of time these formal processes take to conclude. The Committee reflected that the that the information gained from this report should also be used with considering improvements in relation to WRES and WDES performance.
Cultural Programme Update	Presenter Chief Culture and Organisational Development Officer	Purpose For information and noting of actions being taken	Outcome /Action taken The Committee in receiving this report was assured that the delivery against each of the six workstreams was on track. The Committee also noted the continued work on ensuring programmes of change incorporate cultural and organisational development support. The Committee noted the iterative approach to be applied to this work to ensure it remaining aligned to and supporting the Trust strategy delivery over the next five years. The Committee discussed and agreed the value of the

			developed draft cultural anchor statement.
Trust Education Plan 2025 - 2030	Presenter Director of Integrated Education	Purpose For discussion and agreement	Outcome /Action taken The Committee was assured over its alignment with the delivery of the Trust's Strategy to 2030 and the management oversight arrangements established for the delivery of the plan seven main objectives. The Committee in agreeing the plan also provided feedback on elements of the plan and endorsed management's plan to create a delivery scorecard to track the 5-year plan's delivery.
Nursing and Midwifery Workforce Steering Group	Taken for information on the work of the group	For information only	Outcome /Action taken The Committee noted to work of the Steering Group and that there were no matters for escalation.
ICS and System Collaboration	Presenter Chief People Officer	Purpose For information	Outcome /Action taken The Committee noted the continues collaborative working being undertaken.

Meeting Details

Meeting Date	29 July 2025	Chair	Paul Layzell	Quorate	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

People Performance Overview including People Scorecard	Presenter Chief People Officer	Purpose For discussion and assurance	Outcome /Action taken The Committee utilised the overview to bring focus to the key elements of the papers being presented at the meeting. The Committee noted the continuing slight improvement in performance reported across the various workforce KPIs noting that vacancy

			rates have been re set with the staffing out turn increase. The Committee noted this update and recognising the linkage between this update and the BAF strategic risks it has oversight over and the developing Strategy. The Committee discussed the need for the development of a longer-term workforce plan aligned to the Trust's Strategy and the outcome of the Trust Operating Model review in order to develop appropriate longer term recruitment and staff development plans.
CQC allocated actions oversight assurance register	Presenter Chief People Officer	Purpose For discussion and assurance over delivery	Outcome The Committee agreed the level of assurance of progress was reasonably stated, recognising that the oversight of many of these is provided through the workforce scorecard but where there was a need for specific actions it recorded how these had been taken.
Updates from work with system partners	Presenter Chief People Officer	Purpose For discussion and assurance	Outcome The Committee noted the update and the collaboration with the ICB and other NHS partner as they deal with the reductions to overall NHS staffing numbers. The meeting also noted the reported change in the level of engagement with the region given the change in their oversight role.
Culture Programme Update	Presenter Culture and OD consultant / Interim Assistant Director of Leadership & Management	Purpose For information	Outcome /Action taken The Committee in receiving this report was assured that the delivery against each of the workstreams continued to be on track.

			The Committee noted the move of focus for year 2 on developing the infrastructure to support change learning from the success from the previous year. The Committee discussed the developing measures to track the success of the plan and the breadth of work to be achieved through this plan. The Committee noted the level of investment being committed to this area recognising the impact expectation for this investment is high re-enforcing the need to track the changes being made. The Committee noted the scope of the work and agreed with this noting that further work is needed to map these interventions to the strategy delivery and the revised structures as a result of the TOM.
Annual Workforce Equality Report	Presenter Associate Director, Leadership, OD & Engagement	Purpose For discussion and recommendation to the Board	Outcome /Action taken The Committee received the Trust's wider Annual Equality Report noting this incorporated the WRES and WDES data considered at its May meeting. The Committee received assurance over the data quality improvements made supporting a deeper understanding of the priorities for 2025/26. The Committee considered the determined priorities for 2025/26 and provided comments on the analysis provided in the report and that provided through other sources including the Well

			Led development review. It was agreed by the Chief People Officer that the report would be adjusted to include a thematic narrative that links the analysis across the detailed protected characteristics to the priorities for 2025/26. The Committee recommended, following the adjustments agreed to in the meeting, this report to the Trust Board for approval of its publication.
Workforce Inclusion Plan	Presenter Associate Director, Leadership, OD & Engagement	Purpose For discussion and recommendation to the Board	Outcome /Action taken The Committee received the Workforce Inclusion Plan complementing the Annual Workforce Equality Report and noted that its structure focuses on seven key strategic areas of focus each designed to address the priorities from the Trust Annual Workforce Equality Report, the high impact actions identified nationally in this area along with the comments made in the 2023/24 Internal Audit developmental review on the EDI along with feedback from various staff sources. The Committee noted this document was recommended to the Committee by the workforce steering group. The Committee discussed the processes established for the oversight and assurance of delivery through the Workforce Inclusion Steering Group, along with progress being reported transparently within a dedicated internal inclusion dashboard. The Committee was assured over these establishes oversight

			processes and along with noting the interlinkage between this work and that within the Culture and OD workplans. The Committee recommended this work be linked to the Strategy and the Strategy Delivery commitments to both common language to be used along with utilising the established process for the tracking of the wider work across the Trust.
Freedom to Speak Up Guardian Annual Report	Presenter Freedom to Speak up Guardian	Purpose For assurance and recommendation to the Board	Outcome /Action taken The Committee received the Annual report and noted the assurance provided that the supporting processes remained in place. The Committee noted the progress made over the prior year's recommendations and those made for next year. The Committee agreed that the Freedom To Speak Up Guardian Annual report should be shared with the Board for information.
Daily Management System Delivery Report	Presenter Deputy Director of Improvement and Delivery	Purpose For noting	Outcome /Action taken The Committee received the report on the roll out of the Trust's daily management system and supported the review from phase 1 and improvements being incorporated into the roll out of this process to the wider Trust.
Violence Prevention & Reduction quarterly report	Presenter Associate Director, Leadership, OD & Engagement	Purpose For assurance	Outcome /Action taken The Committee through the report took assurance on the Trust's progress against the VPR action plan and that the Trust remains on target to achieve full compliance with the NHS VPR standards by March 2026.

2025-26 People Plan update	Presenter Chief People Officer	Purpose For discussion and assurance	Outcome The Committee received its scheduled report providing an update on the 15 improvement projects showing how these align to each of the 7 people promises within the agreed 2025/26 people plan. The Committee noted the reported progress and acknowledged how its Committee's scheduled business is structured to receive assurance over the people plan delivery. The Committee noted that the mapping of the People Plan to the Strategy Delivery ambitions.
Medical Appraisal and Revalidation annual report	Presenter Chief Medical Officer	Purpose To review and recommend to the Board	Outcome /Action taken The Committee considered the report and agreed this supported the annual declaration content. The Committee recommended the declaration report to the Board for approval and submission.
Consultant Job Plan Project Delivery update	Presenter Chief People Officer	Purpose To note	Outcome /Action taken The Committee noted the progress made with this project and the requested analysis of the current work plan to the Internal Audit think piece. The Committee noted that the Trust's programme had already incorporated the majority of the sector learning from the internal audit report and for the one area this was being considered as the plan is delivered over the remaining part of the year.
Integrated Education Update	Presenter Deputy of Integrated Education	Purpose To note	Outcome /Action taken The Committee noted the report.

Quarter 1 Guardian of Safe Working Hours report	Presenter Taken for assurance without wider discussion	Purpose For assurance	Outcome /Action taken The Committee received the report and noted the Guardian's assurance over the established processes for exception reporting. The Committee noted the reported plans that have been established and being implemented to deliver the national changes to exception reporting by the deadline of the 12 September.
Committee reporting group reports	Presenter Taken for information without wider discussion	Purpose For information	Outcome /Action taken The Committee received these and noted their correlation to the Chief People's oversight report
People Risks update	Presenter Chief People Officer	Purpose To note	Outcome /Action taken The Committee noted the report and recognised that work is to be undertaken to review the recording and management of risks within the organisation. The Committee reflected on thematic analysis of the recorded risks with a workforce implication when considering the workforce strategic risk.
Board Assurance Framework	Presenter Company Secretary	Purpose To review and recommend to the Board	Outcome /Action taken The Committee reviewed its allocated segments and agreed with and recommended score for the workforce risk (risk 3) but with respect of the score for the culture risk (risk 2) given the reports received and discussions it was felt that this risk should be scored higher given the significant breadth of actions still to be completed and so should be scored at 20.

Agenda Item:	16.	Meeting:	Trust Board in Public	Meeting Date:	4 September 2025
Report Title:	Finance & Performance Assurance Committee Chair's Report				
Author(s):	Philip Hogan, Chair Finance & Performance Assurance Committee				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision	For Assurance	For discussion	For Information only	
	No	Yes	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement					
Summary of the report describing	<i>The report provides information over the business undertaken at the Finance and Performance Assurance Committee across the months of May, June and July 2025.</i> <i>The Committee meeting was quorate at each meeting and received its scheduled business.</i> <i>The Committee in accordance with its Terms of Reference approved three investment decisions, relating to the extension to the hours of the mechanical thrombectomy service the purchase of an MRI scanner and the enabling works for the acute floor reconfiguration.</i>				
What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i>					
So What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i>	<i>The Board can take assurance from the oversight being provided by this Committee to the areas of financial and operational performance and the plans to address any risks to the achievement of the Trust annual delivery plan. The Board can also take assurance that the Committee has oversight of the Trust cash management actions.</i> <i>The Board should note that the Committee has sought assurance from within the Trust through a direct presentation from a division on the effectiveness of the revised annual planning and budget setting process applied this year.</i> <i>The Board can also take assurance that the Committee will secure assurance that the Trust's green plan will be adjusted to match the revised national guidance.</i>				
What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s) being made)</i>	<i>The Board can receive the Trust's integrated performance report relating to operational and financial performance with confidence that the Committee has discussed the plans to address the risks in achieving the Trust's annual delivery plan and supported the recommendation at this stage to continue with the current control environment and actions.</i> <i>The Board can receive the BAF with confidence that the content and score for strategic risks 4, 5 and 6 have been scrutinised by the Finance and Performance Assurance Committee.</i>				

Recommendation (linked to What Next section)	The Board is asked to NOTE - The Committee was quorate and considered all the expected reports in line with its schedule of business - The Committee's assurance over the Trust's current plans and controls for the delivery of its annual financial and operational plan - The Committee's recommendation of the scores for their allocated elements of the BAF, strategic risks 4, 5 and 6.					
Assurance / Scrutiny route already undertaken						
Link to Trust Strategy (note which theme)	Patients	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan	<i>The Committee provides oversight of the delivery of the Trust's annual financial and operational plan delivery</i>					
Link to BAF	<i>The Committee has oversight of the key assurances referred to within the BAF for strategic risks 4, 5 and 6 and through their scrutiny of these recorded assurances consider and recommend to the Board their relevant current scores.</i>					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	Yes	Not directly	Not directly	Not directly	Yes	Yes
Other impacts	Equality and Diversity (if yes has HEIA completed)		Environmental		Legal	External Registrations (if yes please indicate which)
	N/A		N/A		Yes	<i>The Trust is required to maintain an effective system of governance, risk management and internal control (FT Code of Governance / FT Licence)</i>

Finance and Performance Assurance Committee Chair's Report

The Finance and Performance Assurance Committee met in each of the months of May, June and July and was quorate at each meeting with at least two NEDs and two Executives present including the Chief Operating Officer and Chief Financial Officer present at each meeting. The Committee at each meeting received its scheduled items of business.

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

Quarter 1 2025/26 Financial Performance Report

At each meeting, the FPC received a report from the Chief Financial Officer on the financial position against the Trust's Break-Even financial plan. The report showed that the Trust had month on month and year to date met its submitted plan.

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

Whilst the Trust had achieved its overall financial plan for each of the three months in quarter 1 there were areas of individual variance. The Committee discussed the plans to mitigate these and the continuation with the Trust's grip and control measures. The Committee welcomed the high-level underlying run rate analysis within the report and noted the reported improvement month on month over the quarter. The Committee discussed the Trust's mechanisms for engaging with the Divisions who were adverse to their run rate plans. The Committee **noted** that a tiered escalation approach was in place utilising the revised divisional accountability meetings led by the Chief Operating Officer. The Committee **noted** the Chief Financial Officer's update on the work to be undertaken during the next month to review for each clinical and corporate division their forecasts to the year end to allow a detailed discussion to be held at the September Committee meeting as to any further grip and control measures that may need to be applied in line with the principles set out with the Board.

The Committee also **discussed** at length the impact the Trust's current deficit position was having on its cash position. The Committee recognised that the short-term cash management actions were effective and whilst the payment to suppliers within 30 days had reduced overall work was targeted at small, local and critical suppliers. The Committee expressed concern over the medium to longer term cash forecasting processes given the reported volatility in the monthly cash position to that within the annual forecast and **asked** for the new Director of Operational Finance to review these processes and bring a report back to the Committee on his finding and any actions.

Efficiency and productivity

The Committee **received** the schedule efficiency and productivity reports at each of its meetings across the quarter. At month 3 the Committee noted that some £97.6m of the revised £109m plan had been assured as having robust plans to deliver and these schemes were progressing into their delivery phase. The plan itself was slightly ahead of planned delivery at month 3 but the Committee recognised the significant delivery expectation in the latter quarter of the year for which those schemes had yet to be assured. The Committee **discussed** this risk and were informed of possible mitigations that are all being looked at. The Committee discussed their concern as to the Trust's capacity to deal with the larger schemes in the latter quarter along with the ambitious capital and transformation programme for the year. The Committee **noted** the update from the Chief Financial Officer on the actions being taken to de-risk the programme.

The Committee was **assured** over the process and diligence being applied to the review of the efficiency programme both centrally and divisionally recognising that at September of last year only some £31m of efficiencies (34% of plan) had been identified (assured) and that for this year by July we had assured some £97.6m (87% of target)

The Committee **agreed** that the regular reporting of the progress of this key plank of the Trust's financial plan would continue to be reported to each Committee meeting recognising the inherent risk that was built into the plan and the possible impact of further industrial action.

Capital

The Committee **noted** that the Trust was at quarter 3 ahead of its capital plan delivery linked to the acceleration of a number of key projects aligned to improving UEC performance and that the full year plan is expected to deliver within the original budget.

The Committee also **noted** the work to develop the Trust's longer term 5 year and was assured over the process for divisional engagement to determine their priorities. The Director of Capital confirmed that the developing plan is being aligned to the Strategy.

The Committee **discussed** that the plan needed to be aligned to the known backlog maintenance and wider estates infrastructure risks

Investment decisions

The Committee in line with its delegated authority **approved** the plan to extend the hours of operation of the mechanical thrombectomy service, the purchase of an MRI Scanner and the enabling work for the Acute Floor Reconfiguration.

Quarter 1 2025/26 Operational Performance

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

The Committee discussed the Trust operational performance report and **noted**:

For urgent and emergency care (UEC) the Trust for quarter 1 saw its 4-hour performance increase to just below 73% which was below the NHS national average performance for the quarter. The 12-hour performance reduced significantly in the quarter with St Richards making the most improvement of all the four Trust A&E departments. The Trust also saw a reduction in ambulance hand over delays at all sites. The Trust through these performance gains was **assured** that the revised UEC action plans were appropriately focused.

Referral to treatment performance saw for a quarter a further improvement to 51.3% which was marginally ahead of the Trust's activity plan for the quarter. The Committee did however **note** the risk within the 65-week patient cohort and **discussed** the plans the Trust has in place to address this recognising that many of the longest waiting patients have complex needs. The Committee was also informed of a specific improvement plan to support the performance within dermatology and **noted** the expected impact of this plan on performance for the next reporting period.

Cancer performance saw a dip in performance in the first quarter of the year narrowly missing the 62-day target with a performance of 61.2%. The faster diagnostic standard performance was just under 75% for the quarter. The Committee **discussed** the dip and

performance and noted that attention had been given to reducing the longest waiting patients securing a reduction in the overall backlog of patients. The Committee **recognised** the patient quality benefits in pursuing that course of action.

In respect of the Trust's diagnostic performance this was ahead of trajectory and sees the Trust within the top quartile of national performance and **noted** that on this run rate the Trust is on track to achieve the 5% target by the year end.

The Committee **recognised** that the period of industrial action whilst handled well by the Trust and its staff did see regrettably some patients' appointments cancelled and whilst all outpatients and the majority of in patients has been rebooked by the time of the meeting this would have an impact on operational performance at the start of quarter 2. The Committee also discussed the plans for winter and were informed that a detailed winter planning paper would be presented to the Board in September.

Worthing and St Richards Surgical Division presentation

The Committee as part of seeking wider input into its process of assuring the Committee received a presentation from the Worthing and St Richards Surgical Division on the Trust's annual planning and budget setting process for 2024/25.

The Committee was **informed** that the process that supported this year's annual plan production was open and collegiate, and this had allowed for a deeper level of engagement to be had with the directorates within the division securing a greater buy in to the final plan and a sense of shared responsibility for its delivery. There has also been a greater openness as to the overall financial context the Trust is operating within. The reset of the budgets for the division was welcomed along with the freedom for the Division to set its priorities within the context of the overall plan which had allowed it to address some long standing resourcing challenges in the area of quality governance.

The Committee **heard** the reflection on what lessons from this last round could be taken into the next round and noted the agreement made by the Finance team to support these with greater training and for the process to commence earlier along with a desire to simplify the data requests.

Environmental Sustainability Report

The Committee **received** a report on the Trust delivery against its developed green plan noting that there has been national guidance issued that will see the plan revised to move its focus to climate adaptation rather than a drive for de-carbonisation. The Committee noted the impact of the changes in the Trust's estate had had in respect of carbon emissions with the Trust LMB increasing the Trust estates footprint.

The Committee **noted** that the revised plan will be developed over the next six months to allow for engagement to enable a clear adaptation focus to be brought into the milestone actions.

Risk and the Board Assurance Framework

The Committee **reflected** on the reports received and the key operational and financial risks they describe and unitised this information when scrutinising their allocated elements of the Board Assurance Framework relating to strategic risks 4, 5 and 6, these being

- risk 4 *We are unable to progress towards medium-term financial sustainability, driven by a failure to deliver the in-year financial plan and/or actions to return to a break-even run rate by M12 2026/27 along with national funding realignment away from Sussex ICB,*

- risk 5 *We are unable to maintain the condition of our non-digital infrastructure or support the required capital investments to deliver our strategic ambitions and*
- risk 6 *We are unable to configure our services and sites to enable us to deliver the Trust's annual performance plan leading to patients having a poor experience and increased safety risks due to extended waits for their treatment.*

Through the information recorded in the BAF, the reports received at the July meeting the Committee **agreed** their prospective quarter 2 scores should not reduce from those recorded at quarter 1.

Referrals to other Committees

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

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details						
Meeting Date	29 May 2025	Chair	Bindesh Shah	Quorate	Yes	
Meeting Date	26 June 2025	Chair	Philip Hogan	Quorate	Yes	
Meeting Date	31 July 2025	Chair	Philip Hogan	Quorate	Yes	
Declarations of Interest	No declarations were raised					
Items received at the Committee meeting						
<u>2025/26 Quarter 1 Financial Performance Report</u> - monthly position - cash reporting - grip and control reports	May	June	July	Presenter Chief Finance Officer / Director of Operational Finance (Jun)	Purpose For assurance	Outcome /Action taken Noted M3 position and delivery that was in line with the submitted plan.
<u>2025/26 Quarter 1 Efficiency & Productivity Reporting</u> - monthly position and assurance process	May	June	July	Presenter Chief Finance Officer / Efficiency Director	Purpose To inform the committee on the update on the 2025/26 plan delivery	Outcome /Action taken Noted the Trust position and the work to manage the inherent risk in the latter quarter of the plan
<u>Capital Investment Progress Report</u> Update on Capital Plan for 2025/26 delivery and the development of the longer term five year plan	May	June	July	Presenter Director of Capital Planning	Purpose To update on the implementation of the 2025/26 capital plan & set out actual position at Q1 end.	Outcome /Action taken Noted the delivery of the was slightly ahead of the plan in quarter 3 and the process for the development of the longer term five year plan
<u>Seagry Report and Draft Action Plan</u>		June		Presenter Chief Finance Officer	Purpose To inform the committee on the work undertaken by the ICS	Outcome /Action taken The committee noted the independent review that all Trusts across Sussex agreed with the ICB for a sense of check of robust delivery processes. This

						showed no areas of risk unknown to the Trust.
Commercial Progress Report Q1 2025/26 including Procurement Update			Jul	Presenter Commercial Director	Purpose To Note	Outcome /Action taken Noted activity undertaken by the commercial directorate
Quarter 1 Environmental Sustainability Report			July	Presenter Chief Finance Officer	Purpose To Note	Outcome /Action taken Noted the activity being undertaken and the move to a focus on climate adaptations
Sussex pathology network memorandum of understanding			July	Presenter Commercial Director	Purpose To note the updated document	Outcome /Action taken Noted
Operational Performance Reporting ▪ Performance Scorecard ▪ Constitutional Standards Performance Report	May	June	July	Presenters Director of Performance and BI / Chief Operating Officer	Purpose For information	Outcome /Action taken Noted progress in elective recovery, diagnostics, and cancer pathways. The level of improvement in urgent & emergency care remains insufficient.
ICS System Update	May	June	July	Presenter Chief Finance Officer/ Chair of Committee	Purpose For information	Outcome /Action taken Noted the work being undertaken within the ICS.
<u>Deep Dive into Cancer 31 day performance</u>		Jun		Presenter Chief Operating Officer	Purpose For information	Outcome /Action taken Discussed and noted the challenges and improvements in the areas of radiotherapy, surgery and chemotherapy
<u>SRH and WRG Surgery Divisional Update</u>			July	Presenter Divisional Leadership Team	Purpose For information	Outcome /Action taken Noted the assurance provide by the Service on the improved annual planning and budget setting process.

<u>3Ts update</u>		Jun		Presenter Chief Operating Officer	Purpose For information	Outcome /Action taken Noted Sussex Cancer Centre – Capital & Revenue Update. Noted continued progression and timescales for national approval.
<u>National Costs Collection Submission Report</u> - Pre submission report - Final submission	May		July	Presenter Director of Strategic Finance	Purpose To note the approach and the final submission.	Outcome /Action taken The Committee noted the approach to preparing and submitting the 2024/25 National Cost Collection and Noted the final submission in July.
<u>Worthing Heat Network Lessons Learnt report</u>		Jun		Presenter Commercial Director	Purpose For information	Outcome /Action taken The committee noted the report that outlined the factors that had led to delayed delivery of heat connection and resultant loss of grant funding
<u>Investment Decisions & Contract Recommendations</u> - mechanical thrombectomy service	May			Presenter Chief Finance Officer/ Chief of Service-Specialist Division	Purpose To Approve	Outcome /Action taken The Committee approved the plan to extend the hours of operation of the mechanical thrombectomy service
<u>Investment Decisions & Contract Recommendations</u> - purchase of a MRI Scanner and - the enabling work for the Acute Floor Reconfiguration.			July	Presenter Chief Finance Officer	Purpose To Approve	Outcome /Action taken The Committee approved the purchase of a MRI Scanner and the enabling work for the Acute Floor Reconfiguration.
<u>CQC allocated actions oversight assurance register</u>			July	Presenter Chief Finance Officer /	Purpose For discussion and assurance over delivery	Outcome The Committee agreed the level of assurance of progress was bit

						asked for clearer cross referencing to be provided as the specific reports providing the evidence of oversight.
<u>Risk and Board Assurance Framework</u>			July	Presenter Chief Finance Officer / Company Secretary	Purpose To agree whether risks at the end of Q1 are fairly stated.	Outcome /Action taken The Committee reviewed their allocated elements and agreed with the Executives' recommendation there are no changes for Q2 from the Q1 scores.



Agenda Item:	17.	Meeting:	Trust Board in Public	Meeting Date:	4 September 2025
Report Title:	Strategy and Major Projects Assurance Committee Chair's Report				
Author(s):	Paul Layzell – NED & Committee Chair				
Purpose of the report: (indicate as appropriate)	For Decision	For Assurance	For Discussion	For Information only	
	N/A	Yes	Yes	N/A	
Reason for not being taken in public (indicate as appropriate)	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement					
Summary of the report describing		The report provides information over the business undertaken at the Strategy and Assurance Committee in July 2025.			
What (summary of current position / issue & why it matters and evidence to support that position etc)		The Committee meeting was quorate at this meeting and received its scheduled business.			
So What (provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)		The Board should note, given this was only the second meeting of the Committee, and many reports were new, there were productive conversations with the report authors on the report content development to enhance the effectiveness of the meetings. The Board can take assurance from the oversight provided by this Committee that there are sound process for the development of the Strategy Delivery Plan. The Board can be assured over the progress of the majority of the major projects within the major projects portfolio. For those flagged by the Strategy and Major Projects Programme Board as having some degree of delivery risk the Committee discussed these and the level of reporting they desired to receive in future meetings in respect of remedial action plans and interdependency risks on other projects in the overall portfolio. The Committee for the acute floor reconfiguration project sought greater detail on action plan in relation to bringing the scheme back on track.			
What Next (summary of intended action and benefits supporting the choices and recommendation(s)being made)		The Board can take assurance through the work of the Committee that focus is being provided to the areas of strategy delivery development and oversight on the major projects portfolio delivery. The Board can also receive the BAF with confidence that the content and score for strategic risks 10 and 11 have been scrutinised by the Strategy and Major Projects Assurance Committee who agreed with the Executives' recommendations to make no change for quarter 2.			

Recommendation <i>(linked to What Next section)</i>	The Board is asked to NOTE - The Committee was quorate and considered all the expected reports in line with its schedule of business - The Committee's request for detail on the acute floor reconfiguration project action plan - The Committee's review of the Strategy Delivery plan and its confirmation that the items listed were appropriate - The Committee's recommendation of the scores for their allocated elements of the BAF, strategic risks 10 and 11.					
Assurance / Scrutiny route already undertaken <i>(please explain where matter previously considered, and assurance provided)</i>						
Link to Trust Strategy <i>(note which theme)</i>	Patient Yes	People Yes	Future Yes	Communities Yes	One UHSussex Yes	Culture Yes
Link to annual delivery plan	<i>The Committee provides oversight of the delivery of the Trust's major projects aligned to the Trust's Strategy which support the delivery of the Trust's annual plan.</i>					
Link to BAF <i>(explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)</i>	<i>The Committee has oversight of the key assurances referred to within the BAF for strategic risks 10 and 11 and through their scrutiny of these recorded assurances consider and recommend to the Board their relevant current scores.</i>					
Link to CQC domain	Safe N/A	Caring N/A	Effective N/A	Responsive N/A	Well-led Yes	Use of Resources N/A
Other impacts	Equality and Diversity (if yes has HEIA completed)		Environmental	Legal	External Registrations (if yes please indicate which)	
	N/A		N/A	Yes	<i>The Trust is required to maintain an effective system of governance, risk management and internal control (FT Code of Governance / FT Licence)</i>	

Strategy and Major Projects Assurance Committee Chair's Report

The Strategy and Major Projects Assurance Committee met on the 31 July 2025 and was quorate with three NEDs and three Executives present, including the Chief Strategy Officer who is the lead executive for the Committee. In attendance were also the Director of Strategy, Director of Capital, Director of Strategic Finance, Director of HR Operations, Company Secretary and for their item the Clinical Director of Research.

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

Major Projects

The Committee received a report on the overall major projects portfolio, a report of the major project pipeline, reports on the Clinical Research Facility project and a report on the Helideck. The Committee also received a report on the capital funding for the portfolio projects.

The Committee discussed the content of these reports and provided feedback on how their content could be enhanced to support the work of the Committee. For the project pipeline, the Committee asked for addition of information on the assessment process leading to their recommendation or not for inclusion.

The Committee focused on projects where any of the cost, time or quality indicators were amber or red, which included the RSCH Acute Floor Reconfiguration (AFR) project, where no further information, in the form of a separate report, had been presented.

The AFR project was discussed, including the drivers of the risk assessment. The Committee agreed that the next meeting should receive a formal report on the outcome of actions being taken currently to bring the project back on track.

The Committee received a report on the Helideck project and noted the key decision dates in Quarter 3 and were assured that the work that was being undertaken will report back for that timescale.

In respect of the Clinical Research Facility, the Committee agreed with the recommendation from the Programme Board to revise the scope of the feasibility study to align to a more strategically aligned space in the LMB and for the feasibility of two Hubs, one at Worthing and one at Princess Royal hospitals, to be included.

Trust Strategy Delivery Plan

The Committee considered the paper provided and agreed it clearly articulated the key year 1 and year 2 priorities. The Committee also held a discussion about the Trust Strategy more widely and agreed to ensure that the golden thread of cultural change is more clearly brought out with a mapping of those key areas of the strategy that will bring the biggest cultural change. This aligned to a discussion at the People and Culture Committee the previous day where having that drawn out will aid the development of a cultural scorecard.

Board Assurance Framework

The Committee scrutinised its allocated element of the Board Assurance Framework relating to strategic risks 10 and 11, these being risk 10 *We are unable to successfully develop and*

deliver our plans which configure our sites and services in a way that aligns with system partners and the ICS strategy and risk 11 We are unable to support, guide and deliver the level of change required to successfully deliver the strategy.

Through the information recorded in the BAF, the reports received at the July meeting the Committee agreed that there should be no changes for quarter 2 to the scores from those agreed at Board for quarter 1

Referrals to other Committees

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

Appendix 1**COMMITTEE HIGHLIGHTS REPORT TO BOARD**

Meeting Details					
Meeting Date	31 July 2025	Chair	Paul Layzell	Quorate	Yes
Declarations of Interest	No declarations were raised				
Items received at the Committee meeting					
Item	Presenter	Purpose of the paper	Action Taken		
Strategy and Major Projects Programme Board Chair's report	Chief Strategy Officer	To provide context for the papers being considered at the meeting	The Committee noted the report of the Strategy and Major Projects Programme Board Chair which provided clarity over this Committee's reporting group's remit. The Committee noted through this report that the Programme Board have received an update on each major project allowing for it to support the respective reports to the Committee.		
Major Project Portfolio Overview report including the major project pipeline	Director of Strategy	To note	The Committee noted the update which summaries for the portfolio as a whole and for each project their position, the interdependencies between projects and the key project delivery risks. The Committee discussed the acute floor reconfiguration project that was flagged having some risk and sought a formal report on the action plan for the next committee The Committee also sought further information be added to the report especially to support the recommendation to add or not new projects to the portfolio.		
Clinical Research Facility Plan	Clinical Director of Research	To note	The Committee agreed with the proposal to revise the scope of this project		
Helipad Update	Director of Capital	To note	The Committee discussed this report and the ongoing work to enable the		

			next decision to be made in quarter 3.
Major Project Portfolio Financial Profile	Director of Strategic Finance	To note	The Committee noted the report and agreed with the suggested improvements to include alongside the project capital costs the revenue costs and planned revenue (productivity) benefits The Committee recognised that the overall Medium Term Financial Model of which the major project portfolio is one part will be reported to the Finance and Performance Committee.
Trust Strategy Delivery Plan update	Director of Strategy	To discuss	The Committee considered the paper provided and agreed it clearly articulated the key year 1 and year 2 deliverables
System Developments	Chief Strategy Officer	To note the wider context the Trust operates in	The Committee noted this update and was assured that the Trust is continuing to engage with the system partners.
Board Assurance Framework	Company Secretary	To review and recommend to the Board the scores for strategic risks 10 and 11	The Committee considered the relevant segments of the BAF and alongside the reports received at the meeting agreed with the executives view of the risk scores.

Agenda Item:	18.	Meeting:	Trust Board in Public	Meeting Date:	4 September 2025
Report Title:	Audit Committee Chair's Report				
Author(s):	Philip Hogan – NED & Committee Chair for this meeting				
Purpose of the report: (indicate as appropriate)	For Decision	For Assurance	For Discussion	For Information only	
	N/A	Yes	Yes	N/A	
Reason for not being taken in public (indicate as appropriate)	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement					
Summary of the report describing		The report provides information over the business undertaken and the Audit Committee in July 2025.			
What (summary of current position / issue & why it matters and evidence to support that position etc)		The Committee meeting was quorate at this meeting and received its scheduled business covering internal audit, counter fraud, a brief update on the external audit process for 25/26, agreeing the annual accounts report to the Council of Governors, and scrutinising risk management and control reports.			
		The Committee also agreed the final stages of the process to appoint the Trust's external auditors on the termination of the current contract.			
So What (provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)		The Board can take assurance from the oversight provided by this Committee over the systems and processes supporting the Trust's Board Assurance Framework including the plan to evolve the risk management process as the Trust matures it's understanding and use of risk within its business.			
		The Board can take assurance on the divisional application of the Trust's risk management policy for the recording of risks, however, the Board should note when considering the BAF the acknowledged lag in the adjustment of the scores for the BAF underpinning highly scored risks to reflect the impact the documented controls are having on the scores, which seems many of these risks showing a too high a current score.			
		The Committee Chair for the period 2024 / 2025 provided an annual report summarising the activity of the Committee and through this the Board can take assurance over the Committee's fulfilment of its terms of reference. (appendix 2)			
What Next (summary of intended action and benefits supporting the choices and recommendation(s)being made)		The Board can take assurance through the work of the Audit Committee on the underlying processes in support of the Trust's BAF and that it referred items linked to the activity of other Committees where of value.			
Recommendation (linked to What Next section)		The Board is asked to NOTE - The Committee was quorate and considered all the expected reports in line with its schedule of business - The Committee's assurance over underlying BAF processes - The Committee chair's report on the activity of the Committee for the 2024/25 year.			

	- The Committee agreed the final stages of the process to appoint the Trust's external auditors at the termination of the current contract.					
Assurance / Scrutiny route already undertaken (please explain where matter previously considered, and assurance provided)						
Link to Trust Strategy (note which theme)	Care	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan	The Audit Committee provides oversight of the Trust's systems of risk management and internal control which underpin the delivery of the Trust's annual plan.					
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	The Committee has oversight of the application of the BAF process with each allocated Board Committee having responsibility for the scrutiny of the recorded assurances supporting the determined current quarterly scores.					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	N/A	N/A	N/A	N/A	Yes	N/A
Other impacts	Equality and Diversity (if yes has HEIA completed)	Environmental		Legal	External Registrations (if yes please indicate which)	
	N/A	N/A		Yes	The Trust is required to maintain an effective system of governance, risk management and internal control (FT Code of Governance / FT Licence)	

Audit Committee Chair's Report

The Audit Committee met on the 22 July 2025 and was quorate and received all its planned business. In attendance were the Chief Financial Officer, the Acting Chief Executive, the Trust's Operational Finance Director, Deputy Director of Finance – operational finance, and Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members. The Chief Information Officer and Head of Information Governance and Data Protection Officer attended for the Data Security and Protection Toolkit report and the Trust's Procurement Officer attended for the relevant report on tender waivers compliance.

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

Risk Management and BAF reports

The Committee considered, reviewed and discussed the underlying processes for the maintenance of the Trust's BAF and as a result were assured over the continuing effectiveness of these processes.

The Committee recognised the confidence the risk management policy compliance report provided over the clinical and corporate divisional processes for registering risks. The Committee discussed the Board's wider reflection that within the organisation there needs to be a shift in focus in this area to address the lag in reflecting the impact of recorded controls is having on the recorded risk scores. The Committee also reflected that whilst commendable work had been undertaken to improve compliance with the established processes, with the increased confidence in the basics there was a now a need to undertake work to remove the recording of issues to allow true risk recording to take place alongside supporting a more wider cultural change to focus on utilising data over the effectiveness of the identified controls to ensure the risk scores better represent the real as to perceived risks.

Internal Audit activity

The Committee received a report on the Internal Audit work undertaken in the quarter and noted the negative assurance opinion on the design of the Trust's system of internal control in respect of ERF data quality, noting this was an identified by executive management as an area of concern and thus the inclusion of this work within the annual IA plan. The Chief Financial Officer provided assurance that the findings were being addressed, and oversight of their delivery would fall to himself. The Committee asked that as part of the 2025/26 internal audit plan a complementary piece of work on wider clinical coding be included to secure assurance on these processes which were also key to addressing the weaknesses identified from this specific work.

The Committee received a request for a change to the internal plan for 2025/26 and approved the incorporation of a review of the Trust's CNST compliance processes in 2025/26.

The Committee noted the positive opinions in respect of the audits covering MHAct compliance and Trust Quality Scorecard.

The Committee also received an update on the progress made by management in delivering the agreed improvement recommendations. The Committee noted the increase in those recommendations where no update had been provided by management. The Committee was informed that the Chief Operating Officer is to meet with the respective director leads to secure the relevant updates for each of the outstanding recommendations.

Data Security Protection Toolkit

The Committee received the report confirming that whilst the assessment criteria had changed significantly for this year, 2024/25, the Trust has established a process of seeking, validating and learning from the assurances being obtained against the established standards. The Committee was informed that the Trust made its required submission by the deadline of the end of June supported by an improvement plan. The submission and associated improvement plan have been accepted and approved by NHSE. The Committee was informed that the improvement plan has a delivery timescale of December 2025.

Local Counter Fraud activity

The Committee considered the Local Counter Fraud progress report for Quarter 1 2025/26 in relation to their work undertaken in respect of reported concerns. The Committee was also updated in response to the actions taken in respect of any reported concerns. Through this report and the update provided by the Trust's Local Counter Fraud Specialists the Committee noted there were no significant fraud risks which Trust needed to be actioned urgently.

The Committee in receiving the LCFS benchmarking report in respect of the level of reactive work at the Trust in comparison to their other clients noted that the Trust's referral patterns and sources of referrals were relatively comparable and took confidence over the quality of referrals at the Trust.

Annual Review of the Trust's External Auditors

The Committee received an update on the performance of the Trust's external auditors and agreed that this was a correct reflection of their work for the 2024/25 year and therefore agreed for it to be presented to the Council of Governors.

Annual Audit Committee Report for 2024/25

The Committee noted the report from the Audit Committee chair for the period to June 2025 and agreed this reflected the work of the Committee and provided assurance that the Committee had met its terms of reference.

Referrals to other Committees

The Committee agreed to share the Internal Audit think piece report on consultant job planning with the whole Board for their information given the work the Trust is undertaking in this area which reports to the People and Culture Committee. The report is encouraging Trusts to accelerate the delivery of this work given the 'pandemic' is now some years behind us.

The Committee referred the early learning review in relation to the losses relating to the failure of a cold store to the Patient and Quality Assurance Committee to secure confidence that all lessons have been learnt.

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	22 July 2025	Chair	Phil Hogan for this meeting	Quorate	Yes
Declarations of Interest	No declarations were raised				
Items received at the Committee meeting					
Item	Presenter	Purpose of the paper	Action Taken		
Board Assurance Framework	Company Secretary	For assurance over the application of the Trust's process	The Committee considered, reviewed and discussed the underlying processes for the maintenance of the Trust's BAF and as a result were assured over the continuing effectiveness of these processes.		
Risk Management Policy Compliance report	Company Secretary	For assurance over the application of the Trust's process	The Committee recognised the confidence the risk management policy compliance report provided over the clinical and corporate divisional processes for registering risks. The Committee discussed the Board's wider reflection that within the organisation there needs to be a shift in focus in this area to addressing the lag in reflecting the impact of recorded controls is having on the recorded risk scores. The Committee also reflected that whilst commendable work had been undertaken to improve compliance with the established processes, with the increased confidence in the basics there is a now a need to undertake work to remove the recording of issues to allow true risk recording to talk place alongside supporting a more wider cultural change to focus on utilising data over the effectiveness of the identified controls to ensure the risk scores better represent the real as to perceived risks.		

Internal Audit Reports - Activity Progress Report - Recommendation Follow Up Report	BDO (Internal Auditors)	For assurance over respective areas of internal control	The Committee noted the work undertaken in the quarter. The Committee noted the negative assurance opinion on the design of the Trust's system of internal control in respect of ERF forecasting data quality noting this was an area identified by executive management as one of a concern at the end of the prior year. The Chief Financial Officer provided assurance that the findings are being addressed, and oversight of their delivery would fall to himself overseen by the Finance and Performance Committee. The Chief Financial Officer informed the Committee that he is engaging with Internal Audit to determine if as part of the 2025/26 internal audit plan a complementary piece of work on wider income and activity recording could be included in the plan. The Committee recognised that such a review would be valuable. The Committee noted the positive opinion in respect of the audits covering Mental Health Act compliance and the Trust Quality Scorecard processes. The Committee reflected that the management responses to each of these recommendations will address the improvements identified. The Committee received the report in relation to their review of the Trust's Data Protection Security Toolkit submission, with Internal Audit explaining the national methodology applied for the provision of their conclusion. The Committee received a request for a change to the internal plan for 2025/26 and approved the incorporation of a review of the Trust's CNST compliance processes in 2025/26. The Committee received an update on the progress made by	

			management in delivering the agreed improvement recommendations. The Committee noted the increase in those recommendations where no update had been provided by management. The Committee was informed that the Chief Operating Officer is to meet with the respective director leads to secure the relevant updates for each of the outstanding recommendations.
Data Security and Protection Toolkit 2024/25	Chief Information Officer and Information Governance Manager / Data Protection Officer	To note the progress made and receive an update on the Trusts processes	The Committee was reminded that the assessment criteria has significantly changed for 2024/25 and whilst the Internal Audit findings were valid at a point of time the Trust made its required submission supported by an improvement plan which has been accepted and approved by NHS E. The Committee was informed that the improvement plan addresses all the matters identified by Internal Audit. The Committee was informed that the improvement plan has a delivery timescale of December 2025 and we have a track record of delivering such improvements within the health records fields. The Committee endorsed the focus on corporate records management and the benefits this will bring. The Committee noted this report is also considered at the RI&D Assurance Committee next week.
Counter Fraud Reports - Activity Progress Report - Reactive Benchmarking Report	RSM (LCFS)	For assurance over respective areas of internal control and for information on the Trust's fraud profile	The Committee noted the work undertaken by the counter fraud team, that there were no elevated fraud risks from the work in the first quarter of the year. The Committee in receiving the LCFS benchmarking report in respect of the level of reactive work at the Trust in comparison to their other clients noted that the Trust's referral patterns and sources of

			referrals were comparable and took confidence over the quality of referrals at the Trust.
External Audit Update - Progress report	GT (External Audit)	To note status of the External Audit work	The Committee noted that the 2024/25 external audit had been concluded with opinions issued and there is a plan to undertake the annual wash up with the Trust to pursue any lessons learnt from the 2024/25 year for the 2025/26 work.
Annual Review of the Trust's External Auditors	Deputy Director of Finance - Operational Finance	To review and recommend to the Council of Governors	The Committee received an update on the performance of the Trust's external auditors and agreed that this was a sound reflection of their work for the 2024/25 year and therefore agreed for it to be presented to the Council of Governors.
Losses, Special Payments and Overpayments Register	Deputy Director of Finance - Operational Finance	To note the report and the assurance it provides over the application of the Trust's processes.	The Committee took assurance from the continued comparably low value of losses and special payments. The Committee received the outcome of the early learning review undertaken in respect of losses as a result of a failure of a cold store. The Committee agreed to refer this matter to the Patient and Quality Committee asking them to secure confidence over lessons learnt potentially via the Estates Improvement Group reporting to that Committee. The Committee received an update from the Chief Procurement Officer on the work being undertaken to ensure that equipment maintenance is recognised at the time of equipment purchase along with the remediation of establishing maintenance programmes. The Committee chair asked that a report on the process for payments to critical suppliers and those to those of local suppliers be provided within the routine reporting to the Finance and Performance Committee.

Tender Waiver Report	Commercial Director	To note the report and the assurance it provides over the application of the Trust's processes.	The Committee noted the continuing relatively low level of these across the year and in the quarter and through discussion the Committee was assured over the processes being applied to support the review of Waivers.
Health and Safety Committee Chairs Report	Company Secretary	Provision of information on the activity of this Committee and that Committee's view of the Trust's Health and Safety risks.	The Committee noted the assurance provided over the meeting of the H&S Committee and the assurance provided that support has been provided by TMC with the issues identified in the meeting.
Annual Audit Committee Report for 2024/25	Committee meeting Chair	For assurance to the Board on the operation of the Committee for 2024/25	The Committee noted the report from the Audit Committee chair for the period to June 2025 and agreed this reflected the work of the Committee and provided assurance that the Committee had met its terms of reference.
External Auditor Appointment	Chief Financial Officer	For agreement	The Committee received an update on process being applied to appoint an external audit provider from 2026/27 year onwards.

Agenda Item:	19.	Meeting:	Trust Board in Public	Meeting Date:	4 September 2025
Report Title:	Company Secretary Report				
Author(s):	Glen Palethorpe – Company Secretary				
Purpose of the report: (indicate as appropriate)	For Decision	For Assurance	For discussion	For Information only	
	N/A	Yes over the quoracy of the Board and Council of Governors and the Board met its publication deadlines	N/A	Yes	
Reason for not being taken in public (indicate as appropriate)	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances (please detail)	
	N/A	N/A	N/A	N/A	
Regulatory Reporting Requirement		The Trust is required to publish its Quality Account and Annual Report and Financial Statement and to hold an AGM			
Summary of the report describing What (summary of current position / issue & why it matters and evidence to support that position etc)	The following is a summary update of matters not covered elsewhere within the Board pack				
	Non Executive Directors				
	The two newly appointed NEDs, Mike Driver and Kate Steadman commenced their terms of office on the 1 August and are being supported through their orientation.				
	Wayne Orr due to work commitments is taking a sabbatical for three months from 1 August to 31 October during which time he will not be undertaking any NED activities. The governors have agreed to “pause” Wayne’s NED tenure for this period.				
	Publication of Annual Reports				
	The Trust has published its 2024/25 Quality Account and 2024/25 Annual Report and Financial Statements. These can be found on our website by using the following links				
	2024/25 Quality Account - https://www.uhsussex.nhs.uk/resources/uhsussex-quality-accounts-report-2024-25/				
	2024/25 Annual Report & Accounts - https://www.uhsussex.nhs.uk/resources/combined-annual-report-and-accounts-2024-25/				
	The Trust is holding its Annual General Members meeting on the 30 September at 18.00 via MS Teams, the relevant teams link will be publicised in the forthcoming weeks.				
	Governor Elections				
	<u>Public Governors</u>				
	The Trust completed its election process for the Arun constituency with Yvonne Price being elected by majority.				

So What (provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)

What Next (summary of intended action and benefits supporting the choices and recommendation(s)being made)

Appointed Governors

The Trust has been informed that Cllr Mitchie Alexander will become the Brighton and Hove City Council appointed governor, an introductory meeting is being arranged to commence their induction.

West Sussex County Council confirmed that Cllr Alison Cooper will remain their appointed governor.

Staff Governors

The election for the Worthing Staff Governor concluded with the Cheryl Giles elected. Introductory meetings are being organised as part of their induction process.

Governor resignation

Claire Bewick-Holmes has confirmed given a change in her role is to end her term as staff governor for PRH at the end of July. The Chair has sent a formal thank you for here support. The Company Secretary will incorporate this vacancy within the next scheduled election process that is planned for those whose terms of office end in early to mid-2026.

Board membership and Quoracy

Whist Wayne is on sabbatical with the recruitment of the two new NEDs the Board will be able to continue to function and during this three-month period Gordon Ferns has agreed to become interim chair of the Charitable Funds Committee a position held by Wayne.

Council of Governors Membership and Quoracy

Whilst the Council will have three vacancies, two within its public constituencies and one within its staff constituencies the Council remains with 18 of its 21 positions filled so will be able to function and take decisions within its quoracy rules (there shall be present at the meeting at least one third of all Governors and of those present, at least 51% shall be elected Governors).

The Annual General Members Meeting on the 30 September provides the Trust the opportunity to present a summary of the 2024/25 year, and this meeting will be followed by a short Council of Governors meeting where the Council will formally adopt the audited 2024/25 Annual Report and Financial Statements.

Recommendation (linked to What Next section)	The Board is asked to NOTE - The Trust has published its 2024/25 Quality Account and 2024/25 Annual Report and Financial Statements in line with the required deadlines. - The successful commencement of the two new NEDs, Mike Driver and Kate Steadman - The appointment of three new Governors Yvonne Price, Cllr Mitchie Alexander and Cheryl Giles and the reappointment of Cllr Alison Cooper - The Trust's AGM will be taking place on the 30 September commencing at 18.00.					
Assurance / Scrutiny route already undertaken (please explain where matter previously considered, and assurance provided)	Not applicable					
Link to Trust Strategy (note which theme)	Patients	People	Future	Communities	One UHSussex	Culture
	Yes	Yes	Yes	Yes	Yes	Yes
Link to annual delivery plan	The Board determine the Trust's Strategy and thus the annual delivery plan					
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	Not directly					
Link to CQC domain	Safe	Caring	Effective	Responsive	Well-led	Use of Resources
	Yes	N/A	N/A	N/A	Yes	N/A
Other impacts	Equality and Diversity (if yes has HEIA completed)		Environmental	Legal	External Registrations (if yes please indicate which)	
	N/A		N/A	Yes	The Trust is required to maintain an effective Board and Council of Governors (FT Code of Governance / FT Licence)	

Trust Board in Public

04 September 2025

APPENDICES



University Hospitals Sussex
NHS Foundation Trust

Perinatal Quality Surveillance – Trust wide summary report

May Data 2025

Purpose and background

Purpose

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

Background

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

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



Introduction

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

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



Contents

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

1. Escalations and celebrations

Escalations for July meeting

- ▶ Rapid independent investigation into maternity and neonatal services announced by Wes Streeting, Secretary of State for Health and Social Care on 23rd June. UHSussex named as one of the 'most concerning' units in the country. To date, no further information about the process is known.
- ▶ Exit from Maternity Safety Support Programme delayed due to the above.
- ▶ Impact on service user confidence and staff wellbeing and morale considerable, especially those involved in the cases of the family lobby group.
- ▶ 'Outlier alert' letter received from National Maternity and Perinatal Audit (NMPA) raising concern regarding 3rd and 4th degree tear rates in 2023. Improvement work had been completed over the last 2 years as this high rate had been identified internally. Improvements were seen, however, the current 3rd and 4th degree tear rates at PRH are showing cause for concerns, immediate improvement actions in place.

Celebrations for July meeting

- ▶ 2 full-day weekday lists plus ad hoc weekend lists running at in LMB at RSCH for planned caesareans, interim solution.
- ▶ 2 team members nominated for Trust Star Awards by families were shortlisted. The Worthing team who provided bereavement care to a family won the Worthing Hospital Hero award.



2. Risk register updates

New risks:

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

- ▶ None

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

Risk No	Risk	Risk Level	Location and reason for closure
2560	Maternity wing- One out of three lifts operational- resulting in a potential delay in performing emergency procedures	12	SRH

Domains

Presentation Title

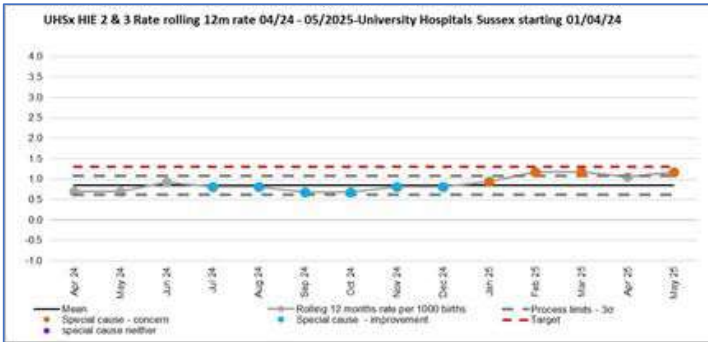
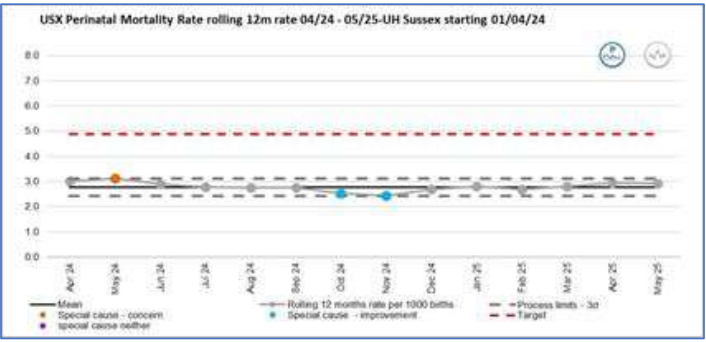
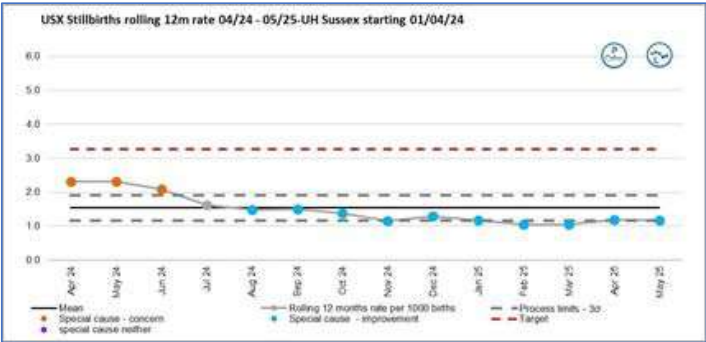
3a) Deaths and Harm

May-25	Latest MBRRACE English National Figure (May 25)	South East Benchmark (May 25)	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	1.62 (2.33 for Level 3 NNICU sites including RSCH, Jul 24 rate)	1.59	1.75	0 NNDs 12 month rolling rate is 2.29/1000	1 NNDs 12 Month rolling rate is 2.59/1000	1 NND. 12 month rolling rate is 1.40/1000	0 NNDs. 12 month rolling rate is 0.52/1000
12 Month Rolling Stillbirth Rate per 1000 births	3.27	3.17	1.17	0 Stillbirths 12 month rolling rate is 1.37/1000	1 Stillbirth 12 month rolling rate is 1.73/1000	0 Stillbirths 12 month rolling rate is 0.47/1000	0 Stillbirths 12 month rolling rate is 1.04/1000
12 Month Rolling Perinatal Mortality Rate per 1000 births	4.89 (5.66 for Level 3 NNICU sites including RSCH, Jul 24 rate)	4.76	2.92	3.66	4.32	1.87	1.56
MNSI Referrals	n/a	n/a	1 x MNSI	0 x MNSI	1 x MNSI	0 x MNSI	0 x MNSI
Serious Incidents (SI)/PSII	n/a	n/a	1 x PSII	0 x PSII	1 x PSII	0 x PSII	0 x PSII

Maternity and Neonatal Safety Investigation (MNSI) Referrals: 1 case RSCH – neonatal cooling – normal MRI

PSII (SI) cases: 1 case - Same as the MNSI case above.

Perinatal Mortality Statistical Process Control (SPC) charts



Outcomes over a 14-month period using 24/25 data as a baseline.

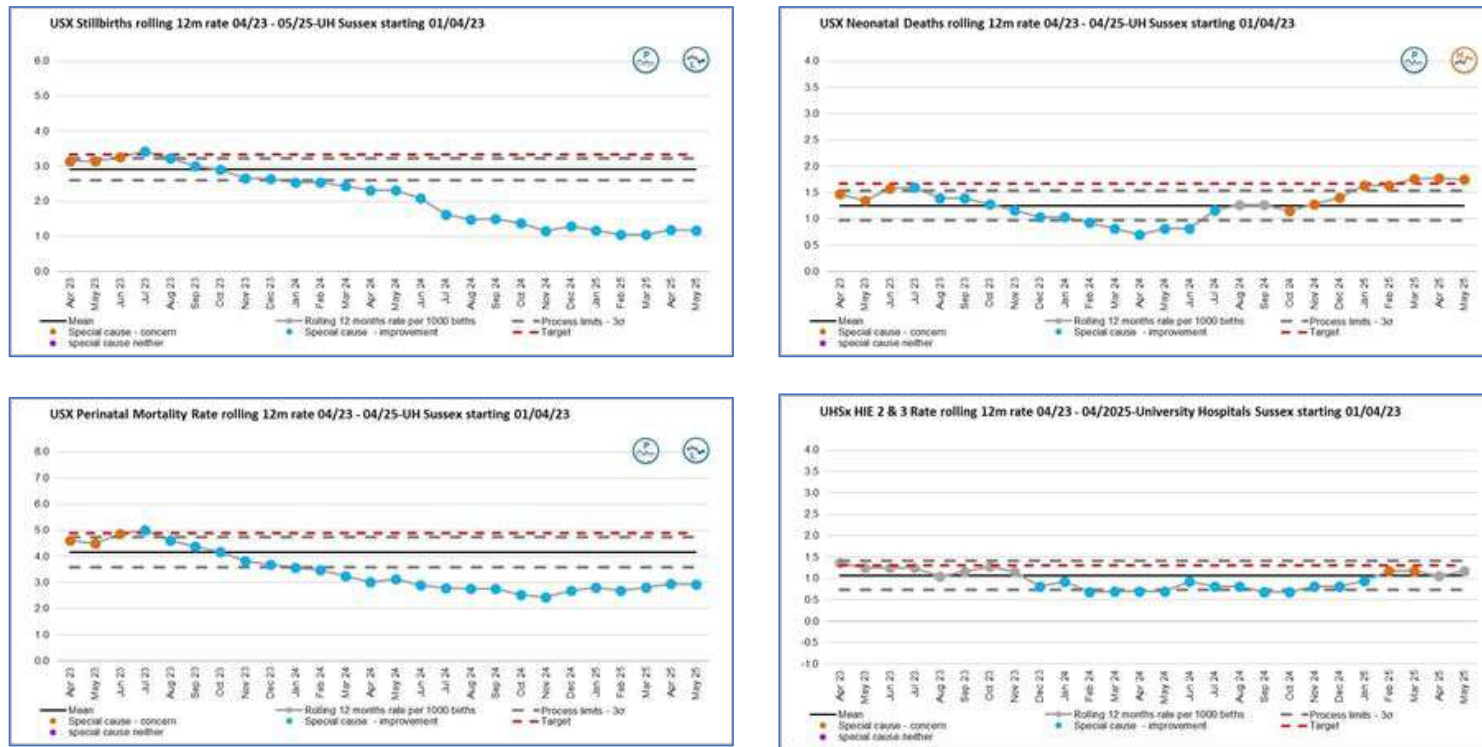
Analysis – The Board can take assurance that perinatal mortality and stillbirth rates remain stable. Thematic reviews of HIE (brain injury) and neonatal deaths have been completed and previously reported to Trust Board. Close monitoring will continue.

Thematic review of neonatal death cases has been completed and reported to Trust Board. No themes identified.

Sadly, there were two neonatal deaths in May (RSCH and SRH). On first review, there were no opportunities to prevent these deaths. The cases will be further reviewed via the Perinatal Mortality Review Tool (PMRT process)



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



Outcomes over a 26-month period using 23/24 data as a baseline.

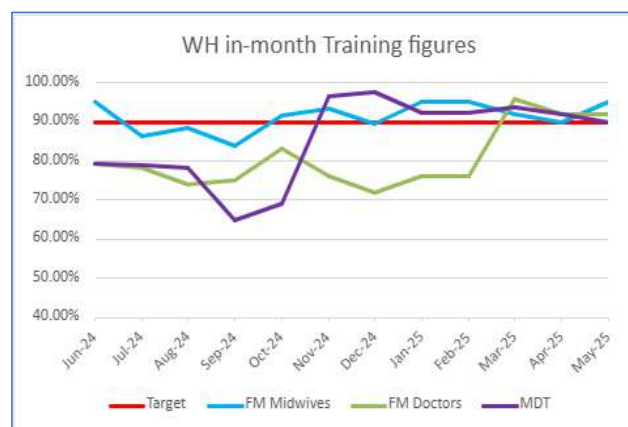
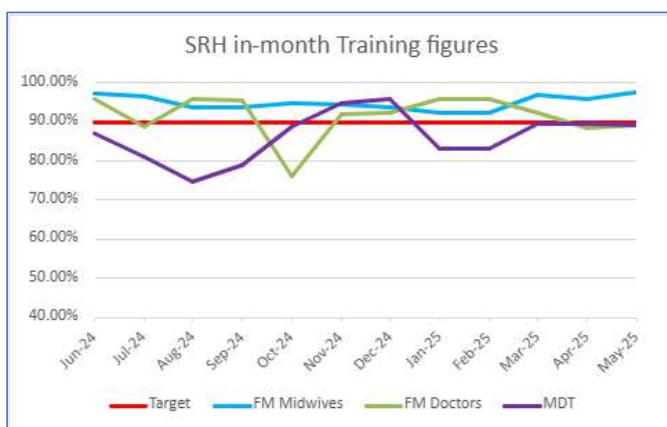
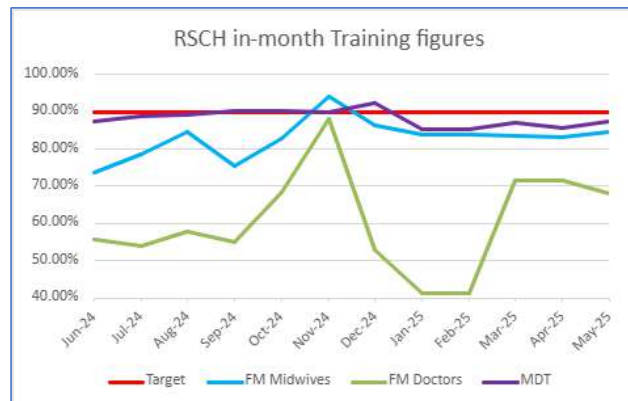
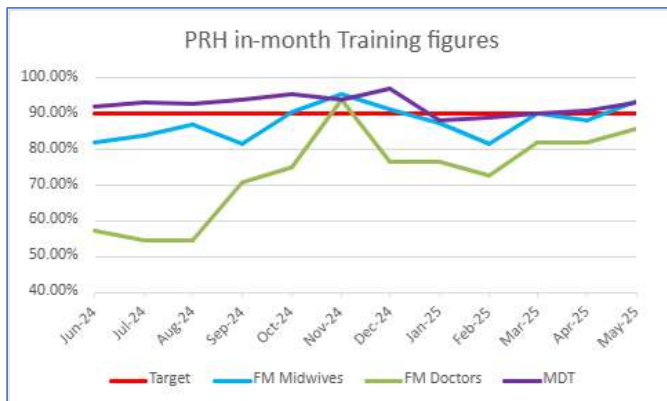
Health inequalities

- ▶ Statistical Process Control (SPC) charts for key indicators stratified to Global Majority groups and most deprived groups are compiled by the Local maternity and Neonatal System (LMNS) for individual sites. Due to the small numbers involved and high number of charts for each indicator and health inequality for each site, presentation of charts within this paper is not possible. The service leads review and analyse the data.

Analysis of May data:

- ▶ Smoking At Time of Delivery (SATOD) rates for those living in 10% most deprived area's at **SRH** showing significant statistical improvement from November 2024.
- ▶ Pre-term birth rate at **RSCH** for those living in 20% most deprived area shows significant statistical improvement from October 2024.
- ▶ As an entire service data do not demonstrate poorer outcomes for service users in Global Majority groups, however, service users living in the most deprived areas are more at risk of preterm and extreme preterm birth. Targeted continuity of carer teams are in place at RSCH/PRH and in development at WH/SRH.

3b) Leadership and training



Training compliance for medical staff at RSCH remains a cause for concern. Site leaders and the obstetric clinical director are focused on improvement.

Improvement is also required in midwifery compliance at RSCH – this will be driven by the head of midwifery.

Specialist training requirements for midwives has increased over the years due to various national requirements and now totals seven whole days per year per person. This is not allowed for in the midwifery headroom and therefore impacts fill rate and bank/agency use. This will form part of the Birth Rate Plus assessment commencing in July.

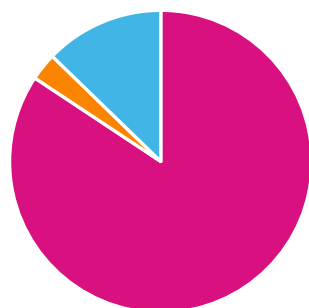
3c) Voice of the user

Voice of the user May 25	Princess Royal, Haywards Heath	Royal Sussex County Hospital, Brighton	St Richards Hospital, Chichester	Worthing Hospital, Worthing
Friend and Family Test	95.00%	85.7%	95.6%	88.0%
Complaints	0	6	0	4
Legal Claims	2	1	0	0
MNVP concerns	0	0	0	0

- ▶ Feedback from Friends and Family and Complaints is given on the next slide
- ▶ A programme of Restorative culture improvements was launched in June 2025, facilitated by experts with lived experience of baby loss. The offer of the programme has been made to the group of parents, however, is now paused following the SoS announcement. This programme facilitators will continue to work with our staff and provide a planned education programme in September.
- ▶ A maternity vision and roadmap has been co-produced by service users and staff and is discussed in the MSSP section of this report.
- ▶ MNVP – there were no concerns raised to the MNVP

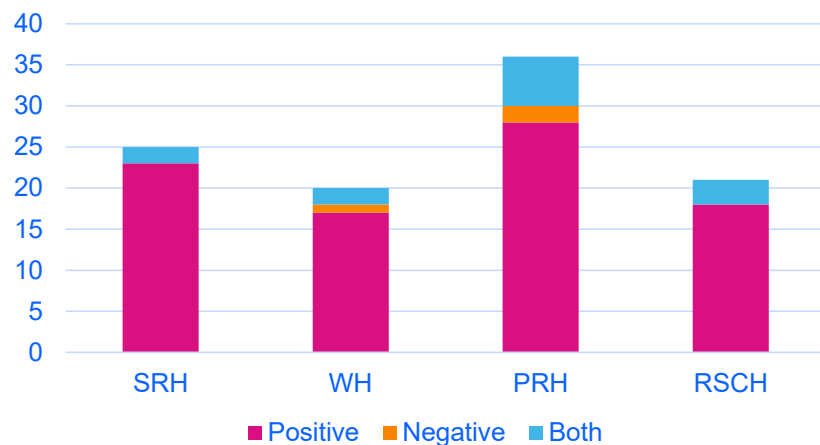
Top three themes from the FFT

Balance of feedback



■ Positive ■ Negative ■ Both

Balance of feedback by site



■ Positive ■ Negative ■ Both

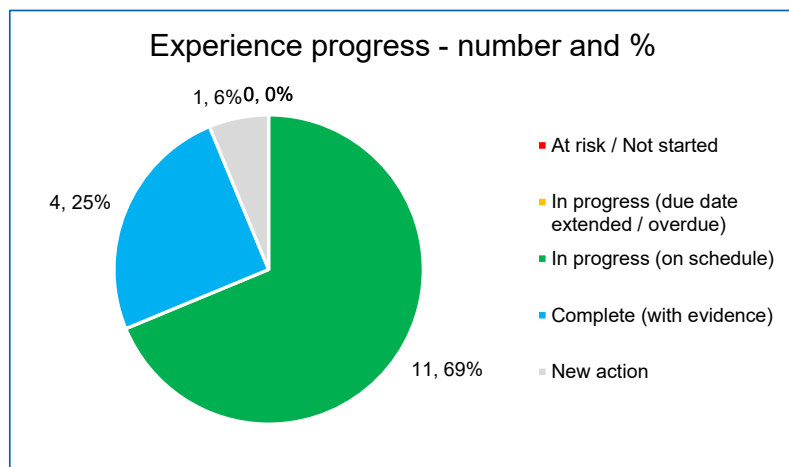
Top 3 Positive Themes:

- 1. Exceptional Midwife and Staff Care:** Midwives described as kind, caring, attentive, knowledgeable, and supportive throughout pregnancy, birth, and postnatal care. Medical professionals treated families with respect, empathy, and professionalism. Specific midwives named with praise for going above and beyond.
- 2. Positive Birth Environment and Experience:** Birth rooms and facilities described as peaceful, calm, and supportive. Use of birthing pools and options for natural birth appreciated. Families felt empowered, informed, and safe, even in challenging situations.
- 3. Effective Communication and Emotional Support** Staff took time to explain procedures, options, and next steps clearly. Emotional reassurance and presence during stressful moments helped patients feel at ease. Continuous monitoring and responsiveness contributed to trust and comfort.

Top 3 Negative Themes:

- 1. Inconsistent Staffing and Resource Allocation:** Perception of understaffing, especially among homebirth midwives and some hospital wards. Some delays in responses to calls for help or during postnatal care. Impact of staffing shortages on continuity of care and overall experience.
- 2. Mixed or Conflicting Advice and Communication Gaps:** Conflicting feeding advice and inconsistent information provided by different staff members. Poor communication regarding patient preferences or birth plans (e.g., requests not passed on). Lack of clear contact information post-discharge and insufficient follow-up details.
- 3. Variability in Attitudes and Professionalism Among Staff** Some hospital staff (nurses, triage midwives, night staff) noted as less helpful or less empathetic. Reports of some unprofessional behaviour and insensitive comments from certain staff members. Desire for better bedside manner and empowerment of mothers rather than fear-based communication.

MatNeo Improvement Plan – Service Experience workstream



Celebration:

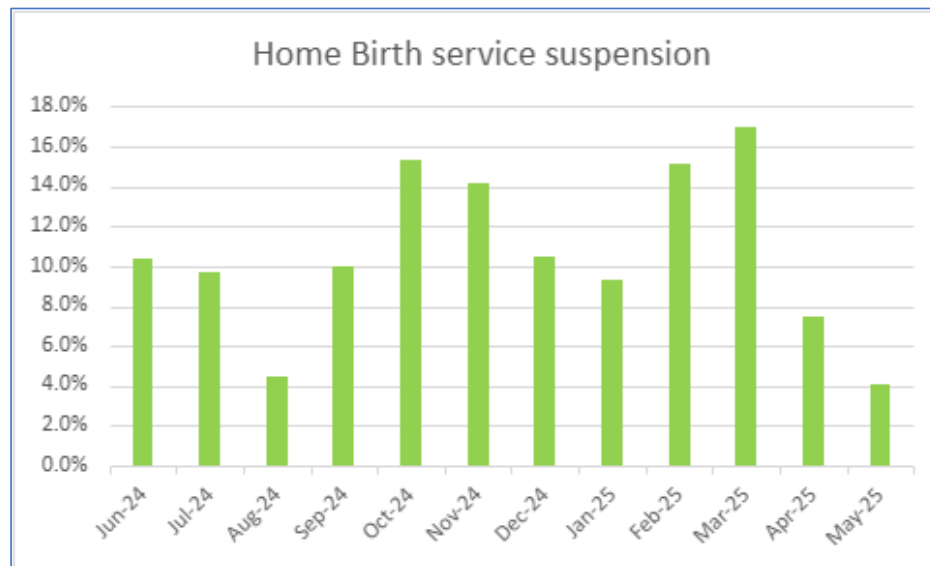
Postnatal reclining chairs and better support for neonatal families

Escalation:

None this month

- ▶ Working group meets monthly, chaired by Head of Midwifery and MNVP strategic lead
- ▶ The group reports into the Maternity and Neonatal Improvement Group, chaired by the Chief Nurse and attended by NHSE, LMNS, MSSP, CQC, MNVP and others
- ▶ Actions developed from FFT and MNVP themes and CQC patient survey feedback
- ▶ The group is working to improve:
 - ▶ Communication with families
 - ▶ Education and information dissemination to families
 - ▶ Service improvements for families on postnatal wards and improved support for those with babies on the neonatal units (e.g. parking, hot meal provision etc)
 - ▶ Improve data to better support families from marginalised groups.

Homebirth suspensions



- ▶ The homebirth service suspension rate has reduced further to 8%. Our homebirth rate was 2.7% (12 Births) and the amount of homebirths not facilitated due to suspending the service was 12% (5 families). The national homebirth rate remains at approximately 2%. In a comparison SASH (East Surrey-neighbouring trust) also had 12 Homebirths in May.

3d) Team feedback

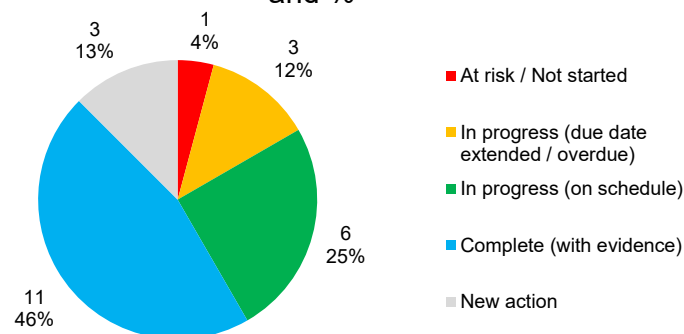


Safety Champions: Terms of reference for the staff forum are being reviewed to be re-aligned with its original intended goals and outcomes. **Positive to celebrate**: Staff raised a concern regarding lack of equipment on the postnatal ward for treatment of jaundice which has now been rectified with a charity bid with two biliblankets per ward.

ImproveWell 1 year on update to go to the Charities committee but can be read at this link: [ImproveWell KPIs - June 2025.docx](#)

3d) Perinatal Leadership and Culture update

Leadership and Culture progress - number and %



Celebration:

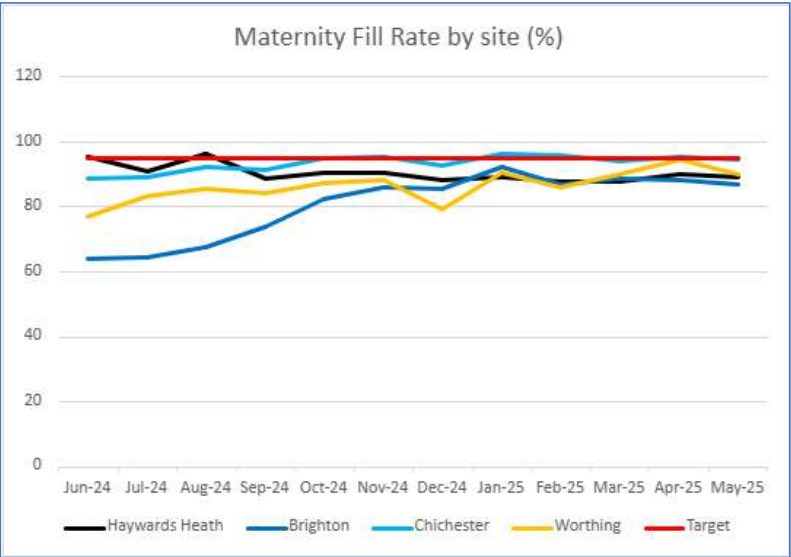
Maternity Vision co-produced with staff and service users

Escalation:

Swipe access and access to IT currently prohibits rotational posts and mutual aid in times of escalation

- ▶ This working group is formed of perinatal staff from across sites and professions and chaired by the Director of Midwifery.
- ▶ Actions are developed based of themes from the MSSP deep dive and SCORE survey results.
- ▶ The group is working to improve:
 - ▶ Strategy and local leadership
 - ▶ Professional Midwifery Advocate offer
 - ▶ Staff support and psychological safety
 - ▶ Cross site orientation and mobility
 - ▶ Communication and appraisal processes

Perinatal workforce - midwifery



Workforce	Princess Royal, Haywards Heath		Royal Sussex County Hospital, Brighton		St Richards Hospital, Chichester		Worthing Hospital, Worthing	
Midwifery B5/6/7 core vacancy	0.00%	↔	13.87%	↓	0.00%	↔	0.00%	↔
Midwifery sickness	4.20%	↓	4.50%	↑	9.00%	↑	8.60%	↑
Actual vs planned staffing	89.42%	↓	87.18%	↓	94.40%	↓	90.08%	↓

- ▶ A reduction in midwifery vacancy rates has resulted in increased fill rates. The vacancy rate in Brighton has increased due to movement of midwives to other teams, this will be rectified when the cohort of newly qualified midwives join in the autumn. Sickness rates remain high on some sites, targeted action supported by HR, is taking place in these specific cost codes.

Perinatal workforce – obstetric

O&G WH/SRH	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	28.71	26.29	2.42
Medical - SAS Doctor	1.53	2.00	(0.47)
Medical - Resident Doctors	44.37	40.01	4.36
O&G PRH/RSCH	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	23.81	22.91	0.90
Medical - SAS Doctor	2.01	0.00	2.01
Medical - Resident Doctors	34.50	39.42	(4.92)

Twice daily Consultant present ward rounds (Ockenden requirement):

- ▶ RSCH – 93.55% (58/62) - escalated to Obstetric Clinical Director
- ▶ PRH – 100%
- ▶ WH – 100%
- ▶ SRH - 100%

St Richards and Worthing Hospitals continue to maintain 100% record and rate for twice daily ward rounds. Princess Royal and Royal Sussex County Hospitals show a significant improvement compared to March data. It is still a held view that twice daily ward rounds are being conducted and not recorded appropriately. This was discussed in the monthly safety and quality meeting and there remains a persistent few consultants that are not using of the QR code process correctly. This has again been discussed in the cross-site consultant meeting and the QR code process modified to achieve 100% compliance.

Perinatal workforce – neonatal nursing

	Princess Royal, Haywards Heath		Royal Sussex County Hospital, Brighton		Worthing Hospital, Worthing		St Richards Hospital, Chichester	
Nursing vacancy rate	13.8%	↑	19.9	↓	18%	↑	8%	↓
Nursing sickness rate	5.6%	↑	7%	↓	4.75%	↓	5.56%	↑
Parenting leave	3.2%		4.8%		0%		4.8%	↑

Active recruitment is ongoing across 4 sites. At our NICU in Brighton a three-year workforce plan to incrementally increase is progressing. The plan forecasts a reduction in vacancy rates to 13% by September 2025 by rolling advertisements for band 5 and band 6 posts.

A key component of the plan is an education strategy aimed at increasing Qualified in Speciality (QIS) with the goal of achieving 70% QIS standard per shift. Currently, QIS coverage is 55%, however this is expected to temporarily dip to 49% in September due to an influx of newly recruited band 5 nurses. Looking ahead, the trajectory includes: 2 WTE awaiting in QIS results and 9WTE scheduled to begin the QIS course in September 2025.

- ▶ Nursing numbers in our Level 1 SCUs have shown significant overall improvement, supported by regular temporary staff working additional bank shifts and substantive employees taking on extra hours—particularly to address staffing gaps at Worthing. Sickness rates remain high, with continued work focused on supporting staff well-being and managing sickness absence.

Perinatal workforce – neonatal nursing - refusals

	Surgical Babies	Extreme Prem 22wks-29wks	Refused – TMBU Staffing	Refused – Maternity refusal (staffing or bed capacity)	Refused – TMBU Full	Refused from Worthing	Out of Network	Refused Unknown	Refused Other	Total number of babies refused
Refusals IN Utero	0	11	3	2	10	2	2	0	0	15
Refusals Ex Utero	1	0	1	0	2	0	0	0	0	3

- ▶ In May, there were a total of 30 IUT and EUT referrals made to TMBU
- ▶ 18 referrals were refused, 12 referrals were accepted
- ▶ 5 of 20 IUT were accepted, 7 of 10 EUT were accepted
- ▶ 3 out of 4 surgical referrals were accepted
- ▶ Most refusals were due to staffing

Perinatal workforce – neonatal medical

Paediatrics WH/SRH	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	30.62	30.80	(0.18)
Medical - SAS Doctor	1.32	4.52	(3.20)
Medical - Resident Doctors	32.00	22.84	9.16

TMBU	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	12.65	14.54	(1.89)
Medical - SAS Doctor	0.00	2.00	(2.00)
Medical - Resident Doctors	18.60	23.41	(4.81)

ANNP's	Budget WTE	Contracted WTE	Vacancies
Nursing & Midwifery - Registered	16.00	15.44	0.56

Consultants

Excess contracted WTE above budget WTE is due to consultant secondment (0.9WTE). Also covering supported return to work (no on call and maternity leave) . In addition 0.1 WTE may be recouped from LMNS and 0.3 from obstetrics

Tier 2 staff

► ANNP's and doctors excess above contracted is in relation to maternity cover

Quality Improvement

CNST, MSSP, MNIP

Presentation Title

24

Maternity Safety Support Programme

Maternity and Neonatal Improvement Plan (Bi-monthly)

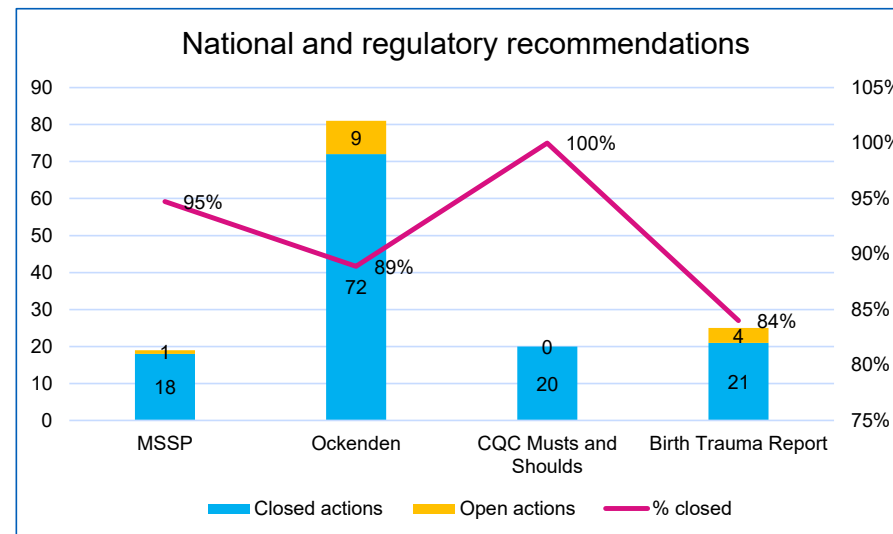
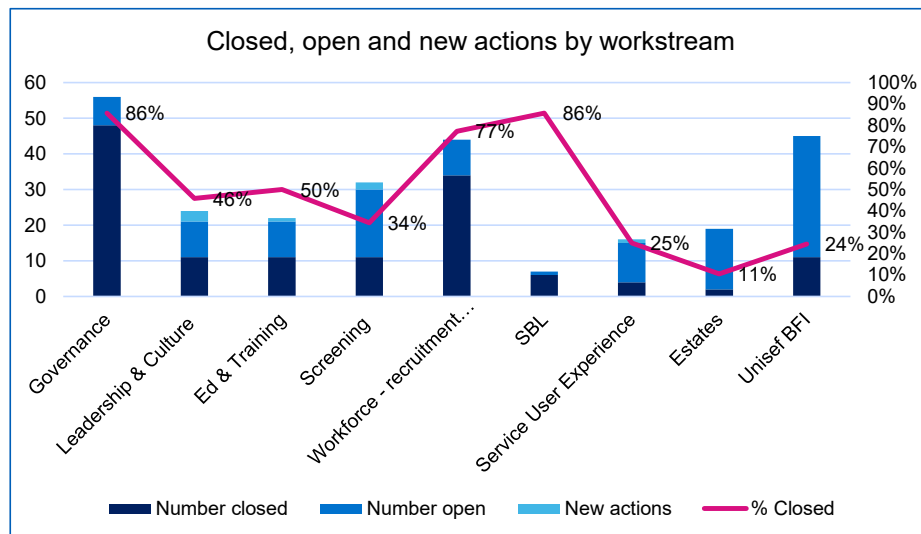
Maternity Incentive Scheme position 25
July 2024

Maternity Safety Support Programme (MSSP)

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



Maternity and Neonatal Improvement Programme



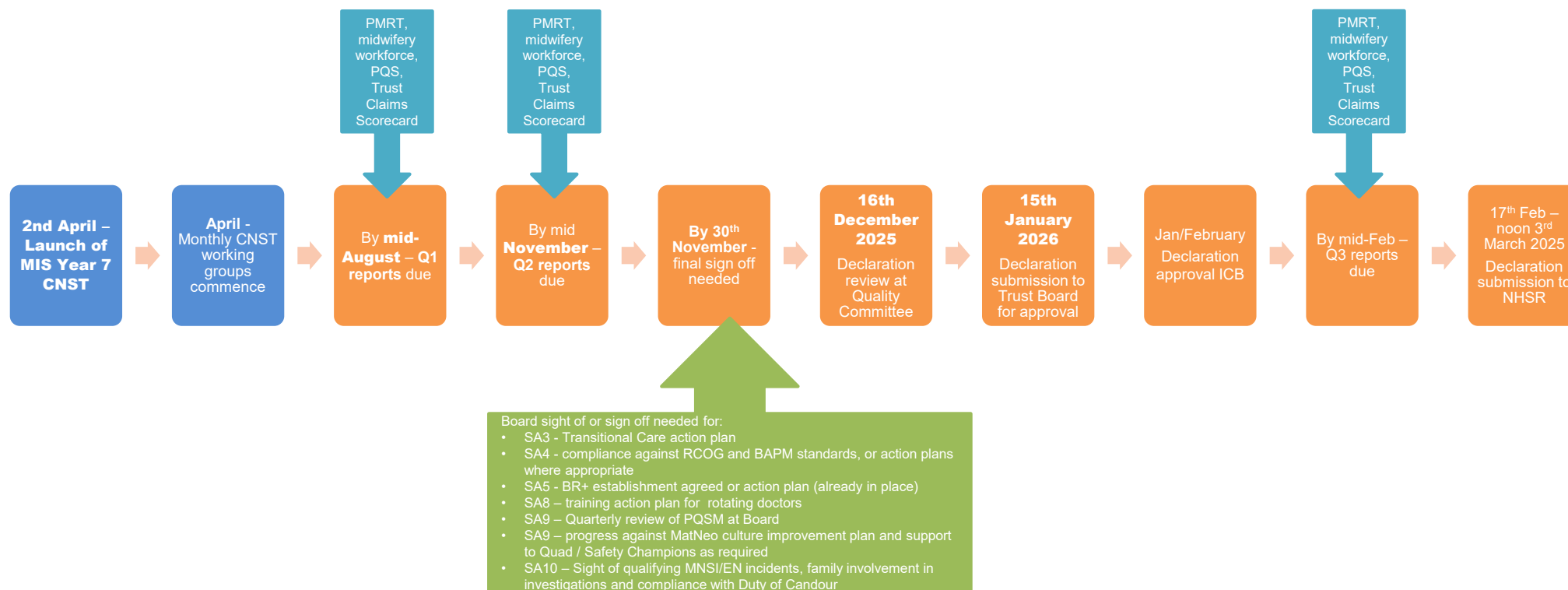
- ▶ The next Maternity and Neonatal Improvement Group is at the beginning of August.
- ▶ The group will focus on updates from the six workstream based on the number of actions that remain open. (See left chart)
- ▶ All workstreams now have neonatal input and involvement, improving the Perinatal approach to improvement work.
- ▶ The most challenged workstream is Estates due to matters outside of the division's control, e.g.:
 - ▶ Sussex House safety issues
 - ▶ Thomas Kemp Tower safety and space issues
 - ▶ Space needed for BAPM compliant Transitional Care on all four units.

Maternity Incentive Scheme CNST

Presentation Title

28

Timeline towards submission (dates TBC)



Successes and Escalations

Confirmation received that Trust's submission was updated to compliant due to mitigations.

Year 7 was published 2nd April 2024. Submission is due by 3rd March 2026. [MIS-Year-6-guidance.pdf \(resolution.nhs.uk\)](#)

Enablers

- Year 7 MIS event held, more support being provided by NHS Resolution
- Actions are mostly business as usual
- Increased medical capacity in leading actions

Barriers – to be escalated

- SA3 (Transitional Care) - the Trust is required to demonstrate progress against the BAPM Transitional Care Implementation action plan from years 5 and 6 of the scheme.
 - Most actions to implement this service require changes to estates across all 4 sites, making progress difficult to evidence.
 - Requires cross-site leadership to ensure aligned approach.
- SA8 (training) - medical trainee compliance requires constant focus to achieve 90% by end of November/
- SA7 – see slide for detail





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SA8 – June training compliance

UHSx	Skills Drills (inc NBLs)		
Staff group	All staff	In date	% compliance
Obstetric Anaesthetic Consultant	37	28	76%
Anaesthetic other	70	55	79%
Obstetric consultants	39	34	87%
Obstetric other	80	62	78%
Midwives inc Bank	527	506	96%
Support staff and nurses inc Bank	209	189	90%
	962	874	91%

UHSx	FM (attendance only)		
Staff group	All staff	In date	% compliance
Obstetric consultants	39	37	95%
Obstetric other	60	53	88%
Midwives inc Bank	516	495	96%
	615	585	95%

- Low MDT skills drills compliance driven by WH/SRH obstetric and anaesthetic compliance
 - Clinical Directors and Operations Manager tasked with developing plan to address within next couple of months
- Fetal monitoring compliance improving month and month



SA7 - Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

- As well as engaging with service users and co-producing service improvements, the Maternity and Neonatal Voices Partnership (MNVP) is expected to be commissioned to participate in and actively influence decision-making on local strategies and policies in maternity and neonatal care. This is meant to be achieved by being quorate members of the following meetings:

MIS CNST meeting requirement	Directorate / divisional meeting name	Frequency	Attending?	Quoracy?	Current issues
Safety Champions	Maternity and Neonatal Safety Champions	Monthly			
Maternity business and governance	Maternity Quality and Safety	Monthly			Invited but not able to attend due to meeting timing.
Neonatal business and governance	Neonatal Quality and Safety / Divisional Quality and Safety Forum	Monthly			Monthly directorate meeting being set up as part of governance framework development
PMRT review meeting	PMRT	Monthly			
Patient Safety meeting	Quality and Safety meetings	Monthly			Invited but not able to attend due to meeting timing.
Guideline committee	Divisional Clinical Effectiveness	Monthly			Covers maternity and neonatal – invite to be sent

SA7 - Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

- The Maternity Quality and Safety meeting (and neonatal, when established) covers both the business / governance side as well as discussing patient safety investigations and incidents. However, the MNVP have been unable to join due to it falling on a non-working day.
- There are two options to address this barrier to compliance:
 - The MNVP reviews their working schedules to attend Quality and Safety
 - The MNVP attend the Divisional Quality Forum which includes a high-level discussion of patient safety, risk management, quality assurance, patient experience and other business for all directorates including maternity and neonatal.

Decision required:

- With MNVP schedules unlikely to change due to personal and family commitments, the Board is asked to approve the proposal to have MNVP as quorate members of the Divisional Quality Forum to meet both the business / governance and patient safety elements of the meeting requirements.
 - This will create a cost pressure of £40 per meeting, to cover the hourly MNVP rate + cost per hour of childcare. (£480 per year).
- In addition, the MNVP also attend the Maternity and Neonatal Improvement Group and have monthly meetings with both the Director and Heads of Midwifery.



Current status of 10 Safety Actions



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Safety Action	Standard	RAG	
SA1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Green	Change to guidance on who can be an 'external' reviewer regarding level of seniority and current clinical practice. Local decision made on seniority.
SA2	Maternity Services Data Set (MSDS)	Green	Business as usual reporting
SA3	Transitional Care and Avoiding Term Admissions into Neonatal units (ATAIN) Programme	Yellow	Required to show progress against BAPM Transitional Care implementation action plan – a number of estates issues are a barrier to implementation.
SA4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yellow	Must achieve full compliance with consultant attendance at RCOG defined clinical scenarios (cannot comply with an action plan to address shortfall).
SA5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Green	No change to standards – business as usual
SA6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Green	LMNS assurance meetings continue
SA7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Red	See additional paper – challenges achieving quoracy at the required meetings
SA8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Red	Medical trainee compliance has dropped since December, needs constant focus.
SA9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Green	Some new elements regarding Quad and Board Safety Champion meeting agendas, but achievable.
SA10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme?	Green	Business as usual processes.

Conclusion and recommendations

The impact of the announcement of the Secretary of State on service users, staff and the leadership team cannot be underestimated. Information regarding the ongoing inquiry process is needed to enable the service to provide appropriate support to these groups. The service is committed to transparency, service user engagement and co-production, and continuous improvement.

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



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University Hospitals Sussex NHS Foundation Trust ATAIN Quarterly Report Quarter: 3 Date: Oct 2024 - Dec 2024



The ATAIN Programme: Background

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

Maternity and neonatal services need to work together to identify babies whose separation could be avoided, and to promote understanding of the importance of keeping birthing people and their babies together when it is clinically safe to do so.

Why is this so important?

There is overwhelming evidence that separation of birthing people and their babies so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on mental health, breastfeeding/chest feeding and long-term morbidity for the birthing person and child.

This makes preventing separation, except for compelling medical reasons, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

The ATAIN Programme

The ATAIN programme was widely introduced in 2018 and forms part of what is now known as the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP). The focus is on babies who are admitted for four key reasons, as these are areas that NHS England believe can have the most impact:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxic-ischaemia)

Data is collected and reviewed on a weekly basis by a multidisciplinary team which includes:

- Midwifery staff
- Obstetric staff
- Neonatal/Paediatric staff
- Neonatal Nursing staff

Often there is useful incidental learning identified when cases are reviewed, but the focus of the programme is to:

- Identify quality improvement work that could reduce causes of harm that can lead to term babies needing to be admitted to a neonatal unit
- Provide evidence to support the development of services that keep birthing people and their babies together when it is safe to do so



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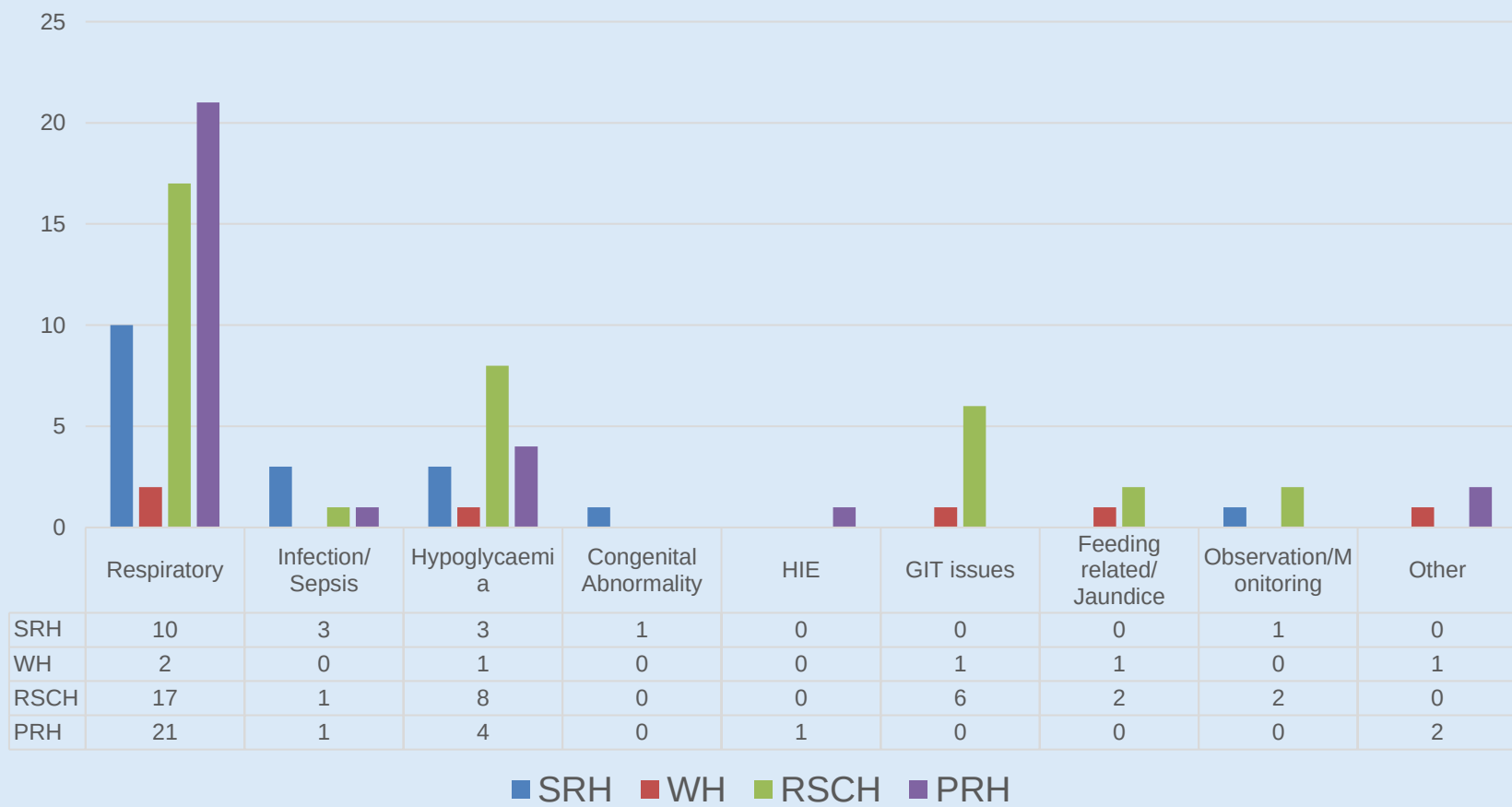
Term Admission Data – UH Sussex Summary

Term Admission Rate (Target <5%)

UHSussex	October	November	December
PRH	5.91%	6.51%	5.42%
RSCH	6.67%	7.53%	5.38%
SRH	3.4%	2.5%	4.1%
WH	1.7%	0%	2.1%



Categorised Admissions to NNU for UHSussex

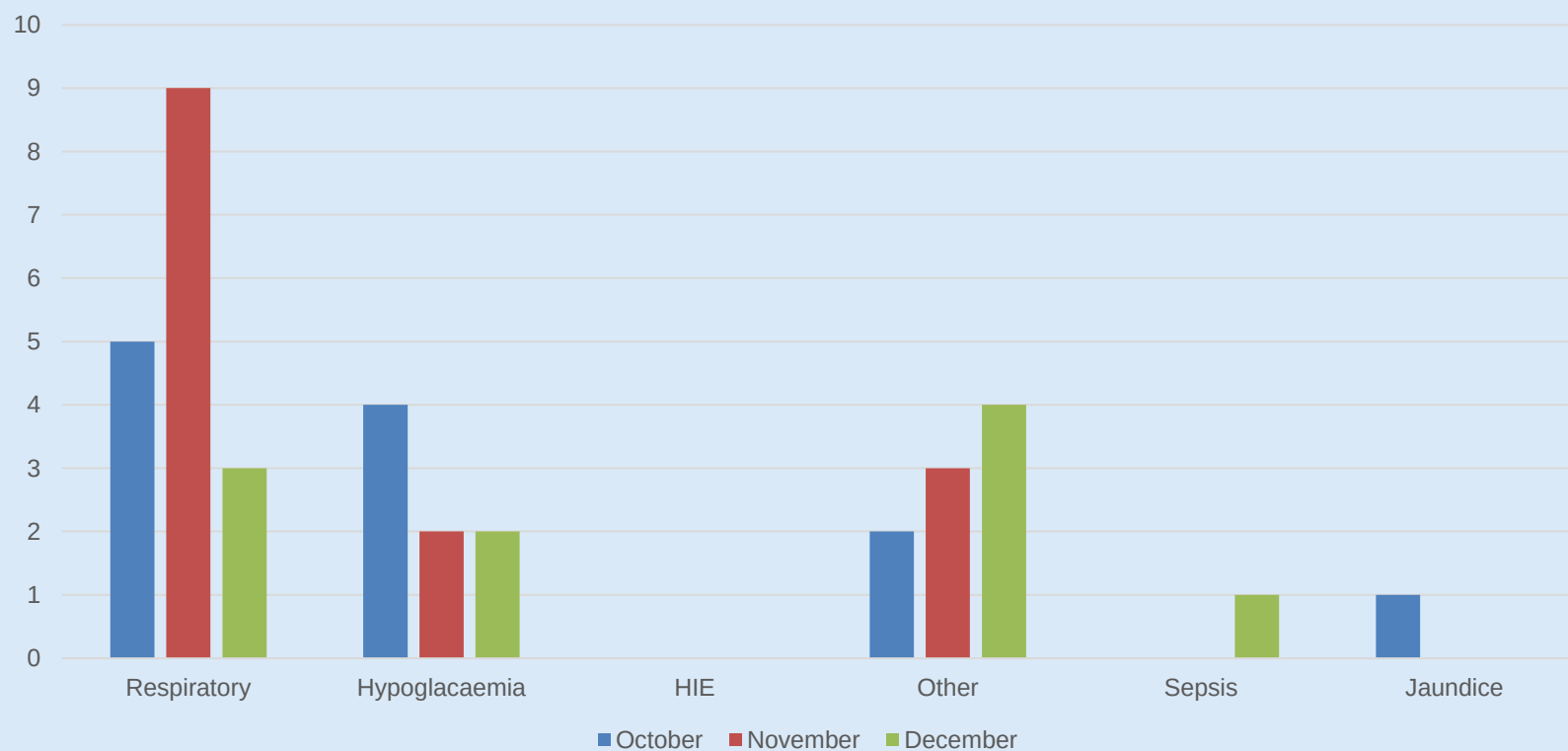


Royal Sussex County Hospital (RSCH) ATAIN Progress Report



Categorised Admissions to NNU

Term Admissions RSCH



RSCH – Learning from the review of term admissions to NNU

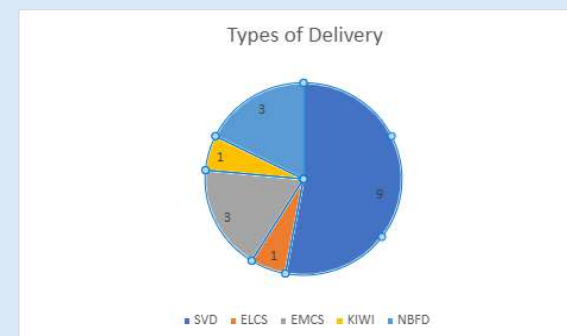
Respiratory Symptoms

Number of admissions = 17

What type of respiratory symptoms:

- Low oxygen saturations
- RDS¹

Type of delivery they were: 9 SVD², 3 EMCS³, 1 ELCS⁴, 3 NBFD⁵, 1 KIWI⁶



Learning extracted

All admissions to the NNU for respiratory reasons were deemed as **appropriate**.

Although all admissions were deemed appropriate, there is currently a QI project underway to provide a decision making tool to support practitioners in an aim to reduce term admissions to TMBU for RDS.

1. RDS: Respiratory Distress Syndrome – a serious lung condition in newborns, especially premature babies, caused by a lack of surfactant, a substance that helps the lungs expand and breathe properly
2. SVD: Spontaneous Vaginal Delivery
3. EMCS: EMergency Cesarean Section
4. ELCS: ELective Cesarean Section
5. NBFD: Neville-Barnes Forceps Delivery
6. KIWI: vacuum-assisted or ventouse delivery

RSCH – Learning from the review of term admissions to NNU

Hypoglycaemia / Jaundice

Number of admissions = 8 hypoglycaemia / 1 Jaundice

Maternal risk factors increasing the risk of hypoglycaemia in the newborn:

- Sepsis – a life-threatening medical emergency that occurs when the body's response to an infection causes damage to its own tissues and organs
- Antihypertensives – medication to bring down blood pressure
- GIDDM – Gestational Insulin Dependent Diabetes Mellitus
- Cleft – a split or gap in the upper lip and/or the roof of the mouth (palate), which can occur at birth

Learning extracted

All admissions deemed appropriate.

1 baby could have remained with mum on the postnatal ward if closer observations could have been provided in a BAPM (British Association of Perinatal Medicine) transitional care ward giving NG (nasogastric tube) feeding support.

RSCH – Learning from the review of term admissions to NNU

Asphyxia (perinatal hypoxic-ischaemia)
No admissions for this quarter.
Learning extracted

RSCH – Learning from the review of term admissions to NNU

Other
Number of admissions = 10 Type of delivery they were: 4 SVD, 2 EMCS, 4 ELCS Reasons for admission: • 4 surgical admission - 2 for bowel obstruction – requiring surgery - 2 for surgical review for ongoing vomiting • 1 poor feeding & increased weight loss • 1 suspected sepsis • 2 bilious vomiting • 2 CFM monitoring – Cerebral Function Monitoring – a continuous bedside monitoring system used to track brain activity in neonates)
Learning extracted
1 baby could have remained with mum on the postnatal ward with more feeding support and wouldn't have required admission if a BAPM transcare ward giving NG feeding support was available.

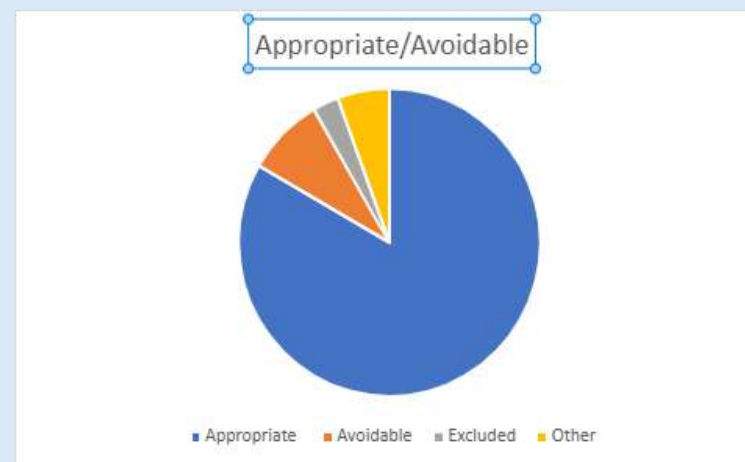
RSCH Avoidable Admissions

RSCH Avoidable Admissions

Total number of avoidable admissions: 3

Themes:

- NGT (nasogastric tube) siting on the PN (postnatal) ward
- Improve feeding postnatally
- Develop TC (transitional care) provision

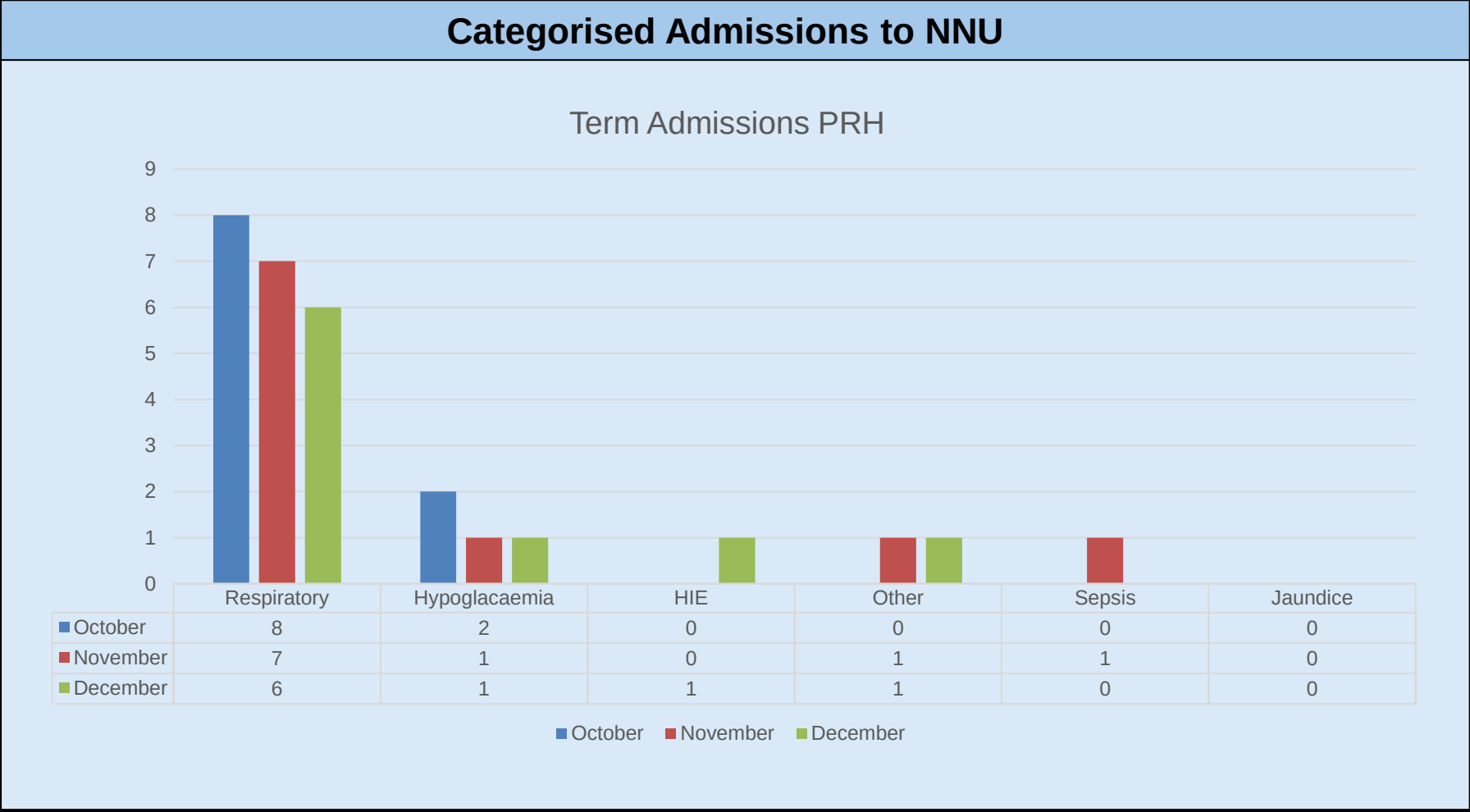




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Princess Royal Hospital (PRH) ATAIN Progress Report





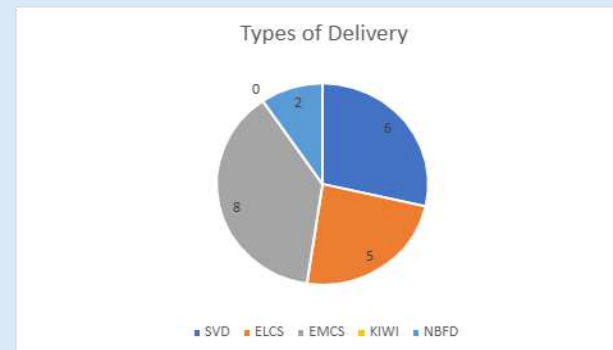
PRH – Learning from the review of term admissions to NNU

Respiratory Symptoms

Number of admissions: **21** – of these, all were deemed appropriate

What type of respiratory symptoms:

- RDS
- Pneumonia
- Suboptimal sats
- Dusky episodes – bluish discoloration of the skin and mucous Membranes, indicating low oxygen levels in the blood



Type of delivery they were: 6 SVD, 2 NBFD, 5 ELCS, 8 EMCS

Learning extracted

All babies transferred to the NNU from delivery suite were given appropriate time to adjust to extrauterine life (>30mins) with additional respiratory support by means of facial oxygen, prone positioning and adequate thermoregulation on the resuscitaire

4 out of the 5 babies delivered by ELCS DID NOT receive steroids prior to their birth at 37/40, 1 over 39/40 and therefore did not qualify for steroids

All babies received optiflow on admission to NNU and 1 experienced green aspirate on admission. 1 transferred to Evalina for cardiac investigation on day 4

QI project in place to develop a decision-making tool in an aim to reduce term admissions to SCBU for RDS

PRH – Learning from the review of term admissions to NNU

Hypoglycaemia

Number of admissions = 4.

Type of delivery they were: 2 EMCS, 2 ELCS,

2 appropriate admissions

- Poor feeding
- Petichial rash – tiny, non-blanching red or purple spots can be due to various causes, including thrombocytopenia (low platelet count), trauma during delivery, or infections

1 Avoidable (discussed in Avoidable slide)

1 Excluded due to Cleft lip and palate

Learning extracted

1 baby was deemed avoidable as early warning signs not identified in a case of suspected RDS and ?meconium aspiration and feeding support.

1 baby was excluded in the ATAIN review as it was noted to have an extensive cleft palate on the right side with a poor gag reflex. Reviewed by cleft team and subsequently deemed safe to feed orally.

2 babies noted to have a petichial rash, sunken fontanelles, low BM's requiring Glucoboost and IVF. Feeding support needed improving.

PRH – Learning from the review of term admissions to NNU

Asphyxia (perinatal hypoxic-ischaemia) /sepsis

1 admission for HIE – hypoxic-ischemic encephalopathy (brain damage due to oxygen deprivation and/or lack of blood flow)

Delivered by EMCS

1 case of Sepsis delivered by SVD commenced on IVABS (IV Antibiotics) following yellow/green vomits lactate

Learning extracted

Delay going to theatre to allow for maternal decision making. Admitted on Optiflow, IV Glucose (fully Breastfed on Day 2) Hyponatraemic on admission normalised after IV Sodium.

PRH – Learning from the review of term admissions to NNU

Other
Number of admissions = 2 Type of delivery they were: 1 NBFD, 1 EMCS
Learning extracted
Both deemed as appropriate admissions 1 baby was diagnosed with Muscular dystrophy which later passed away in a hospice, deemed as an appropriate admission 1 baby excluded due to a subgaleal bleed (A serious condition where blood accumulates in the loose connective tissue between brain and the skull which can lead to blood loss, shock, anemia, and other complications)

PRH Avoidable Admissions

PRH Avoidable Admissions

3 cases were deemed as avoidable

2 Cases were excluded

- 1 baby was excluded in the ATAIN review as it was noted to have an extensive cleft palate on the right side with a poor gag reflex. Reviewed by cleft team and subsequently deemed safe to feed orally.
- 1 baby went to GOSH for a suspected Subgaleal Bleed.

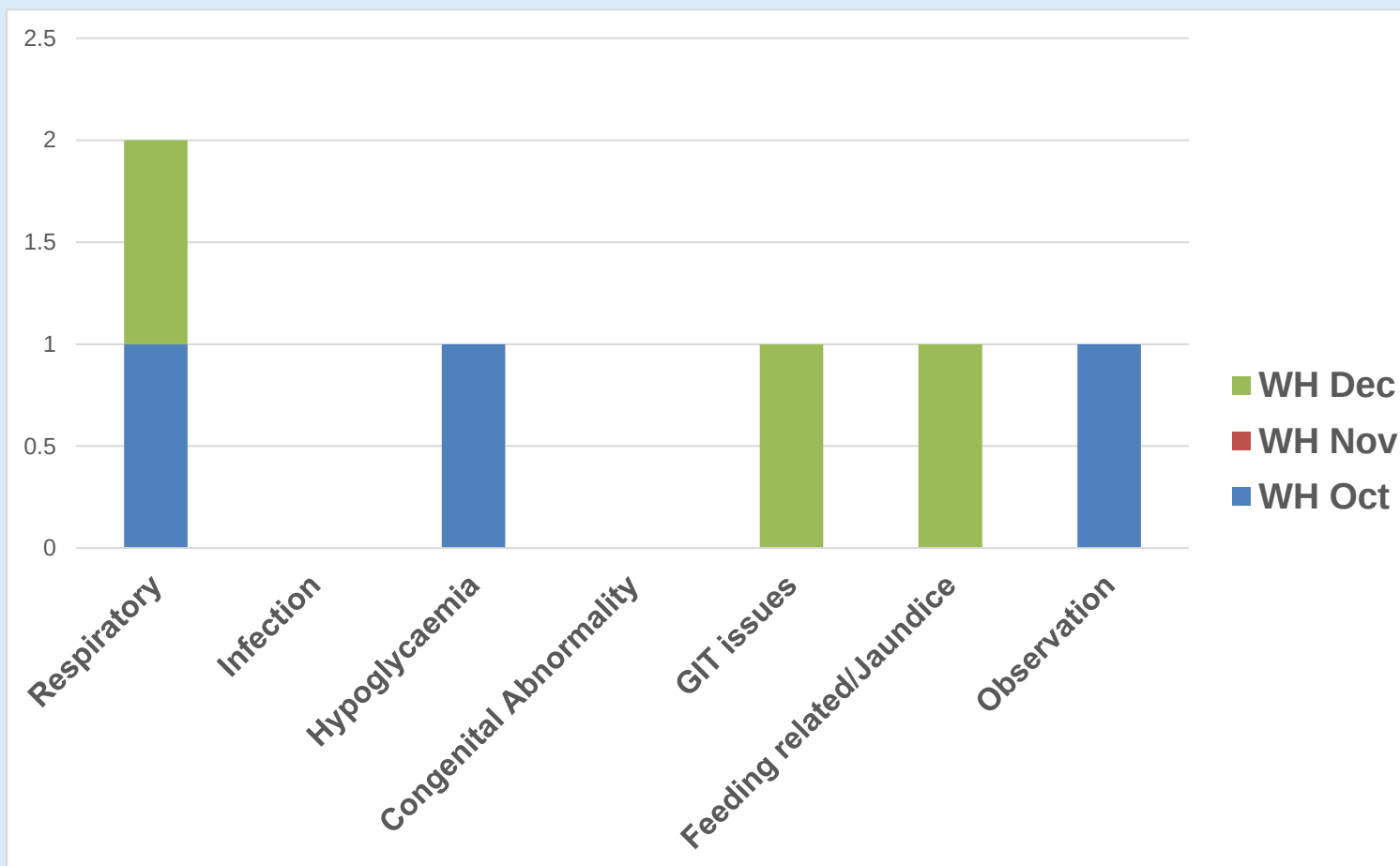
Themes

- Improve TC facility
- Improve feeding facility, lactation consultant for PRH not in post for this Quarter
- Continue to develop QI project to aid in reducing PRH term admissions Led by Neonatal consultant to aid in assessing the need for respiratory support
- Continue to negotiate Obstetric presence at PRH/RSCH Atain meetings.

Worthing Hospital (WH) ATAIN Progress Report



WH Categorised Admissions to NNU



WH – Learning from the review of term admissions to NNU



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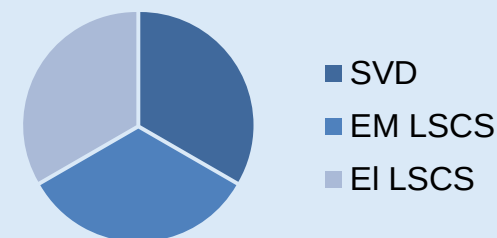
Respiratory Symptoms

Number of admissions = 3

What type of respiratory symptoms:

- Low saturations with inability to maintain saturations without additional oxygen
- Large pre & post ductal saturation difference (15%)
- Dusky episodes
- Diagnoses include Meconium Aspiration¹ (1) & RDS (2)

BIRTH TYPE



Types of delivery: 1 SVB's 1 Em CS due to an abnormal AN CTG following prostin insertion and 1 EI LSCS for previous.

Learning extracted

All admissions to the NNU for respiratory reasons were deemed as unavoidable.

2 babies admitted received a full 30 minutes of positive end-expiratory pressure (PEEP) prior to transfer to SCBU, it is unclear from the documentation if the other did.

All babies required optiflow to maintain saturation levels following resuscitative measures of inflation and ventilation breaths.

The baby born by spontaneous vaginal birth required intubation at 2.5 hours of age. She was transferred to a tertiary centre for on-going care with a diagnosis of meconium aspiration, confirmed by chest x-ray. Despite low cord gases (A 7.038 V 7.183) she did not require therapeutic cooling. It was noted however she became hypothermic during the handling procedures.

Both babies born by LSCS had dusky episodes shortly after birth with a working diagnosis of respiratory distress syndrome and received <24 hours optiflow.

1. Meconium Aspiration: occurs when a newborn inhales meconium (first stool) mixed with amniotic fluid into their lungs

WH – Learning from the review of term admissions to NNU



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Hypoglycaemia / Jaundice / Asphyxia (perinatal hypoxic ischaemia)

There was 1 admission to NNU for hypoglycaemia and 1 admission due to jaundice both from the postnatal ward. There were no admissions for asphyxia (perinatal hypoxic ischaemia)

The baby admitted for hypoglycaemia had been born by emergency LSCS under spinal anaesthesia following IOL (induction of labour) due to IUGR – intrauterine growth restriction (0.4th – 2nd birth centile). The mother did not labour. The baby was unable to maintain his blood sugars therefore admitted for enhanced care at 48 hours of age. Baby remained on NNU for a further 5 days.

The baby admitted for jaundice was born by emergency LSCS under spinal anaesthesia. Risk factors included maternal atrial fibrillation, raised BMI (>50), PET (pre-eclampsia), GDM on insulin. LSCS performed due to deteriorating maternal condition in labour. Baby monitored on hypo-pathway as necessary. Admitted on PN day 2 with raised SBR, requiring quadruple phototherapy and NG feeds to facilitate hydration. Stayed for 25 hours.

Learning extracted

All admissions to the NNU for hypoglycaemia and jaundice were deemed as **unavoidable**. Measures had been taken to try and keep mothers & babies together

- The hypo-pathway in both cases had been followed and management was appropriate.
- Appropriate, timely escalation to paediatric team.
- Extensive feeding plans put in place.
- Both babies admitted from postnatal ward.
- Both babies born with good apgars at birth.

WH – Learning from the review of term admissions to NNU

Other
Number of admissions = 1 Type of delivery: EMCS due to suspected chorioamnionitis and delay in first stage of labour. Reasons for admission: • Baby screened for suspected sepsis at time of birth due to maternal pyrexia in labour and a prolonged SRM (spontaneous rupture of membranes) of 26 hours. However, was admitted the following morning due to bilious vomiting. Following a period of monitoring required transfer for a upper gastro-intestinal contrast/surgical review as is standard practice. Contrast study showed slow gastric emptying but no evidence of malrotation. Returned back to postnatal ward with ongoing antibiotics.
Learning extracted
This admission was considered <u>unavoidable</u>

WH Avoidable Admissions

WH Avoidable Admissions

There were **no** admissions that were considered **avoidable** following review.

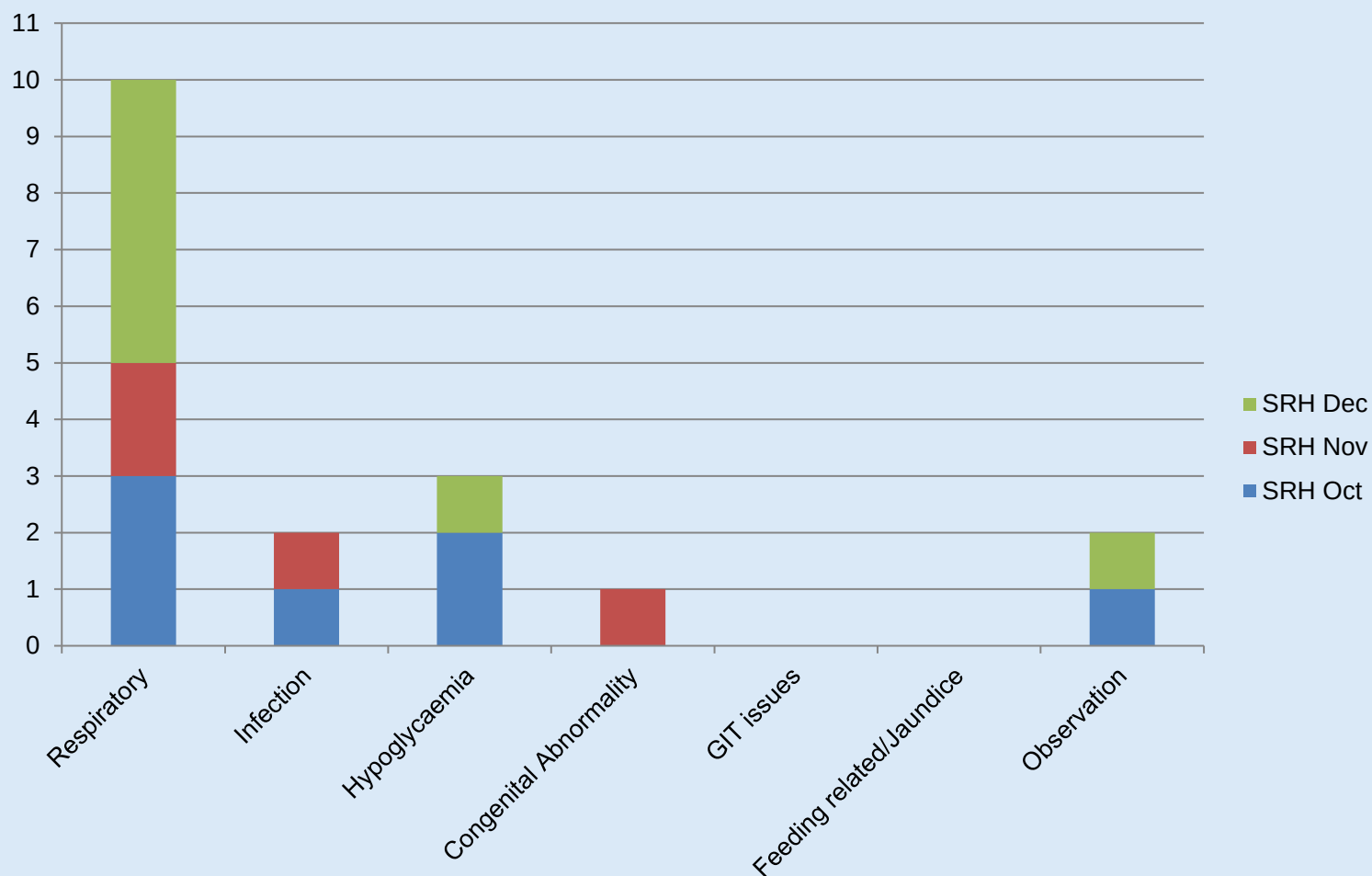
Themes identified throughout review:

- There does not seem to be consistency with the use of PEEP (positive end-expiratory pressure – maintaining pressure in the lungs at the end of expiration which helps keep alveoli (tiny air sacs in the lungs) open and prevents collapse, improving oxygenation), however it is acknowledged that this is a very small sample (6)
- 5 out of the 6 babies were born with good apgars. Only 1 had an apgar of <7 @ 5 minutes of age
- 5 out of the 6 babies delivered by LSCS (4 x emergency, 1 elective)
- 2 of the 4 that required an EMCS had an abnormal antenatal CTG (not in labour)
- Worthing have consistently low rates of admission to NNU in comparison to all other sites – this needs to be explored further.

St Richards Hospital (SRH) ATAIN Progress Report



SRH Categorised Admissions to NNU



SRH – Learning from the review of term admissions to NNU



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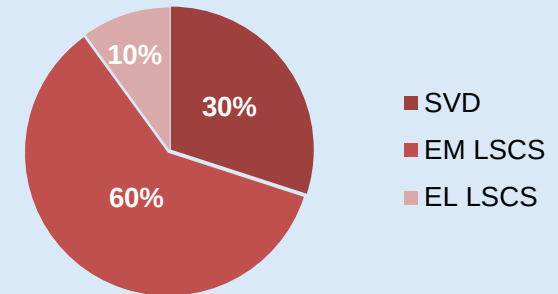
Respiratory Symptoms

Number of admissions = **10**

Types of delivery: 3 SVB, 6 Em CS (3 x Cat 3 2 maternal request, 1 booked EI LSCS but went into labour) 1 x EI LSCS

What type of respiratory symptoms:

- Low saturations with inability to maintain saturations without additional oxygen
- Chest recession
- Grunting/nasal flaring
- Increased work of breathing
- Dusky episodes
- Diagnoses include Respiratory Distress Syndrome (RDS), Transient Tachypnea of the Newborn (TTN), meconium aspiration and a pneumothorax.



Learning extracted

8 admissions to the NNU for respiratory reasons were deemed as **unavoidable**, **2** therefore potentially **avoidable**.

Of the 10 babies transferred (8 from labour ward, 2 from the birth centre) 9 had supportive positive end-expiratory pressure (PEEP) for at least 30 minutes to help facilitate the clearance of fluid from the lungs; therefore improving oxygenation by increasing lung volume and reducing alveolar collapse in an attempt to reduce likelihood of admission.

All babies required additional oxygen in order to maintain saturations above 90% necessitating admission to NNU for respiratory support with optiflow in 7 cases and high flow nasal oxygen in 3. It was noted that 2 of these babies had a low temperature on admission (36.1 & 36.4).

1 baby required transfer to a tertiary centre, intubated and diagnosed with meconium aspiration.

2 babies were born by Em LSCS due to abnormal antenatal CTG's.

2 out of the 10 babies admitted had apgars < 7 at 5 minutes of age.

SRH – Learning from the review of term admissions to NNU



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Hypoglycaemia

Number of admissions = **3**

Type of delivery: 3 Em LSCS (2 x in labour)

1 baby required inflation and ventilation breaths at birth following a pathological CTG. Risk factors included meconium stained liquor ?suspected listeria due to colour of liquor. Responded well and initially remained with Mum but admitted within 2 hours due to low BM's (Blood glucose level Monitoring).

1 baby has persistently low BM's; was on hypo-pathway due to Mum being on labetalol. Admitted at 9 hours of age. For further intervention.

1 baby was born following an abnormal antenatal CTG. Admitted at 1 hour of age due to an undetectable blood sugar.

Learning extracted

2 admissions to the NNU for hypoglycaemia were deemed as unavoidable, **1** therefore potentially avoidable

All babies were born by emergency LSCS under spinal anaesthesia

All babies were treated for suspected sepsis.

2 out of the 3 babies had apgars <7 @ 5 minutes.

Jaundice & Asphyxia (perinatal hypoxic-ischaemia)

0 Admissions to NNU for jaundice or asphyxia

Learning extracted

N/A

SRH – Learning from the review of term admissions to NNU

Other
Number of admissions = 5 Type of delivery they were: 2 SVB, 2 Em CS, 1 EI LSCS Reasons for admission: • 2 babies were admitted with signs of infection (tachycardia, raised temperature) requiring enhanced monitoring and further treatment/investigations. Both mothers had pyrexia in labour. • 2 babies were admitted for observation; 1 baby had several 'dusky' episodes on the postnatal ward. Had further investigations (NAD), SVIA throughout admission and no further episodes witnessed. The other was following a fall to the floor (unsure if head was hit) whilst on postnatal ward. No marks/bruises, normal tone, equal reactive pupils. No further action required. • 1 baby was born with a cleft palate and diagnosed with Pierre Robin Syndrome (severe micrognathia). Transferred to tertiary centre for on-going care. (Under SPIRE cleft centre)
Learning extracted
• Appropriate escalation to paediatric team noted. • Consideration to enhanced monitoring/increased skill set on PN ward may have allowed babies to remain with their mothers. • A review of scan images with the undiagnosed cleft/PRS were considered abnormal with further review required to the fetal medicine consultant which did not happen. This has been escalated.

SRH Avoidable Admissions



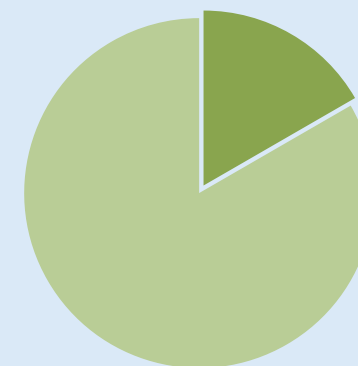
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SRH Avoidable Admissions

Total number of avoidable admissions: **3 out of 18** admissions were deemed **avoidable** (17%)

Themes identified throughout review:

- Temperature regulation - 2 babies were cold on admission to NNU – 1 from LW, 1 from Birth Centre. This was considered to have contributed to the overall respiratory symptoms and therefore to the admission.
- It was learnt that if PEEP is required on the birth centre, the resuscitaire must be connected to piped oxygen as the cylinders will not allow for 30 minutes – visual prompts have been added to resuscitaires to alert staff.
- Earlier intervention with feeding/hypo management may have prevented admission for 1 baby.
- Enhanced monitoring facilities on the PN ward may allow babies to remain with their mothers



■ AVOIDABLE ■ UNAVOIDABLE

Acknowledgement

With the review of these cases, it must be acknowledged that each review is completed in isolation with known limitations. The acuity at the time of each birth is not reviewed, therefore it is not known what other clinical activity there is across all departments, what the staffing level is and if there are any other factors that may influence a decision to admit a baby to NNU. An addition to this review to help inform the QI work into ATAIN would be to do a deeper dive into the time each baby spends on NNU to determine if there is any opportunity to return babies back to their mothers/ birthing person sooner under transitional care and if there is anything that hinders this process.

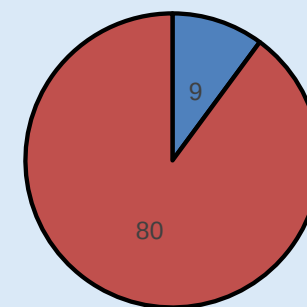
Summary

For the total of Quarter 3, the benchmark of <5% of admission to the Special Care Baby Unit was met for the duration at WH (1.7%, 0% & 2.1%) and for SRH (3.4%, 2.5%, 4.1%). PRH and RSCH did not meet the benchmark for any month during Quarter 3 (PRH 5.91%, 6.51%, 5.42%, RSCH 6.67%, 7.53%, 5.38%).

There were 36 admissions to NNU from RSCH, 29 admissions from PRH, 18 admissions from SRH and 6 admissions from WH which is a total of 89 term admissions to the SCBU/NNU.

The majority reason for admission this quarter across all four sites was again due to respiratory support.

Overall, 89.9% (80) of admissions across all four sites were considered unavoidable with appropriate management with 10.1% (9) considered as potentially avoidable. This is an increase of 2.5% (from 7.6%) when compared to Q2.



■ AVOIDABLE ■ UNAVOIDABLE



Summary of progress

[SA3 ATAIN and TC Action Plan Cross Sites.xlsx](#)

New actions will be added after dissemination of the report, agreed through the ATAIN & TC steering group

Transitional Care

Quarter 3 (October, November, December 2024)

PRH, RSCH, SRH, WH



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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 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

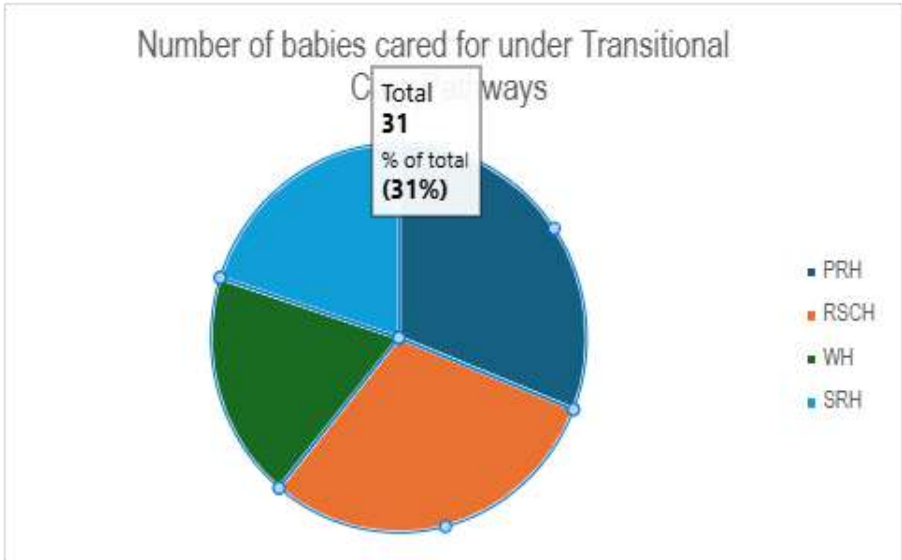
- Gestation 35-36+6 weeks at birth who do not fulfil criteria for intensive or high dependency care.
- Risk factors for sepsis requiring IV antibiotics, but clinically stable and/or stable baby who has developed (or been identified as having) risk factors for sepsis, requiring IV antibiotics
- At risk 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

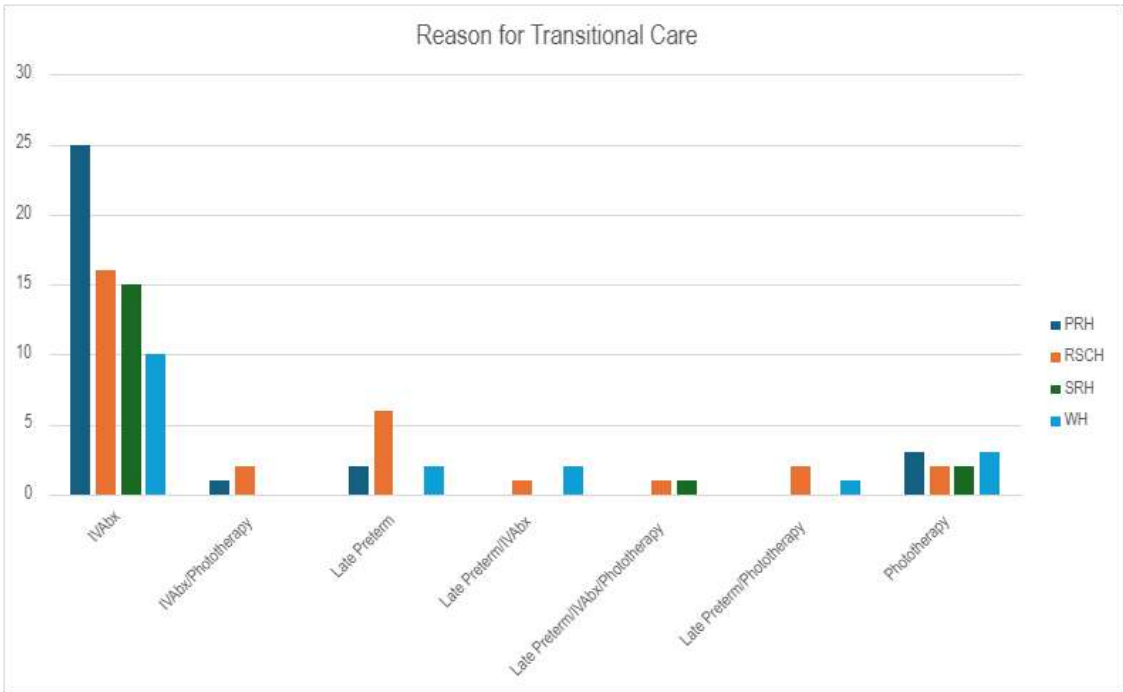
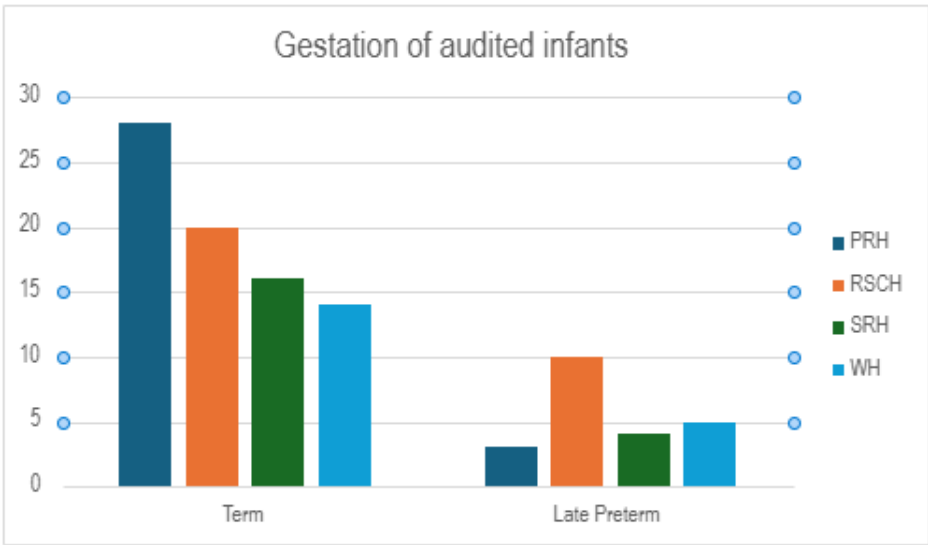
A sample of neonatal medical records of babies who met the criteria for Neonatal Transitional Care were audited between a 3-month period of October to December 2024.



Infant’s care pathways, via their neonatal medical records on Badgernet were audited: PRH 31 sets, RSCH 30 sets, SRH 20 sets and WH 19 sets.

Results

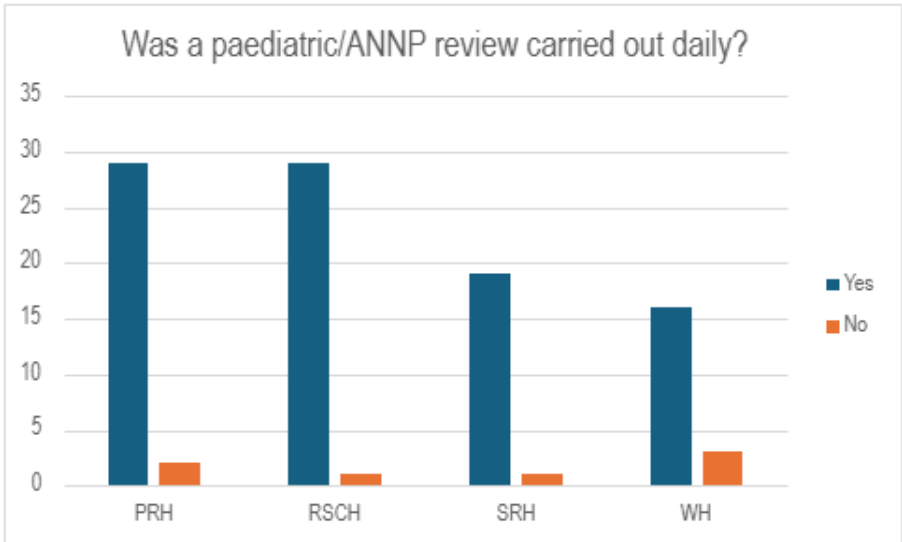
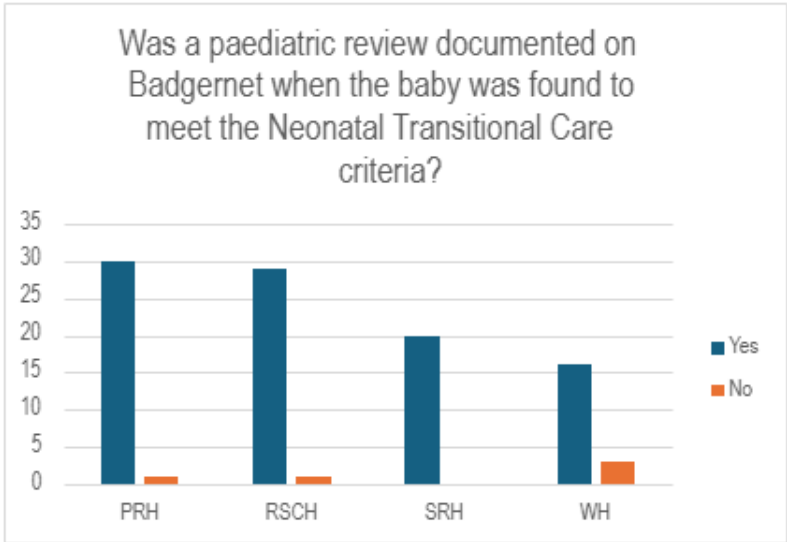
Most of the cases audited were term gestation neonates.



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

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.



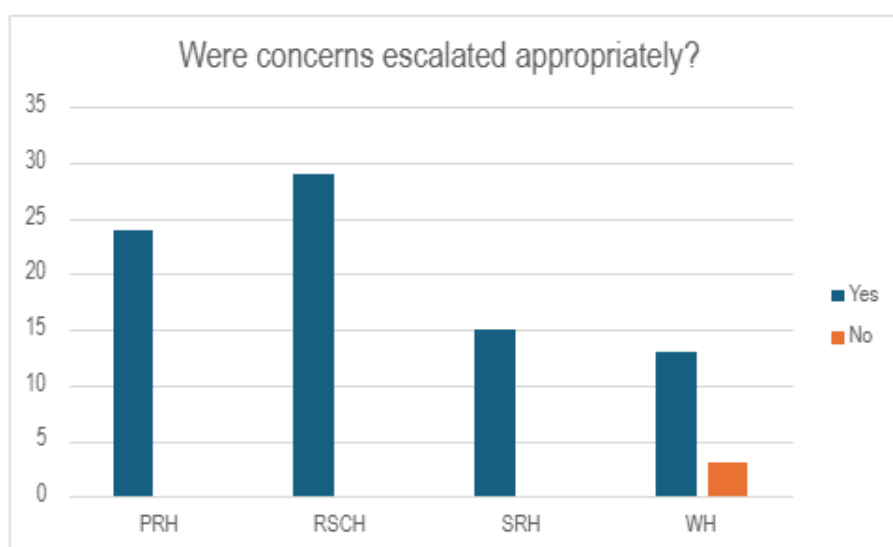
All babies at SRH cases were appropriately reviewed when found to meet the Neonatal Transitional Care criteria. However, documentation of Initial Neonatal/Paediatric reviews showed gaps in 5 cases (3 at Worthing, 1 at RSCH & 1 at PRH)

7 babies in total did not receive daily reviews. 2 at PRH, 1 RSCH, 1 SRH & 3 at WH.

This could be attributed to the documentation being located separately on Metavision or paper notes at SRH & WH. However, this cannot be confirmed as this was beyond the scope of this audit but has been raised with the clinical director for neonatology.

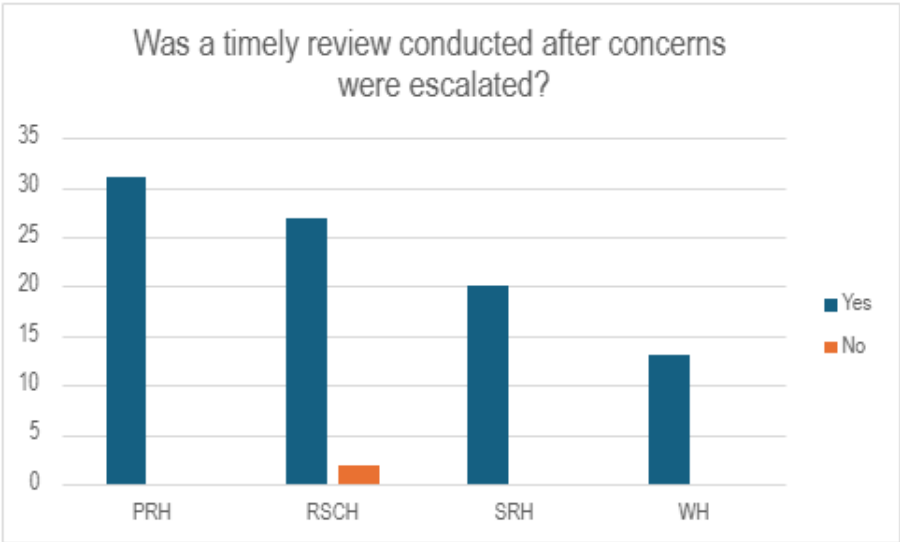
6 out of the 7 babies had followed the appropriate TC pathway and completed full observation period, however it was not possible to deduce why the daily review was not completed in these cases.

There has been considerable improvement for PRH regarding documented daily reviews as this had been an ongoing issue in previous reports.

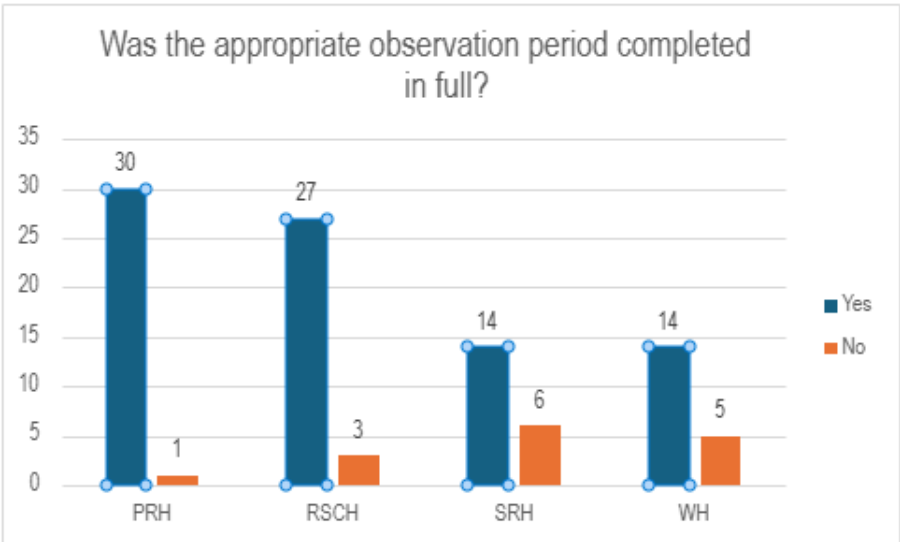


All cases reviewed at PRH and RSCH and PRH were escalated appropriately. However, at WH:

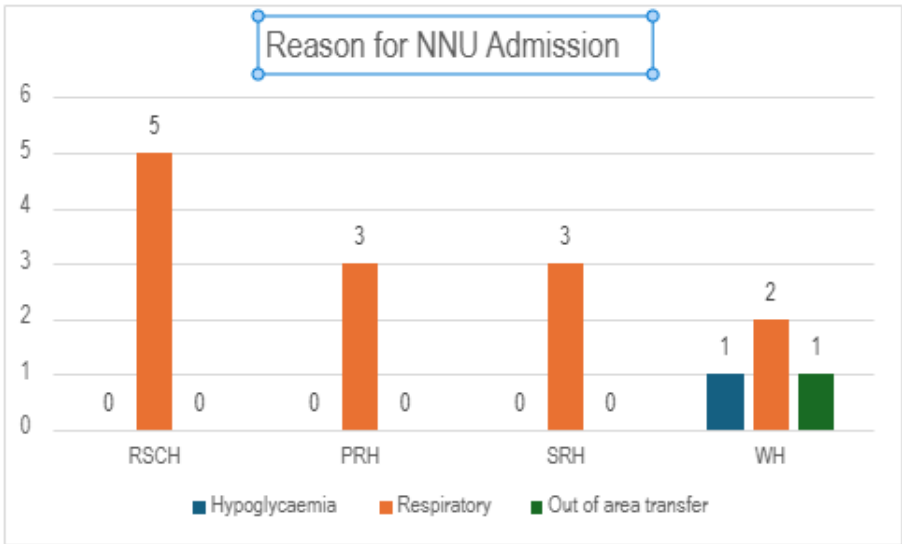
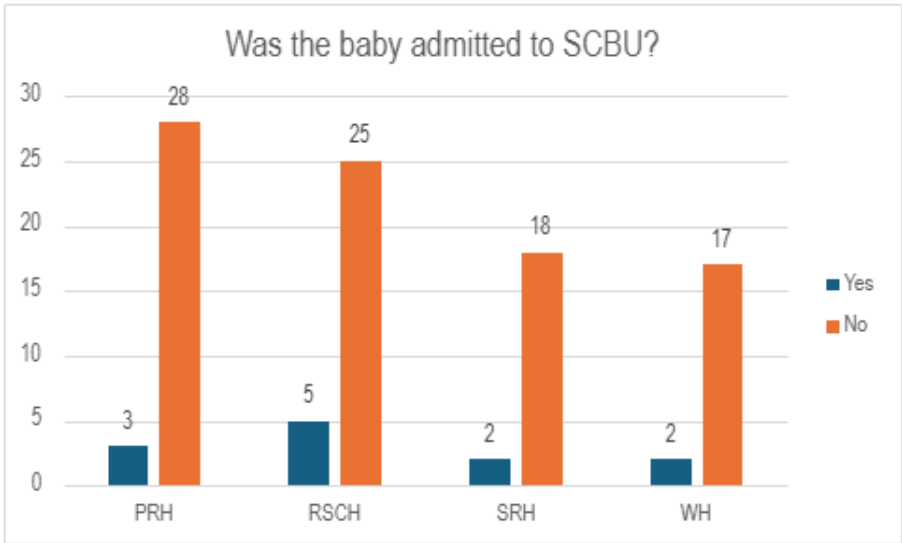
- A 36 week neonate, 2 x sets of observations were initially not escalated. Raised respiratory rate of 66/min and pyrexia of 37.8 degrees and observations were not done 4 hourly in the first 24 hours
- A 40 week neonate, 1 x low temp not escalated and 1 x low respiratory rate were not escalated
- A 35+1 week neonate, concerns were not escalated appropriately however there is no further information provided within the data collection tool to make further comment.



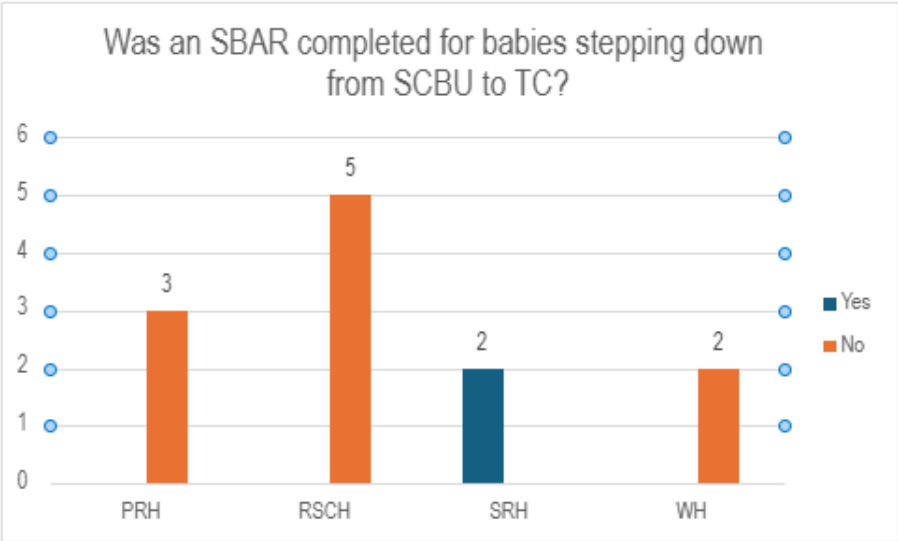
There were 2 babies at RSCH that did not receive a timely review from the neonatal team when this was escalated to them. For one baby, there were 4 sets of abnormal observations over a 5-hour time span, the SHO was bleeped 3 separate times before a review was performed. For the other baby, there was a delay 4.75 hours before review was performed. Unfortunately, no further detail has been provided therefore cannot be commented on within this report but again has been escalated to the clinical director for action and identification of potential risk.



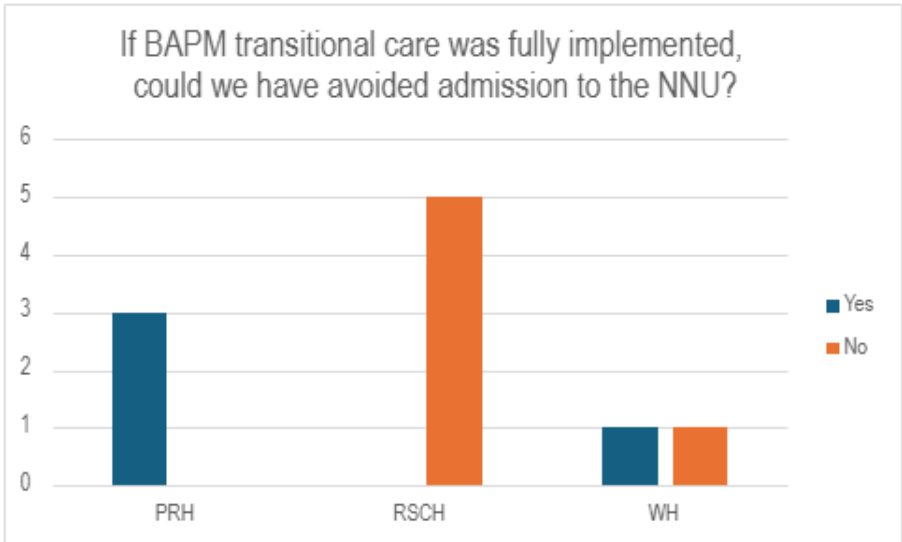
No sites were 100% compliant with regards to completing observations in full. The numbers for lack of completion were higher at SRH & WH. It is acknowledged that Nursery Nurse staffing is different across sites and a more thorough review will be needed if this is established to be a reoccurring theme.



TC admission to NNU is shown in the graph above.
Most of these cases were for respiratory reasons.



Of all the babies that were readmitted to the postnatal wards after a special care admission only SRH completed an SBAR. Ongoing work in the form of a QI project is underway to improve upon SBAR being completed for each baby stepping down from SCBU/NNU to TC.



This is a new addition to this audit to try and establish the number of infants that could have avoided admission if BAPM transitional care was fully implemented.

3 babies were identified at PRH & 1 at WH that could have remained on the postnatal ward if BAPM TC was fully implemented.

This aspect of the audit needs to be developed further to establish what type of TC if implemented on the postnatal wards could have avoided separation and an admission to special care.

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 being documented has improved since the last quarter especially at PRH.
- Delay in neonatal team reviews being performed/documentated on BadgerNet may be due to staffing constraints or increased workload pressures on the unit.
- Poorer completion of neonatal observations at WH.
- Lack of documented SBARs continues to be a theme when babies are stepping down from special care.

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: [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. This still needs to be implemented and is the focus of the new year.
- QI project across all four sites focussing on neonatal care with a focus on hypoglycaemia, feeding and SBAR
- Review and align neonatal guidance across all four hospital sites.
- Review and increase neonatal staffing capacity at PRH.
- Review of current data collection to have more in depth understanding of why observations are not completed in full, reviews are not timely, and escalations do not occur so that this can inform future practice & learning
- Review of current data collection to look at how this audit can inform & support the further development of Transitional Care Services at UH Sussex

Perinatal Mortality Review Tool
(PMRT)

Reports of Cases from Q4 (January to March 2025)

University Hospitals Sussex- Maternity
Princess Royal, Royal Sussex County, Worthing and St Richard's Hospitals

This is the final report in this format I will put together.

August 2025- Quarter 4-Outcomes only

November 2025 - Quarter 1 report will be a complete report which will include the data and outcomes and themes.

This will aid identification of themes and will also fall in line with the quarterly presentation to LMNS (Local Maternity and Neonatal System). This change also matches with the PMRT guidance of reports for trust boards and ensures we continue to meet CNST (Clinical Negligence Schemes for Trusts) requirements.

Aims

The aim of the Perinatal Mortality Review Tool (PMRT) programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units.

This report will identify any themes and the consequent action plans. The report will evidence the required standards outlined below from CNST Year 6.

The PMRT tool supports:

- Systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process.
- A structured process of review, learning, reporting and actions to improve future care.
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided.
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented.
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across several deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable.
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.

- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports, a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

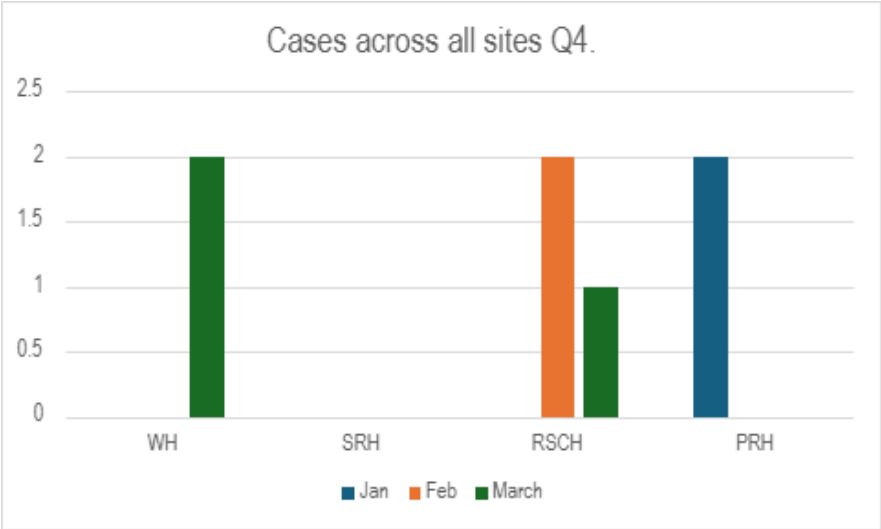
Standards

The standards this report will measure against are using the CNST Year 6 and are as follows.

- Notify all deaths:** All eligible perinatal deaths should be notified to MBRRACEUK within seven working days.
- Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.
- Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.
- Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.

Data

There were 7 deaths reported in this period, across the Trust.



Outcomes

Standard A

Notifications-

Eligible deaths that require notification are:

- **Late fetal losses** – the baby is delivered between 22⁺⁰ and 23⁺⁶ weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred. The eligibility criteria for MBRRACE-UK Perinatal Death Surveillance System are based on gestation at delivery irrespective of when the death occurred.
- **Stillbirths** – the baby is delivered from 24⁺⁰ weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks' gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.
- **Late neonatal deaths** – death of a live born baby (born at 20 weeks' gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.
- **Post-neonatal deaths** – We are no longer collecting information for post-neonatal deaths because of the difficulty in ensuring complete data collection from the wide variety of places of death for these cases.
- **Terminations of pregnancy:** The termination of pregnancy notification criteria have been updated (10/07/24) - only registered stillbirths or neonatal deaths resulting from a termination of pregnancy should be notified.

Eligible perinatal deaths are to be notified to MBRRACE-UK within seven working days. There were 8 PMRT eligible perinatal deaths and all 8 were notified within 7 days. (100%).

Standard B

Seek parents' views of care: For at least 95% of all the deaths of babies eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide

feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.

There were 7 deaths which required parent's perspectives of care and questions they have sought. Of these cases **100%** have received duty of candour. All questions and perspectives are presented to the PMRT review panel to support the review and to enable answers. These will be added to the report following multidisciplinary review.

The Trust are compiling a database of available literature for families that do not speak/read English as their first language. Having information translated has led to delay in obtaining parent perspective and feedback in previous years. As the need arises, all sites will be able to access these translations.

Standard C

The following deaths should be reviewed to meet CNST safety action one standards:

- All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)
- All stillbirths (from 24+0 weeks' gestation)
- Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth). While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.

For deaths of babies who were born and died in the Trust, multi-disciplinary reviews using the PMRT should be carried out.

Starting the Review

95% of reviews should be started within two months of the death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review.

If a case requires assigning to another Trust for a review, this may affect the ability to meet some of the deadlines for starting, completing, and publishing that review. This will be accounted for in the external CNST validation process.

There were 7 deaths eligible for starting the review within 2 months of the death. **100%** of reports were commenced within this period.

Final Report

To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include a member from a relevant professional group who is external to the unit who can provide 'a fresh pair of eyes' as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews, and you may need to be selective as to which deaths are reviewed by the team including an external member. **100%** of reviews have or are planned to have a multi-disciplinary review.

From January 2025 a member of the MNVP (Maternity and Neonatal Voices Partnership) have attended the reviews to ensure service user involvement.

For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out considering those findings.

A minimum of 60% of multi-disciplinary reviews should be published within six months. There are 6 deaths that are eligible for a report.

Outcomes and Themes

Cases are graded by the PMRT panel to establish whether care contributed to the baby's death and the care the mother/birthing parent received following the birth of their baby. These are defined as follows:

Grading of care of the mother and baby up to the point that the baby was confirmed as having died.

- A - The review group concluded that there were no issues with care identified up to the point that the baby was confirmed as having died
- B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the mother following confirmation of the death of her baby.

- A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby

- B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
- C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
- D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Review Outcomes

January

WH

No cases reviewed this month.

SRH

No cases reviewed this month.

PRH

No cases reviewed this month.

RSCH

2 cases reviewed

February

WH

No cases reviewed this month.

SRH

No cases reviewed this month.

PRH

1 case reviewed

RSCH

2 cases reviewed

WH

1 case reviewed

March

WH

No cases reviewed this month.

SRH

No cases reviewed this month.

PRH

1 case reviewed

RSCH

No cases reviewed this month.

Avoidable Perinatal Deaths

Avoidable deaths are considered where the review group identified care issues which they considered may have made a difference to the outcome for the baby or likely to have made a difference to the outcome for the baby. These are graded by the panel at the time of the review.

Due to the time taken to publish final reports on PMRT, avoidable deaths are taken from the previous quarter’s cases. There were 0 avoidable perinatal deaths from Quarter 3 2024.

Themes

No themes were identified in this quarter. We have retrospectively identified a theme in quarter 3. 2 cases were reviewed where families expressed unhappiness about the information given following a preterm rupture of membranes diagnosis, they both felt information was lacking and they were ill-prepared for the possible outcomes. This was discussed at the panel reviews where the neonatal and obstetric consultant agreed that some collaborative work could improve this. Following discussion with the LMNS they informed me this work was already being carried out and that they will share the information with us.

Conclusion

Key

	Standard met for PMRT & CNST
	Not applicable for CNST but ‘to be met’ for PMRT
	Standard required for PMRT & CNST ‘to be met’
	Standard not met for PMRT & CNST
	Not applicable for PMRT & CNST

PMRT Number	Site	Surveillance and Notification (Standard A)	Parents Perspective Sought (Standard B)	Published report (Standard C)	Grading of care
96274	RSCH	Met	Met	Met	B, A, A.
95823	RSCH	Met	Met	Met	A, A.
96023	RSCH	Met	Met	Met	B, A, C.
96448	PRH	Met	Met	Met	A, A.
96416	RSCH	Met	Met	Met	A, A, B.
96229	PRH	Met	Met	Met	A, B.
96716	PRH	Met	Met	Not yet met	B, B, A. B, B, B.

Summary

The action plans from the individual PMRT reviews are added to the Quality & Safety Action Tracker and monitored through this forum across all four sites.

Action Plan

Recommendation	Action	Person Responsible	Date Due Completion
Joint PMRT meeting across the 4 sites.	Align job plans and meeting schedules	Governance leads, Chief of Division, Director of Midwifery	Q4-Update-Was scheduled to start January 2025 delayed due to job planning. Has been escalated and currently sitting with the executive team. In the interim we are scheduling meetings monthly.
Placenta histology should be carried out by a perinatal pathologist.	Explore the possibility of using the same perinatal pathology service for placental histology for RSCH/PRH. Raised to Risk Register in October.	Clinical Directors and Chief of Service	May 2025- Dissected placentas currently being sent to Portsmouth Perinatal pathology service but future funding not confirmed. There are still significant delays with reporting.
Review of patient information given to families with a Preterm rupture of membranes diagnosis.	Neonatal and obstetric teams to liaise and discuss information for families in future. Await feedback from LMNS.	LMNS	Awaiting LMNS feedback.

Mortality and Learning from Deaths 2024/25 Annual Report



University Hospitals Sussex
NHS Foundation Trust

Learning from Death Mortality Overview - 2024/25

*Data source SHMI Module HEDS and includes of out of hospital deaths.

2024/25 breakdown by hospital site per month. **Latest data available.**

Month	PRH				RSCH				WGH				SRH				UHSx Acute Adult Deaths			
	Adults who died within 30 days of discharge	Crude Mortality (12 Month Rolling)	HSMR (12 Month Rolling)	SHMI (12 month rolling)	Adults who died within 30 days of discharge	Crude Mortality (12 Month Rolling)	HSMR (12 Month Rolling)	SHMI (12 month rolling)	Adults who died within 30 days of discharge	Crude Mortality (12 Month Rolling)	HSMR (12 Month Rolling)	SHMI (12 month rolling)	Adults who died within 30 days of discharge	Crude Mortality (12 Month Rolling)	HSMR (12 Month Rolling)	SHMI (12 month rolling)	Adults who died within 30 days of discharge	Crude Mortality (12 Month Rolling)	HSMR (12 Month Rolling)	SHMI (12 month rolling)
Apr-24	14	1.51	80.50	94.18	30	2.76	99.53	109.02	47	2.97	101.74	102.93	25	2.91	98.46	104.27	116	2.75	97.45	103.70
May-24	13	1.48	78.19	91.49	21	2.69	97.89	107.81	34	2.97	101.29	101.46	42	2.90	97.04	103.89	110	2.33	96.14	103.43
Jun-24	22	1.49	78.35	92.58	38	2.66	96.84	108.98	38	3.01	102.87	101.69	34	2.91	96.76	103.27	132	2.67	96.19	102.78
Jul-24	15	1.49	76.26	92.15	32	2.66	96.60	110.38	45	3.02	102.27	102.07	30	2.98	99.18	104.81	122	2.45	96.27	103.63
Aug-24	18	1.49	74.78	93.71	26	2.68	97.35	111.97	34	3.06	102.01	101.64	24	2.93	98.83	103.82	102	2.34	96.08	103.80
Sep-24	13	1.47	72.95	92.02	28	2.67	96.39	112.31	46	3.10	102.65	104.13	36	2.86	98.31	101.85	123	2.39	95.58	103.94
Oct-24	21	1.40	70.68	89.77	37	2.63	96.37	113.73	41	3.12	101.46	104.17	40	2.87	98.74	102.28	139	2.38	95.07	104.16
Nov-24	15	1.35	69.06	87.32	28	2.62	97.37	114.63	42	3.14	102.98	104.47	30	2.84	98.97	101.85	115	2.51	95.42	104.09
Dec-24	21	1.47	74.76	91.75	30	2.59	98.05	114.58	40	3.11	100.30	103.59	50	2.85	101.07	103.18	141	3.11	96.42	104.74
Jan-25	25	1.55	76.29	93.88	32	2.52	99.40	114.53	36	3.13	99.82	103.04	48	2.86	100.47	103.30	141	3.17	96.76	104.81
Feb-25	22	1.57	78.29	94.84	25	2.51	99.94	115.07	42	3.16	100.21	103.59	36	2.85	100.58	103.26	125	2.81	97.30	105.24
Mar-25		1.59				2.48				3.22				2.80				2.60		
Total	199				327				445				395				1366			

Note: There were 32 child deaths between Apr-24 and Mar-25 excluded from adult deaths.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at UHSx and the number that would be expected to die on the basis of average England figures.

Learning from Death Mortality Overview - 2024/25

2024/25 breakdown of adult deaths under the care of UHSx by hospital site per quarter, compared with 2023/24. Deaths per 1000 bed days.



University Hospitals Sussex
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Older population in West Sussex contributing to higher number of deaths per 1000 bed days at WGH and SRH.

2024/25 Deaths per 1000 Bed Days				
	PRH	RSCH	WGH	SRH
Q1	1.4	1.1	2.3	2.2
Q2	0.9	1.1	1.8	2.3
Q3	1.3	1.3	1.9	2.6
Q4	1.5	1.2	2.5	2.8

Note: Bed days data taken from dashboard PB004 - Length of stay insights

UHSx Adult Deaths	Q1	Q2	Q3	Q4	2024/25 Total	2023/24 Total	Variance
No. adult deaths recorded	984	916	1055	1118	4073	4247	174
No. of adult patients that died registered as having a Learning Disability (LD)	10	11	10	9	40	25	15
No. of adult patients that died known to have Severe Mental Health illness (SMH)	8	8	3	3	22	29	7

	Other		PRH		RSCH		WGH		SRH		UHSx Acute Adult Deaths		
2024/25	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	2024/25 Total
Q1	1	0	76	12	244	45	296	25	267	18	884	100	984
Q2	0	0	69	6	273	36	280	20	218	14	840	76	916
Q3	0	0	93	11	327	35	287	21	271	10	978	77	1055
Q4	0	0	108	12	317	28	359	21	245	28	1029	89	1118
Total	1	0	346	41	1161	144	1222	87	1001	70	3731	342	4073

Note: 1 x adult (over age of 18) died at RACH.

	Other		PRH		RSCH		WGH		SRH		UHSx Acute Adult Deaths		
2023/24	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	Inpatient Deaths	ED Deaths	2024/25 Total
Q1	0	0	70	5	283	32	319	12	209	6	881	55	936
Q2	0	0	75	6	278	34	276	11	288	10	917	61	978
Q3	0	0	96	9	311	51	334	26	332	14	1073	100	1173
Q4	0	0	78	5	295	57	359	22	319	25	1051	109	1160
Total	0	0	319	25	1167	174	1288	71	1148	55	3922	325	4247

Key Observations

- Deaths per 1000 bed days shown opposite. Expected higher numbers at WGH and SRH due to population.
- 1 inpatient adult death at RACH (young adult oncology patient.)
- Increased acute adult deaths during Q3 and Q4 - expected finding due to winter pressures.
- Lowest number of adult deaths in Q2 during summer months.
- 174 fewer adult deaths in 2024/25 compared to 2023/24.
- 7 fewer adult deaths in patients with known Severe Mental Health illness. Average 5.5 per quarter in 2024/25; 7.25 in 2023/24.
- 15 more adult deaths in patients with known Learning Disability - attributed to greater awareness of online reporting to LeDeR. Average 10 per quarter in 2024/25; 6.25 in 2023/24, with less cases reported in Q3 and Q4.

Learning from Death Mortality Demographics - 2024/25

Deaths by IMD Decile (1 = most deprived, 10 = least deprived.) 2024/25 breakdown by quarter.

Demographics for 2024/25 Adult Deaths	Q1	Q2	Q3	Q4	Total	% of total adult deaths
1	37	28	32	30	127	3.12%
2	62	54	55	46	217	5.33%
3	68	84	90	88	330	8.10%
4	64	62	74	71	271	6.65%
5	117	104	118	127	466	11.44%
6	150	159	165	171	645	15.84%
7	136	98	146	148	528	12.96%
8	138	106	139	175	558	13.70%
9	109	114	124	134	481	11.81%
10	100	103	108	113	424	10.41%
Missing	3	4	4	15	26	0.64%
UHSussex Total	984	916	1055	1118	4073	
No. in most deprived postcodes (D1-4)	231	228	251	235	945	
% in most deprived postcodes (D1-4)	23.48%	24.89%	23.79%	21.02%	23.20%	

Demographics for 2024/25 SJR referrals	Q1	Q2	Q3	Q4	Total	% of all SJR referrals
1	13	5	5	6	29	4.13%
2	22	10	9	8	49	6.97%
3	21	19	13	14	67	9.53%
4	20	14	9	9	52	7.40%
5	28	21	13	15	77	10.95%
6	32	28	15	20	95	13.51%
7	39	25	14	11	89	12.66%
8	21	21	25	31	98	13.94%
9	20	22	14	15	71	10.10%
10	25	14	15	16	70	9.96%
Missing	2	0	2	2	6	0.85%
UHSussex Total	243	179	134	147	703	
No. in most deprived postcodes (D1-4)	76	48	36	37	197	
% in most deprived postcodes (D1-4)	31.28%	26.82%	26.87%	25.17%	28.02%	

Key Observations

- **23.20% (945) acute** adult deaths and **28.02% (197)** SJR referrals within most deprived postcodes (D1-4.)
- Consistent proportion of adult deaths within most deprived postcodes (D1-4), ranging between **21.02% (Q4)** and **24.89% (Q2)** but greater variance for SJR referrals, ranging between **25.17% (Q4)** and **31.28% (Q1.)**
- Highest number of adult deaths (**15.84%**) related to D6 while highest number of SJR referrals related to D8 (**13.94%**), closely followed by D6 (**13.51%**)

Note: Table includes all referrals received during 2024/25.

Learning from Death Mortality Demographics - 2024/25

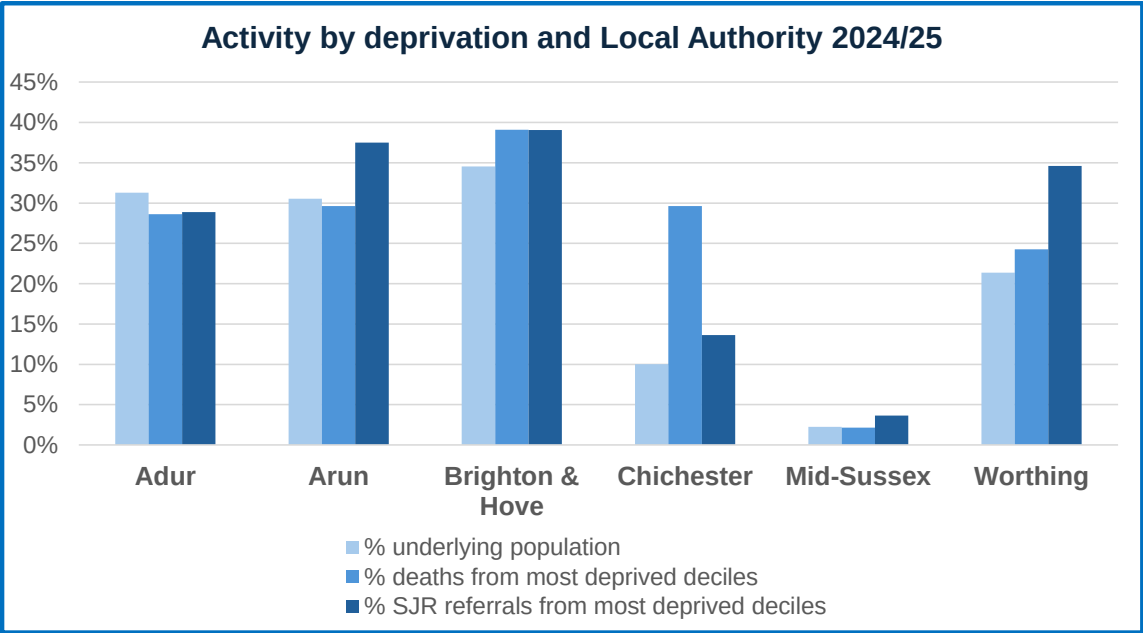
Deaths by IMD Decile (1 = most deprived, 10 = least deprived)

2024/25 Local Authority overview



Demographics for 2024/25 by Local Authority	Adur	Arun	Brighton & Hove	Chichester	Mid-Sussex	Worthing
% underlying population	31.28%	30.55%	34.54%	10.02%	2.25%	21.38%
% deaths from most deprived deciles	28.63%	29.62%	39.10%	29.62%	2.14%	24.28%
% SJR referrals from most deprived deciles	28.89%	37.50%	39.05%	13.64%	3.64%	34.62%

Note: Table does not include Eastbourne, Hastings, Lewes, Rother, Wealden, East Sussex, Horsham or Crawley Local Authorities.



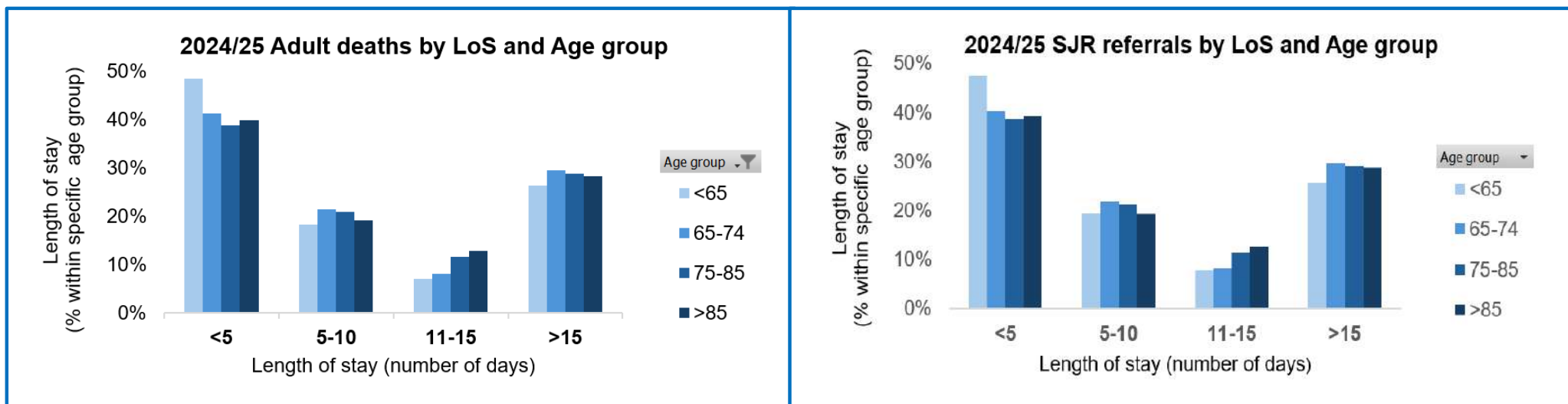
Key Observations

- **Adur:** Fewer deaths and SJR referrals from most deprived than in underlying populations (latter could indicate access issues.)
- **Arun, Chichester and Mid-Sussex:** More SJR referrals from most deprived than in underlying populations.
- **Brighton & Hove and Chichester:** More deaths in most deprived than expected based on underlying population.
- **Worthing:** More deaths in most deprived than expected based on underlying population and greater SJR referrals.



Learning from Death Mortality Deaths by Length of Stay & Age Group - 2024/25

2024/25 breakdown of adult deaths by length of stay (number of days) and age group.



Key Observations

- LoS dispersal similar across all age groups, with minimal variance between **acute** adult deaths and SJR referrals. However, higher proportion of LoS less than 5 days observed in under 65 age group.
- Highest proportion of adult deaths in over 85 age group, followed by 75-85 age group (expected finding.)
- Consistently low deaths in under 65 age group but high frequency of accepted SJR referrals.
- **33.10% (1348)** adult deaths with LoS less than 5 days; next highest LoS greater than 15 days at **23.13% (942.)**
- Highest number of SJR referrals with LoS greater than 15 days **35.09% (80.)**
- LoS could not be calculated for **753 (18.49%)** adult deaths and **28 (12.28%)** SJR referrals due to missing admission dates.
- [Admission date added as mandatory field on ME referral form since 10/03/2025.](#)

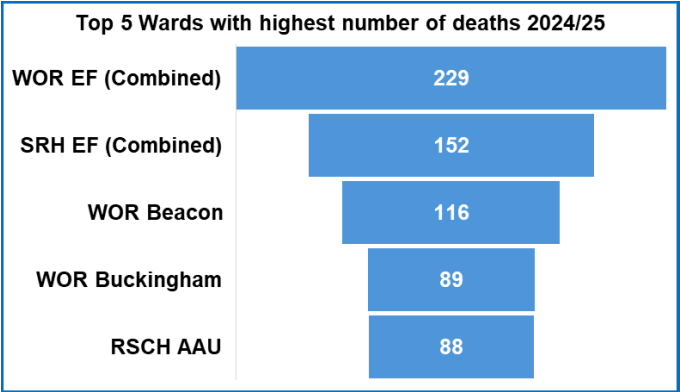
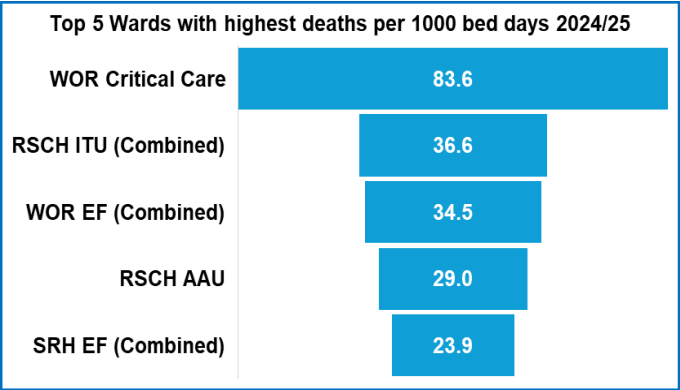
Learning from Death Mortality Deaths by Ward - 2024/25

2024/25 breakdown of adult deaths by ward (by highest number of deaths and deaths per 1000 bed days.)



Adult Deaths on Ward 2024/25				
Adult Deaths on Ward (order of incidence for no. of deaths)	No. of deaths	No. of deaths per 1000 bed days	% of site specific deaths	% of all adult deaths
WOR EF (Arrival, A, B, C, D Combined)	229	34.5	17.14%	5.62%
SRH EF (Combined)	152	23.9	14.56%	3.73%
WOR Beacon	116	9.9	8.68%	2.85%
WOR Buckingham	89	11.7	6.66%	2.19%
RSCH AAU	88	29.0	6.74%	2.16%
SRH Petworth	88	15.5	8.43%	2.16%
LMB C8	83	11.1	6.36%	2.04%
PRH Balcombe	80	13.7	20.67%	1.96%
RSCH ITU (LMB Critical Care Wards A7 & C7 Combined)	79	36.6	6.05%	1.94%
SRH Boxgrove	78	11.8	7.47%	1.92%
WOR Byworth	77	12.5	5.76%	1.89%
PRH Pyecombe	75	12.1	19.38%	1.84%
SRH Ashling	75	12.0	7.18%	1.84%
LMB C9	71	9.5	5.44%	1.74%
SRH Fishbourne	71	9.6	6.80%	1.74%
WOR Botolphs	70	11.7	5.24%	1.72%
WOR Eastbrook	68	12.1	5.09%	1.67%
WOR Critical Care	67	83.6	5.01%	1.64%
SRH Birdham	66	9.8	6.32%	1.62%
RSCH A&E (Combined)	63	17.7	4.83%	1.55%

Note: Bed days data taken from dashboard PB050 - LOS Programme dashboard



Key Observations

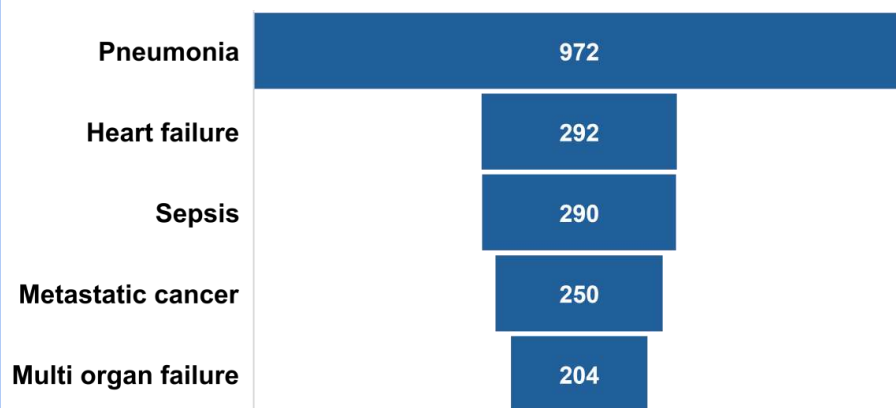
- Top 5 wards with highest number of deaths equated to **674 (16.57%)** of all adult deaths across UHSx.
- Expected high level of adult deaths across Critical Care/ITU and Emergency Floor due to treating critically unwell patients. Deaths at **WOR EF, SRH EF, RSCH AAU, RSCH A&E** and **RSCH ITU** accounted for **15% (611)** of all adult deaths across UHSx.
- **229** adult deaths in **WOR EF**; **17.14%** at WGH, **5.62%** across UHSx, with **34.5** deaths per 1000 bed days.
- **WOR Critical Care** had highest number of deaths per 1000 bed days (**83.6**) but three times fewer deaths than **WOR EF**.
- Highest number of **PRH** deaths occurred on **Balcombe**; **20.67%** at PRH, **1.96%** across UHSx, with **13.7** deaths per 1000 bed days.

Learning from Death Mortality Cause of Death - 2024/25

2024/25 top 5 common causes of acute adult deaths (1a on MCCD) by UHSx hospital site.

Most Common Cause of Death (1a) Acute Adult Deaths 2024/25						
	PRH	RSCH	WGH	SRH	UHSx Total	% of all Adult Deaths
Heart failure	30	79	76	107	292	7.17%
Metastatic cancer	19	98	70	63	250	6.14%
Multi organ failure	24	93	54	33	204	5.01%
Pneumonia	146	251	324	251	972	23.86%
Sepsis	31	81	70	108	290	7.12%
Total	250	602	594	562	2008	49.30%

Top 5 Causes of Death (1a) - Acute Adult Deaths 2024/25



Key Observations

- **23.86% (972)** of all **acute** adult deaths had **pneumonia** listed as **1a** on the MCCD (expected finding.)
- Top 5 common causes of deaths on MCCDs were **pneumonia, heart failure, sepsis, metastatic cancer and multi organ failure**. These accounted for **49.30% (2008)** of all **acute** adult deaths.
- **6.51% (265)** cases had no given cause(s) of death on the ME referral form. Likely due to CoD not being agreed and/or referral to the Coroner. These cases have been excluded from the top 5.
- No comparison with 2023/24 as cause(s) of death not collated for Mortality & Learning from Deaths reports until 2024/25.

Note: There may be more than one given cause of death listed on **1a, 1b, 1c, 1d** and/or **2** of the death certificate.

Learning from Death Structured Judgement Review (SJR) Referrals - 2024/25



2024/25 breakdown of cases referred to SJR including top common causes of acute adult deaths (1a on MCCD).

UHSx SJR Referrals - All Received								
	Other	PRH	RSCH	WGH	SRH	2024/25 Total	2023/24 Total	Variance
Q1	1	21	100	86	35	243	120	123
Q2	0	13	99	48	19	179	133	46
Q3	0	15	68	35	16	134	148	14
Q4	0	13	76	38	20	147	155	8
Total	1	62	343	207	90	703	556	147
% of all SJR referrals	0.14%	8.82%	48.79%	29.45%	12.80%			

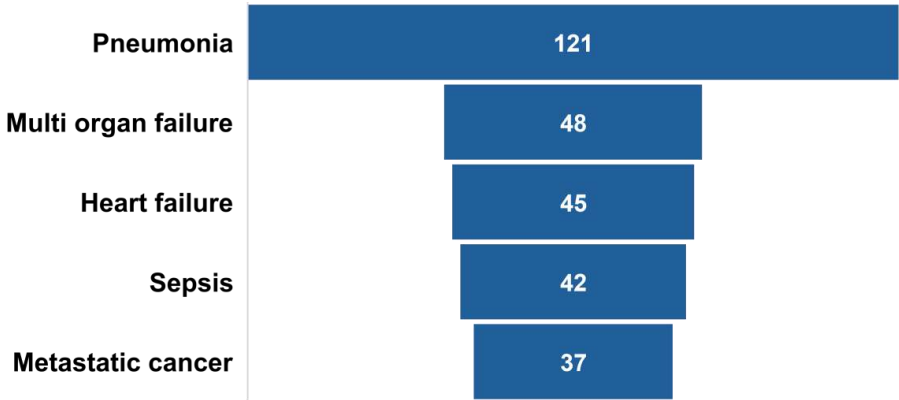
Note: 1 x adult (over age of 18) died at RACH.

Key Observations

- 147 more SJR referrals in 2024/25 than in 2023/24. 17.26% (703) adult acute deaths referred for SJR compared to 13.09% (556) in 2023/24.
- Peak SJR referrals during Q1; 243 in 2024/25, 120 in 2023/24.
- Highest number of SJR referrals received related to adult deaths at RSCH, 48.79% (343) compared to WGH, 17.95% (244) in 2023/24.
- 17.21% (121) SJR referrals had pneumonia listed as 1a on the MCCD (expected finding.) Data not collated in 2023/24.
- Top 5 causes of adult deaths accounted for 41.68% of all SJR referrals.
- 19.63% (138) SJR referrals had no given cause(s) of death on the form. These cases have been excluded from the top 5.

Most Common Cause of Death (1a) SJR Referrals 2024/25						
	PRH	RSCH	WGH	SRH	UHSx Total	% of all SJR referrals
Heart failure	4	17	12	12	45	6.40%
Metastatic cancer	2	22	11	2	37	5.26%
Multi organ failure	5	25	14	4	48	6.83%
Pneumonia	17	41	43	20	121	17.21%
Sepsis	5	18	8	11	42	5.97%
Total	33	123	88	49	293	41.68%

Top 5 Causes of Death (1a) - SJR Referrals 2024/25

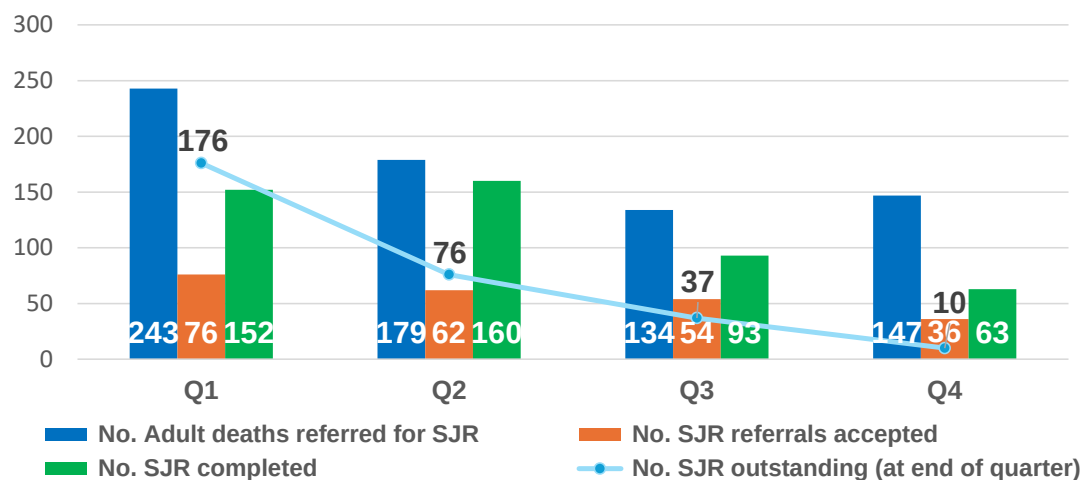


Note: There may be more than one given cause of death listed on 1a, 1b, 1c, 1d and/or 2 of the death certificate.

Learning from Death Structured Judgement Review (SJR) Data - 2024/25

2024/25 SJR referred, completed and outstanding at the end of each quarter, compared with 2023/24.

2024/25 Structured Judgement Review (SJR) Referrals



Structured Judgement Reviews Referrals	Q1	Q2	Q3	Q4	2024/25 Total	2023/24 Total	Variance
No. Adult deaths referred for SJR	243	179	134	147	703	556	147
No. SJR referrals accepted	76	62	54	36	228	556	328
No. SJR completed	152	160	93	63	468	257	211
No. SJR outstanding (at end of quarter)	176	76	37	10			

Key Observations

- At the start of 2024/25 there was a backlog of **585** SJRs. Cases were reviewed by the Trust Mortality Lead and Senior SJR Reviewers, who assessed end of life quality of care and decided whether to proceed to a comprehensive Structured Judgement Review.
- **703 (17.26%) acute** adult deaths referred for independent SJRs. Of these, **228** referrals were accepted and **468** completed, which included those outstanding at the end of 31 March 2024.
- **211** additional SJRs completed in 2024/25 than in 2023/24.
- A weekly SJR Triage Panel was introduced in 2024/25 Q2, which led to lower numbers of accepted referrals. Hence, considerable variance from 2023/24 (**328**.)
- **32.43%** of SJR referrals accepted during 2024/25.
- Significant reduction in number of SJRs outstanding, quarter on quarter, with **10** SJRs outstanding as of 31 March 2025.
- **No** outstanding SJRs over 60 days or over 90 days from the date of referral as of 31 March 2025.

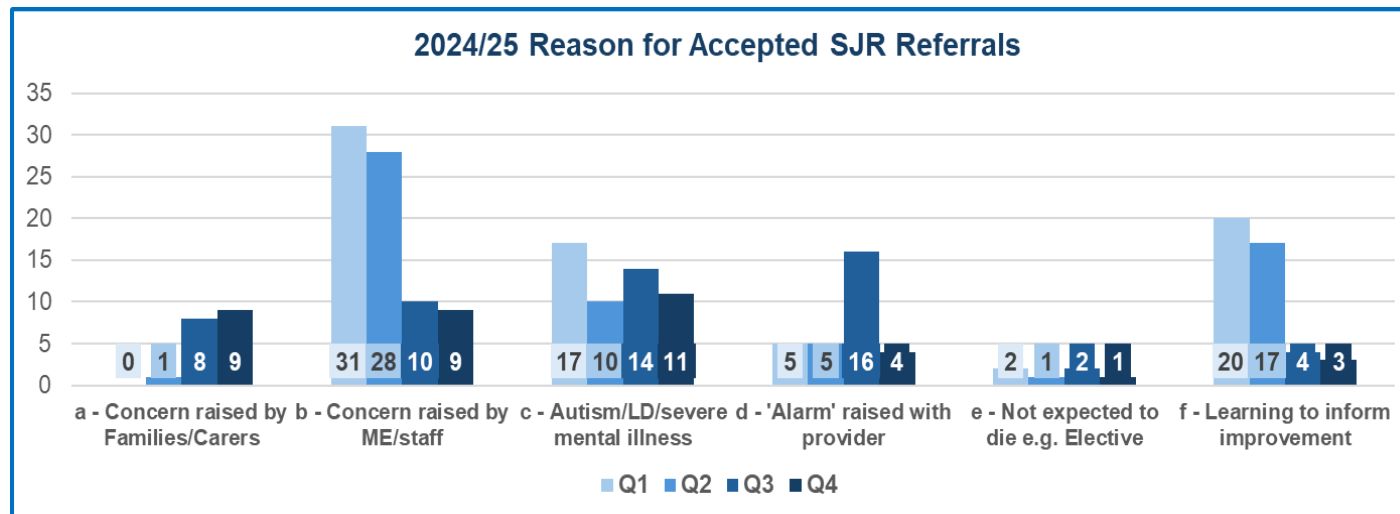
Learning from Death Structured Judgement Review Referrals - 2024/25

2024/25 breakdown of reason(s) for accepted SJR referrals by quarter.

Key Observations

- Approximately **95%** of SJR referrals were received through the Medical Examiner Service, with **5%** from the Patient Safety Team and/or Clinical Divisions.
- **Concern raised by ME/staff** was the highest reason for **accepted** SJR referrals at **11.10% (78.)**
- The second highest reason was **Autism/LD/severe mental health illness** at **7.40% (52.)** Expected finding due statutory requirement.
- An increase in the number of SJR referrals **received** due to **Concerns raised by Families/Carers** was observed in 2024/25. This can, in part, be linked with media coverage on historical General Surgery cases.

Note: Table details accepted SJR referrals only.



Reason for Accepted SJR Referrals						
	Q1	Q2	Q3	Q4	2024/25 Total	% of accepted SJR referrals
a - Concern raised by Families/Carers	0	1	8	9	18	2.56%
b - Concern raised by ME/staff	31	28	10	9	78	11.10%
c - Autism/LD/severe mental illness	17	10	14	11	52	7.40%
d - 'Alarm' raised with provider	5	5	16	4	30	4.27%
e - not expected to die e.g. Elective	2	1	2	1	6	0.85%
f - learning to inform improvement	20	17	4	3	44	6.26%
Total	75	62	54	37	228	

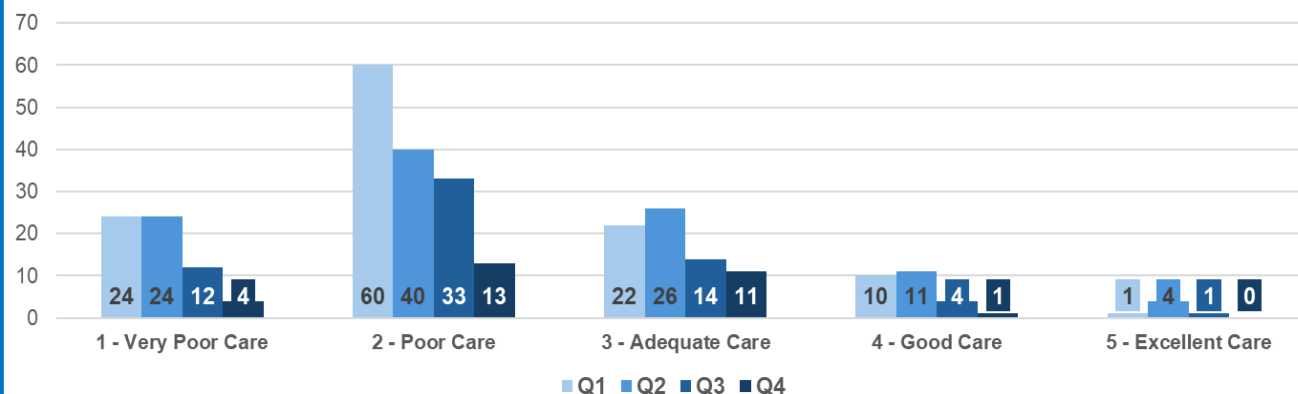
Note: Table includes accepted SJR referrals only.

Learning from Death SJR Mortality Panel Outcome Scores - 2024/25

2024/25 Mortality Panel scores following completion of SJRs by SJR Reviewers, compared to 2023/24.

Mortality Panel Scores							
	Q1	Q2	Q3	Q4	2024/25 Total	2023/24 Total	Variance
1 - Very Poor Care	24	24	12	4	64	13	51
2 - Poor Care	60	40	33	13	146	119	30
3 - Adequate Care	22	26	14	11	73	59	14
4 - Good Care	10	11	4	1	26	53	27
5 - Excellent Care	1	4	1	0	6	13	7
Total	117	105	64	29	315	257	58

2024/25 Mortality Panel Scores



A Panel of SJR Reviewers and the Mortality & Learning from Deaths Manager review completed SJRs with a score of **1 (Very Poor Care)**, **2 (Poor Care)** or **3 (Adequate Care.)** In 2024/25 Q4 routine review of cases scoring **3** was reinstated, with random selection in 2024/25 Q3 and Q2.

Key Observations

- Descending number of SJRs reviewed per quarter attributed to reduction in accepted referrals.
- Fewer Panels in 2024/25 Q4 due to Chair/SJR Reviewer/LfD team availability.
- **58** more SJRs reviewed at Panel in 2024/25 than in 2023/24.
- **46.35% (146)** of SJRs reviewed at Panel scored **2 (Poor Care)**; a considerable reduction from **77.43% (119)** in 2023/24. This can be accounted for by changing parameters on cases discussed.
- **20.32% (64)** of SJRs reviewed at Panel scored **1 (Very Poor Care)**; **51** more than in 2023/24, **5.06% (13.)**
- **23.17% (73)** scored **3 (Adequate Care)**; **22.96% (59)** in 2023/24.
- **89.84% (283)** of all SJRs reviewed scored **between 1 and 3**; increase from **70.43% (191)** in 2023/24.
- **10.16% (32)** scored **4 (Good Care)** or **5 (Excellent Care)**; decrease from **25.68% (66)** in 2023/24.

Learning from Death SJR Mortality Panel Identification of Harm - 2024/25

Cases where the Mortality Panel identified that death *may have been avoidable* during 2024/25, compared with 2023/24.

Potentially avoidable deaths					
2024/25	PRH	RSCH	WGH	SRH	UHS Total
Q1	0	1	1	0	2
Q2	0	6	0	0	6
Q3	0	2	1	1	4
Q4	0	0	0	0	0
Total	0	9	2	1	12

Potentially avoidable deaths					
2023/24	PRH	RSCH	WGH	SRH	UHS Total
Q1	0	1	3	1	5
Q2	0	0	0	0	0
Q3	0	0	1	0	1
Q4	0	1	0	1	2
Total	0	2	4	2	8

Key Observations

- **12 (0.29%) acute** adult deaths identified by the Mortality Panel as '**may have been avoidable**' in 2024/25, compared to **8 (0.19%)** in 2023/24.
- Majority of cases downgraded to low harm following review by the relevant Division - see table opposite.

Potentially avoidable deaths investigation outcome					
	Case No.	Site	DoD	Mortality Panel Date	Update
Q1	1	WGH	01/11/2023	23/05/2024	Downgraded to low harm.
	2	RSCH	16/02/2022	27/06/2024	Downgraded to low harm.
Q2	3	RSCH	19/07/2019	25/07/2024	Local Learning Review (LLR)
	4	RSCH	06/12/2022	25/07/2024	Downgraded to low harm.
	5	RSCH	17/12/2022	18/07/2024	Downgraded to low harm.
	6	RSCH	27/03/2024	01/08/2024	DoC letter sent 08/05/2024. PSII.
	7	RSCH	19/06/2023	22/08/2024	Downgraded to low harm.
	8	RSCH	26/06/2024	10/09/2024	DoC letter sent 01/11/2024. PSII, final report awaited. Coroner Inquest pending.
Q3	9	RSCH	10/07/2022	15/10/2024	Downgraded to low harm - Coroner concluded natural death.
	10	RSCH	19/06/2024	29/10/2024	Downgraded to low harm.
	11	WGH	28/10/2023	14/11/2024	Downgraded to low harm.
	12	SRH	06/07/2024	19/11/2024	Downgraded to low harm.

No cases were identified by the Mortality Panel as 'may have been avoidable' in 2024/25 Q4.

Learning from Death SJR Mortality Panel Identification of Harm - 2024/25

DATIX raised post-Mortality Panel where moderate, severe or fatal harm identified, or where Good Care has been identified during 2024/25, compared with 2023/24.

SJRs that resulted in Incident and/or Good Care DATIX post-Mortality Panel												
	PRH		RSCH		WGH		SRH		2024/25 UHSx		2023/24	Variance
	No. Incident DATIX	No. Good Care DATIX	No. Incident DATIX	No. Good Care DATIX	No. Incident DATIX	No. Good Care DATIX	No. Incident DATIX	No. Good Care DATIX	No. Incident DATIX	No. Good Care DATIX	No. Incident DATIX	No. Incident DATIX
Q1	3	0	5	0	24	3	18	1	50	4	8	42
Q2	2		19		10		11		42	0	6	36
Q3	0	0	8	4	9	2	1	1	18	7	9	9
Q4									0	0	36	36
Total	5	0	32	4	43	5	30	2	110	11	59	51

Note: Good Care DATIX temporary paused in 2024/25 Q2 to allow LfD team to focus on triaging SJR referrals. No DATIX raised in 2024/25 Q4. Therefore, data should be treated with caution.

Key Observations

- **110** Incident Datix raised post-Panel by the LfD team in 2024/25, compared to **59** during 2023/24. Increase attributed to greater number of SJRs completed/reviewed at Mortality Panel.
- **11** Good Care Datix raised. No 2023/24 comparator as not previously logged by the LfD team.
- Good Care Datix were temporarily paused in **2024/25 Q2**, to enable the LfD team to focus on triaging SJR referrals.
- During **2024/25 Q4** the Panel did not identify moderate, severe or fatal harm, therefore **no** Datix were raised. For the single case that scored **4 (Good Care)** at Panel, SJR and Panel discussion outputs were shared with the relevant DQSM to disseminate positive learning.

Learning from Death SJR Mortality Panel Learning Themes - 2024/25

Learning themes identified at Mortality Panel during 2024/25

Top 10 learning themes identified from Mortality Panel

- Delay to diagnosis/treatment
- Delay to/no DNACPR/TEP
- Delay to/no palliative care team involvement/EOLC decision-making
- Delay to/no senior input/review
- Delay in recognising deteriorating patient
- Unplanned readmission/poor discharge planning.
- Lack of advanced care planning
- Poor communication with family/NOK
- Poor documentation in hospital records
- Unnecessary investigations.

Recurrent Themes

- Discharge/advance care planning, EOLC (lack of TEP and/or DNACPR) and delayed recognition of deteriorating patient were recurrent themes.
- Additional themes in 2023/24 included:
 - Issues with the prescribing system in A&E
 - Strike effect
 - Systemic issues relating to the transfer of patients between hospital sites

Top 3 positive learning themes identified

- Early recognition of deterioration with appropriate management
- Good EOLC and communication with family/NOK
- Good decision making and involvement of palliative care team.

Learning from Death Update - 2024/25 Reporting Improvements

What? So What? What's Next?

2024/25 Mortality & Learning from Deaths Additional Reporting Criteria	
Q1	Adult deaths and SJR referrals by Index of Multiple Deprivation (IMD) Decile Reason for SJR referral
Q2	Activity by deprivation and Local Authority Adult deaths by ward Most common cause of death - acute adult deaths Most common cause of death - SJR referrals Number of community deaths Number of SJR referrals triaged as not required and common themes
Q3	Adult deaths and SJR referrals by age group Adult deaths and SJR referrals by length of stay (LoS) LeDeR feedback Measureable improvements Next of kin feedback - community deaths
Q4	Activity by accepted SJR referrals Learning from Deaths update - building stronger feedback loops

Building stronger feedback loops in 2025/26

- DQSMs can access SJR and Panel discussion outputs post-Panel, to discuss identified learning with relevant teams and feed back on learning/actions taken.
- New LfD Action Tracker launched for 2025/26. Divisions to assign Action Owners, provide progress updates and document measurable improvements, supported by LfD Improvement Manager.
- Mortality & Morbidity Surveillance Group due to meet on 29/04/2025, strengthening communication with M&M and Medical Examiner Leads, as well as identification of themes.

Key Observations

- Learning from Deaths Policy reviewed and updated in November 2024.
- Reporting developed during 2024/25 to include a breakdown of adult deaths and case record reviews (SJR) by deprivation, age and length of stay.

Note: Table shows demographics and other criteria introduced into UHSx reporting by quarter.

Mortality and Learning from Deaths 2024/25 Measurable Improvements

Improvements delivered following learning from deaths during 2024/25.

2024/25 Mortality & Learning from Deaths Measurable Improvements	
Q1	Learning themes: Medication/Waiting for treatment Update of fractured neck of femur proforma Fascia iliaca block (FiB) audit presented at Patient Safety Forum Provision of FiB kits on ED trolleys FiB training segment at SHO induction Utilisation of ultrasound facilities
Q2	Learning theme: Governance/organisation systems and processes Introduction and review of action log at start of Mortality & Morbidity meetings Themes generated from action log shared as new agenda item on bimonthly Clinical Governance meetings, to disseminate to wider team
Q3	Learning theme: Governance/organisation systems and processes Learning from deaths involving fractured neck of femur embedded into Clinical Governance meetings
Q4	Learning themes: Documentation/Palliative Care Updated Treatment Escalation Plan (TEP) form to better consider and document reasons for Medical Emergency Team (MET) calls. Syringe Pump training video uploaded to IRIS and Sharepoint
Note: A fascia iliaca block (FiB) is used in the pain management of a fractured neck of femur (hip fracture)	



Key Observations

- There were several notable improvements derived from learning from deaths during 2024/25, including:
 - Management of #NOF
 - Structure and content of Mortality & Morbidity/Clinical Governance meetings
 - Updated TEP form.

Medical Examiner Office Update - Acute Inpatient Data - 2024/25

New regulations governing Medical Examiners took effect in England and Wales on 09 September 2024.

Information provided by Lead MEOs, on behalf of independent ME Service.

2024/25 breakdown by UHSx hospital site per quarter, compared with 2023/24.



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	PRH			RSCH			WGH			SRH			UHSx Acute Adult Deaths		
2024/25	% Scrutinised	Referred to Coroner	Investigated by Coroner	% Scrutinised	Referred to Coroner	Investigated by Coroner	% Scrutinised	Referred to Coroner	Investigated by Coroner	% Scrutinised	Referred to Coroner	Investigated by Coroner	% Scrutinised	Referred to Coroner	Investigated by Coroner
Q1	100.00%	21	11	99.67%	103	60	100.00%	54	28	100.00%	48	27	99.92%	226	126
Q2	100.00%	7	4	100.00%	110	57	100.00%	43	19	100.00%	45	21	100.00%	205	101
Q3	99.39%	18	12	98.01%	83	52	100.00%	33	14	100.00%	48	27	99.35%	182	105
Q4	100.00%	20	13	98.83%	97	69	100.00%	55	27	100.00%	40	21	99.71%	212	130
Total	99.85%	66	40	99.13%	393	238	100.00%	185	88	100.00%	181	96	99.74%	825	462

Note: RSCH-PRH 14 deaths not scrutinised. 1 x incomplete Panda form (No QAP discussion recorded.) 8 x BCI non-scrutiny of 'obvious' HMC referrals inquest such as RTC's. 5 x referred to HMC without scrutiny to avoid delay.

	PRH			RSCH			WGH			SRH			UHSx Acute Adult Deaths		
2023/24	% Scrutinised	Referred to Coroner	Investigated by Coroner	% Scrutinised	Referred to Coroner	Investigated by Coroner	% Scrutinised	Referred to Coroner	Investigated by Coroner	% Scrutinised	Referred to Coroner	Investigated by Coroner	% Scrutinised	Referred to Coroner	Investigated by Coroner
Q1	96.02%	22	13	98.42%	124	56	99.20%	48	28	100.00%	57	25	98.41%	251	122
Q2	96.18%	15	7	96.02%	80	35	98.91%	63	30	100.00%	50	23	97.78%	208	95
Q3	98.81%	22	11	99.46%	122	65	100.00%	60	29	100.00%	51	26	99.57%	255	131
Q4	100.00%	23	7	99.29%	117	66	100.00%	42	22	100.00%	45	24	99.82%	227	119
Total	97.75%	82	38	98.30%	443	222	99.53%	213	109	100.00%	203	98	98.89%	941	467

Note: 35 (6 x WGH, 22 x RSCH, 7 x PRH) deaths not scrutinised. 33 x BCI non-scrutiny/referred to HMC without scrutiny to avoid delay. 2 x records not completed satisfactorily.

Key Observations

- **99.74%** **acute** adult deaths scrutinised; **98.89%** in 2023/24.
- **100%** **WGH-SRH** **acute** adult deaths scrutinised.
- **20.26% (825)** adult deaths referred to Coroner and **11.34% (462)** investigated. Of those cases referred, **56%** investigated. Similar findings to 2023/24, with **22.16% (941)** referred to Coroner; **11% (467)** investigated, **49.63%** of cases referred.
- Highest number of Coroner referrals at **RSCH**.
- Average time taken from referral to issuing MCCD during 2024/25 Q3 and Q4 **2.7 days**.
- Longer turnaround times at **RSCH** and **PRH** attributed to staffing levels.
- During 2023/24 **763 (17.97%)** MCCDs issued within 3 days.

Medical Examiner Office Update - Community Deaths Data - 2024/25

New regulations governing Medical Examiners took effect in England and Wales on 09 September 2024.

Information provided by Lead MEOs, on behalf of independent ME Service.

2024/25 breakdown by community catchment per quarter.

Total Adult Deaths - Community						
	Q1	Q2	Q3	Q4	Q2-Q4 Total	2024/25 Total
Brighton & Mid Sussex	126	181	298	405	884	1010
West Sussex	679	689	907	1047	2643	3322
Total	805	870	1205	1452	3527	4332

Note: New regulations governing Medical Examiners came into effect in 2024/25 Q2.

86 GPs and other community providers onboarded in preparation for statutory mandate.

2024/25	Brighton & Mid Sussex			West Sussex			2024/25 Q2-Q4 Total		
	% Scrutinised	Referred to Coroner	Investigated by Coroner	% Scrutinised	Referred to Coroner	Investigated by Coroner	% Scrutinised	Referred to Coroner	Investigated by Coroner
Q1									
Q2	100.00%	12	7	100.00%	70	17	100.00%	82	24
Q3	99.23%	18	5	100.00%	87	21	99.62%	105	26
Q4	100.00%	16	7	100.00%	111	15	100.00%	127	22
Total	99.74%	46	19	100.00%	268	53	99.87%	314	72

Note: RSCH-PRH 2 community adult deaths not scutinised. 1 x referral rejected due to post mortem by HMC. 1 x referred to HMC without scrutiny to avoid delay. Referrals to Coroner not routinely monitored in 2024/25 Q1 as not accepting reportable referrals, hence exclusion of Q1 data from table.



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Key Observations

- **4332 community** adult deaths; twice as many in **West Sussex (3222)** than in **Brighton & Mid Sussex (1010.)** Expected finding with older population in West Sussex.
- Ascending number of **community** adult deaths per quarter attributed to new ME regulations. Significant increase in Q3 and Q4 attributed to winter pressures.
- Between 2024/25 Q2 and Q4 **100% West Sussex** deaths scrutinised; **99.62% Brighton & Mid Sussex** deaths scrutinised.
- Between 2024/25 Q2 and Q4 **8.90% (314)** adult deaths referred to Coroner and **2.04% (72)** investigated. Of those cases referred, **22.93%** investigated.
- Average time taken from referral to issuing MCCD during 2024/25 Q3 and Q4 **2 days** in **West Sussex**; **4.2 days** in **Brighton & Mid Sussex**. Longer turnaround time attributed to staffing levels.

Medical Examiner Office Update - Acute NOK Feedback - 2024/25

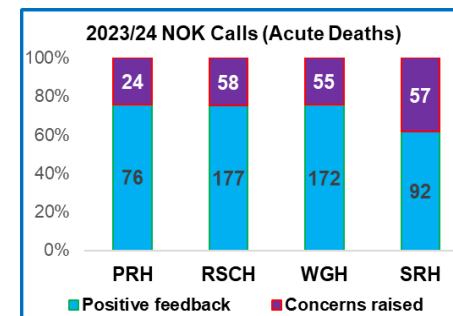
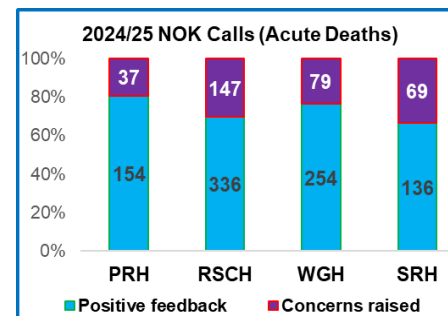
2024/25 breakdown of positive feedback and concerns raised by families/Next of Kin calls by UHSx hospital site per quarter, compared with 2023/24.

Information provided by Lead MEOs, on behalf of independent ME Service.

NOK Positive Feedback & Concerns (Acute Adult Deaths)										
	PRH		RSCH		WGH		SRH		Total	
	Positive feedback	Concerns raised	Positive feedback	Concerns raised	Positive feedback	Concerns raised	Positive feedback	Concerns raised	Positive feedback	Concerns raised
2024/25										
Q1	41	6	83	19	60	14	23	14	207	53
Q2	45	8	63	33	47	12	26	11	181	64
Q3	30	17	110	52	57	13	38	19	235	101
Q4	38	6	80	43	90	40	49	25	257	114
Total	154	37	336	147	254	79	136	69	880	332

NOK Positive Feedback & Concerns (Acute Adult Deaths)										
	PRH		RSCH		WGH		SRH		Total	
	Positive feedback	Concerns raised	Positive feedback	Concerns raised	Positive feedback	Concerns raised	Positive feedback	Concerns raised	Positive feedback	Concerns raised
2023/24										
Q1	4	0	6	3	0	0	0	0	10	3
Q2	8	4	9	7	45	24	36	28	98	63
Q3	34	8	79	16	77	16	21	15	211	55
Q4	30	12	83	32	50	15	35	14	198	73
Total	76	24	177	58	172	55	92	57	517	194

Note: Routine monitoring of NOK feedback began in 2023/24 Q2. Hence low numbers for 2023/24 Q1.



Key Observations

- **501** more feedback responses in 2024/25 (**1212**) than in 2023/24 (**711**.) However, routine monitoring of NOK feedback did not begin until 2023/24 Q2.
- Two-thirds of all feedback was positive.
- **880 (72.61%)** positive feedback responses; numerical increase (**517**) but minor % decrease (**72.71%**) from 2023/24.
- **332 (27.39%)** concerns raised; numerical increase (**194**) but minor % decrease (**27.29%**) from 2023/24.
- Highest collective number of positive feedback and concerns raised received for **RSCH** followed by **WGH**. Similar dispersal seen in 2023/24.

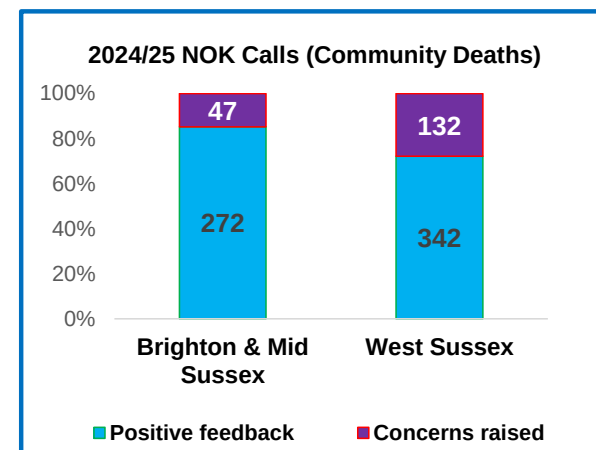
Medical Examiner Office Update - Community NOK Feedback - 2024/25

2024/25 breakdown of positive feedback and concerns raised by families/Next of Kin calls by community catchment per quarter.

Information provided by Lead MEOs, on behalf of independent ME Service.

NOK Positive Feedback & Concerns (Community Adult Deaths)						
	Brighton & Mid Sussex		West Sussex		2024/25 Total	
2024/25	Positive feedback	Concerns raised	Positive feedback	Concerns raised	Positive feedback	Concerns raised
Q1	39	4	57	21	96	25
Q2	89	12	56	17	145	29
Q3	81	10	77	42	158	52
Q4	63	21	152	52	215	73
Total	272	47	342	132	614	179

Note: Routine monitoring of NOK feedback for deaths in the community began in May 2024. 2024/25 Q1 data is therefore two months only.



Key Observations

- Routine monitoring of NOK feedback for **community** adult deaths began in May 2024. Therefore no 2023/24 comparator.
- Two-thirds of all feedback was positive.
- **614 (77.43%)** positive feedback responses.
- **179 (22.57%)** concerns raised.
- Higher volume of NOK responses in **West Sussex**, attributed to higher number of deaths.

Medical Examiner Office Update - NOK Feedback Themes - 2024/25

Top learning themes from Medical Examiner Service calls to families/Next of Kin for **acute** and **community** adult deaths during 2024/25.

Information provided by Lead MEOs, on behalf of independent ME Service.



Top 5 positive themes for ACUTE deaths

- Good communication
- Good nursing care
- Good support from ME team
- Good quality care
- Positive end-of-life care



Top 3 positive themes for COMMUNITY deaths

- Good communication
- Good quality care
- Good support from ME



Top 5 concerns raised for ACUTE deaths

- Delay to assessment/treatment
- Discharge planning
- Facilities & Estates issues
- End-of-life care issues
- Poor communication



Top 5 concerns raised for COMMUNITY deaths

- CoD given on MCCD
- Delay to assessment/treatment
- Discharge planning
- Poor access to GP/teams
- Poor communication

2024/25 Mortality & Learning from Deaths Annual Report Highlights

174 fewer adult deaths in 2024/25 (**4073**) compared to 2023/24 (**4247**.) **23.20%** (**945**) acute adult deaths and **28.02%** (**197**) SJR referrals within most deprived postcodes (D1-4.)

20.26% (**825**) adult deaths referred to Coroner and **11.34%** (**462**) investigated. Of those cases referred, **56%** investigated. Similar findings to 2023/24.

23.86% (**972**) of all acute adult deaths and **17.21%** (**121**) SJR referrals had pneumonia listed as 1a on the MCCD (expected finding.)

Expected high level of adult deaths across Critical Care/ITU and Emergency Floor due to treating critically unwell patients. Deaths at **WOR EF**, **SRH EF**, **RSCH AAU**, **RSCH A&E** and **RSCH ITU** accounted for **15%** (**611**) of all adult deaths across UHSx.

147 more SJR referrals in 2024/25 (**703**) compared to 2023/24 (**556**.) SJR Triage Panel introduced in 2024/25 Q2, with 2024/25 SJR acceptance rate of **32.43%**.

10 SJRs outstanding as of 31 March 2025 with none older than 60 or 90 days from date of SJR referral. At the start of 2024/25 there was a backlog of **585**.

58 more SJRs reviewed at Panel in 2024/25 (**315**) than in 2023/24 (**257**.) **46.35%** (**146**) of SJRs scored **2 (Poor Care)**; at Mortality Panel, which represents a considerable reduction from **77.43%** (**119**) in 2023/24. This can be accounted for by changing parameters on which cases were discussed at Mortality Panel and a shift in cases scoring **1 (Very Poor Care.)**



Palliative and EOLC Annual Report: 2024 /25

Introduction.

The UHSx Supportive and EOLC Group, has continued to cover issues and assurances for Palliative & End of Life Care, Treatment Escalation Plans & DNACPR and Communication Training, reporting directly to Patient Safety Group and QSGS Quarterly.

End of life care is one of the core services of University Hospitals Sussex NHS Foundation Trust. The trust caters for a population of 1.8 million with approximately 1700 beds across 4 hospital sites. Currently around 40% of deaths in our locality occur within hospitals across sussex. For UHSx 4073 deaths occurred in Hospital which is approximately 23% of the total deaths recorded by NHS Sussex

University Hospitals Sussex is committed to continuing the excellent work that all our hospitals have been undertaking to ensure we meet the six ambitions for palliative and end of life care (Ambitions Framework 2021-2026):

- 1

Each person is seen as an individual
- 2

Each person gets fair access to care
- 3

Maximising comfort and wellbeing
- 4

Care is coordinated
- 5

All staff are prepared to care
- 6

Each community is prepared to help

Palliative & EOLC 2024/27 Strategy:

Vision: To have an equitable, sustainable hospital specialist palliative care service that is leading improvement, development, and innovation to improve patient experience, ensuring high quality care in the last phase of their life. That is supported by the UHSx Supportive & EOLC Group:

Patient	Improve Specialist Palliative Care Teams response to those recognised as dying and symptomatic, thus improving Patient/Carer experience.
People	Improve parent teams’ confidence in managing care of the dying and associated symptoms, thus improving Staff commitment to excellent care
Quality	Improve our organisation’s ability to recognise deterioration from life-limiting illness and acknowledge unavoidable death and this impact on Mortality rates.
Sustainability	Improve HPCT productivity, in triage and allocation of workforce.



Systems & Partnerships	Earlier recognition of deterioration from life-limiting illness, with the potential to promote earlier EOLC transfer of care to community setting.
Research & Innovation	Create an innovative and evidence-based approach to improve care of the dying in an acute setting that is replicable in other organisations.

This strategy details Palliative & EOLC Teams intent to continue to improve end of life care for patients and their families over the next 3 years to 2027 with four key aims:

1. To provide personalised, dignified end of life care for patients and their families
2. To ensure all patients and healthcare professionals in all four hospitals have access to specialist palliative care advice and support that is evidence based, adequately resourced and available 7 days per week.
3. To ensure an educated, competent, and confident workforce
4. To partner with others to provide seamless care for patients approaching the end of life.

This Annual report identifies, our measurable goals and whether we achieved these, alongside each of the four key objectives, indicating our progress and identifying are key actions for 2025/25

2024/25 Measurable Goal:

- To have streamlined and aligned our Trust's SPC Team's processes of communication, information sharing and have a system of routine data collection for every quarter by 1st October 2024. Through the UHSx Supportive & EOLC Group: **Achieved see Appendix 1 re quarterly updates to Cancer Division/PSG and QGSG**
- To continue to have input with the care of >90% of patients dying in hospital on e-comfort observations. **Partially Achieved, see report.**
- Support and monitor the e-comfort personalised end of life care plan on PatienTrack, aiming for **80%** of dying patients in the hospital to be cared for with EOL care plan in place. **Partially Achieved, see report.**
- With **60%** of assessments and evaluations completed. By March 2025. **Partially Achieved, see report**
- To have a standardised Trust PEOLC education program for post graduate clinicians, registered nurse, nursing associates, health care assistants and AHPs, by 2027. **Achieved, see report**
- Deliver UHSx EOLC study day to over 120 people by 1st October 2024. **Achieved, see report**
- Deliver 5 day Fundamentals of Palliative Care in an Acute Setting course to 60 RNs by April 2025 **Achieved, see report**
- To review our Palliative & EOLC strategy against the NACEL 2023/24 results, to inform specific areas to target. **Partially Achieved, SeeCare and NCEPOD data aligned with Patient Experience and Learning from death data, NACEL data Jan24/Dec24.**

Palliative & EOLC Associated Risks:

Risk management (TOP FIVE RISKS)			
Risk (Title and ID)	KEY Mitigations (in place / to be developed)	Current risk score	Target risk score
UHSx Palliative Care Team are unable to sustain current workforce practice on all 4sites causing an increased risk to patient experience and safety ID: 1421	There is an identified risk linked directly to patient experience, avoidable harm and mortality due to both the absence of a palliative care service on sight at UHS BTN/PRH seven days a week [current risk 184] and the ability to sustain the current 7/7 working practice at UHS WTH/SRH. Patients living in the last phase of their lives admitted at the weekend will not have access to specialist palliative care review on the east and are at risk of a reduced service on the West, therefore symptoms and holistic care needs may go un-met.	16	4
Delay in appropriate symptom management for Palliative and EOLC patients due to accessibility of appropriate T34 Syringe Pumps ID:1115	Recent Datix theme identified and escalated to UHSussex Chief RN around lack of, and accessibility to acquire a T34Syringe Pump [This medical device ensures the delivery of appropriate medications to control symptoms in a 24 hour period]. Investigation highlighted legacy BSUH currently have less than 30 Syringe pumps in circulation [a deficit of 33 pumps from our original stock]. Legacy BSUH does have 55 new Syringe Pumps to replace existing stock which needs to be decommissioned. However the EOLC & Mortality Board alongside the Equipment Library has identified the risk that these new pumps could go missing again, due to a lack of hospital wide tracking process or a digital gps solution to monitor this small piece of equipment, ensuring their timely return to the equipment Library	9	4
Respect tool implementation in some areas could cause confusion and error (Legacy no 1356) ID: 742	There is some national Guidance that would suggest the implementation of the Respect tool allowing patients to work with health care professionals in the planning of their care including their resuscitation status. The locality has decided not to be early adopters of this tool. Other Trust are now using this posing a risk that patients will be admitted to the Hospital with this tool resulting in confusion around Resus status.	9	4
UHSx Palliative Care Team are unable to sustain current Education commitments with increased workforce practice on all 4sites causing an increased risk to patient experience and safety.	Increased demand across UHSx for Palliative & EOLC Education including YODO, Fundamentals in Palliative Care, SIM Communication Skills. Currently no PEOLC Practice Educator to coordinate and support the delivery of essential teaching	12	4

To provide personalised, dignified end of life care for patients and their families

Background:

- All individuals living in the last phase of their lives should feel that their care is personalised and co-ordinated that maximises their comfort and well-being.

UHSx SEOLC 2024/27 Strategic Goals:

- Develop and embed the UHSx SWAN project, Nationally the Swan model of end of life and bereavement care is used to support and guide the care of patients and their

loved ones that we care for at the end of life and after they have died. "Sign, Words, Actions, Needs".

- Support and monitor the e-comfort personalised end of life care plan on PatientTrack, aiming for **80%** of dying patients in the hospital to be cared for with EOL care plan in place.
- Develop robust data collection and outcome measurement to evaluate and continuously improve current EOLC quality in hospital via SeeCare, NACEL and Tendable.
- Promote appropriate use of Treatment Escalation Plans and the RESPECT process to ensure patients have access to treatments appropriate to their needs and wishes.
- Review and develop Patient and Carer feedback with support from PEEG, LfD and ME services.
- Review the provision of available space to speak to relatives and patients privately and availability of sufficient side rooms across UHSx.
- Review the potential provision of inpatient beds for specialist palliative care alongside oncology/ haematology for the Cancer Division
- Pilot EOLC Volunteer Service at RSCH and develop plans with UHSx Charities to roll-out across all 4 hospital sites.

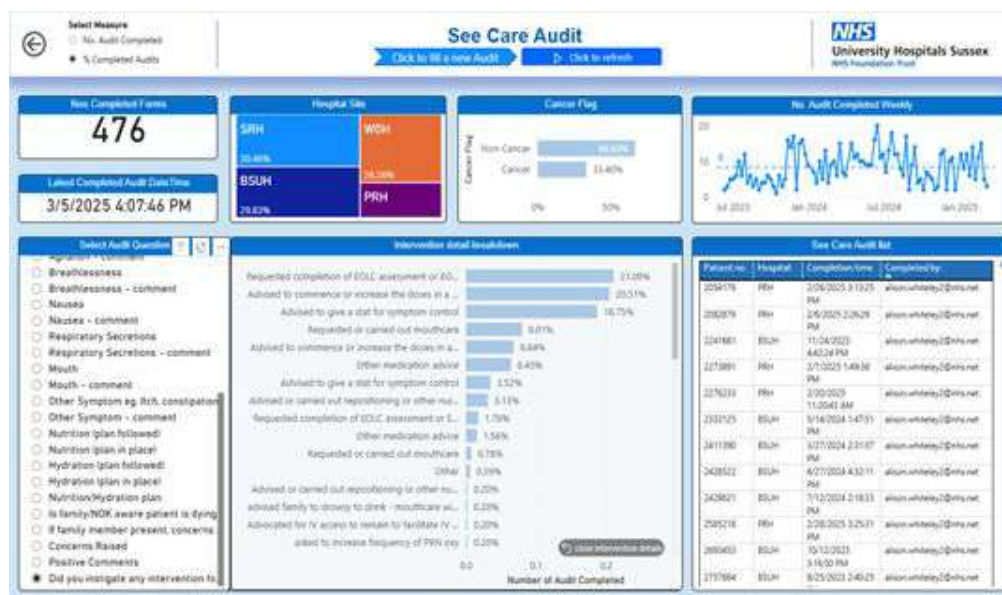
2024/25 Progress:

- Comfort Care Plans have become well established over all 4 hospital sites:

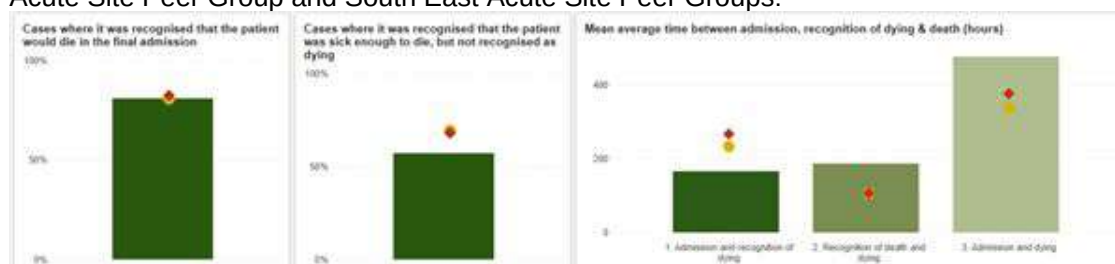


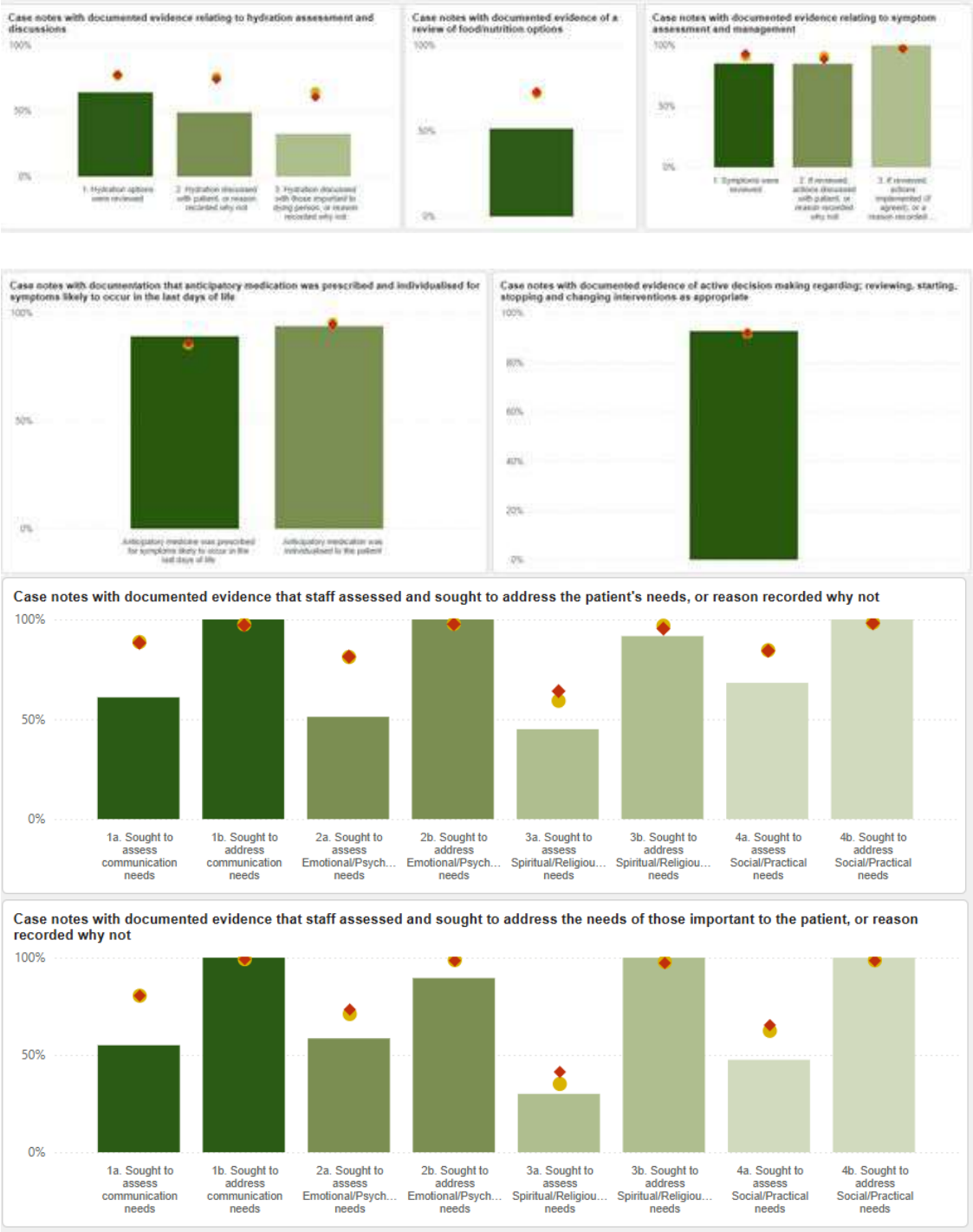
- Approximately 76% of patients who die at UHSx are 'recognised as dying'
- On average a person remains on a comfort care plan for 3-4 days prior to death
- On average 26% of patients commenced on comfort obs are discharged out of hospital.
- This data is now routinely shared with all divisions, having a breakdown of their specific ward areas.

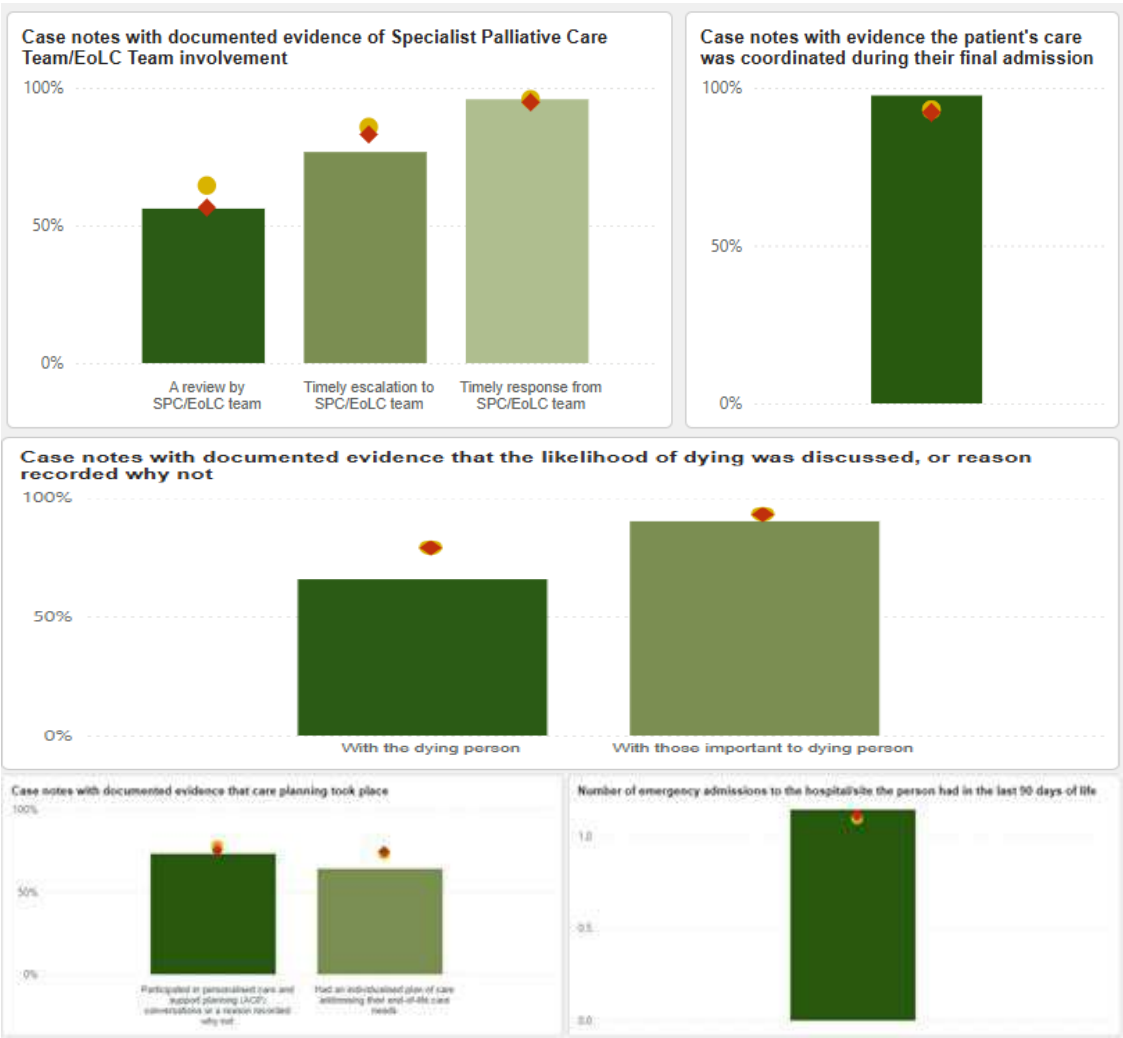
- SeeCare remains the Hospital Palliative Care Teams continuous Audit on care of a dying person, which embedded in the EOLC scorecard.
- To date: 476 individuals on a comfort care plan have been reviewed
- 12% of total deaths at UHSx:



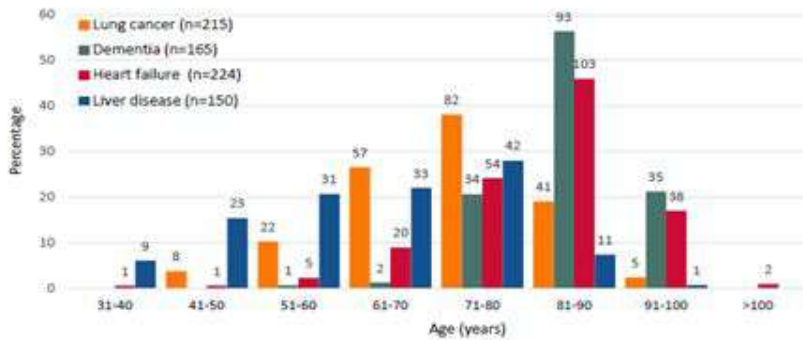
- 98% have had anticipatory medications prescribed
- 97% of families were aware their relative/friend was dying:
 - at the time of assessment 60% had no concerns and only 13% raised concerns [primarily around symptom control, which was managed at the time of audit]
- 92% had a Nutrition plan in place that was followed
- 89% had a Hydration plan in place of which 88% had their hydration needs met
- 63% of audit assessments, required SPCT input, [primarily around managing symptoms]
- 45% symptoms managed with a syringe pump
- 53% have had a completed assessment
- 43% have had a daily evaluation
- UHSx participated in NACEL 24/25 and are awaiting the full results from the audit. [Appendix 1]
- Triangulated against our SeeCare data, is reassuring, with no areas for concern.
- Data from Jan24/Dec24 indicates, we are routinely close or within both Sample for Acute Site Peer Group and South East Acute Site Peer Groups:







- UHSx also participated in the NCEPOD 2024: “Review of the quality of care provided to adult patients towards the end of life”: these results have been shared with QGSG, WGH/SRH Surgery, WGH/SRH Medicine, RSCH/PRH Medicine, Cancer, PSG, via the Supportive & EOLC Group.
- N=431:



- Highlights:
 - Not enough patients had access to early palliative care alongside existing treatments to improve symptoms and quality of life

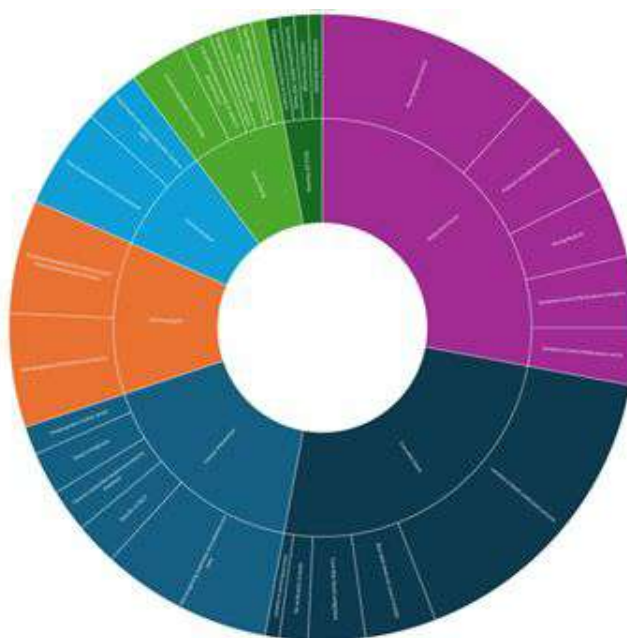


- Death and dying was not discussed as often as it could have been. More people need to have their end of life care wishes recorded.
- Care co-ordinators are an accepted standard in cancer services but were less common for other advanced chronic conditions.
- Specialist palliative care services were not always available in hospitals nor involved when needed.
- Training to identify when palliative or end of life care will help was not always provided or available.

2025/26 Action Plan:

- UHSx NCEPOD Action Plan:
 - Parallel Planning
 - Cancer Division: Supportive Oncology Clinics
 - Perioperative assessments for older people
 - End Stage Liver MDM
 - Normalise EOLC Conversations
 - HPCT EOLC Education Strategy 2025/27
 - Care is co-ordinated
 - Review EOLC Discharge priorities with NHS Sussex, AACC and Hospice Alliance
 - Training
 - HPCT EOLC Education Strategy 2025/27
 - Sharing of Advanced Care Planning
 - Scope transfer of information from new EPR with community databases such as System1
 - LPA
 - Increase presence of Dying Matters week across UHSx
- Continue to input into NACEL.
- Increase number of assessments and evaluations completed on Patient Trac, through HCP training and education
- Develop Person Centred documentation for a dying person for the healthcare record.
- Collaborate with NHS Sussex on EOLC Discharge Planning and Admission Avoidance
- Develop our Power BI data to review EOLC Discharges and re-admission rates
- Explore how Palliative and EOLC will be presented in new EPR systems

Patient Experience 2024/25:



EOLC Complaints:

We have seen a 149% increase in complaints associated with patients dying at UHSx 2024/25 [92] from 2023/24 [37], not all of these are related to Palliative and EOLC

Of note this is only 2.25% of all 2024/25 hospital deaths at UHSx

92 Complaints, 37 emerging themes, 482 total recorded themes [% of complaints]			
Clinical Interventions 29%	Concern raised that death associated to treatment/no treatment [54%]	Lack of clear management plan. [51%]	Not recognising supportive and palliative care need [36%]
Deteriorating Patient 6%	Family expectation to continue treatment, despite deterioration [22%]		
Communication 33%	Perceived abandonment with lack of empathy/compassion [52%]	Poor Communication from professionals [64%]	Parent Team not communicating /struggling with Family re EOLC [35%]
Care of Dying 19%	Poor Care 46%	Inappropriate Environment to deliver EOLC [17%]	Low staffing levels impacting on ability to prioritise EOLC [19%]
EOLC Discharge 6%	Failed EOLC Discharge [11%]		Lack of support on Discharge [10%]
Symptom Control 7%	Poor Symptom Control [29%]		Concerns re prescribed medication [opiates/midazolam] [5%]
Care After Death 0.6%	Bereavement Office, delay in medical certification [2%]		Care after Death process not followed [1%]

- Top Emerging themes:
 - Poor Communication from professionals [64% of complaints]
 - Concern raised that death associated to treatment/no treatment [54% of complaints]
 - Perceived abandonment with lack of empathy/compassion [52% of complaints]
 - Lack of clear management plan [51% of complaints]
 - Not recognising supportive and palliative care need [36% of complaints]

- Parent Team not communicating /struggling with Family re EOLC [35% of complaints]
- Poor Symptom Control [29% of complaints]
- Low staffing levels impacting on ability to prioritise EOLC [19% of complaints]

- **The staff experience:**

Insufficient staff levels impacting on ability to deliver high quality end of life care and moral injury causing compassion fatigue.

- Reflecting from complaints continues to form part of the UHSx Supportive and EOLC Group divisional feedback, and is embedded into our SPCT Education strategy 2025/27, through the compelling use of patient stories. [Appendix 2]

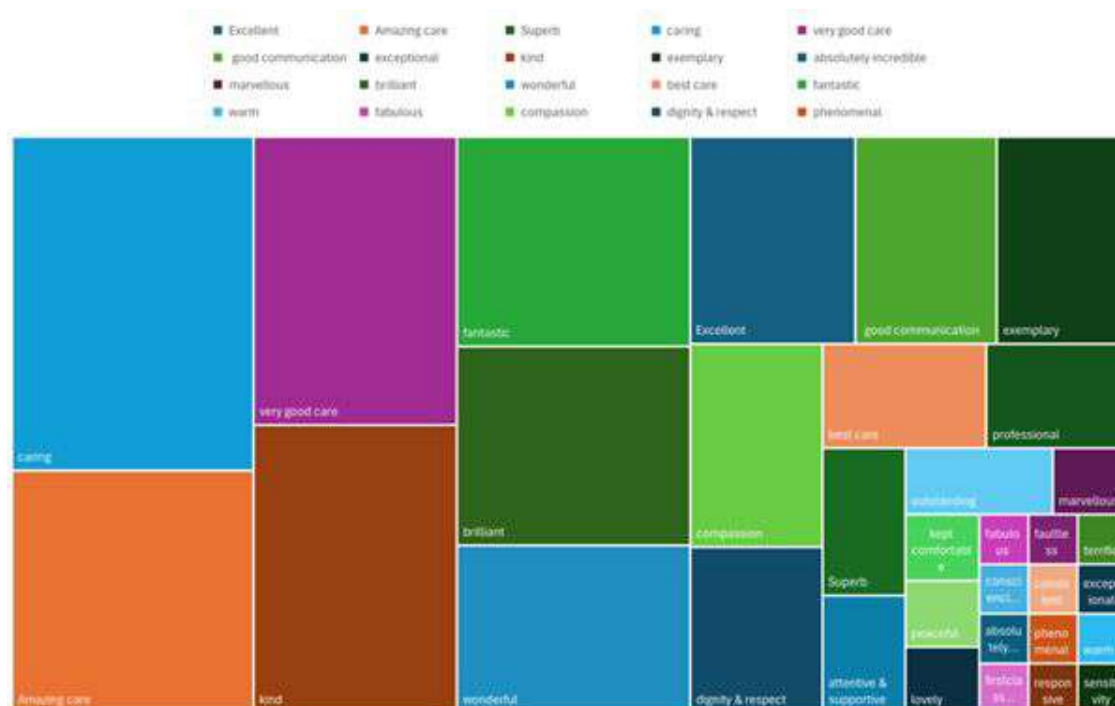
Datix 2024/25:

63 Datix, 51 emerging themes, 136 total recorded themes [% of datix]			
Clinical Interventions 37%	Not recognising supportive and palliative care need [19%]		
Deteriorating Patient 25%	Treatment Escalation Plan did not match Patient deterioration/condition [13%]	Late recognition of Palliative Care Needs [13%]	
Communication 17%	Poor Communication from professionals, not communicating with families [11%]		
Care of Dying 16%	Low staffing levels impacting on ability to prioritise EOLC [10%]		
EOLC Discharge 6%	Failed EOLC Discharge [3%]		Inappropriate admission [1.5%]
Symptom Control 60%	Poor Symptom Control [25%]	Problem managing syringe Pump [12%]	JIC Medications not given [14%]
Care After Death 54%	variation in Death notification process [35%]	Blue slide sheet not used in transfer [8%]	Care After Death undignified [6%]

- Top emerging Themes:
 - Variation in Death notification process [35% of Datix]
 - Poor Symptom Control [25% of Datix]
 - Not recognising supportive and palliative care need [19% of Datix]
 - JIC Medications not given [14%]
 - Low staffing levels impacting on ability to prioritise EOLC [10% of Datix]
- Datix themes have supported:
 - New TEPv9 and its associated rollout [Appendix 3]
 - Increase in attendance at PEOLC teaching
 - New Syringe Pump training video available on IRIS
 - Supports need to increase Communication skills training
 - Care After Death process's now addressed via UHSx Mortuary Group
 - Care After Death training video in process

Plaudits:

Collaborating with the Learning from death team and MEO's, we have reviewed 179 plaudits from recently bereaved relatives:



"The care was amazing. Hospital was really full, and Flu was rife but even though Nurses were stretched to their limit, they provided both excellent care to dad and also us as a family. We are hugely grateful."

"The nurses were clearly busy but still took the time for us as a family. We felt they all went above and beyond."

- SPCT have successfully launched our EOLC Link Roles across UHSx
- 82 participants
- RSCH/PRH links have attended a workshop to discuss action plans for 25/26
- RSCH have successfully commenced The Friend in Need service
- This is a volunteer-led initiative at Royal Sussex County Hospital Brighton, dedicated to providing companionship and emotional support to patients and their loved ones navigating end-of-life care. Our trained volunteers offer a listening ear, a comforting presence, and practical support, helping to create a calmer environment and offering respite for families. We support patients nearing the end of life who may be lonely or isolated, as well as their loved ones who would appreciate emotional support.
- Our first volunteers started in January 2025. From January - March (end) we saw 82 patients, 52 return visits, totalling 134 visits, dedicating a approximately 85 hours at the bedside.

2025/26 Action Plan:

- The Friend in Need service have key aspirations to include expanding our service availability from the current 3 days per week to 5-7 days. We also hope to extend our

reach across the entire hospital trust to ensure even more patients in need of companionship and support can benefit from our volunteers.

- Increase the amount of communication skills training available to UHSx: however, this directly links to risk: 2359, whereby SPCT lack the resource to prioritise training over clinical need
- Liaise with Patient Experience re routine collection of patient experience data around Palliative and EOLC.

To ensure all patients and healthcare professionals in all four hospitals have access to specialist palliative care advice and support that is evidence based, adequately resourced and available 7 days per week.

Background:

UHSx operates a Specialist Palliative Care service across all 4 hospital sites

Referrals to the specialist palliative care team (SPCT) are accepted for patients who:

- Have active, progressive, advanced disease of any diagnosis with a probable prognosis of less than 12 months.
- Have a complex level of need exceeding the skills and/or capacity of the current caring team and are over 18 years of age
- Patients that are within the last days of life.
- The UHSx SPCT provides support for:
 - Multiple, complex or refractory physical symptoms
 - Complex end of life care
 - Difficult social, psychological and spiritual issues
 - Complex family and carer needs requiring specialist support
 - Discharge planning when the situation is complex or to facilitate transfer to hospice for appropriate patients
 - Support and advice to ward teams in all aspects of caring for patients at the end of life.
 - Support with the rapid discharge of patients who have been identified as being in the last days to short weeks of life whose preferred place of care is not hospital.

UHSx SPCT specific 2024/27 Strategic Goals:

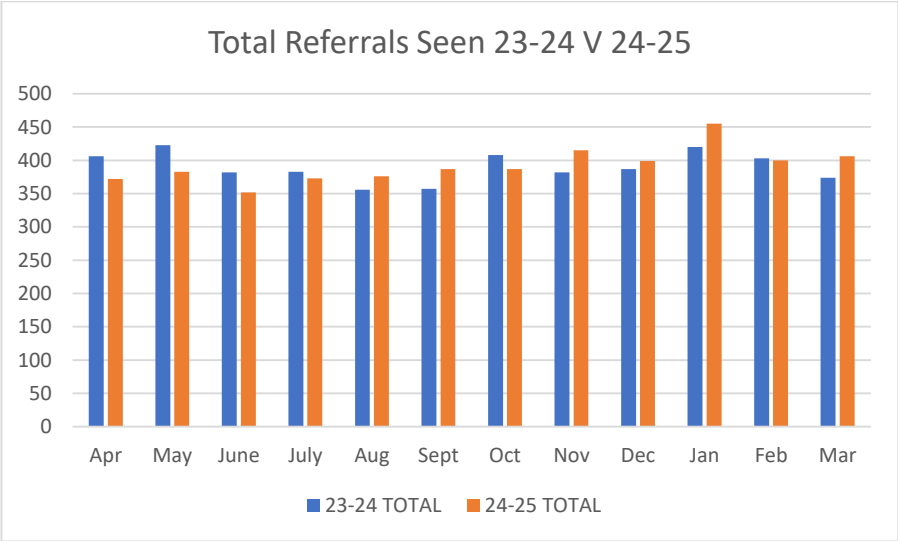
Patient	Timely and proactive reviews: We currently strive to review patients the same working day as referral. Ability to assess holistic needs, provide good patient-centred communication and Advance Care Planning: Our ability to contribute towards shared-decision making and EOLC discharge planning. Family & Friends experience. Patient experience, safety and quality.
People	Staff sickness/absence, job satisfaction, retention of those in the SPCT. Morale. Unable to meet expectations of service. Team working with wider hospital teams. Community palliative care teams.
Quality	Consistent and equitable level of service. Provision of high quality PEOLC. Timely recognition of dying. Conversations about PEOLC needs. Increasing complaints and Datix.
Sustainability	Initiatives to improve productivity. Improvements in digital systems to support PEOLC. PEOLC education and communication skills training for all hospital health care staff. Teaching commitments to BSMS.
Systems/Partnerships	EOLC Discharges - Patient flow through the hospital, increasing readmission rates.
Research and Innovation	Ability to lead and take part in studies to improve our evidence-based practice and PEOLC services.

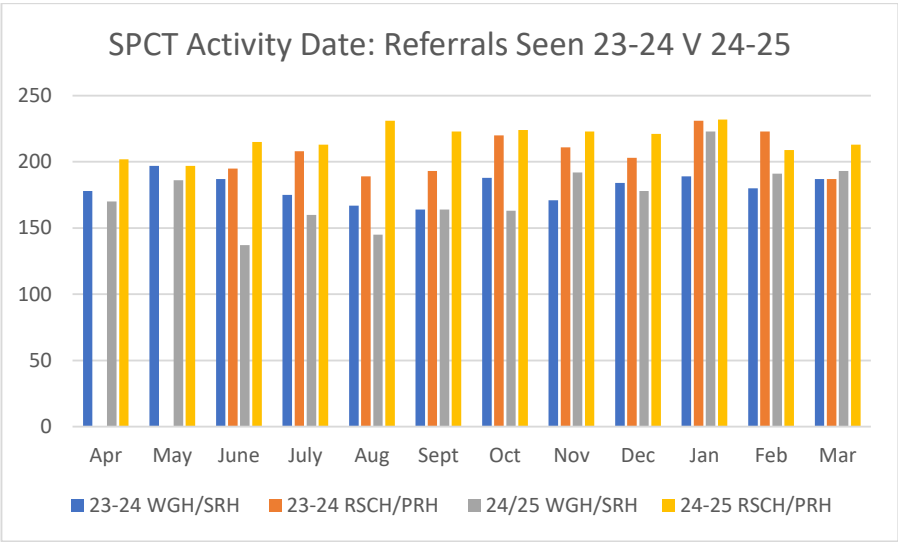
- Business Case: to support 7-day week face to face palliative care CNS/AHP cover on all UHS hospital sites with palliative care consultant on call for remote support.

- Business Case: to support cancer division MDM palliative care representation, increase ability to provide trustwide Education, increase trustwide input into Advance Care Planning.
- Ensure an increased presence of palliative care team on Emergency Floor and A&E
- Use of robust data collection and outcome measurement to evaluate and continuously improve services.
- Maintain a portfolio of palliative care and end of life care badged clinical trials and QI projects with the aim of establishing a supportive and palliative care research department.
- Alongside Cancer Division review and develop a Supportive Oncology Model providing earlier access to palliative care support using virtual wards and patient reported outcomes

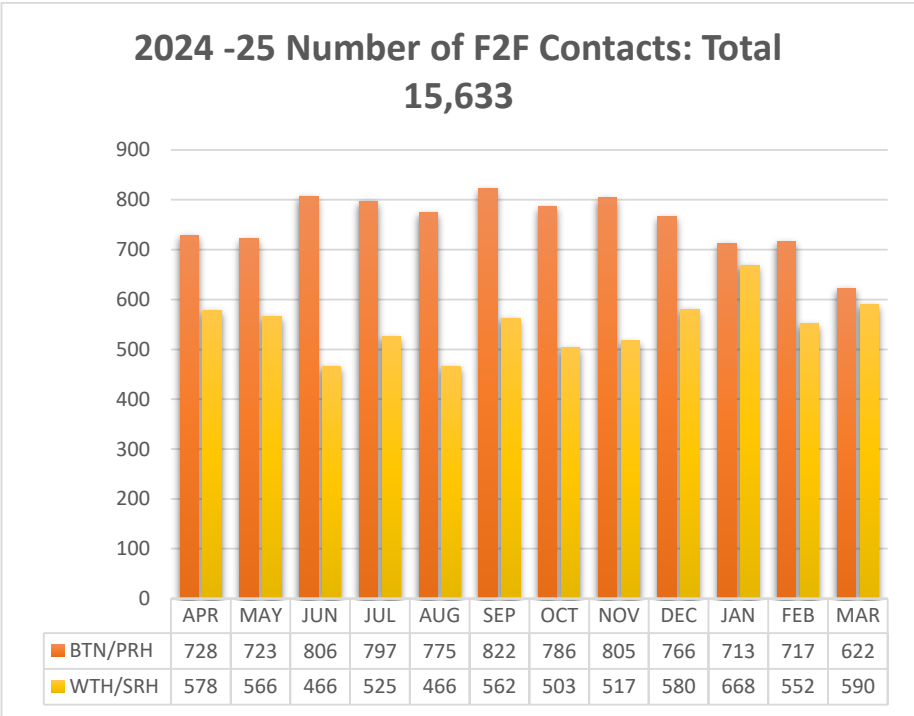
Progress:

- We have been successful with our business case to provide 7/7 face to face CNS cover across our main hospital sites, alongside the successful recruitment of 2 new Palliative Medicine Consultants to create a ‘Supportive Oncology’ outpatient programme for those patients living with a treatable yet incurable cancer. [Appendix 4]
- SPCT activity remains high across all 4 sites: with 24-25 showing a 0.5% increase [4681:23-24 v 4705: 24-25]

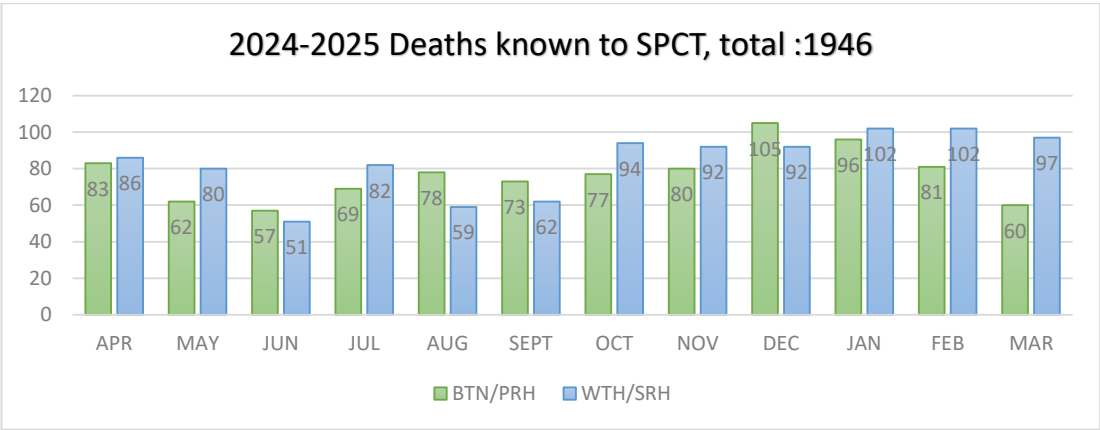




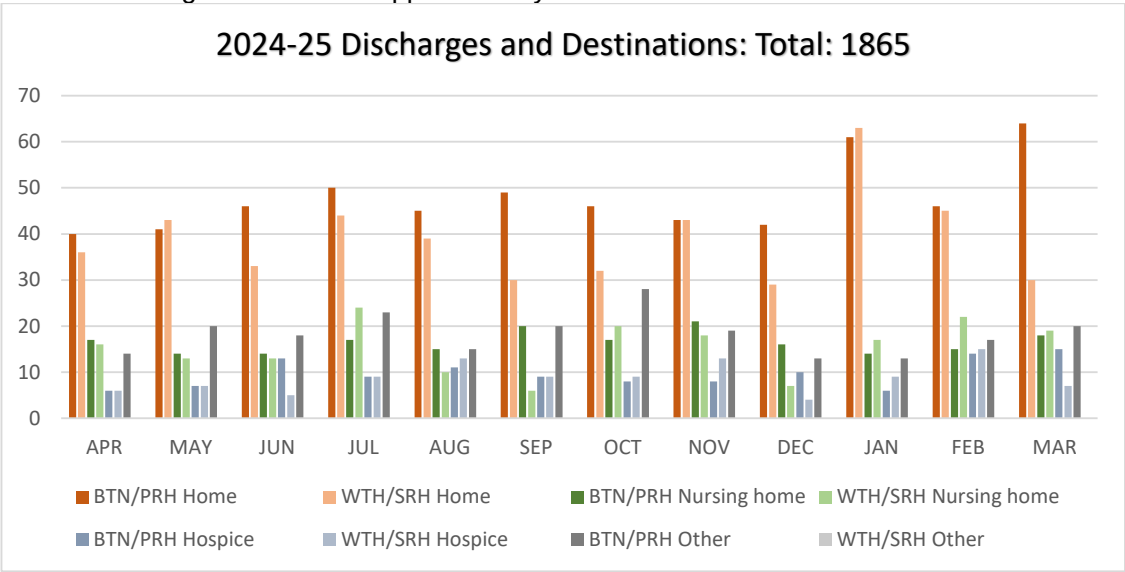
- With the number of contacts increasing from 11006 [23-24] to 15633 [24-25], a 42% increase.



- SPCT have been involved in the individualised care of dying for 1946 people, this equates to 48% of the total adult deaths recorded for UHSx [4073]



- SPCT have been involved in 1865 discharges [a 34% increase from 23/24]
- These discharges account for approximately 40% of referrals seen:



- Approximately 56% return Home
- Approximately 20% are transferred to Care Home
- Approximately 12% are transferred to Hospice:
- A snapshot of RSCH/PRH referral data indicates the variation from SPCT referral requests to Hospice IPU to actual admission to those Hospices:
- RSCH/PRH constitutes 6% of our total discharges to Hospice IPU.
- We refer approximately 6% of our total referrals seen to Hospice IPU, of which only half are successfully transferred.



RSCH/PRH Hospice Referrals April 2024 - March 2025													
Hospice	Total Ref	D/C to Hospice		Alternative Place of Care Agreed					Hospice Bed Offered Too Unwell for Transfer	Died Before Hospice Bed Offered		Total Number Died in Hospital	
				Home	NH d/c	Other Hospice	SCAC in hosp	%					
SPSJ	104	70	67%	2	2	5	9	17%	1	15	14%	25	24%
Marslets	101	46	46%	9	6	4	12	31%	0	24	24%	36	36%
St. Barnabas	16	9	56%	1	0	1	2	25%	0	2	13%	4	25%
St. Catherine's	16	8	50%	1	0	2	4	44%	0	1	6%	5	31%
St Wills E	8	2	25%	0	0	4	1	63%	1	0	0%	2	25%
St Wills C	6	1	17%	0	0	0	1	17%	0	4	67%	5	83%
HITW	11	5	45%	0	0	2	1	27%	0	3	27%	4	36%
St. Michael's	2	1	50%	0	0	0	0	0%	0	1	50%	1	50%
Total	264	142	54%	13	8	18	30	26%	2	50	19%	82	31%

- Weekly both BTN/PRH & WGH/SRH know of approximately 60-80 patients across all sites respectively who have supportive and palliative care needs, this is postulated from both routine online referral data and proactive screening of the acute floor daily. While not all may be perceived as having specialist palliative care needs, SPCT routinely support those teams attempting to plan for either a good EOLC discharge or individualised care for a dying person in hospital, being mindful that nationally 40-50% of UK deaths still occur in Acute Setting.
- Sadly, a proportion of UHSx patients die during discharge planning due to their complex EOLC discharge planning needs, which are exacerbated by social care delays, inadequate IPU Hospice provision across UHSx population, sadly these are not new phenomenon and is potentially increasing due to late recognition of palliative care need and subsequent delayed referral to our team.

Research and Innovation

- SPCT continue to add to the PEOLC evidence base through novel QI research: [Appendix 5]
- We continue to evolve our digital footprint on both Patient Trac, EPMA and Power BI
- UHSx HPCT have successfully transferred Palliative and EOLC Guidance onto UHSx Sharepoint:
[Palliative and End of Life Care EOLC \(Trustwide\)](#)

2025/26 Action Plan:

- Develop 'Supportive Oncology' pathway and clinics: KPI to reduce crisis admission for cancer patients and treatment burden, for those patients living with a treatable yet incurable cancer.
- UHSX SPCT to collaborate with local SCFT and Hospice Alliance on EOLC Discharges and EOLC Admission Avoidance.
- UHSX SPCT to collaborate with Transfer of Care hubs and AACC to reduce EOLC Patients time in hospital

To ensure an educated, competent, and confident workforce:

Background:

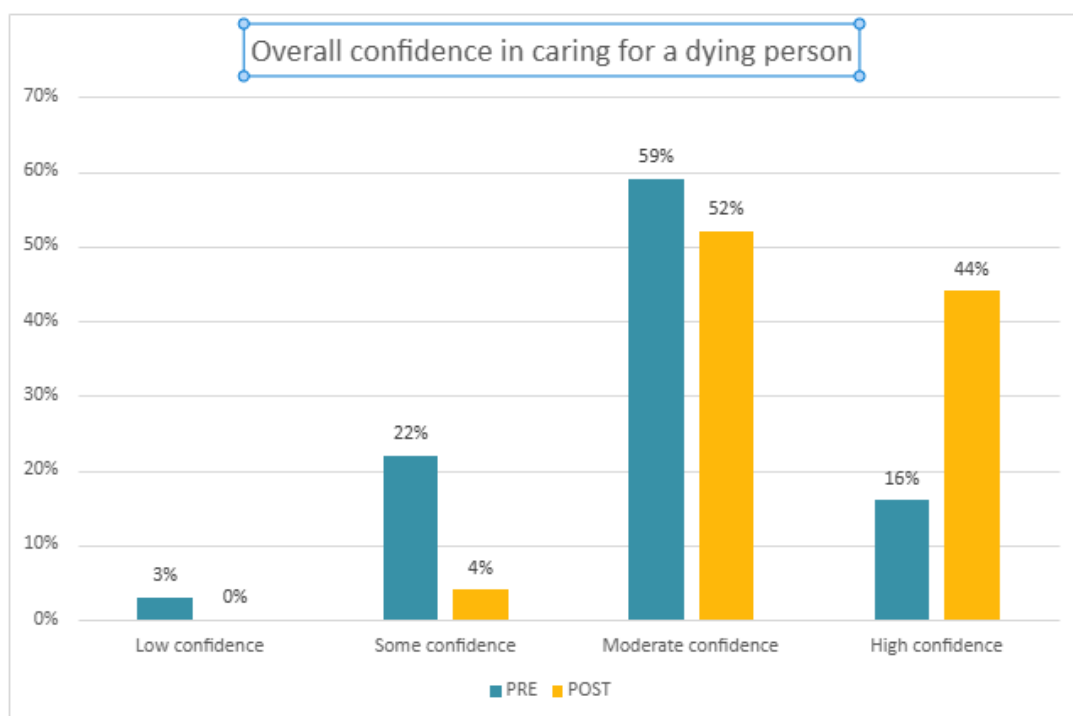
- All staff require the confidence and competence to feel prepared to care for an individual living in the last phase of their lives.

UHSx SEOLC 2024/27 Strategic Goals:

- Promote and deliver the UHSx PEOLC Education strategy: You Only Die Once EOLC SD [1 Day course: aspiration to run Monthly], Fundamentals of Palliative Care in an Acute Setting [5 day course: 2 intakes annually], Communication Skills Training: BBN Workshop and SIM training [Aspiration to run monthly], continue to support UHSx Sage and Time communication training
- Collaborate with UHSx Practice Development Team to create a hub for communication skills training.
- Re-establish UHSx Clinical Link Roles for PEOLC in all ward areas
- Promote self-directed online learning resource via IRIS and NHS eELCA
- Develop and maintain Palliative & EOLC guidance and key prompt cards on UHSx Sharepoint
- Tailored education and training for the medical workforce, to incorporate key learning from the Learning from Deaths process.
- Adequate staff support through wellbeing initiatives, Schwartz rounds and counselling services where needed.
- Continue Education link with BSMS.
- Support Multi-Disciplinary Pre and Post Registration Training needs via placement within the HPCT
- Support PhD/MD students linked to BSMS with an interest in EOLC

2024/25 Progress:

- UHSX SPCT have supported in the training associated to PEOLC and Communication skills for over 1,334 HCPs
- Further communication skills training has been delivered to 308 participants, through a multiprofessional faculty lead by the Lead for Psychological Therapies.
- EOLC Study Day: You only Die Once has been successfully rolled out across all 4 hospital sites
- 199 members of staff have attended Apr-Mar 24-25



- Clear positive shift in confidence post study day.
- Fundamentals of Palliative Care in an acute setting, is now part of UHSx practice development programme, and has been awarded accreditation with University of Chichester:
- 74 Health Care Professionals, have attended through 3 cohorts
- Positive feedback, show an increased confidence in managing Palliative Care Patients in an acute setting.
- Communication Skills Simulation: Sim is sick enough to Die
- Commenced August 2024: 56 participants
- We believe this to be a novel approach to communication skills training, whereby a multi-professional SIM is used, consisting of: Nurses (69%), Dietitians (11.5%), Occupational Therapists (7.7%), Doctors (3.8%) and Critical Care Outreach (3.8%).
- On average candidates reported a 46.7% improvement in confidence handling most palliative conversations after the SIM. 97% felt the course met their learning needs.
- UHSx has developed a Multiprofessional faculty who provide Communication skills training which is coordinated by, Lead for Psychological Therapies & administered by Cancer Services Psychological Therapies, The courses are delivered by facilitators from Cancer psychological Therapies team, Chaplaincy, Practise education, Lead RN PEOLC, Cancer Matrons & CNSs.
- Sage & Thyme: Communication skills: 160 attended
 - 76% said they'd definitely recommend it to a colleague
- Handling Bad News: 112 attended
 - 95% said they'd definitely recommend it to a colleague

- Level 2 Psychological Skills Training – 36 Attended
 - 100% said they found it extremely useful/ useful
- UHSx Specialist Palliative Care Teams have delivered training across UHSx [both formal and informal]: 1005 participants & 218 visitors:
 - RSCH/PRH: 365 HCPs [local communication skills, comfort obs, HCSW, AAU, Fy1&2]
 - RSCH/PRH visitors 160, totalling 560 hours [Medical Students, Jnr Drs, Nursing Students, AHPs, Community Colleagues]
 - WGH/SRH: 535 [local communication skills, comfort obs, HCSW, AAU, Fy1&2]
 - WGH/SRH visitors: 58 [Medical Students, Jnr Drs, AHPs, Nursing Students, AHPs, Community Colleagues]
 - Cancer: 105 [Fundamentals of Cancer care]

2025/26 Action Plan:

- Increase HCP confidence in caring for EOLC patients
- Review SPCT education Strategy 25/27
- Continue YODO and Fundamentals courses, increase attendance
- Expand SIM is sick enough to die across all 4 sites
- Recruit a Practice Development Nurse into a combined roll: Cancer/Palliative & EOLC, to support the development of a university pathway.

To partner with others to provide seamless care for patients approaching the end of life.

Background:

- Emerging evidence indicates that nationally those living in the last 2 years of life have multiple acute admissions with local variation showing, highlighting that although those with a cancer cause of death are far less likely to die in hospital, they are at substantially greater risk for other outcomes. In particular, multiple emergency admissions (40% more likely) and multiple A&E attendances (31% more likely)
- Since 2022, health and care partners recognised the PEOLC programme as a priority area of focus and a Sussex Palliative and End of Life Care (PEoLC) all age Programme Oversight Group was established of which UHSx is represented via the Supportive & EOLC Group. This is a multi-stakeholder group with wide reaching representation across the Sussex system. A Strategic Action plan covering 2022-25 was developed with the following vision:

‘Our collective aim in Sussex is to make the last stage of a person’s life as good as possible, through working together confidently, honestly, and consistently to help each individual and the people important to them’

UHSx SEOLC 2024/27 Strategic Goals:

- Collaborate with NHS Sussex ICB and SCFT to ensure patients felt to be in the last year of life are appropriately consented and referred to the ECHO service and continue to lobby for a similar service across the entire UHS catchment area.
- Ensure successful implementation of pan Sussex Anticipatory Prescribing Guidelines and Medication Instruction Chart.
- Streamline processes for EOLC discharge Home or Nursing Home with NHS Sussex AACC

- Streamline processes and communication with local hospice services.
- Work with NHS Sussex ICB and SCFT on the rollout with RESPECT in the locality, ensuring processes at the `front and back door` are aligned.
- Widen access to specialist palliative care for groups with currently unmet need, e.g. attending liver failure and other non-cancer conditions MDMs, improve links with specialist ACPs and CNSs

2024/25 Progress:

- UHSx Supportive & EOLC Group has remained a quorate member of the NHS Sussex Palliative & EOLC Oversight Group
- Sussex Palliative Care Hospital Collaborative have started to collaborate on comparing activity data and have established an annual Hospital Palliative Care forum.
- We have successfully rolled out the NHS Sussex Medication Instruction chart and its associated guidance [Appendix 6]

2025/26 Action Plan:

- April 2025 following the collaboration to present at B&H HOSC, SCFT, UHSx and the Hospice Alliance have formed a task and finish group to address the health inequalities End Stage Liver Disease patients face across Sussex.
- To establish patient information requirements around 'Services associated to PEOLC' and 'Respecting Faith and Culture in EOLC'
- Collaborate with NHS Sussex with the Macmillan Social Investment opportunity to create a Palliative and End of Life care (PEoLC) centralised coordination service across Sussex.

Care After Death

Background:

- We continue to work closely with our colleagues in the Medical Examiner's Office, Mortuary, Bereavement Office and Learning from Deaths Team
- All are valued members of the Supportive and EOLC Group
- Lead RN PEOLC now member of UHSx Mortuary Steering Group

UHSx SEOLC 2024/27 Strategic Goals:

- Unify our processes for care after death across all 4 hospital sites and create a standardised policy.

Progress:

- UHSx Care After Death Policy, finalised Summer 2024 [Delay due to national Medical Examiner Legislation]

- UHSx Care After Death Peer Review completed across all 4 sites [Appendix 7]
- Top emerging themes:
 - All staff interviewed take pride in their part of providing dignified care after death.
 - New Care After Death documentation is widely used: some areas outstanding:
 - Datix has supported in resolving this issue
 - Blue Slide Sheet for Care After Death transfers now widely used: some areas outstanding:
 - Datix has supported in resolving this issue: Manual Handling Teams now ensure part of 2 yearly update.
 - Concealment Trolleys, brake system increase risk of unsafe transfer:
 - Mortuary Steering Group aware
 - Signage:
 - Mortuary Steering Group ongoing discussion with how best to address

Action Plan:

- Triangulate Care After Death themes, from MEO, LFD to complaints data
- Care After Death training video being developed

Deteriorating Patient Treatment Escalation Planning:

Background:

- The Supportive and EOLC Group continued to support the Critical Care Outreach Teams quality improvement work around Treatment Escalation Planning and reduction in unnecessary Met Calls

Strategic Goals:

- Ensure Treatment Escalation Planning [TEP] process' are followed in accordance with local Guidance.
- Oversee the digitalisation of DNACPR and TEP into UHSussex e-Health Records

Progress:

- Recognition that current TEP and Met call data is siloed by hospital site, that current trend data observing timeliness of clinical observations struggles to articulate the multiple issues surrounding the deteriorating patient.
- Through a task and finish group successfully created TEPv9

Action Plan:

- Lead RN PEOLC now member of UHSx Deteriorating Patient Steering Group and UHSx ROMG, where these issues will be discussed.

Key Recommendations:

- Executive Sponsorship to provide appropriate resource into Communication Skills Training trust wide, SEOLC Group has identified multiple communication and professional behaviour issues, alongside our work with PSG, PEEG and LfD.

- Executive sponsorship to support the collaboration with NHS Sussex with the Macmillan Social Investment opportunity to create a Palliative and End of Life care (PEoLC) centralised coordination service across Sussex.
- Executive sponsorship to support UHSx, SCFT and the Hospice Alliance address the health inequalities End Stage Liver Disease patients face across Sussex, through the development of a UHSx Liver MDM and pathwat for ES Liver Disease.
- Support Palliative & EOLC Education Strategy 2025/26.

Appendices:

Appendix 1:



NACEL 2024 Quality Improvement Certifi

Appendix 2:



Patient%20Experien
ce%20Two%20storie

Appendix 3:



TEP v9
UHSussex.pdf

Appendix 4:

Problem statement	There is increasing demand for palliative care – ageing population, multi-morbidity, increasing incidence of cancer and dementia (main drivers for the increasing need). Estimates suggest demand for palliative care will increase by 42% over the next 10 years. Locally that increased demand is already evidenced with our increasing referrals to the hospital palliative care team, but also our overwhelmed local hospice services. The challenges in community provision result in increased non-elective admissions for patients in the last year of life. Without action our hospitals will become overwhelmed with potentially avoidable admissions. Currently UHSx is a national outlier for the size of its palliative care team Recommendations are 1 consultant per 250 hospital beds (APM 2012) or 2.2 WTE per 100 000 population. Currently we have 1 consultant per 460 hospital beds (3.8 consultants for 1750 beds – should have 7 consultants as per this guidance)
Action required	Support SCFT to have palliative care patients on general virtual wards for admission avoidance and early discharge An education programme and ward presence to ensure dying patients needs are recognised and acted upon

	A rapid discharge pathway for imminently dying patients with a digital solution to support informal carers with this Access to 24/7 telephone support from a UHS palliative care consultant, with CNS face to face presence 7 days per week. A digital risk escalator and follow up with advance care planning to reduce future admissions
Supporting information	NICE guidance and Quality statements as well as NHS England Commissioning guidance for SPC states that patients in all localities should have access to 24/7 Palliative Care advice and face to face assessment Singh et al, BMJ Palliative and Supportive Care July 2023
Benefits	Reduced overall admissions in the last 3 months of life (cost saving) More patients dying in their preferred place of care (cost saving and improved quality) Fewer complaints relating to EOL care (improved quality) Few clinical incidents relating to EOL care out of hours (improved quality) Competent staff who feel well supported and able to deliver end of life care (investing in people) UHS recognised as a national leader for innovation in the field of palliative and end of life care, whilst providing a quality service to its local population (research and innovation). Ability to effectively work collaboratively with ECHO across the organisation and step down weekend SLA with Marletts.
Financials	2.0 WTE x Palliative Care Consultants (based Worthing/RSCH/PRH)- £287k FYE 2.0 WTE x cancer nurse specialists - - £116k FYE

Appendix 5:

2025 The role of the acute oncology service in a comprehensive cancer management pathway
Williams H , Marshall E Lillis A Minton O Journal of Cancer Policy [The role of the acute oncology service in a comprehensive cancer management pathway. - ScienceDirect](#)

2025 'No Right Time, no right place'- conversations in acute cancer care - results of a Macmillan focus group Lillis A Williams H Marshall E Jones M Henderson S Minton O Future healthcare Journal ['No Right Time, no right place'- conversations in acute cancer care - results of a Macmillan focus group - ScienceDirect](#)

2025 The importance of integrated care/inter-professional when dealing with oncological emergencies Clinics in integrated care Marshall E, Minton O , Cunliffe A , Selvaratnam R [The importance of integrated care when dealing with oncological emergencies - ScienceDirect](#)

2025 Integrating ePROMs: A Key Opportunity for England's National Cancer Plan Wheelwright S Minton O Shilling V Journal of Cancer Policy [Integrating ePROMs: A Key Opportunity for England's National Cancer Plan - ScienceDirect](#)

2024 British Society of Gastroenterology practice guidance on the management of acute and chronic gastrointestinal symptoms and complications as a result of treatment for cancer. Jervoise N Andreyev, Richard Adams, Jan Bornschein, Mark Chapman , Dave Chuter, Sally Darnborough, Andrew R Davies..., Ollie Minton¹⁷ et al [British Society of Gastroenterology practice guidance on the management of acute and chronic gastrointestinal symptoms and complications as a result of treatment for cancer | Gut](#)

2024 "Exploring the impact of the Care and Support System for Patients and Carers, a remote monitoring and support system for palliative and end-of-life care: a mixed methods feasibility study"
by Roma Maguire, Lisa McCann, Claire Singleton, Paul Perkins, Minton O , Nicola McCann, Emma Longford et al <http://preprints.jmir.org/preprint/69394>

2024 Kamal, L., Kano, Y., Stevens, AM. Minton O *et al.* Assessing the sensitivity and acceptability of the Royal Marsden Palliative Care Referral “Triggers” Tool for outpatients with cancer. *Support Care Cancer* **32**, 730 (2024). <https://doi.org/10.1007/s00520-024-08921-5>

2024 BMJ learning module authorship – pain management & emergencies in palliative care

- [Palliative care: Symptom control at end of life](#)
- [Palliative care emergencies in the community](#)
- [Palliative care: managing pain at end of life](#)

2024 Flanagan K, Vickerstaff V, Wheatstone P, Minton O, Taubert M, Hudson B, White N. Virtual reality technology for pain management in advanced cancer (Protocol). *Cochrane Database of Systematic Reviews* TBD, Issue TBD. <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD016078/full?highlightAbstract=realiti%7Crealiti%7Cvirtual>

2024 Bass S Stewart E Savage E Minton O “Did we do our best?” An Appreciative Inquiry into whether our hospital delivered person-centred compassion to those who died from nosocomial COVID-19 Mortality <http://dx.doi.org/10.1080/13576275.2024.2366843>

2024 Wiltshire J Grout J et al Minton O An analysis of healthcare usage & place of death in England for all adults who died in 2021/22 *American Journal of hospice and palliative medicine* <https://journals.sagepub.com/eprint/VBHMAYVZFG9PGPV9JUV7/full>

2024 Stone P Minton O Richardson A et al Methylphenidate versus placebo for treating fatigue in people with advanced cancer: randomized, double-blind, multi-center, placebo-controlled trial <https://ascopubs.org/doi/10.1200/JCO.23.02639>

2024 Stewart E Ford-Dunne S Minton O Digitally recording comfort observations in the last days of life *American Journal hospice and palliative medicine* *American Journal of Hospice and Palliative Medicine@OnlineFirst* <https://doi.org/10.1177/10499091241234859>

Appendix 6:


Community%20palli
ative%20prescribing


Palliative Care
Medication Instructi

Appendix 7:


Peer%20Review%20
Document%20-%20C


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Agenda Item:	14.3	Meeting:	Trust Board in Public	Meeting Date:	4 September 2025
Report Title:	Patient Safety Incident/Duty of Candour Compliance Annual Report 2024/25				
Sponsoring Executive Director:	Maggie Davies Chief Nursing Officer				
Author(s):	Jo Habben Director of Patient Safety and Learning Sam Machen Associate Director of Patient Safety and Learning Luciana Thorpe Patient Safety Incident Investigation Manager				
Purpose of the report: <i>(indicate as appropriate)</i>	For Decision PSG/QGSG	For Assurance PQC/QGSG	For discussion PSG	For Information only	
	Yes	Yes	Yes	N/A	
Reason for not being taken in public <i>(indicate as appropriate)</i>	Commercial confidentiality	Staff confidentiality	Patient confidentiality	Other exceptional circumstances <i>(please detail)</i>	
	N/A	Yes	Yes	Yes / N/A	
Regulatory Reporting Requirement	CQC Regulation 12: Safe Care and Treatment CQC Regulation 17: Good Governance CQC Regulation 20: Duty of Candour NHSE Patient Safety Incident Response Framework				
Summary of the report describing	For committee assurance. - To update the board on the metrics, trends and learning from Patient Safety Incidents reported annually during 2024-25. - To report the Trust compliance with the Health and Adult Social Care Act 2008 (Regulated Activities) Regulations 2015: Regulation 20 Duty of Candour.				
What <i>(summary of current position / issue & why it matters and evidence to support that position etc)</i>	Assurance to the board/committee can be provided on the following work programmes: ✓ The Patient Safety Incident Response Framework (PSIRF) is well embedded within the governance workstreams ✓ PSIRF is achieving its overarching aim of providing fluidity to the investigatory tools that are used across the organisation (as opposed to pre PSIRF where SI or concise were the two investigatory methods) ✓ PSIRF has resulted in more incidents being investigated (not related to an increase in harm, more related to increased investigation of lower harm incidents) ✓ The Datix (DCIQ) incident reporting system is evidencing a month on month increase on the rate of reporting per 1000 beddays to reach the target of >60. This is a positive indicator of an open learning culture. For the first time since we were a merged organisation, we are in the top 20 Trusts for incidents reported (not adjusted for 1000 beddays).				

What <i>(provide meaningful analysis drawing out as appropriate implications against Trust Strategy / Delivery Plans / Strategic or Regulatory risks etc and any options for addressing these)</i> What Next <i>(summary of intended action and benefits supporting the choices and recommendation(s)being made)</i>	✓ There is evidence of increased vigilance with monitoring the learning themes and trends from mortality and morbidity reviews and structured judgement reviews (SJR). Incident reports, complaints and friends and family feedback. Limited assurance is provided regarding: ✓ Compliance with Duty of Candour (Regulation 20): Annual reporting demonstrates positive compliance with all 3 components of the audit. Across the whole year, compliance with initial conversation is 96%, sending of letter is 95% and dissemination of reports to patient/family is 88%. Overdue investigations (ELR/LLR/PSII) are increasing impacting the last ‘stage’ of candour and the compliance with inquest governance. The current risk and mitigations are: ✓ The divisional governance structure/workforce are not standardised or adequately staffed to support compliance with incident investigation and candour. The proposal for an enhanced trained workforce is currently paused awaiting outcome of the pending Targeted Operation Model (TOM) review.												
Recommendation <i>(linked to What Next section)</i>	The Trust Board is asked to approve the contents of the report.												
Assurance / Scrutiny route already undertaken <i>(please explain where matter previously considered, and assurance provided)</i>	1) Patient Safety Group 2) Quality Governance Steering Group – 21 July 2025 3) Patient & Quality Committee - July 2025												
Link to Trust Strategy <i>(note which theme)</i>	<table><tr><th>Care</th><th>People</th><th>Future</th><th>Communities</th><th>One UHSussex</th><th>Culture</th></tr><tr><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td></tr></table>	Care	People	Future	Communities	One UHSussex	Culture	Yes	Yes	Yes	Yes	Yes	Yes
Care	People	Future	Communities	One UHSussex	Culture								
Yes	Yes	Yes	Yes	Yes	Yes								
Link to annual delivery plan													
Link to BAF <i>(explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)</i>	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 ‘<i>Zero harm occurring to our patients when in our care</i>’, with a target to reduce the number of all harms categorised as ‘low, moderate, severe harm and death’ by 5%.												
Link to CQC domain	<table><tr><th>Safe</th><th>Caring</th><th>Effective</th><th>Responsive</th><th>Well-led</th><th>Use of Resources</th></tr><tr><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Yes</td></tr></table>	Safe	Caring	Effective	Responsive	Well-led	Use of Resources	Yes	Yes	Yes	Yes	Yes	Yes
Safe	Caring	Effective	Responsive	Well-led	Use of Resources								
Yes	Yes	Yes	Yes	Yes	Yes								



Other impacts	Equality and Diversity (<i>if yes has HEIA completed</i>)	Environmental	Legal	External Registrations (<i>if yes please indicate which</i>)
	N/A	N/A	Yes	Yes CQC/NHSE



Main Report

1) Patient Safety Team: Work Programmes



2) The Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) responds to calls for a new approach to incident management, one which facilitates inquisitive examination of a wider range of patient safety incidents “in the spirit of reflection and learning” rather than as part of a “framework of accountability”. Informed by feedback and drawing on good practice from healthcare and other sectors, it supports a systematic, compassionate, and proficient response to patient safety incidents; anchored in the principles of openness, fair accountability, learning and continuous improvement.

The Patient Safety Incident Response Framework (PSIRF) provides the NHS with guidance on how to respond to patient safety incidents, with no distinction between incidents and ‘serious incidents’ – for the purpose of learning. As such it is relevant to all bodies involved in providing; commissioning, supporting, overseeing and regulating NHS-funded care. This includes services operating as part of a primary care network and other independent, non-NHS providers of NHS-funded care/services.

In December 2023, UHSussex commenced the programme management of the implementation of PSIRF.

3) Patient Safety Specialists

The requirement for NHS organisations in England to identify one or more person as their designated Patient Safety Specialist(s) is a key part of the NHS Patient Safety Strategy. These specialists work full time as patient safety experts, providing dynamic, senior leadership, visibility, and support. In addition, they will support the development of a patient safety culture, safety systems and improvement activity.

UHSussex has 3 Patient Safety Specialists that have all received the recommended training for the role, including the Silver Health Safety Investigation Branch (HSIB) Investigator Training and the NHS Patient Safety Syllabus Training L3&4. In 2024 Kellie Bryan also completed a postgraduate certificate in Human Factors and Ergonomics for Patient Safety (with distinction).

Figure 1. Patient Safety Specialists



4) Patient Safety Partners

The NHSE Patient Safety Framework for involving patients in patient safety is split into two parts:

- Part A: Involving patients in their own safety
- Part B: Patient safety partner (PSP) involvement in organisational safety

Following successful recruitment, two PSPs now actively contribute to the Trust Patient Safety work programmes. John and Amy present at every Trust Patient Safety Group and also were instrumental in the development of the Trust Duty of Candour e learning training.

Figure 2. Duty of Candour training presenters and Patient Safety Team


University Hospitals Sussex
NHS Foundation Trust

Meet the Presenters

 Deborah Habben Director of Patient Safety and Learning	 Ellie Ryan Head of Safety Investigation	 Luciana Horpe Patient Safety Incident Investigation Manager	 John Aquiss Patient Safety Partner	 Amy Night Patient Safety Partner		
 R Samachen Associate Director of Patient Safety	 Shlee Etcalfe Head of Patient Safety	 Bill Eng Business Intelligence Project Manager	 Laura Ains Patient Safety Data Analyst	 Aomi Sellwo Patient Safety Incident Investigation Business Support	 Hys Ester Divisional Business Support	 Ary Hild Patient Administrator



PSPs John and Amy during filming the training introduction.

5) The Patient Safety Group

The purpose of the bi-monthly meeting is to monitor, and provide assurance on, all aspects of the delivery of safe, reliable care in line with the NHSE England Patient Safety Strategy. This includes the provision of assurance of the trust's compliance with all regulatory requirements, and that a safety culture is embedded across the trust's clinical divisions and sites; with staff taking ownership of the patient safety agenda.

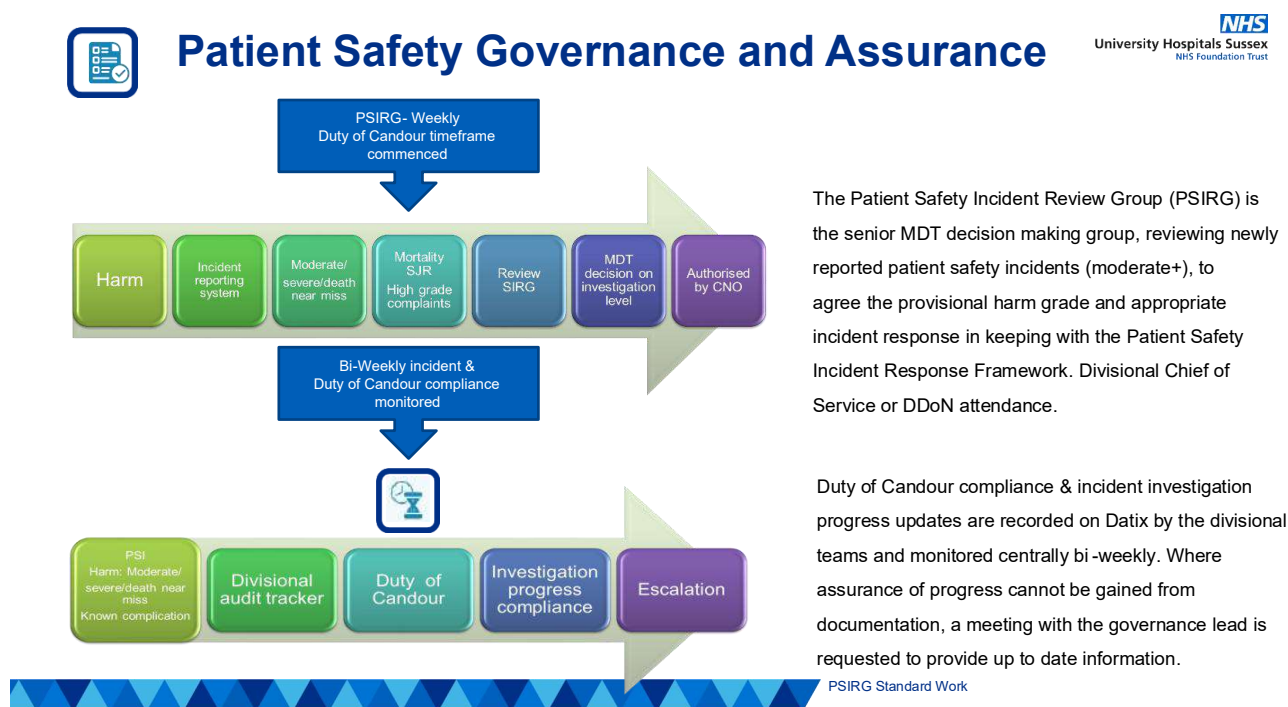
The PSG reports directly to the monthly Trust Quality Governance Steering Group.

6) The Patient Safety Incident Response Group (PSIRG)

The primary role of the weekly Patient Safety Incident Review Group (PSIRG) is to review all reported unexpected deaths and new incidents (including near misses), graded moderate or greater harm on RL DATIX IQ.

PSIRG will also review any high-grade complaints shared by the Patient Experience team, Staff's with a poor care grading, and alerts shared by the Safeguarding teams, to ascertain whether they reach the threshold for a patient safety incident response.

Using a senior multidisciplinary approach, the panel/group will agree the provisional incident harm grading, a proportionate incident response in keeping with PSIRF, and/or any escalation required. Each month, a summary report outlining themes and trends from the meeting is submitted to the UHSussex Patient Safety Group (PSG) and copied to the divisions. The summary report will include numbers and brief details of new, open and closed patient safety incidents (ELR/LLR), and never events/PSIIs, as well as the numbers of overdue investigations.

Figure 3. Quality Governance

7) National Learning

The HSSIB (Health Services Safety Investigations Body) and MNSI (Maternity and Newborn Safety Investigations) are both involved in healthcare safety investigations, but they focus on different areas. HSSIB investigates patient safety incidents across the NHS, while MNSI specifically focuses on maternity and newborn safety. MNSI is a special health authority hosted by the Care Quality Commission (CQC).

Published reports relevant to UHSussex are presented and discussed at the Patient Safety Group.

1. April 2024: Temporary staff – involvement in patient safety investigations
2. May 2024: Patients at risk of self-harm: continuous observation
3. June 2024: Keeping children and young people with mental health needs safe: the design of the paediatric ward
4. Oct 2024: Sexual safety: implications for patient safety
5. Dec 2024: Medication not given - administration of time critical medication in the emergency department
6. Mar 2025: Medication not given - anticoagulation before and after a procedure

Shared with targeted audiences rather than at PSG:

- April 2024: Retained swabs following invasive procedures
 - January 2024: multiple mental health reports (see below)
-
1. Mental health inpatient settings (Jan 2025)
 2. Mental health inpatient settings: Creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge (Jan 2025)
 3. Mental health inpatient settings: Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services ec 0 4
 4. Investigation report: Mental health inpatient settings - out of area placements (Nov 2024)
 5. Creating conditions for learning from deaths and near misses in inpatient and community mental health services: Assessment of suicide risk and safety planning (interim report Sep 2024)

8) Never Events 2024-25

Nationally 403 patient safety incidents appeared to meet the definition of a Never Event in the Never Events list 2018 (published 28 February 2018). This number is subject to change as local investigations are completed.

Of the 403

- 185 were in relation to wrong site surgery
- 106 were in relation to retained foreign object
- 50 were in relation to wrong implant/prosthesis
- 23 were in relation to misplaced naso/oro gastric tubes
- 14 were in relation to administration of medication by the wrong route

In 2024-24 UHSussex reported 5 Never Events:

- Never event: administration of medication by the wrong route x1
- Never event: wrong site surgery x1
- Never event: wrong site injection x1
- Never Event: wrong implant/prosthesis x2 (Ophthalmology and Obstetrics)

9) Local Learning: Patient Stories

Patient stories are presented at PSG and divisional governance forums.

2024/25 Patient Story publications:

1. Delayed treatment potentially leading to cancer progression
2. Patient with metastatic disease lost to follow up
3. Inpatient fall
4. Missed opportunity to diagnose spinal fractures
5. Management of patient with small bowel obstruction (Figure 4)
6. Never event: retained surgical swab (Figure 5)
7. Complication of surgery
8. Blood transfusion delay
9. Undertreated hypokalaemia
10. Delayed radiological finding
11. Missed lung lesion
12. Management of ascitic drain
13. Delayed follow-up endoscopy appointment

Issue number 10a October 2024

Patient Safety Learning

Quality

Patient Story

Learning from LLR 8074: Complication of surgery

Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have

Background

A patient underwent a Hartmann's procedure as an emergency at 02:00hrs on the 13th of April 2024. Following the operation, postoperative ileus was presumed however on the 21st of April a Computerised Tomography (CT) scan reported findings that the wrong viscous end had been brought out as the stoma, and that there was colonic dilatation and a left pelvic faeculent collection identified. On the 22nd of April, this finding was confirmed during an emergency laparotomy:

Oedematous small bowel. Large, distended caecum that was perforated in a linear tear. Feculent material emanating from the tear. Contamination of faeces was contained largely in the centre of the abdomen and not spread across all areas, it was contained by a loop of small bowel, the medial caecal wall, and the omentum. The descending colon was stapled off and oversewn with prolene and tucked around the back of the sigmoid colon that was matured as a colostomy.

A subtotal colectomy and formation of ileostomy was performed; the rectal stoma was left in place. The patient was admitted to the intensive care unit for 19 days. The patient underwent CT (Computerised Tomography) guided drainage of a pelvic collection on the 15th of May. Intravenous antibiotics under the guidance of the microbiology team continued until the date of the patient's discharge on the 31st of May.

Excellent Care, Every Time
Where Better Never Stops

Findings, learning and actions

STRATEGIC THEMES

Finding:

This was a surgical error which occurred at the point when the surgeon identified the distal end of the bowel incorrectly as the proximal end.

Finding:

Immunosuppressed patients may require a different approach to assessment for complications post operatively and a lower threshold for further investigation. During the post-operative recovery clinical ward team markers had not indicated a significant post-operative complication and the surgical team had suspected an issue which would resolve over time. Prolonged postoperative ileus requires further evaluation and therefore on day 9 a CT scan which identified that the bowel end formed as a stoma was the incorrect end and was completed.

Finding:

Two senior surgeons operated, and the assisting surgeon reported confidence in his colleague's decision making. In this patient's case, the perforation was limited to a small area and therefore a shorter section of bowel was resected (3.3cm). This meant that both proximal and distal ends could reach up to the stoma site which would not usually be possible. This also meant that twisting of the longer lengths of remaining bowel was possible making it appear to the surgeon that the distal end of the bowel was the proximal end. This complexity of both distal and proximal ends being available, coupled with the confidence with the surgeon's decision making, meant that there would not have been an active check that the correct (proximal) end was the part of the bowel that was being brought out.

Learning:

All surgeons who do this procedure must start by thinking carefully about strategies to avoid forming a stoma with the wrong end. Different techniques can be employed to identify the distal and proximal bowel limbs intraoperatively. For example, using a long suture to make a mark on the distal limb.

Learning:

Secondary strategies are those that can be taken postoperatively to recognize that the error has occurred and intervene in a timely fashion to correct the problem. Teaching about managing immunosuppressed patients with acute abdomens will be delivered to the surgical team.

Learning:

Engaging other surgical team members to perform an independent double-check of the surgical site and mark is a principle to prevent wrong site surgery. During procedures such as this, the same principles could be applied whereby the surgeon clarifies that the correct limb has been identified as distal by verbally saying, "This is the distal limb," and ask if they agree. It is not part of a standardized protocol, but more of a common sense conversation with the people involved. This will be encouraged for future procedures to ensure any future cases do not have misidentification of the wrong part of the bowel being brought out and formed into a stoma.

Action:

The Consultant surgeon has changed his clinical practice and marks the proximal bowel with a long suture to ensure it is clearly identifiable.

Action:

Teaching sessions for the surgical team regarding the pre and post operative management of the immunosuppressed patient.

Action:

Confidence can lead to significant risks in healthcare, including unchecked errors, reduced vigilance, impaired communication, and delayed corrective actions. Addressing these human factors through thoughtful design, comprehensive training, and effective communication strategies is crucial in reducing errors and improving patient safety.

Issue number 8a 2024

Patient Safety Learning

Patient Story

Learning from Never Event PSII— Retained surgical swab

Quality

Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have

Background

A mother attended the Emergency Department on 26 December 2023, a day after finding, and removing an object from her vagina. The object was found to be a surgical swab, considered to have been retained during her baby's delivery, as the mother had given birth to her first baby five weeks before on 18 November 2023, and required delivery by vaginal forceps.

The mother was reviewed by an obstetrician, and she was assessed to be systemically well. A vaginal swab was taken and sent for microbiological testing, and the mother was prescribed a course of antibiotics.

The incident was immediately reported, and an investigation commenced to understand how the retained swab had not been recognised at the time of the instrumental delivery, or at any time during the postnatal period.

LocSSIP: Standard for WHO Five Steps for Safer Surgery (Trust wide)



Key findings

- ⇒ The roles and responsibilities of the theatre team during vaginal procedures in theatre needs urgent review.
- ⇒ The theatre WHO checklist was not used. The development of a maternity specific WHO is recommended, and it's use during emergency theatre cases advised.
- ⇒ It is recommended that swab and instrument counts following vaginal procedures in maternity theatres are undertaken between operating doctors and the theatre team.
- ⇒ It is recommended that the use of Badgernet is introduced within maternity theatres to standardise the documentation of procedures and the swab and instrument counts.

Summary of safety actions

1. Develop a Standard Operating Procedure which clearly defines the roles and responsibilities for swab and instrument counts post vaginal procedures in maternity theatres.
2. Badgernet to be implemented for use within maternity theatres.
3. Develop a maternity specific WHO checklist for maternity theatres.

10) Training

A new e-Learning module: Essentials for Patient Safety launched in 2024 for all UHSussex staff. In addition, face to face training delivered by the Patient Safety Team, including three 'levels' mapped in accordance with the Patient Safety training syllabus curriculum. Individuals identified to be learning response leads will be expected to complete all three levels – level 1, 2a, and 2b. The training dates are uploaded to IRIS for learning response leads to book onto courses. The objectives of each session can be seen below:

Level 1 – Patient Safety Fundamentals

- To explore theories of safety and how they relate to everyday work, safety, and improvement
- To identify Human Factors as a discipline and how it relates to safety
- To understand how complexity affects healthcare related tasks
- To understand systems thinking and how it can be used in patient safety investigation

Level 2a – Patient Safety and Safety Science

- To explore the theory around systems thinking, human factors, and how they relate to everyday safety and improvement
- To have guided practice in applying Human Factors to safety and investigations
- To have guided practice in mapping systems within health care and appreciating variation and complexity
- To understand how to relate variation and complexity to everyday tasks relevant to patient safety

Level 2b – Practical applications – learning response leads

- To become familiar with how you would decide which investigatory method to use under PSIRF
- To identify the theory and application of an After-Action Review (AAR)
- To identify how to apply systems thinking in investigations
- To identify the theory and application of a thematic review
- To understand the format of PSIs for this Trust
- To identify system-based recommendations and actions, rather than person-focussed

To date (2024-25) 216 senior staff have been trained in all 3 modules. More training is scheduled for 2025-26.

Dr Sam Machen has written 2 publications, BMJ Open Quality (Thematic Review) and a chapter within *Patient Safety: Emerging Applications of Safety Science*. (Figure 6)



11) Patient Safety Annual Report

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%.

Annual report - For actual harms (approved) graded as low, moderate, severe and death the numbers reported for the highest percentage of reported patient safety incidents are graded as no harm. Pressure damage and falls are the most common themes within the low harm categories. The top reporting themes remain tissue viability incidents (including moisture related skin damage) and inpatient falls.

Death/Catastrophic: of the 49 catastrophic incidents reported, treatment and procedure related concerns constitute 24% of these cases, followed by falls at 12%. A thematic review has been completed for falls resulting in severe harm or death to provide a deep dive into this portfolio by the Head of Nursing for Harm Free Care. The majority of these incidents proceed to inquest.

Major/ Severe harm: 115 cases. Inpatient falls resulting in severe harm is a top theme, with 45 (37.13%) incidents in this category. This increasing number has been reported and escalated to the deputy chief nurse for quality and lead for harm free care/fundamental standards to care to include within the improvement programmes.

Inpatient falls, medical review, diagnostic testing, treatment and procedure and medication error remain top themes.

Moderate harm: 512 incidents reported and confirmed as moderate harm.

Top themes pressure damage: 20%, treatment and procedure: 14.45% and inpatient falls: 13.09%.

A revised harm category of psychological harm has recently been added/updated by NHSE and is highlighted as an example for when patients have delayed surgery or mental health patients awaiting specialist treatment.

This harm level may be downgraded when incidents have been fully investigated or via the mortality and morbidity (M&M) divisional governance review process.

Emergent themes within the moderate and severe harm/death categories remain patients lost to follow up/referral to treatment and mental health care and treatment within acute care settings. This data correlates with the highest risks noted on the Trust risk register.

Patient Safety Incident Investigation (PSII) Death and MNSI¹ criteria²: Target 0 harm (Appendix 1)

In 2024/25:

¹ Maternity and Newborn Safety Investigations

² Eligible babies include all term babies (at least 37+0 completed weeks of gestation) born following labour who have one of the following outcomes.

1. **Intrapartum stillbirth:** where the baby was thought to be alive at the start of labour but was born with no signs of life.
2. **Early neonatal death:** when the baby died within the first week of life (0-6) days of any cause.
3. **Severe brain injury** diagnosed in the first 7 days of life, when the baby:
 - Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); or
 - Was therapeutically cooled (active cooling only); or
 - Had decreased central tone and was comatose and had seizures of any kind.
4. **Maternal Deaths:** Direct or indirect maternal deaths in the perinatal period (during or within 42 days of the end of pregnancy). Coincidental maternal deaths will not be investigated.

- 50 new SII's were raised, of these :
 - 10 maternity cases were referred to MNSI
 - 5 Never Events were raised
 - 1 was downgraded
- All legacy pre-PSIRF Serious Incident investigations (Serious Incident Framework 2015) have been submitted to ICB Quality Team, and all have now been closed.

Slides 25-27 outline the decision-making process for investigation level under the new framework.

Slides 32-33 detail the current Sit-Rep catalogued by division of the patient safety incident response.

Duty of Candour: Target 100%

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

- Compliance with initial DoC conversation/apology **Annual 96% (increase)**
- Compliance with initial DoC letter: follow up from meeting/conversation 95% (increase)
- Compliance with investigations/ review findings shared with patients/ families 88% (increase)

An overall average score of the 3 components forms the Trust compliance score:

Q4 overall aggregate compliance score = 93% (increase)

Please note, the increase in scores is due to the data covering a whole year period rather than quarterly scores which look back at the active cases across a 3-month period. As such, the annual review allows us to look at all cases (of which the majority may be closed) and get a more reliable representation across the year. This means that there may have been delays, but that when the incidents were finally closed the requisite standards were met. As such, comparison of quarterly figures and annual figures should be avoided but arguably annual figures give us a better representation of the overall picture of DoC whereas quarterly data shows real time data and may identify real time contributions to delays

The charts in the report demonstrate the divisional compliance with Duty of Candour.

- 593* notifiable safety incidents were audited against the Duty of Candour and Being Open Policy. In 2024/2025, Duty of Candour conversation was held in 569/593 cases
- 585** notifiable safety incidents were audited against the Duty of Candour and Being Open Policy. In 2024/2025, Duty of Candour letter was sent out in 555/585 cases (95%)

**Incidents for which the degree of harm had not been confirmed have been excluded from the dataset for analysis.*

***Incidents meeting exemption criteria were excluded from the analysis. I.e. for which patients/ NoK declined receiving an investigation or no NoK was recorded for a deceased patient.*

Where final DoC was not enacted, it was due to investigations being either not finalised or undergoing final ratification. The teams are expected to enact the full DoC process in 100% of the cases, unless exemption criteria is met.

To improve the quality of Regulation 20 Duty of Candour compliance reporting, the new DCIQ incident module has revised the data collection tools and process to ensure Trust compliance.

- This new report includes detailed data to ensure that patient and families are communicated with at the earliest opportunity when moderate/severe harm or death has occurred.
- The DCIQ templates have been collaboratively designed with stakeholder and divisional support.
- Patient Safety and Duty of Candour Training has been available on the IRIS e-learning platform since Q3 24/25.

PSIRF look back:

- The aim for the organisation is to be (1) more proportionate in its decision making based upon safety science principles, (2) provide more rapid investigations for incidents to gain learning quicker and communicate to families quicker, (3) engage with staff and provide restorative support, and (4) ensure civility for staff through just culture.
- More investigative tools have been used, with 5 different investigation tools used in 2024-2025 compared to just 2 in 2022-2023.
- Of these different investigation tools, over 50% are Early Learning Reviews which allow the Trust to complete investigations in a more proportionate way and ensure rapid identification of learning.
- Over 2024-2025 the Trust aimed to investigate more cases, and we did this successfully – with a higher number of cases investigated month by month (slide 22).

The Trust has not seen an increase in harm across this year, so this identifies we are investigating more lower harmed incidents which allows heightened understanding more of the safety concerns/themes which are not solely driven by harm grading of incidents.

- The Patient Safety Team have trained 216 learning response leads in a 2-day training course on safety science, human factors, and investigatory science.
- In the recent NHSE Learning From Patient Safety Events (LFPSE) reporting data, UHSussex are in the top quartile of the highest reporting organisations (not adjusted for bed days or type of NHS Provider). Therefore initial early indications are that more staff at UHSussex are reporting and identifying safety and quality concerns.

Key Recommendation(s):

The Quality Governance Steering Group is asked to approve the contents of the report.

APPENDIX 1
Patient Safety Incident Investigations (including Never Events and maternity MNSI referrals
2024-25)



APPENDIX 1

Patient Safety Incident Investigations (including Never Events and maternity MNSI referrals)

STEIS Number	RLDatix ID	Severity	Heading	Hospital site	Service - Division	Date declared
2024/5273	12145	Fatal	Unexpected re-admission or re-attendance	RSCH	Specialist	05/06/2024
2024/6096	253839	Fatal	SJR Potentially avoidable death	RSCH	Surgery (RSCH & PRH)	05/07/2024
2024/6750	16427	Fatal	Delay in obtaining clinical assistance	RSCH	Surgery (RSCH & PRH)	31/07/2024
2024/8036	13945	Fatal	Missed deterioration of kidney function	RSCH	Surgery (RSCH & PRH)	18/09/2024
2024/8116	24112	Fatal	Post-op complication potentially contributing to a patient's death	RSCH	Surgery (RSCH & PRH)	25/09/2024
2024/8307	24225	Fatal	Missed AKI	RSCH	Medicine (RSCH & PRH)	02/10/2024
2024/8847	23166	Fatal	Neonatal death and maternal transfer to ITU/HDU	PRH	W&C Obstetrics	22/10/2024
2024/8876	24818	Fatal	Missed diagnosis of meningitis	RSCH	Medicine (RSCH & PRH)	23/10/2024
2024/9513	29046	Moderate	MNSI - Baby sent for cooling	PRH	W&C Obstetrics	13/11/2024
2024/9577	29231	Fatal	Undertreated hyperkalaemia	Worthing	Medicine (WTH & SRH)	20/11/2024
2024/9749	30666	Fatal	Missed opportunity to diagnose	RSCH	Medicine (RSCH & PRH)	27/11/2024
2025/526	36119	Severe	MNSI Baby transferred for cooling	RSCH	W&C Obstetrics	15/01/2025
2025/670	35094	Severe	MNSI Baby transferred for cooling	Non UHSussex site	W&C Obstetrics	15/01/2025
2025/815	38482	Fatal	Delayed Medical Review	RSCH	Surgery (RSCH & PRH)	03/02/2025
2025/1139	39985	Moderate	MNSI Baby transferred for cooling	PRH	W&C Obstetrics	12/02/2025
2025/1140	40350	Moderate	Never event - administration of medication by the wrong route	RSCH	Specialist	19/02/2025
2025/1260	41007	Moderate	MNSI Baby transferred for cooling	SRH	W&C Obstetrics	26/02/2025
2025/1584	41384	Fatal	Delayed review of patient with tachycardia	Worthing	Medicine (WTH & SRH)	05/03/2025
2025/1583	41873	Fatal	Delayed treatment for Colchicine overdose	Worthing	Medicine (WTH & SRH)	05/03/2025
2025/1581	43449	Fatal	Toxic epidermal necrolysis secondary to antibiotics	PRH	Surgery (RSCH & PRH)	12/03/2025
2025/1579	40592	Fatal	Missed patient deterioration	RSCH	Surgery (RSCH & PRH)	12/03/2025
2025/1585	43011	Fatal	Neonatal Death	Worthing	W&C Obstetrics/ Neonates	12/03/2025

2025/1596	43186	Low harm	Never event - wrong site surgery	Worthing	Surgery (WTH & SRH)	13/03/2025
2025/1692	42339	Fatal	Missed opportunity to diagnose & treat sepsis & APL	Worthing	Medicine (WTH & SRH)	19/03/2025
2025/1890	45211	No harm	Never Event - wrong implant (wrong contraceptive device)	Worthing	W&C Obstetrics	31/03/2025
2024/5057	4182	Fatal	Death of a patient detained under Section 3	Royal Sussex County Hospital	Medicine RSCH/PRH	27/04/2024
2024/5065	2737	Fatal	Patient death following fall	Royal Sussex County	Medicine RSCH/PRH	17/05/2024
2024/5060	6924	Fatal	Cardiac Arrest	Worthing	Surgery (WTH & SRH)	17/04/2024
2024/5062	10163	Fatal	Failure to monitor blood sugar	RSCH	Specialist	22/05/2024
2024/6406	14145	Fatal	Cardiac arrest due to hypokalaemia secondary to a high output stoma with inadequate potassium replacement	SRH	Surgery (WTH & SRH)	17/07/2024
2024/5061	9825	Moderate	MNSI IUD	Worthing	W&C Obstetrics	15/05/2024
2024/5067	5178	Fatal	Delay or omission of intentional rounding	RSCH	Medicine (RSCH & PRH)	24/04/2024
2024/9055	19373	Fatal	Delay in starting transfusion	Worthing	Medicine (WTH & SRH)	30/10/2024
2024/7172	18815	Moderate	Never event - wrong site injection	Southlands	Surgery (WTH & SRH)	15/08/2024
2024/6075	14588	Severe	MNSI Concealed pregnancy	PRH	W&C Obstetrics	26/06/2024
2024/5179	11841	Moderate	Never Event - wrong implant/prosthesis	SHE	Surgery (RSCH & PRH)	30/05/2024
2024/6050	14307	Moderate	MNSI Intra-uterine death	SRH	W&C Obstetrics	26/06/2024
2025/805	20119	Fatal	Cardiac Arrest following deterioration	Worthing	Medicine (WTH & SRH)	21/08/2024
2024/10085	22585	Fatal	Inpatient fall contributing to a patient's death	PRH	Medicine (RSCH & PRH)	05/12/2024
2024/6042	13931	Moderate	MNSI Baby transferred for cooling	SRH	W&C Obstetrics	26/06/2024
2024/7622	16487	Fatal	Death following inpatient fall	SRH	Specialist	04/09/2024
2024/7777	21915	Fatal	Delayed recognition of deteriorating patient	SRH	Medicine (WTH & SRH)	11/09/2024
2024/8305	23115	Fatal	Potentially preventable death	Worthing	Medicine (WTH & SRH)	02/10/2024
2024/8306	24696	Fatal	LD patient death	Worthing	Medicine (WTH & SRH)	02/10/2024
2024/6634	16309	Severe	MNSI Baby transferred for cooling	RSCH	W&C Obstetrics	26/07/2024
2025/689	37199	Fatal	Inpatient fall contributing to a patient's death	Worthing	Medicine (WTH & SRH)	22/01/2025

2024/6779	14396	Fatal	Inpatient fall contributing to a patient's death	PRH	Medicine (RSCH & PRH)	03/07/2024
2024/9853	26304	Fatal	Neonatal death due to sepsis	Worthing	W&C Obstetrics	02/12/2024
2025/418	34424	Fatal	Inpatient fall contributing to a patient's death	RSCH	Medicine (RSCH & PRH)	02/01/2025



Patient Experience Annual Report 2024/25



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1. Introduction

The mission of University Hospitals Sussex through 2024 and 2025 – what we were striving to achieve – was to provide: ‘*excellent care every time*’. All our efforts to do this put the interests of our patients first and foremost, and are underpinned by our values which were selected by our staff, patients and public:

- ▶ Compassion
- ▶ Communication
- ▶ Teamwork
- ▶ Respect
- ▶ Professionalism
- ▶ Inclusion

In the NHS, patient experience encompasses how patients, families, and carers feel during their interactions with healthcare services, and is considered a key aspect of quality alongside clinical excellence and patient safety. It emphasises understanding and acting upon patient feedback to improve care and meet needs. The NHS Constitution established the principles and values of the NHS in England. The principles guide the NHS in everything it does and principle four states: ‘The patient will be at the heart of everything the NHS does.’

Delivery of high-quality patient experience by the NHS has been increasingly challenging since the covid pandemic. Public satisfaction with the NHS has reached a historic low, with just 21% of British adults expressing satisfaction, according to the 2024 British Social Attitudes survey, a sharp decline from 60% in 2019. Concerns include waiting times and staff shortages, despite strong public support for the NHS's core principles.

However, for University Hospitals Sussex there remains a strong local commitment to delivering excellent care everywhere and improving patient experience. It has been a proud year for the patient voice within the Trust with increasing focus on patient insights at all levels of the Trust’s governance and decision making, and bespoke patient engagement shaping new pathways and services, including for discharge, a new

cancer centre, new colorectal cancer pathways, family engagement and customer service through 2024/25.

This annual report describes the progress against the patient experience strategy, as well as the insights and performance of the trust on patient experience for 2024/5.

2. Strategic developments and improvements in patient experience

2.1 Improving processes

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

- ▶ Increasing the capacity of the complaints team with an extra complaints manager, in response to increasing volumes of complaints received.
- ▶ Embedding increasingly efficient processes for management of concerns and complaints, in response to increasing demand from patients as a result of growing numbers of complaints and concerns received. This has included increasing the number of complaints resolved through early resolution. In March 2025, almost a quarter of all complaints received were closed quickly through early resolution.
- ▶ Bereavement services across the Trust are integrated and working under a single operational procedure.
- ▶ The friends and family test reporting system – envoy – has been rolled out, with new hierarchies enabling more responsive reporting by clinical area, site, division and touchpoint and with bespoke surveys developed in response to feedback from clinical teams
- ▶ Bespoke interactive training sessions have been delivered to divisional Envoy users along with a simple user-guide.
- ▶ Closer working with patient safety services in the implementation of the patient safety incident response framework (PSIRF) and representation on the panel of the patient safety incident review group (PSIRG) has enabled improved triangulation of learning from patient feedback and patient safety escalations.
- ▶ Implementation the new DCIQ reporting system for patient feedback in Q1 2024/25
- ▶ Patient Experience and Engagement Group (PEEG) forming a core part of the trust's quality governance structures and to act as the programme board for the patient experience strategy

- ▶ The integrated, trust-wide improvement tracker has been strengthened to capture improvement opportunities and actions generated from national patient surveys and from Healthwatch reports and feedback.
- ▶ National patient survey results are reported to Trust Management Committee and Patient and Quality Committee
- ▶ Patient Stories are now shared and presented at Trust Board.

2.2 Patient Experience Strategy

The Trust’s Patient Experience Strategy for 2022-2025, along with a summary strategy on a page, was approved in 2022 and implementation of the strategy has continued in 2024/25.

Figure i: Patient Experience Strategy on a Page



Over the lifetime of the strategy the following improvements have been delivered

The Patient Experience Plan for 2025-2030 has been drafted, and in early 2025/26 this will be aligned to the new Trust Strategy and be subject to a stakeholder engagement plan. The plan will describe the national context for patient experience, how this aligns to the trust's ambitions and goals and how within the wider framework of quality governance a high-quality patient experience will be delivered.

Other successes in 2024/25 include – with these described in further detail in later sections:

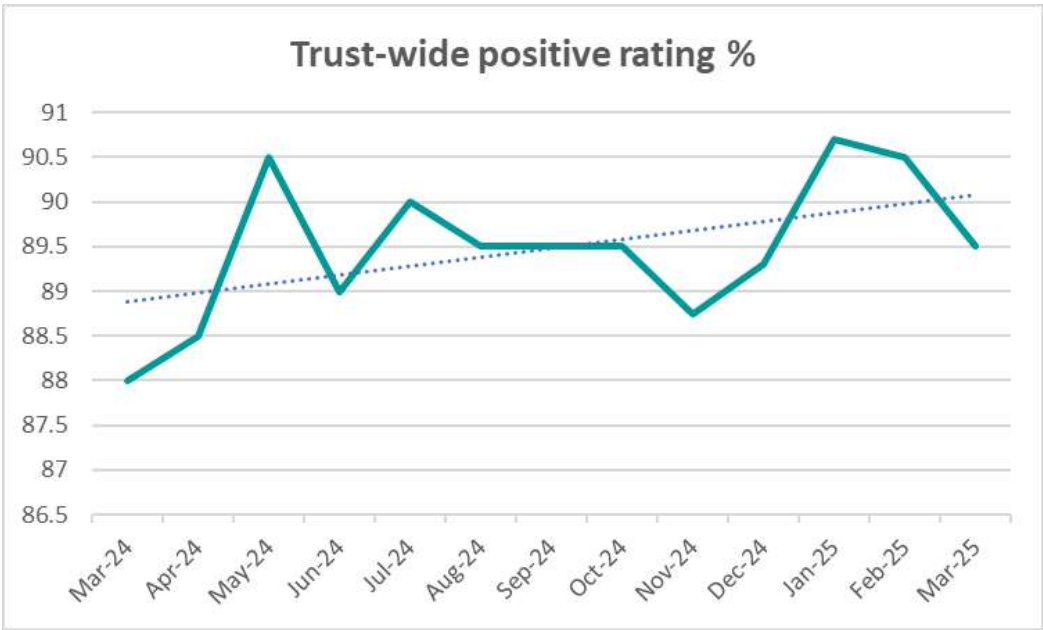
- ★ New visiting policy to improve patient experience and family engagement
- ★ Further successful implementation of the 'Welcome Standards' project (customer service excellence) in response to patient feedback, following successful bid to charitable funds – this included being a finalist in a national customer service award.
- ★ Development of improvement patient access, including booking systems and patient letters including through net call
- ★ More patient information leaflets published following review by patients
- ★ Focused engagement with patients on key trust developments to ensure the patient voice shapes the Trust approach to strategic improvements, working with Healthwatch and other partners – including colorectal cancer and the new cancer centre
- ★ Nurse-led patient experience rounds to ensure the patient's voice is routinely sought through the Fundamental Standards of Care programme.

3. Friends and Family Test (FFT) insights and performance

Throughout 2024/25 the overall positive rating (patients rating their care as ‘good’ or ‘very good’) for the Trust using the Friends and Family Test (FFT) system was 89.5%, slightly lower than the previous year based on 127,851 survey responses – a response rate of 23%.

An improving overall level of patient-reported positivity was observed through 2024/25 and increasing percentages of patients reporting a negative experience. As such, although the True North is off track as the local target of 90% was not met, there is an improving trajectory.

Figure ii: Trust positive % ratings by month



3.1 Patient experience of emergency departments

44% of all FFT responses are from the emergency departments, and as such Trust-wide reporting is confounded by patient experience of EDs. This remained static through 2024/25 (see figure 5). However, patient reported positivity of EDs at University Hospitals Sussex remained above the national average at over 80% (latest available national data in May 2025 is January 2025 with an average of 80% positive).

Figure iii: patient reported positive experience of emergency departments by site and trust for 2024/5

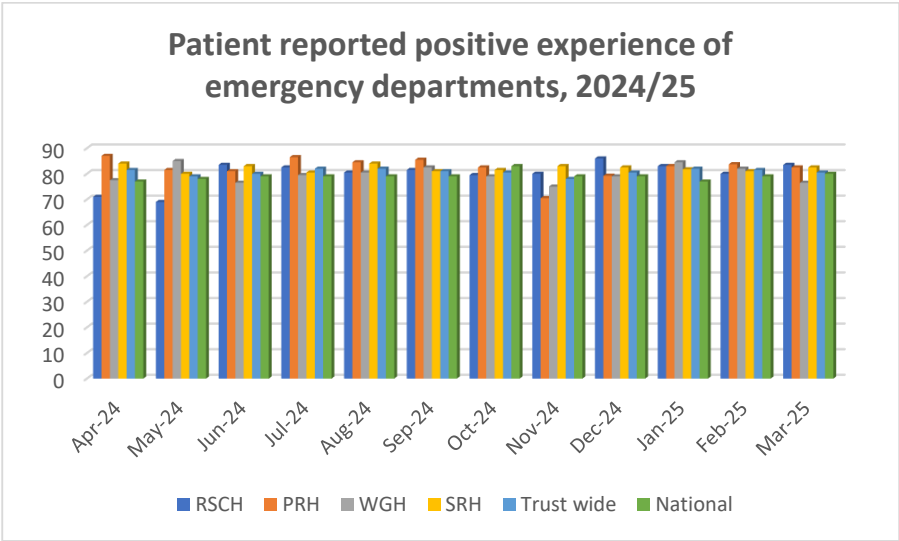


Figure iv. Themes in positive and negative reviews of emergency departments



As demonstrated by the thematic word analysis in figure 6, patients were most positive about the staff, and most negative about waiting times and experience in their feedback.

*We had to wait 7 hours to be seen. I'm 80 years old and was having breathing difficulties due to a virus. Once seen the doctors and nurses were excellent and can't fault the care. The waiting however was horrendous. **Worthing ED patient***

*The care and treatment I received from the whole team at A& E, Scan and EACU was excellent and very professional. **RSCH ED patient***

*Unacceptable length of time waiting to be seen. After 2 hours we were told it would probably be another 4 hours. The waiting area doesn't have enough room for everyone to sit, let alone be comfortable, whilst feeling ill or in pain. Its like a third world country. Totally unacceptable in this day and age. **RSCH ED***

*Very happy with the service yesterday, although very, very busy, but the service was excellent, and the staff are very helpful and keep you informed of what's going on. Thank you so much. **SRH ED patient***

The lower levels of patient positivity with the EDs reflects the challenges the Trust's emergency departments have experienced in meeting standards, including 4 hour waits.

An increase in concerns from patients about corridor care was noted in 2024/25, with 792 patients raising concerns about the corridor in their feedback via FFT, compared to 599 patients in 2023/24.

The staff are working in an intolerable environment having to treat patients in corridors, including the taking of blood from a man who sat beside me.

My 84-year-old mother was in a corridor of the trauma section of A&E on a trolley for over 24 hours before she got on to the ENT ward. It was chaos in there her trolley was just inches from others either side of her and she had to wriggle to the end to be able to get taken to the toilet. It was an unsafe environment for an elderly and frail lady. She needed peace and quiet after a very traumatic situation and instead she was in the middle of a crowded chaotic situation.

Actions were taken throughout the year, with ED improvement plans in place for each site, including focused action to reduce corridor care. Furthermore, the reconfiguration of the emergency floor at RSCH will improve the environmental experience for patients once completed.

3.2 Inpatient experience

Inpatient reported positivity remained largely consistent in year, with the significant majority of patients describing their care as good or very good, based on 36,590 responses. At an average of 92.5%, this is below the national average of 95%, however this is largely explained by the inclusion of parts of the emergency floor within inpatient rather than ED data for UHSx, which distorts the ratings due to the waiting associated with treatment in the emergency floor.

*Left in a chair for thirteen hours. Everyone was nice and helpful but I'm nearly 90. We all know the NHS is overworked and starved of funds. But if I'm asked to be honest, it was a bad experience. **Worthing Clinical Decision Unit patient – included as an 'inpatient'***

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

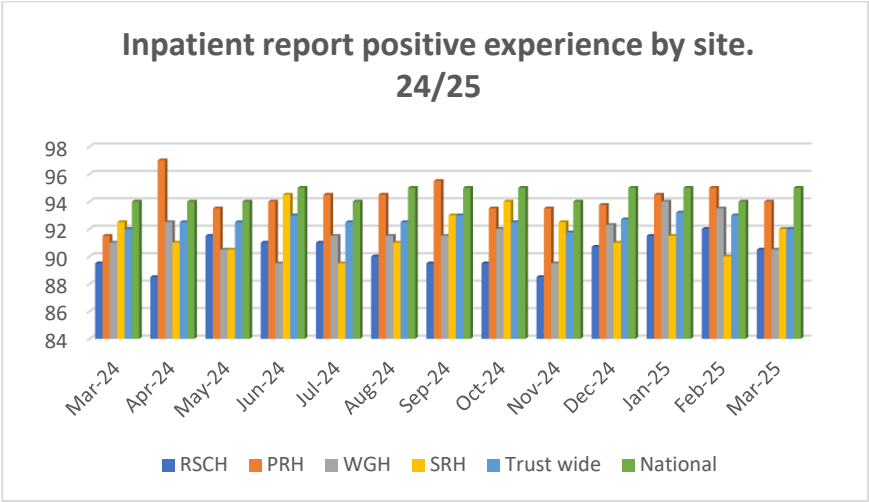


Figure vi. Most prevalent themes in inpatient feedback



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

*Service was excellent, staff were very attentive everything went as discussed. Staff would explain in detail what was going to happen. I cannot fault the service I received. **SRH theatres' patient***

The service provided by the Drs and nurses was excellent. They were kind and considerate. I gave a 2 purely because there was a long delay. **RSCH Endoscopy patient**

Poor communication, documentation issues. Not reviewed by doctor I was assured that I would see. Medics didn't listen to my lived experience. **EACU patient, RSCH**

Lack of communication was our biggest concern. We were not told anything unless we asked. One day we waited 5 hours to see a doctor who didn't really know what was going on as he had only seen my mum that day. **SRH Chilgrove patient**

Inpatient experience at RSCH was less positive than other sites – upon analysis this is due to the inclusion of EACU (emergency ambulatory care unit) as an inpatient care, despite being part of the emergency department, where waits contribute to fewer of the highest ratings.

3.3 Outpatient experience

Outpatients reported improved experience in 2024/25 than the previous year, with 95.85% rating their experience as ‘good’ or very good – up from 94.5% in 2023/24, and above the national average of 94%.

Figure vii. Most prevalent themes in outpatient feedback



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

Professional and timely service, went in four minutes after my scheduled appointment, who can ask for more than that! Brilliant, efficient, friendly. WGH phlebotomy patient

Appointment six months overdue, had to chase twice to get booked in, three hour wait on the day. Urology patient, PRH

A more empathetic consultancy and examination would have been very welcomed and with better outcomes considering the intimate nature of appointment. Lower GI, CTC

I saw three different members of staff for tests plus the consultant and this all happened in a timely manner without long waits or any glitches. Each staff member introduced themselves and explained the test to be done. Courteous and efficient service so thank you. Opthamology patient, PRH

3.4 Maternity patient experience

It has been a very positive year for maternity services. Maternity patient reported positivity remained at or above the national average throughout the year, at an average of 94% in 2024/25, based on the reported experience of 1327 patients. This reflects positive outcomes data, including reducing neonatal death rates, and excellent engagement of the Maternity and Neonatal Voices Partnership (MNVP) described in a later section.

Figure viii. Patient reported experience of ‘birth’ (maternity) v national

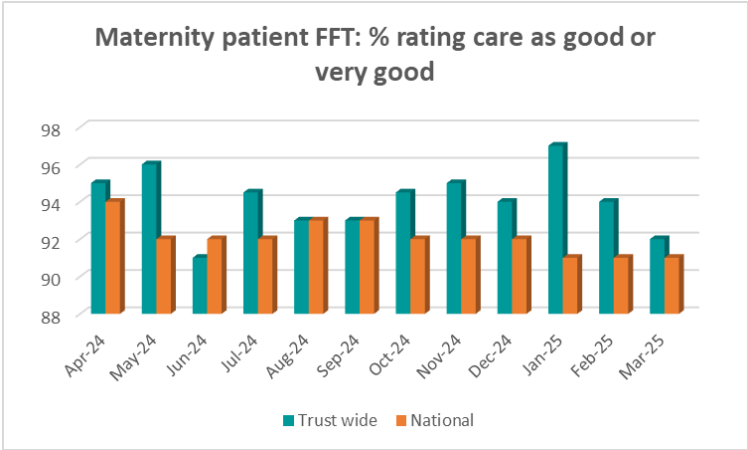


Figure ix. Most prevalent words in positive and negative maternity (‘birth’) reviews



Patients report a positive experience of the staff, but that they found there to be fewer staff to care from them than they would have preferred at some times, and that when this was the case, the care was not as they had hoped. The minority of patients who reported a poor experience reported issues with staff behaviour including midwives and obstetricians, with communication being poor.

‘All the midwives were amazing, they looked after us so well and provided amazing care for me, my husband and my new baby’

You couldn’t have done anything better, midwives were excellent, we came in quite late and they were happy to let me lead with hypnobirthing method and assist where they thought helpful ie when to change breathing, warm compress, delayed cord clamping etc I didn’t even need to ask. After care was also excellent, especially as was discharged but then had heavy bleed as leaving so they kept me in & did some tests & explained everything thoroughly. I was so pleased. Thank you

Individual staff were great and willing to offer care when able but due to being so short-staffed patients care needs were not met.

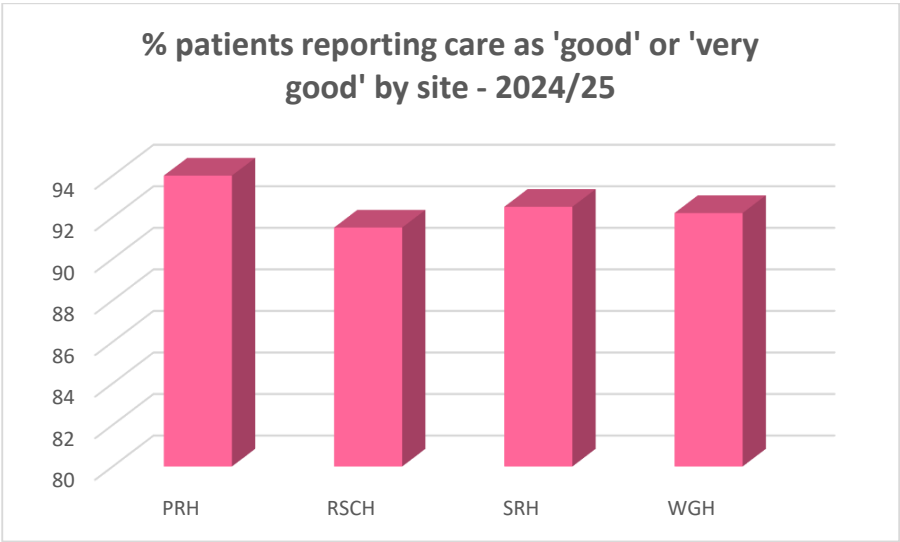
Wasn't listened to, miscommunication, poor/mixed communication, poor interested in patients, poor personalised care, no empathy, rushed doctor reviews without even going through full medical history

During 2024/5, the results of the Maternity patient survey were published, and these are reported in section 5. Working with the local Maternity Voices Partnership, the maternity services continue to respond in an agile way to patient feedback and to improve the experience of birthing people and their families.

3.5 Patient experience by site

Across all sites, the most positive patient feedback is at Princess Royal Hospital. Whilst themes are largely similar across all sites – with the quality of staff and care influencing a positive experience, and waiting, appointment issues and staff behaviour influencing negative reviews. At PRH, fewer patients had a negative experience based on the quality of care. All sites achieved an overall positive rating greater than 92% which meets the Trust target of 90%.

Figure x. % patients reporting care as good or very good by site



4. Complaints and Concerns

4.1 Complaints process and standards

For those wishing to make a complaint about their care, NHS Model Complaints Handling Policy 2021 describes a set of quality standards with which to comply:

'We believe at the heart of an effective complaint handling system are four core pillars, which these Standards are based on:

- ▶ *welcoming complaints in a positive way and recognising them as valuable insight for organisations*
- ▶ *supporting a thorough and fair approach that accurately reflects the experiences of everyone involved*
- ▶ *encouraging fair and accountable responses that provide open and honest answers as soon as possible*
- ▶ *promoting a learning culture by supporting organisations to see complaints as opportunities to improve services.*

The Complaint Standards align with all the legal requirements arising from the NHS Complaint Regulations and other subsequent regulations that relate to complaint handling.'

The NHSE complaints policy requires that complaints are acknowledged within three working days. The policy does not set a timescale for a response rather it describes the processes and quality approaches that will be taken. However, it sets out that if NHS England has not provided a response within six months, they will write to the complainant to explain the reasons for the delay and outline when they can expect to receive the response. At the same time they will notify the complainant of their right to approach the PHSO without waiting for local resolution to be completed.

The trust complies with these standards by:

- ▶ Welcoming complaints in a positive way
- ▶ Acknowledging complaints within three working days
- ▶ Being thorough and fair
- ▶ Giving fair and accountable responses.

Throughout 2024/25 the Trust continued the trajectory from previous years with increasing numbers of complaints received. In total, 1589 complaints were received (up from 1,221 in 2023/24) – an average 132.5 per month but increasing trajectory through the year, with 172 complaints received in March 2025. Contacts to PALS have also continued to increase.

Figure xii: numbers of complaints received 2023-2025

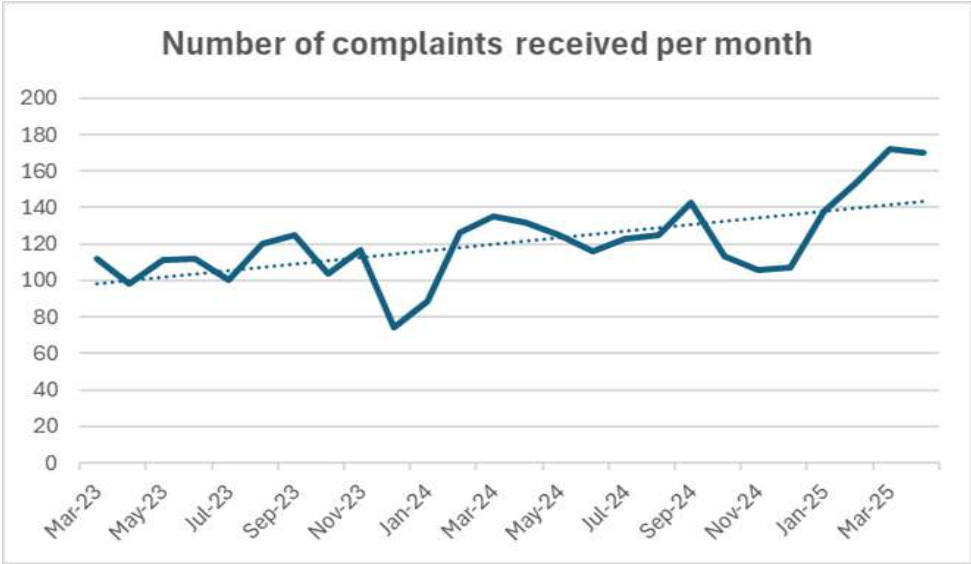
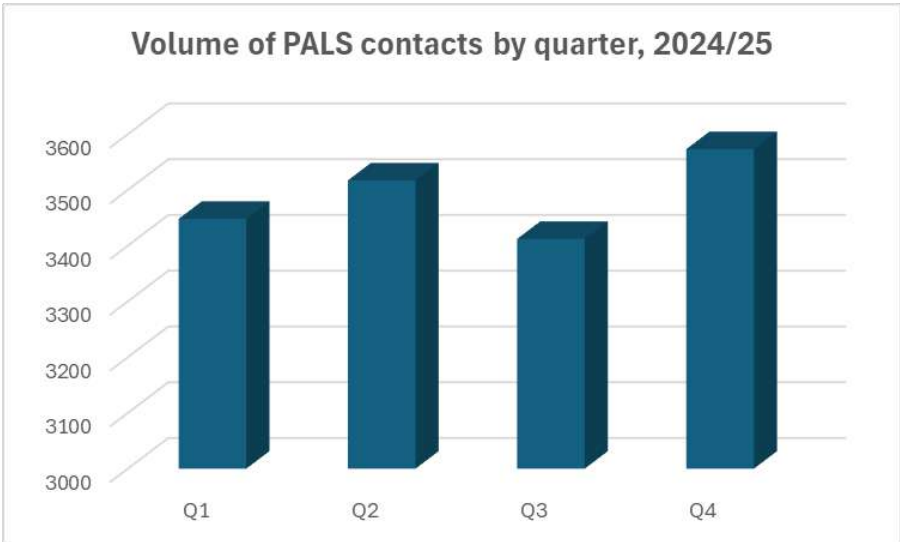


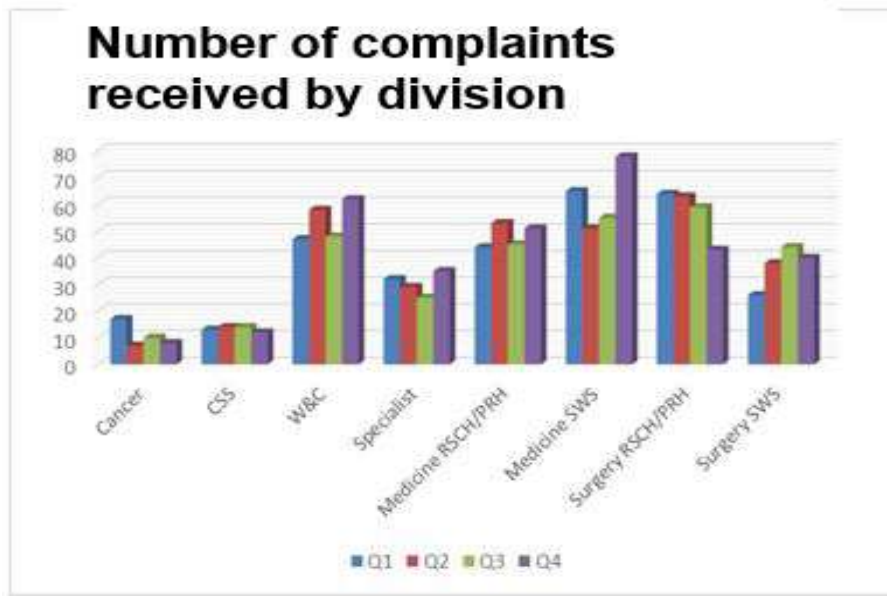
Figure xiii. Volume of PALS contacts, 2024/25



4.2 Complaints and concerns insights data and themes

The number of complaints is variable by division.

Figure xiv. Number of complaints per division by quarter.



4.2.1 Complaints about waits and delays

Across the year, the drivers of complaints were multifarious but the majority were not driven by emergency department or inpatient experience, but rather from patients whose experience was impacted by delays, errors, or missed actions, such as waiting times for appointments or surgery, cancellations, being lost to follow up, or not having received timely or appropriate results and treatment.

Figure xv. Source of complaints 2024/25

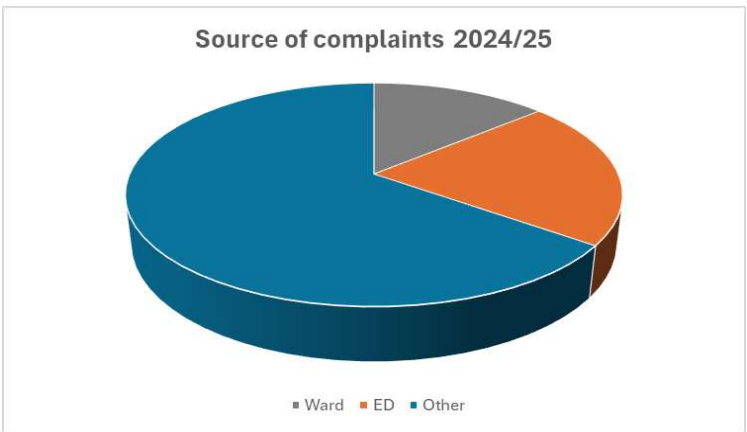
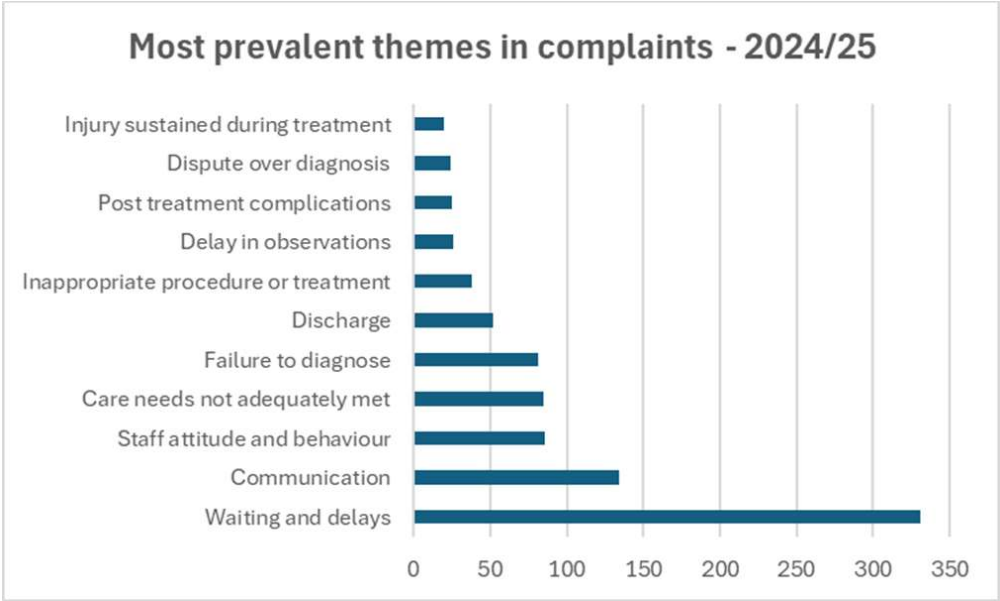
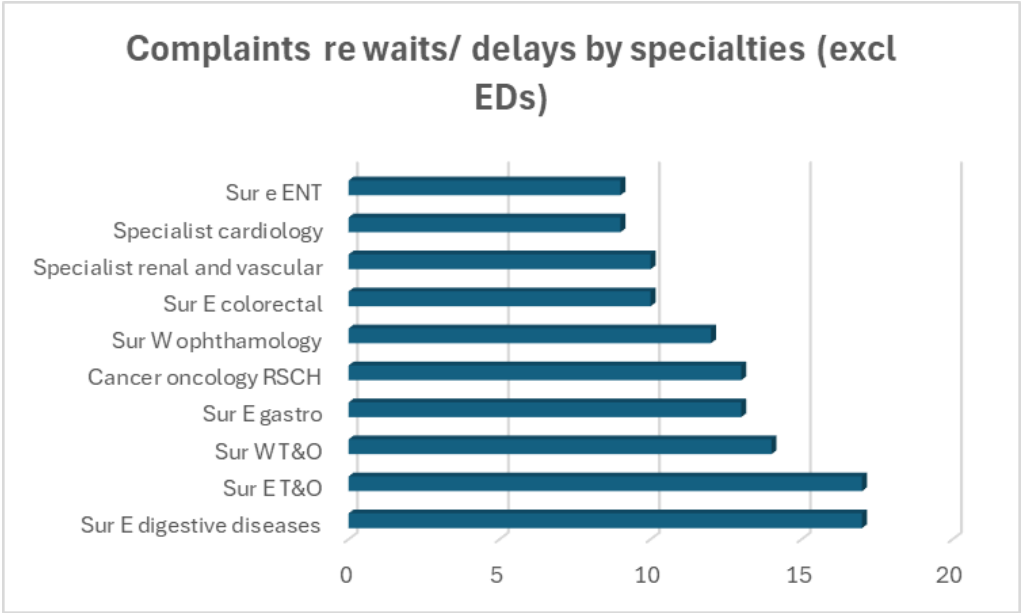


Figure xvi. Most prevalent themes in complaints (DCIQ categories)



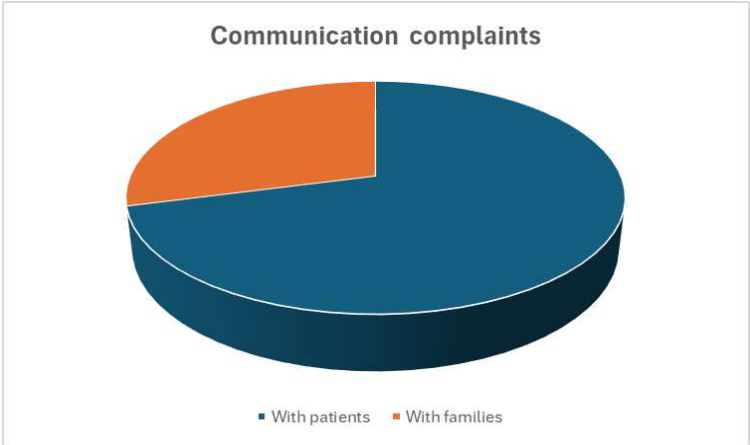
When analysed by division and clinical specialty, there are noted contributors to the complaints volume relating to delays, errors and waiting, providing an opportunity to explore and address the drivers of poor experience. A summit in Q1 2025/26 will explore the actions and opportunities for divisions with the most prevalent complaints in this theme.

Fig. xvii Complaints regarding waits and delays by specialty (excluding emergency departments)



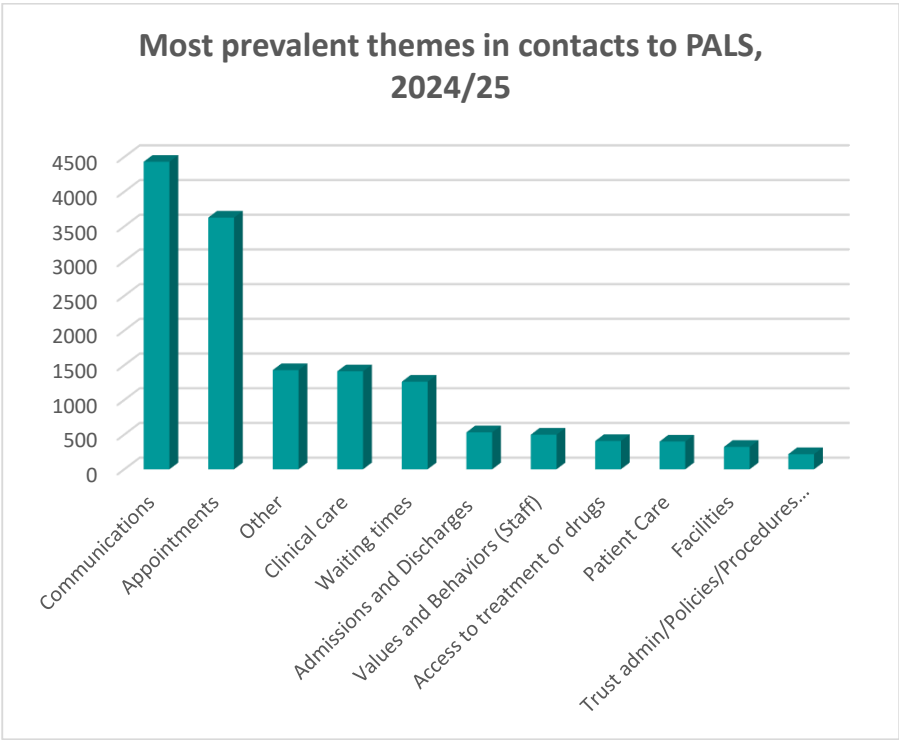
4.2.2 Complaints about communication

Figure xviii. Source of communication complaints



Most complaints about communication came from patients, rather than families, carers or loved ones. Concerns about communications are also the main source of contacts to PALS.

Figure xix. Themes in PALS contacts, 2024/25



Complaints from patients (n=95) were difficult to analyse as content was broad and there are limited opportunities for thematic analysis. However, the most prevalent

service areas were Worthing ED, followed by RSCH ED. Complaints from families (n=39) were similarly difficult to analyse due to the breadth of the services, however most prevalent in such complaints were PRH and Worthing EDs, largely due to communication between specialties, incorrect discharge letters or explanations to families about the care plan.

When combined with PALS insights, the primary driver of concerns about communication is a lack of responsiveness from clinical areas, with patients unable to get through on the telephone or lacking responses to other forms of communication.

Other themes included:

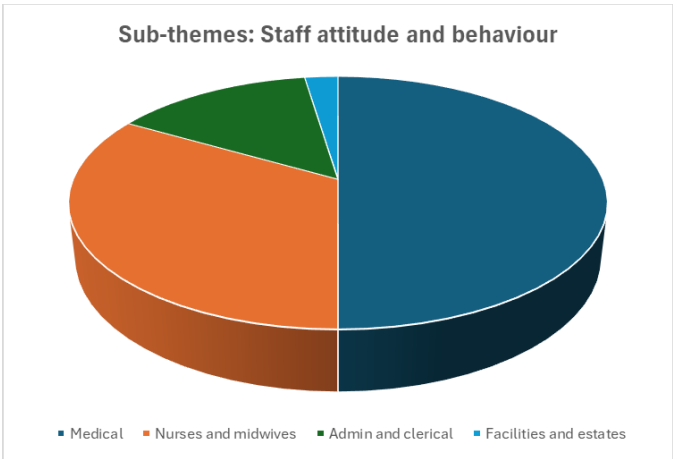
- ▶ Patients not feeling they are listened to, or being taken seriously;
- ▶ Patient and their families reporting that there was not an appropriate response to mental health or neurodivergence.
- ▶ Telephone manner when outpatient appointments are undertaken virtually
- ▶ Providing poor explanations
- ▶ Lacking compassion.

These insights inform the plans for communication training in 2025/26.

4.2.3 Complaints about staff attitude and behaviour

When analysed by staff group, the most prevalent source of complaints about staff attitude and behaviour is medical staffing, with a reduction in negative feedback about reception teams noted since the implementation of the welcome standards. When analysed by service area, some specialties have been identified as having a higher number of complaints about medical staff's behaviour – these are being addressed with service leads. Complaints about registered staff are triangulated with workforce insights to inform appraisals, and further training to improve levels of compassion and high-quality communication are planned for 2025/26.

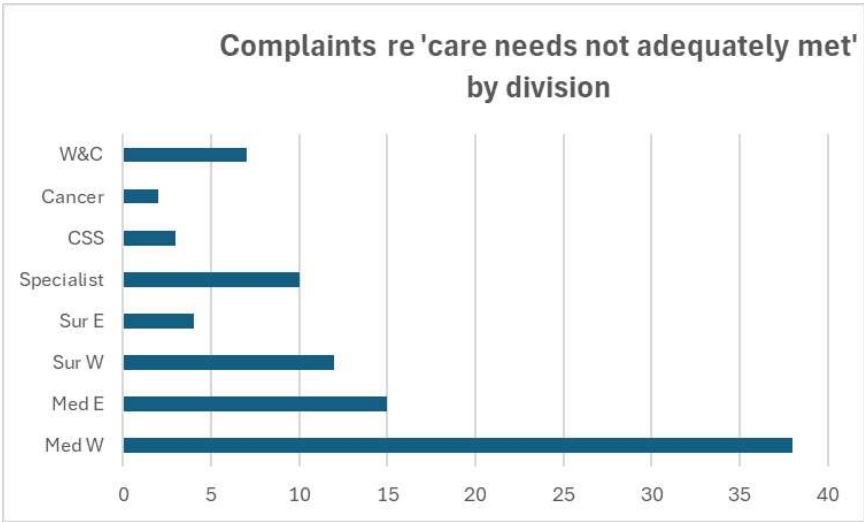
Figure xx. Source of staff attitude complaints



4.2.4 Complaints that care needs are needs not being adequately met

When analysed by division, themes and insights regarding opportunities for improvement are identified, however it is noted that the data is extracted from Datix categories where there may be category bias from staff working on different sites influencing the trust-wide comparative data. These themes were triangulated with complaints relating to inpatient areas, failure to diagnose and staff attitude and behaviour which identified that medicine wards at Worthing are an outlier in terms of prevalence, particularly for medical staff. In response to these insights, service specific interventions are planned for Q1 2025/26 with medicine teams in Worthing, to establish improvement actions. Ward based improvements are triangulated alongside fundamental standards of care data through the nursing quality assurance group monthly.

Figure xxi. Complaints regarding care needs not being adequately met



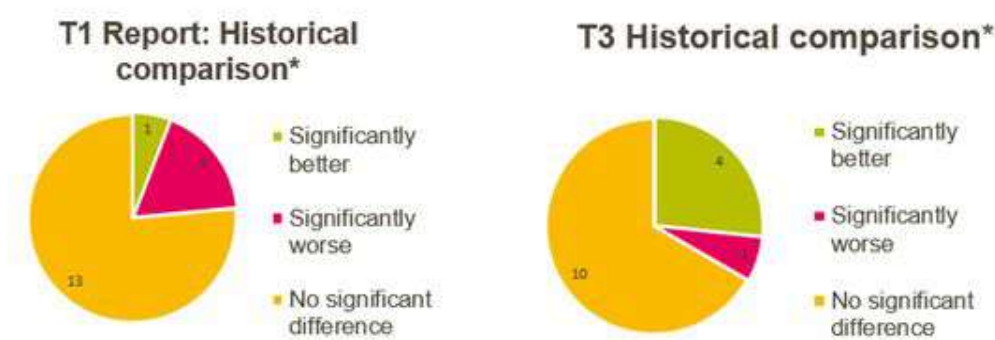
5. National patient surveys

The National Patient Survey Programme (NPSP) is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England. University Hospitals Sussex (UHSx) commissions Picker to administer the surveys. A number of surveys were undertaken or results received in 2024/5 as described in the following sections.

5.1 Urgent and Emergency Care Survey

University Hospitals Sussex surveys were undertaken for type 1 services (Accident and Emergency services) and type 3 services (urgent treatment centres) in 2024. The summary in figure xxii. demonstrates improvements in UTC experience from previous years, but a decline in some areas for accident and emergency services.

Figure xxii: Summary historical comparison



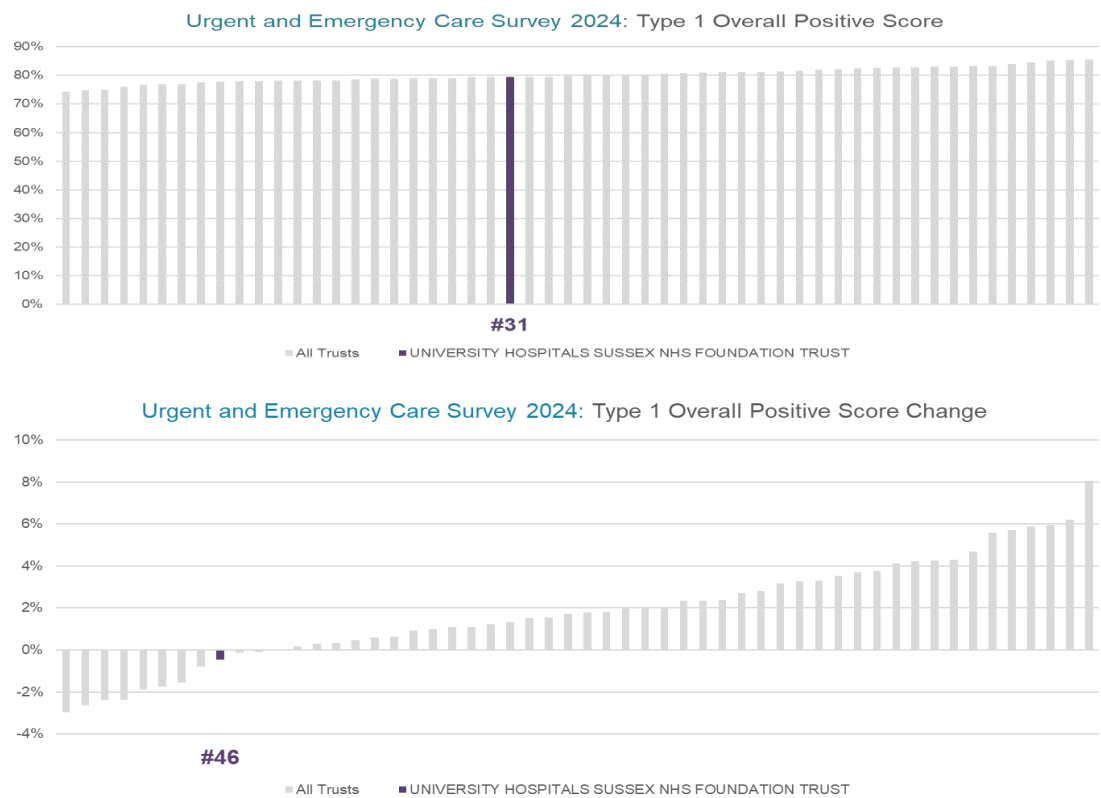
Although the Trust's overall performance was in the middle of the pack, UHSx accident and emergency performance has deteriorated more than most other Trusts since the 2022 survey was undertaken. Particular improvement opportunities are identified for UHSx with:

- Patients receiving the necessary help from 111
- Spending less than 12 hours in A&E – including creating more time with Drs and nurses (RSCH)
- Confidence and trust in the Drs and nurses (all sites)
- Privacy during examinations (SRH and RSCH)

- Improving communication at SRH
- Improving access to food and drink at WGH
- Safety and security in the waiting room

Positive experiences are identified in understanding why tests are needed, knowing who to contact when worried and giving information on medications. The insights from the survey have informed UEC improvement plans for each site.

Figure xxiii. Type 1 overall position score and position score change



For type 3 services (UTCs) the overall scores and position in the pack much improved on previous survey in 2022. Improvement opportunities include: 4 hour waits, keeping patients informed during the wait and security in the RSCH waiting room.

Figure xxiv. Type 3 overall position score and positive score change



A deep dive into patient feedback relating to the emergency department was undertaken following a visit from CQC. This identified that the most prevalent reason for providing feedback was to reflect a positive experience. Reflecting overall positivity levels, the most prevalent theme in patient feedback was positive feedback about the quality of the experience of care and treatment, followed by positive comments about staff and the care provided by them

The most prevalent themes in negative feedback related to:

- ▶ The department being overcrowded and busy
- ▶ Waiting too long
- ▶ Concerns about the corridor
- ▶ Concerns about there being too few staff

There was a lot of people in corridors in beds these should be moved to another area as it was pretty shocking to see

Great doctors and nurses. Awful facilities in A and E corridor. We were all crammed in. No beds and not enough nurses for toilet if you cant walk. Feel so sorry for staff and patients. Staff do their best

There were increasing numbers of complaints relating to corridor care from the previous year.

'To our disgust she was left in a corridor with my father by her side and left there until 19th February (entered 15th February). My father had to sleep in a hard chair upright to stay by her side for 3 nights. I was disgusted by what I saw in awful surrounding. She was given treatment as needed but was surrounded by other patients that were ill, drug addicts, mentally disturbed, drunks which involved people in fights. Due to these circumstances security was also involved. How can this be called a safe environment? After treatment she was moved to a ward. She had a bed next to a toilet with no privacy then given a handbell for the nighttime. She became very distressed.' **RSCH ED patient complaint**

The actions taken following the CQC visit resulted in a noted improvement in patient experience in EDs in April, up to 84% of patients rating their experience as good or very good.

5.2 National inpatient survey

The Adult Inpatient Survey runs every year. All eligible organisations in England are required to conduct the survey. The 2023 inpatient survey was published in 2024.

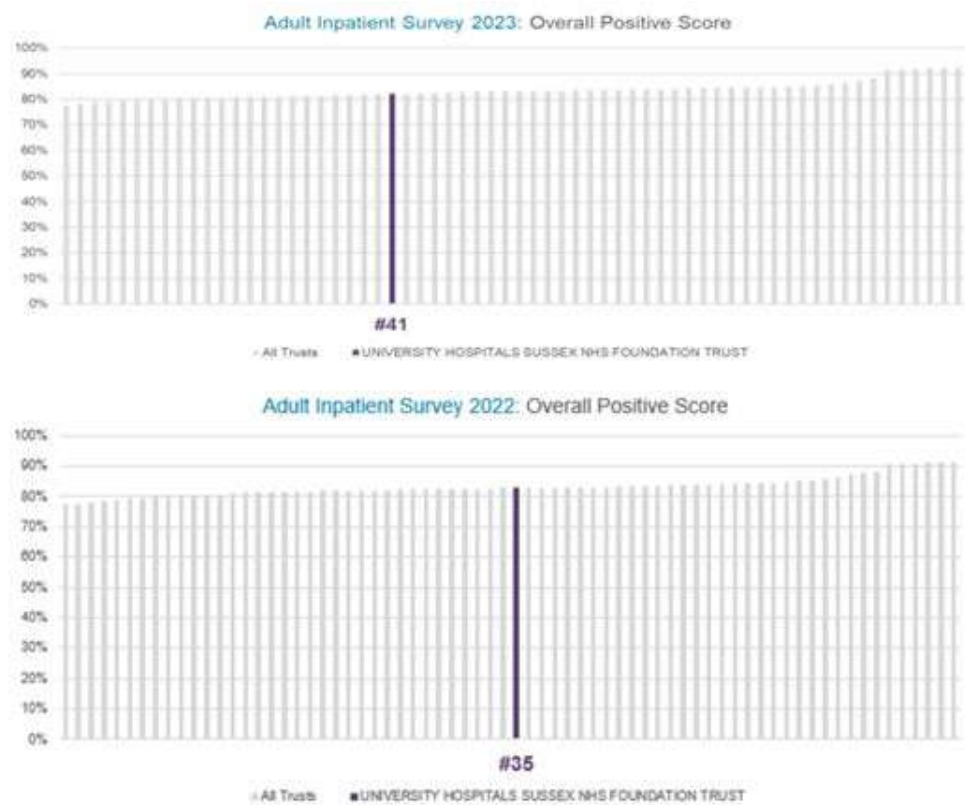
The survey results identified that the trust is 'about the same' as the national pack in most categories. UHSx saw improvements in food related experience, and noise at night, however overall ranking has dropped – although % rating overall experience 7/10 or greater increased, this was at a lower rate than for most of the Trusts in the country.

The worst performing themes were:

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

In response to feedback from patients a number of actions have been pioneered. This includes the introduction of patient experience surveys and audits for inpatients as part of the fundamental standards of care programme, a new visiting policy to encourage family engagement, and a programme of improvement work relating to discharge described in section 6.

Figure xxv. Adult inpatient survey overall positive score - 2023 compared to 2022

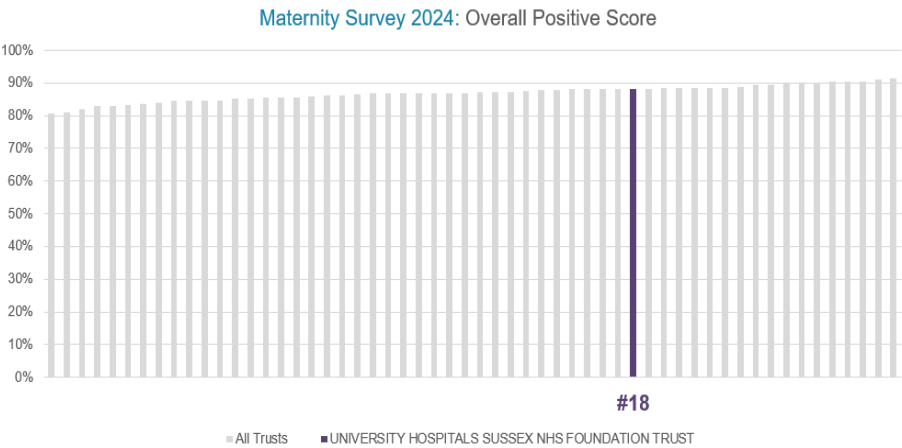


5.3 National Maternity Survey

The national maternity survey results were published in 2024. When compared with the national profile of responses, University Hospitals Sussex was average in terms of performance across most questions and positioned in the top third of trusts.

Figure xxvi. Overall positive score – maternity

The league table shows your overall positive score's ranking in comparison to the overall positive score of every other organisation that ran the [Maternity Survey 2024](#) with Picker. The overall positive score is the average positive score for all positively scored questions in the survey.



High performance and improvements were noted in getting help, being offered a choice, managing pain, having partner able to stay for as long as they wanted, involvement in decisions, concerns being taken seriously and being given enough information.

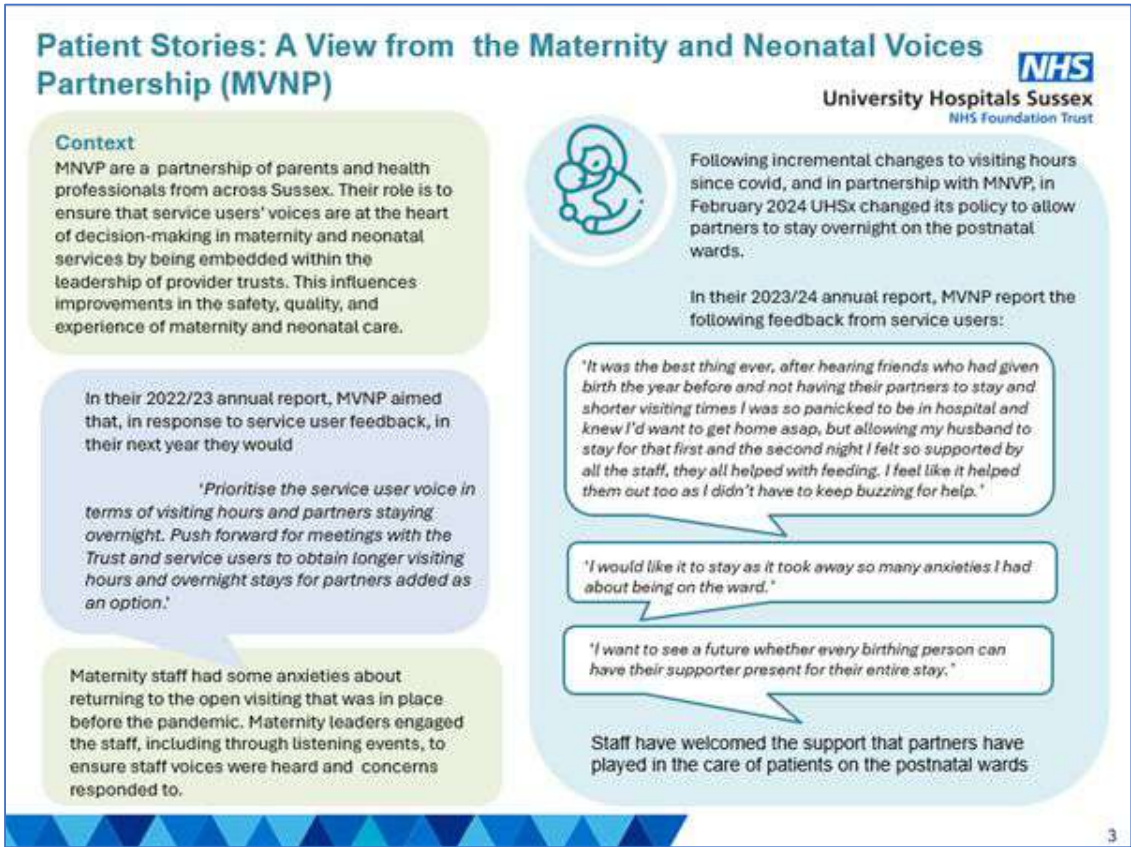
Opportunities for improvement were noted regarding access to support with mental health, seeing the midwife as much as they wanted and being aware of medical history, which have informed an improvement plan within the maternity service.

6. Patient engagement, action and improvement

Patient engagement has remained a priority through 2024/25 and the voice of patients has had increasing profile across the Trust’s governance and transformation. Attentive to the voice of patients, including those who may face barriers to accessing care or who are at risk of inequalities in health outcomes, the Patient Experience and Engagement Group (PEEG) oversees and coordinates performance and improvements, including using the patient experience improvement tracker tool.

The experience of patients is now front and centre of the Trust’s public board meetings, with a patient story being used to open the meetings and orientate the Board toward patients’ insights.

Figure vxvii. Example of a patient story to the Board



Reflections and Actions

Key reflections

- ▶ Prior to the changes the Trust's maternity national patient survey identified a low level of patient satisfaction with the ability of partners to stay after birth (34% positive)
- ▶ Patient experience and insights are critical to the Trust's approach – services listened to the feedback from patients and working in a co-productive way with partners resulted in significant improvements in the patients' experience.
- ▶ Improvements in patient experience were noted in the national maternity survey for 2024, with 'Found partner was able to stay with them as long as they wanted' the most improved score.
- ▶ Feedback from maternity service users since the policy change evidences improved experience of having partners to stay, but that more comfortable facilities for partners' sleep would be preferred.

'Staff were incredible! | If I could have given a better number I would! All the staff were helpful and put me at ease. I could not have asked for better care! I am so grateful for the staff I can't think of any improvements to be made, other than recliner chairs for partners throughout the wards as I found it very important my partner was with me throughout the long stay' **Patient feedback, November 2024**

Discussion point for the Board

What role can the Board play in creating the culture that enables co-production and excellent patient care?



University Hospitals Sussex
NHS Foundation Trust

Actions so far

- ▶ A full programme of engagement has been undertaken on a Trust-wide visiting policy, in response to patient feedback about family engagement, and with learning from the maternity policy change. Extended visiting hours have been agreed in the new policy in January 2025.
- ▶ In response to recent patient feedback, maternity teams have submitted a bid to the charities for 20 new reclining chairs to improve the comfort of staying partners.

4

Further to the stories for board, extensive patient engagement has taken place which has informed and shaped the Trust's improvements. This includes the following examples:

- ▶ New visiting policy
- ▶ Welcome standards
- ▶ End of life care
- ▶ New Sussex Cancer Centre
- ▶ Transfer of colorectal cancer services from Brighton to Worthing
- ▶ Collaboration with Healthwatch, including enter and views and PLACE
- ▶ Discharge from hospital
- ▶ Maternity and neonatal voices partnership
- ▶ Learning from ward-based patient experience

6.1 Visiting Policy

Through surveys and other patient feedback, the Trust identified that family engagement was an improvement opportunity, and as such, reviewing family and carer visiting was a priority in 2024/25. This also support a change in the regulations regarding the role of visiting hospital patients with a new emphasis on human rights and person-centred care, including the right of the patient to have a family life, with the onus on trusts to have the most minimally restrictive visiting provision. There is a body of clinical evidence that optimum access to visits from family and loved ones’ benefits patient experience.

Following engagement with staff, the public, governors and other trusts, a decision was made to extend visiting times for adult inpatient areas from 15.00-20.00 to 10.00-20.00 daily. Supporting tools including a visitors’ charter were also developed to support implementation of the new policy, which will be evaluated in 2025/6.

Figure vxviii. Visitors’ charter

Visitor guidance

Working together for the benefit of our patients.

NHS
University
Hospitals Sussex
NHS Foundation Trust

We know that visitors play an important role in supporting our patients throughout their stay with us. So we offer open visiting in our general adult inpatient wards (this excludes some areas such as maternity, children's, end of life care and dementia) between **10am and 8pm each day**. During this time up to two adults can be at the patient's bedside. Please talk to the nurse in charge for the best times to visit during these hours, or for any questions you have.

Our staff will:

- **Show our Trust values**
We value compassion, inclusion, respect, communication, teamwork and professionalism.
- **Respect our patient's wishes and dignity**
There may be times when visitors will be asked to leave the area, please work in partnership with us to support all patients.
- **Do all we can to protect patients from infection**
This may mean restricting visiting times or moving patients.
- **Keep people informed**
With the patient's consent, keep the next of kin or named contact informed and supported on any decisions about care.
- **Support carers**
So that, in line with our carers' policy, those with carers passports can still support those they care for. And provide information to unpaid family and friend carers on sources of support such as carer support organisations.
- **Maintain the environment**
Do our best to create a clean, calm and restful environment.

We ask visitors to:

- **Be considerate to everyone on the ward**
We have a zero tolerance to abuse. Please be mindful of others and keep noise to a minimum. Please put phones on silent.
- **Stay away if you have an infection**
Please do not visit if you have a respiratory infection or diarrhoea and/or vomiting within the previous 48hrs.
- **Follow infection control principles**
Including washing your hands before and after visiting and not sitting on the bed.
- **Support us in protecting patient dignity**
We may need you to step away to maintain a restful environment or for patient dignity.
- **Help us get your loved one home**
Bringing in the patient's clothing, footwear and wash bags, and encouraging them to change into fresh clothing, can help a patient to recover quicker.
- **Help us keep patients active and support at mealtimes**
Where appropriate to do so, help the patient to be mobile and, if needed, support with eating and drinking.
- **Respect patient confidentiality**
Understand that information cannot be given out without the patient's consent.

If you have any concerns at any time then please raise these with the nurse in charge. If you're not satisfied with the response then you can contact our Patient Advice and Liaison Service (PALS) at uhussex.pals@nhs.net. Please see our website for more information about visiting and what to expect: www.uhussx.nhs.uk/patients-and-visitors.

6.2 Welcome Standards

The welcome standards were informed by tens of thousands of reviews from patients, patient charter standards from Healthwatch and best practice from the private sector customer service excellence standards, as well as colleagues from Communications and Patient Experience. The Standards were developed around the trust's values in collaboration with Healthwatch and are applied using the head – theory of customer excellence; the heart – staff commitment and values; and hands – theory in practice.

At the heart of the Welcome Standards is the patient voice and tackling the priorities for improving patient experience, as defined by the Trust's patients and their representatives. The standards are set out against each of our six values with descriptors for the standards within each value. The standards are applied through three components:

- ▶ Services **self evaluate** against the standards as described in appendix A
- ▶ Teams undergo **training** to understand the standards and then self-evaluate their service against the criteria. For any standards not met staff would review the guidance and take further actions.
- ▶ Services are **independently validated**, through mystery shop visits by Healthwatch, against the principles of the standards. If they are met, the service will be awarded a kitemark. So far all mystery shop visits that have been completed (Worthing emergency and main reception teams, St Richards emergency and main reception teams, and Brighton main reception teams) have been successful.

Further training and mystery shop visits been undertaken identifying demonstrable improvements in patient and visitor experience. This has informed the wider implementation of the programme across main receptions, emergency departments and ward areas.

The pilot commenced in the Louisa Martindale Building, and positive impact was identified with a 27% increase in patients reporting a positive experience of their welcome at reception post implementation of the welcome standards training with the

new team at LMB front desk. More than three times as many patients went out of their way to make a comment about the positive experience at reception.

An appraisal of the effectiveness of the Programme following training has been undertaken using a thematic analysis of hundreds of patient reviews before and after implementation. The following are examples of the impact of the programme on patient experience:

Figure xxvix: Patient reported experience of receptions pre- and post -implementation of Welcome Standards training

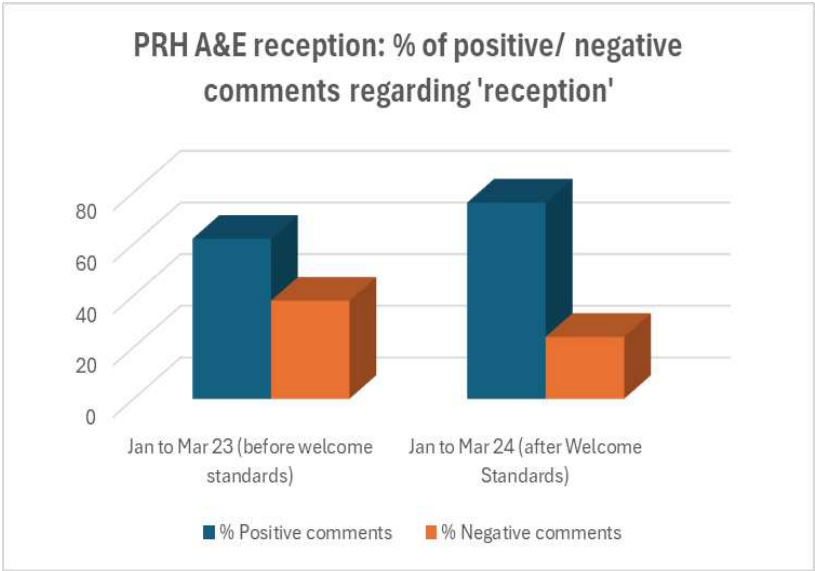
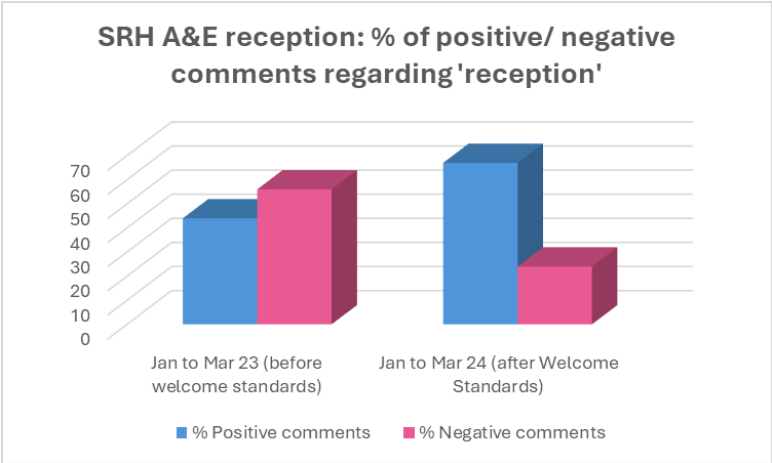


Figure xxx: Patient reported experience of receptions pre- and post -implementation of Welcome Standards training



Feedback from patients after the programme had been implemented included:

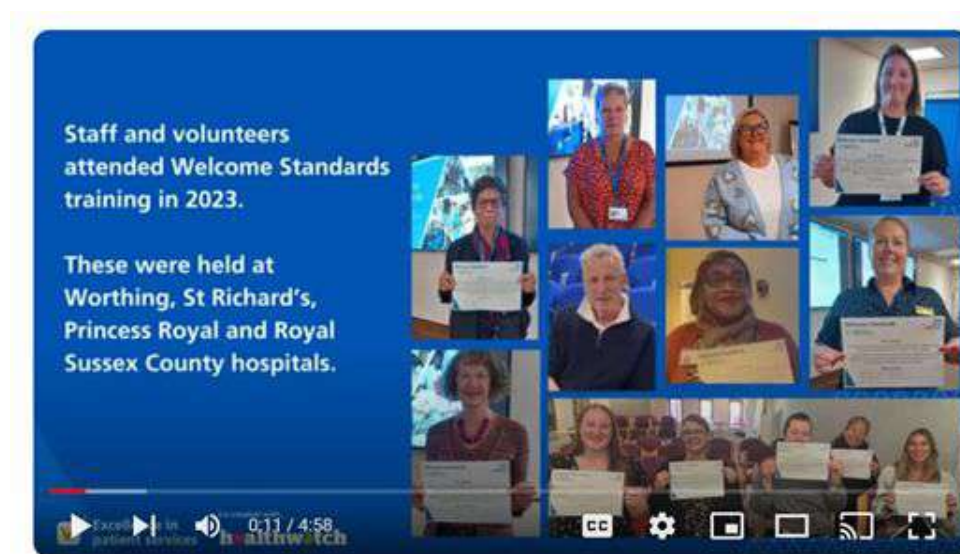
Yesterday's reception was superb at A&E. The professional standards were above expectation especially bearing in mind that the whole Department was very, very busy. Every element of my treatment was at the same high level.

My experience of your function was amazing in so many ways, your receptionist was efficient and managed expectations well. I saw her also deal with an older lady who had fallen, and she came outside of her screen and helped the lady over to get seated

When I was first entered A&E, the reception area was absolutely brilliant. The interaction between people of different faiths and different colours, it was one of everyone working together.

Other identified benefits from the programme are to staff wellbeing and engagement, with participant testimony evidencing this.

Participant testimony is available here: [Welcome Standards video story - University Hospitals Sussex NHS Foundation Trust \(uhsussex.nhs.uk\)](https://www.youtube.com/watch?v=UWp1Q1Q1Q1Q)



Furthermore, the validation of the successful implementation of the standards by Healthwatch has added further assurance that the evidence based programme is effective in improving customer service.

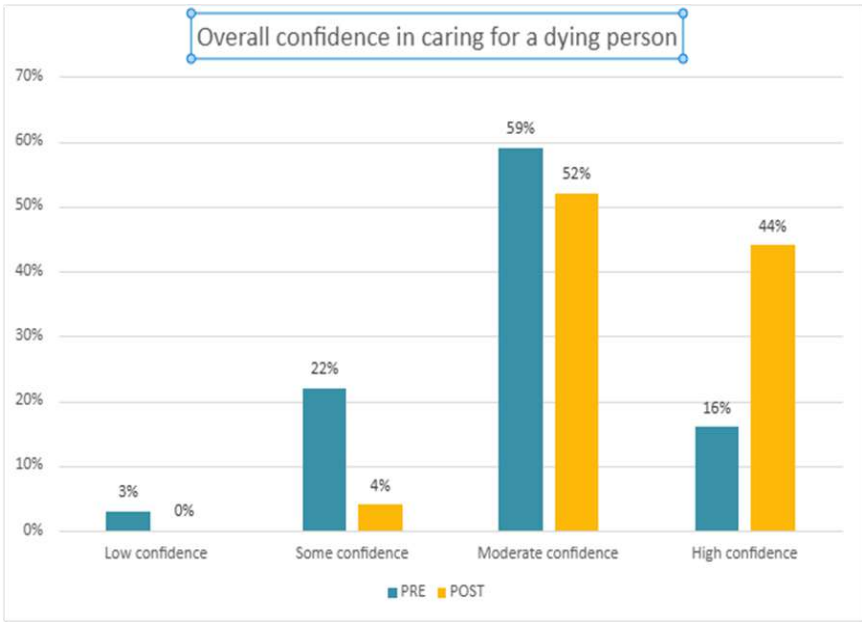
The success of the Welcome Standards programme is reflected with the initiative judged as a finalist in a national customer service award, and runner up in the patient involvement category of the national clinical audits. In 2025/26, the welcome standards will be integrated within business-as-usual training and customer service to embed the work within the Trust's new strategy.

6.3 End of life care

The UHSx Supportive and end of life care (EOLC) Group, has continued to cover issues and assurances for palliative and EOLC, treatment escalation plans and DNACPR and communication training, reporting to PEEG and QGSG. The experience of dying patients is monitored using a number of sources, by the head of EOLC, including analysis of complaints' themes, data from medical examiners and comfort care data. As well as opportunities for improvement, collaboration with learning from deaths teams identified plaudits from recently bereaved families.

Key developments include a business case for palliative care being improve with two new palliative care consultants to be recruited alongside a cancer specialist nurse. The EOLC sitting service pilot commenced and a care of the dying front sheet is being piloted. The objective of ensuring an educated, competent and confident workforce has been progress through a UHSx and SPFT training programme for over 1,300 health care professionals, alongside the fundamentals of palliative care course and other training on supporting a positive experience of dying, attended by 74 professionals with positive results.

Figure xxxi. Improvements in confidence in caring for a dying person



6.4 New Sussex Cancer Centre

As part of stage 2 of the 3TS programme, patient engagement on the development of the new Cancer Centre has continued. A blended approach of online and in person engagements events has been used, with diverse stakeholder groups including patients and their family and friend carers, Health Watch, family and friend carers and carer support organisations participating, as well as Sussex Cancer Alliance, staff, and governors. The focus of events in 2024/25 included service provision, structural and interior design, car parking and green travel, retail offer, and planning updates.



6.5 Transfer of colorectal cancer services from Brighton to Worthing

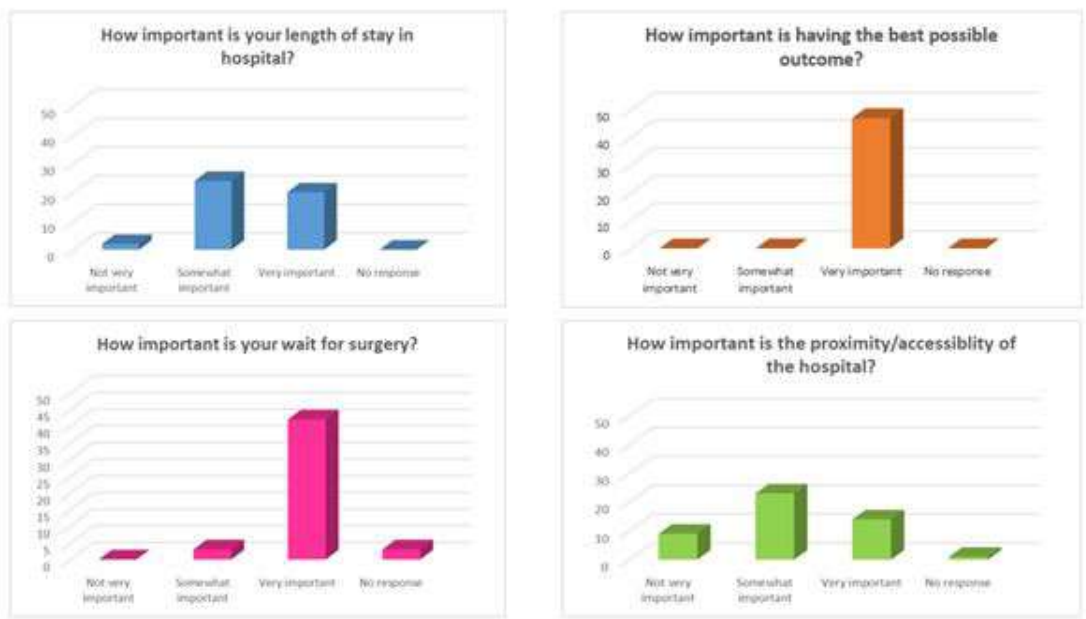
The proposal to move colorectal cancer surgery from the Royal Sussex County Hospital (RSCH) to Worthing Hospital involved a full case for change highlighting the patient benefits.

To inform the decision-making process, a two stage patient engagement plan was developed to provide an opportunity for feedback from patients, carers and patient representatives:

- ▶ Stage 1 – All patients that underwent colorectal cancer surgery at RSCH in the previous year were contacted via text and given the opportunity to respond to a survey on the potential surgery move. Both quantitative and qualitative responses were sought and 47 of 122 patients responded to the survey giving comprehensive feedback.
- ▶ Stage 2 – An engagement workshop was set up with invitees from Healthwatch, Carers Association, ICB, Trust Governors, EDI, patients and Charities to provide feedback on the proposal and to discuss options to mitigate concerns.

The survey identified the following patient views

Figure xxxii. Patient responses to colorectal cancer survey



Patient feedback identified that patients favoured the faster service available at Worthing, but that more information about their care and support with transport if needed would help a small number of them, which was then actioned.

I myself had my Colorectal surgery cancelled on the day at Brighton due to capacity issues. It was extremely stressful as I was very concerned about delays to my treatment.

Lives are at stake when cancer surgery is cancelled or delayed. Anything that can reduce this risk should be considered

6.6 Collaboration with Healthwatch, including enter and views and PLACE

Throughout 2024/25, close working and co-production with Healthwatch has continued, supporting and enabling the voice of the patient to shape and inform improvements across a range of sites and services through informative post-visit reports. This included:

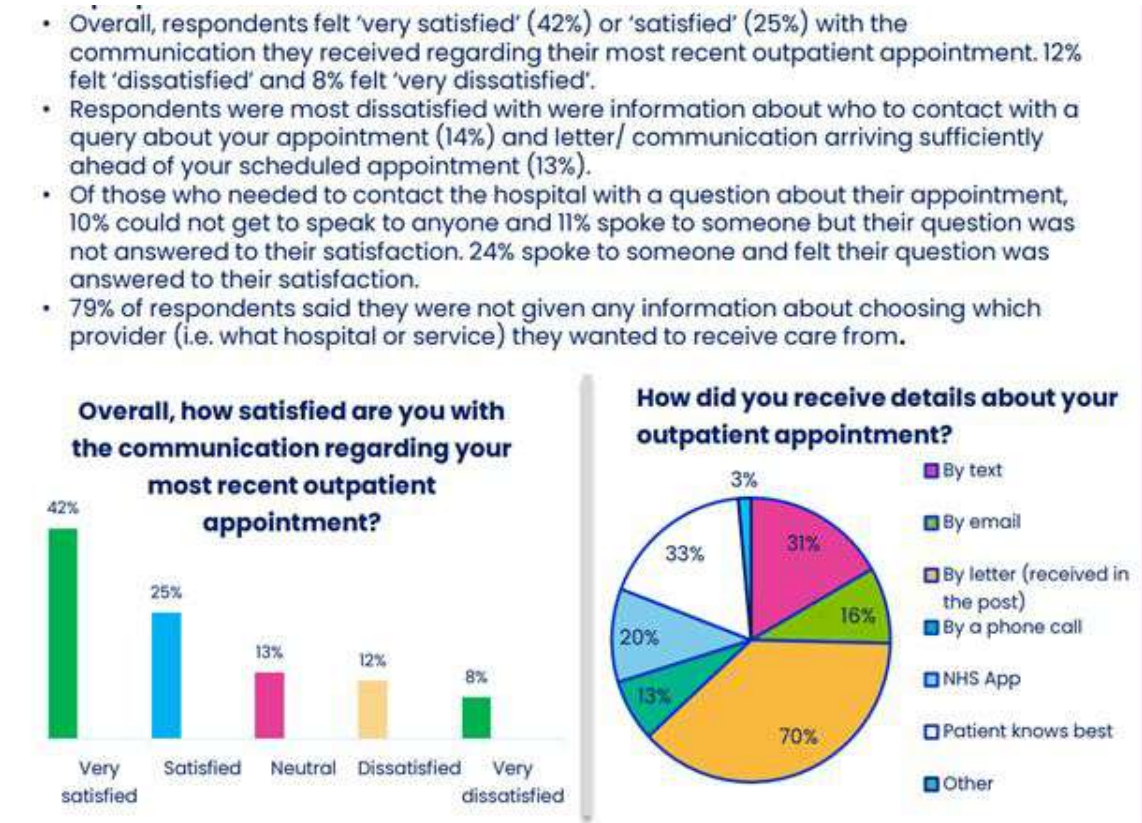
- ▶ An enter and view of the fracture clinic at RSCH
- ▶ A survey to review patient experience of outpatient letters
- ▶ A survey to review patient experience of discharge from hospital
- ▶ An enter and view of the emergency department
- ▶ Participation in national PLACE (patient led assessment of the clinical environment)

Insights generated have encouraged actions to deliver improvements. For example, the following was feedback from a patient in the fracture clinic:

 The staff were all very friendly and obviously working hard but they seemed let down by the online systems, and it seemed like more work was being created because of poor comms and appointment booking processes. 

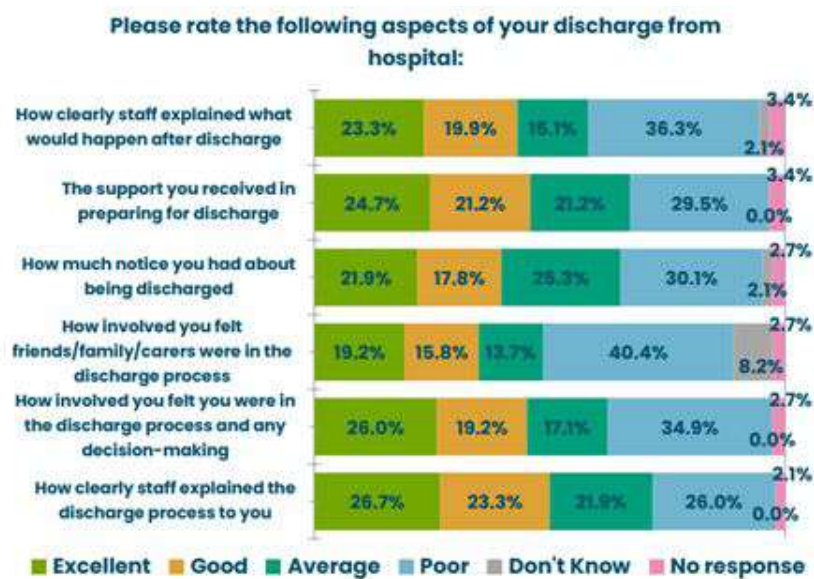
Through 2024/25, further additions to the implementation of netcall is changing how patients engage with the Trust around appointments, booking and enquiries, using interactive voice management systems – whilst there were some early issues raised by patients, the team implementing the system have continually improved its functionality through listening to feedback. A survey to review the experience of outpatient letters and contact identified that increasing numbers of patients are satisfied with this process compared to previous years, evidencing that the improvements are benefitting the patient experience. An excerpt is included below:

Figure xxxiii. Excerpt from Healthwatch report on outpatient appointment contacts



The Healthwatch survey on discharge experience triangulated insights from other sources of feedback, such as the national inpatient survey, with most concern relating to engagement of families and carers which is explored in section 6.7.

Figure xxxiv. Excerpt from Healthwatch survey on discharge experience

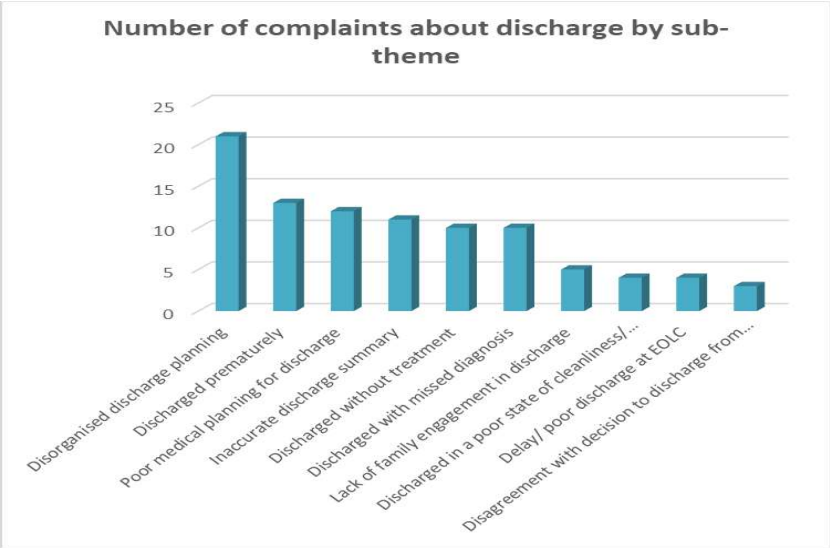


The enter and view of the emergency department which was requested by the trust following a CQC visit, provided valuable insights into the patient experience. Healthwatch scored all areas of the department highly for the environments being welcoming, safe, caring, well-organised and calm, with the scores ranging from between seven, to ten out of ten. Compared to their previous visit in March 2024, the scores awarded to the Emergency Department Reception and Majors and Resus had improved. Their suggested areas for improvement were: improving signage; installing video displays and positioning information systems to make them more accessible; improving fire and safety; providing clearer staff IDs and information about staff uniforms; and improving patient dignity (majors). The medicine division have taken forward actions relating to information about waiting times and staff uniforms, with the reconfiguration of the departments supporting with safety and dignity.

6.7 Discharge from hospital

Further to insights from the national inpatient survey, analysis of complaints relating to discharge identify that patients are concerned about rushed emergency care discharge (missed diagnosis, no treatment so readmission/reattendance, and inaccurate discharge summaries); and care and engagement prior to discharge, ensuring equipment and meds are available and the plan is clear.

Figure xxxv. themes in complaints relating to discharge



Senior nursing teams have led a programme of improvements relating to discharge, including training materials and resources, welcome leaflets for patients and standard operational procedures for discharge lounges, in addition to leading on board rounds to ensure multi-disciplinary plans are made for each patient requiring support on discharge from the hospital.

Figure xxxvi Discharge leaflet



6.8 Maternity and Neonatal Voices Partnership

MNVP is a partnership between the Trust and the commission. The Chair’s role is to seek out the service user experience of maternity services. Progress in 2024/25 included work on the understanding inequality in outcome and experience for maternity service users and supporting

partners to be able to stay at the hospital after the birth. Changes made to the policy on partners being able to stay has improved the experience of birthing families.

In their 2023/24 annual report, MVNP report the following feedback from service users:

'It was the best thing ever, after hearing friends who had given birth the year before and not having their partners to stay and shorter visiting times I was so panicked to be in hospital and knew I'd want to get home asap, but allowing my husband to stay for that first and the second night I felt so supported by all the staff, they all helped with feeding. I feel like it helped them out too as I didn't have to keep buzzing for help.'

'I would like it to stay as it took away so many anxieties I had about being on the ward.'

'I want to see a future whether every birthing person can have their supporter present for their entire stay.'

6.9 Learning from ward-based audits

Weekly ward-based audits using data led patient experience questions have led to a series of improvements. For example, feedback about noise at night resulted in deployment of ear plugs and eye masks, and the development of a 'Hush' poster for the wards.

Figure xxxvii. Quiet at night poster



7. Insights from other patient experience service

7.1 Chaplaincy

Chaplaincy teams across the trust provide spiritual and pastoral support for patients and staff. Through 2024/235 the chaplaincy team has continued to deliver staff support and end of life pastoral care for patients, as well as a range of other activities, including:

- ▶ Leading the religion and belief network across the Trust
- ▶ Participating in Pride events and other network activities
- ▶ Remembrance events for covid and Remembrance day
- ▶ Baby loss services
- ▶ Undertaking body donation funerals for the loved ones of deceased patients who have donated their bodies to medical science.

7.2 Bereavement services

The bereavement service runs across the Trust's four main sites and complements the care and support routinely offered to bereaved relatives by hospital and community staff. Bereavement officers provide sympathetic information, advice and guidance to bereaved relatives and carers by helping them through the practical arrangements following the death of a loved one in hospital including:

- ▶ Registering the Death
- ▶ Funeral Directors
- ▶ The Coroner and Coroner's Office

The team support the families of more than 6,000 deceased patients per year and worked closely alongside medical examiner services to improve opportunities for learning from deaths.

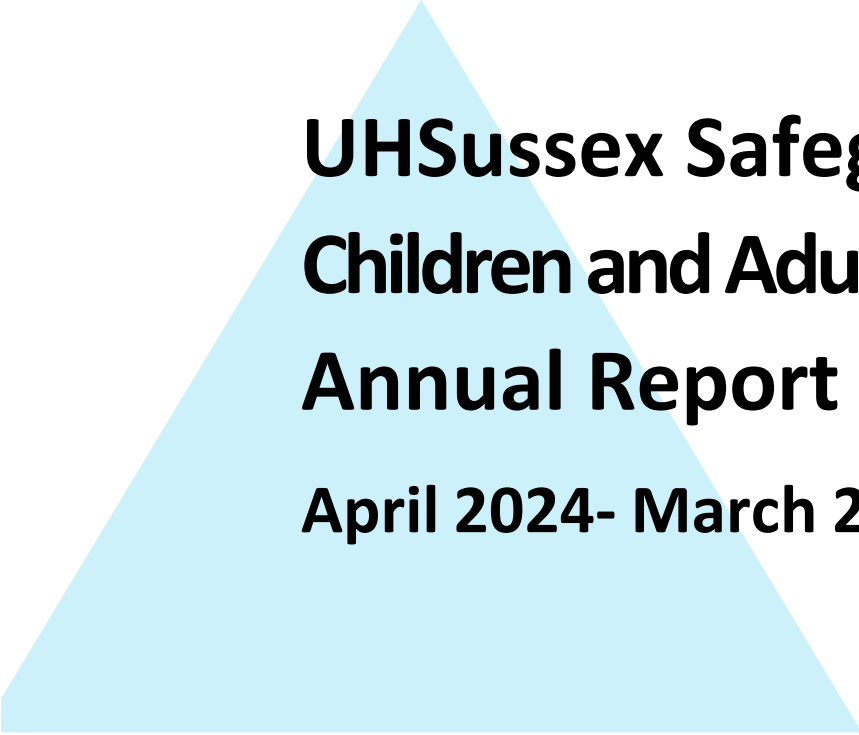
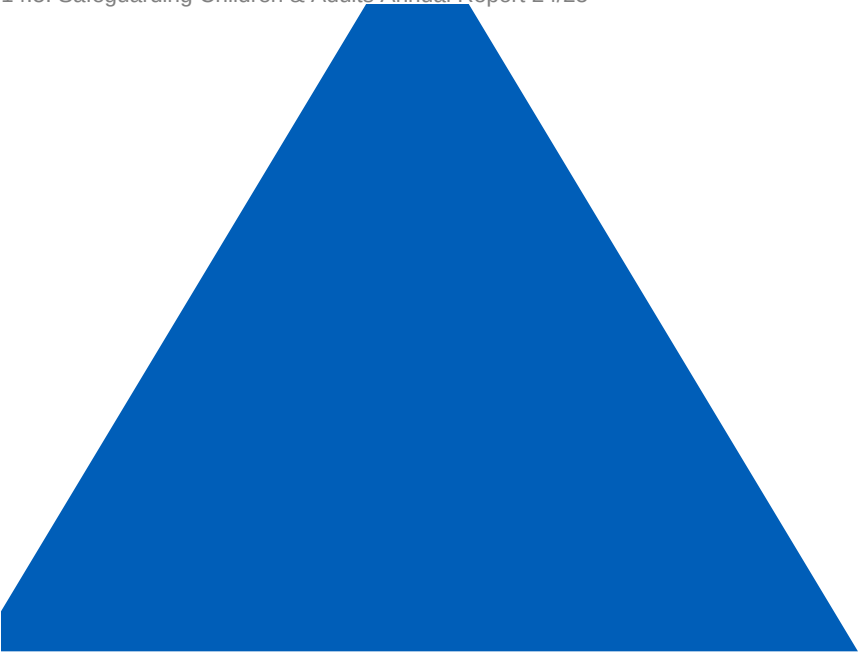
'The team managed to arrange a body viewing at quite short notice. This was invaluable to my mother who was convinced the hospital got the wrong person as she wasn't present when her partner died so had issues believing the fact. Seeing him and having that moment to understand (she doesn't always understand) was obviously very sad for her but really needed and she found some kind of understanding in that'.

8. Summary and Next Steps

Despite new challenges in 2024/25, including a significant increase in the numbers of complaints and concerns raised by patients, decreasing public confidence in the NHS and adverse media coverage the year saw many improvements to support a good patient experience, such as those detailed in this annual report.

There is also much to look forward to in 2025/26:

- ▶ Embedding the voice of patients in delivery plans for the new Trust strategy, supporting excellent care, every time, and in line with the 10-year plan.
- ▶ Further enablement of the patient voice to shape major programmes and clinical pathways
- ▶ A new patient experience plan to be developed and launched, in line with the new strategy
- ▶ A greater focus on the drivers of complaints that require systemic changes and strategic commissioning, including the potential for delivering patient-centred contacts at scale
- ▶ Development of a person-centred care framework
- ▶ Continued reduction of referral to treatment times for planned care and cancer treatment, and improved ED performance
- ▶ Further optimisation of the netcall system to improve patient bookings and the quality of patient letters.



UHSussex Safeguarding Children and Adults Annual Report April 2024- March 2025

Beulah Chizimba - Associate Director of Nursing Safeguarding

Natalie Beltramo Gibson – Head of Nursing Safeguarding Children & Adults



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1.Introduction

Effective Safeguarding arrangements seek to prevent and protect individuals from harm or abuse, regardless of their circumstances. Safeguarding is firmly embedded within the core duties and statutory responsibilities of University Hospital Sussex NHS Foundation Trust (UHSussex). In discharging its duties for Safeguarding, UHSussex acknowledges that protecting children, young people, and adults who are at risk is a shared responsibility that requires efficient collaboration between UHSussex's staff members and partner agencies.

The context of safeguarding at UHSussex continues to change annually in line with listening to the lived experience narratives of our patients locally and nationally, including large scale inquiries and legislative reforms. It remains the responsibility of UHSussex, and each individual healthcare professional working in the Trust, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied when delivering care and support.

1.1 Purpose

UHSussex is required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver. It is required to submit an annual report for safeguarding to the trust board providing overall assurance on the effectiveness and quality of these safeguarding arrangements.

This report will:

- Provide an overview of the UHSussex safeguarding team activity in 2024/25.
- Provide accountability for the Trust's safeguarding responsibilities
- Identify emerging risks and trends related to safeguarding
- Outline the key safeguarding priorities for 2025/26

2. Executive Summary

This annual report outlines the progress, challenges, and strategic direction of the Safeguarding agenda across UHSussex for the period April 2024 to March 2025. It captures performance across the Trust, identifies risks, and provides assurance for statutory compliance. It also marks a transition in leadership, with a new Assistant Director for safeguarding in post from 1st April 2025, driving quality improvement and strategic alignment going forward.

2.1 Statutory Responsibilities and Assurances

This report demonstrates that safeguarding is embedded at every level in the organisation, with effective governance processes in place. The following statutory responsibilities have been met during 2024/25 as laid out in the NHS England Accountability and Assurance Framework (June 2024):

- The Chief Nurse is the SRO and Board Executive Lead for safeguarding children, adults at risk and Prevent. Alongside the Deputy Chief Nurse and Associate Director of Safeguarding provide strategic leadership and oversight of safeguarding.
- A Lead Nurse including named nurses, named doctors and a named midwife for safeguarding children and children in care were in place.
- A Lead Nurse and named lead for adult safeguarding were in place.
- A Mental Capacity Act (MCA) lead was in place.
- Robust recruitment processes are in place, with pre-employment clearance for all new staff. UHSussex complies with guidance in relation to modern day slavery and human trafficking and undertakes enhanced Disclosure and Barring (DBS) checks for staff working with children and adults.
- Arrangements for dealing with allegations against staff in UHSussex is established. The Management of Allegations Policy is in place and supports robust management of any allegations with due regard to professional accountabilities.
- Policies, protocols, and processes are in place to support the assessment of need and vulnerability of children, young people and adults accessing UHSussex services. These are also aligned to Pan Sussex Policies and Procedures.
- A Safeguarding training programme is in place to ensure UHSussex staff have received the requisite 'essential-to-role' safeguarding training, including Safeguarding Adults, Safeguarding Children, Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) and Prevent training. Work continues to improve uptake of Level 3 safeguarding training across children and adults.

- Safeguarding training is included in UHSussex induction programmes for all staff and volunteers as part of staff onboarding.
- Safeguarding supervision, (mandatory and ad hoc) is delivered by the safeguarding team to support staff in decision making and prioritising the needs and wishes of children, young people, and adults, where there is a high level of complexity, risk, and vulnerability. Work continues to embed safeguarding supervision across safeguarding adults. Named Professionals receive safeguarding professionals from the ICB safeguarding team.
- Learning from safeguarding incidents, reviews, and audits is systematically shared through divisional governance forums, Harm Free Care Panels, and the Safeguarding Operational and Strategy Committees. Key themes and lessons from Safeguarding Adults Reviews (SARs), Domestic Homicide Reviews (DHRs), and internal early learning reviews are embedded into policy updates, training content, and supervision.
- Policies, arrangements and records, to ensure consent to care and treatment is obtained from patients at UHSussex in line with legislation and guidance are in place.

2.2 Key Achievements in 2024/25

- Significant improvements in Level 3 safeguarding adult training compliance from 52.8% in Q2 to 80% in Q4.
- Significant improvements in the Oliver McGowan training from 80% to 90% in Q4.
- Expanded access to virtual and in-person safeguarding training across all main sites.
- Embedded learning from Domestic Abuse, Self-Neglect and MCA statutory reviews.
- Enhanced safeguarding escalation processes and alignment with Harm Free Care panels.
- New audit programme for MCA and DoLS launched across the Trust
- Tri -site Safeguarding event – paediatric clinical governance programme with guest speaker from early help talking about neglect and best practise
- Supervision sessions increased across sites
- Safeguarding children case of the month – to celebrate good practice and share learning commenced at all sites.
- Quarterly Safeguarding Children Newsletter launched.

2.3 Challenges and Risks in 2024/25

- Variable attendance levels of training sessions.

- Variation in DoLS application across sites posing legal compliance risks. There is need to explore DOLS across specific sites where numbers are lower.
- Disruption from changes to local authority safeguarding referral systems has disrupted established data flows and reporting. This leaves us with incomplete and non-comparable information on referral volumes, timeliness, and outcomes of referrals.
- Long waits for mental health beds remain a recurrent risk in Emergency Departments and wards.
-

2.4 Priorities for Safeguarding Children and Adults 2025/26

The following areas are set as priorities for 2025/26 and will form the basis of the safeguarding workplan:

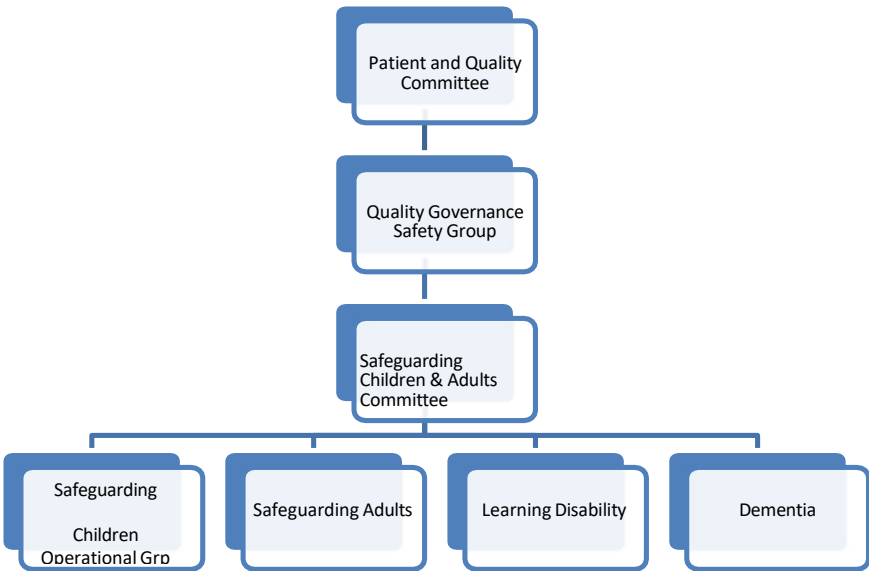
- Standardise processes and data collection across UHSussex safeguarding teams.
- Agree an annual audit and quality improvement plan.
- Data collection to capture further information related to children in care.
- Focus for 2025/26 needs to be on the internal facing intranet page to improve communication.
- Work together with safeguarding adult, maternity teams and stakeholders.
- Develop an 'all age' Level 3 safeguarding children training programme which strengthens transitional safeguarding for 16- 25 years old young people.
- Work with directorates and divisions to improve safeguarding training compliance to above 85% for all levels
- Work with partner agencies to develop an exploitation and violence reduction strategy.
- Work alongside key stakeholders to strengthen provision of youth work support across UHSussex.
- Share key learning from case reviews at committee and embed into practice.
- Strengthen the voice of the child and individual including user engagement for Safeguarding.
- Implement Audit plan for 2024-26 and link to actions from S11 audit and evidence improvement.
- Develop a standard safeguarding page for communications on UHSussex intranet for cross site use.
- Standardise referral process across the trust.
- Strengthen DOLs across sites.
- Strengthen the process for monitoring and review of risks.

3. Governance and Accountability

3.1 Safeguarding Governance Structure

The governance for Safeguarding is delivered through a quarterly Safeguarding Strategy Committee chaired by the Chief Nurse or Deputy Chief Nurse, with oversight from the Quality Governance Steering Group and Board Patient and Quality Committee. Safeguarding operational groups for adults and children provide monthly and quarterly reporting.

ICB Designated Safeguarding colleagues attend to ensure system-wide alignment and oversight of UHSussex arrangements. Divisional Director of Nursing representatives attend the committee to ensure safeguarding priorities are embedded at an operational level, and feed back to their local clinical governance meetings.



The following Operational Groups report to the Safeguarding Strategy Committee:

- Safeguarding Children Operational Group
- Safeguarding Adults Operational Group
- Dementia Steering Group
- Learning Disability and Autism Steering Group

3.2 Reporting Framework

A monthly exception report and a comprehensive quarterly report are provided to the Quality Group Steering Group (QGSG) and the Board Patient and Quality Committee (BPQC).

Quarterly reports include:

- Mandatory training and supervision performance

- Updates on partnership working
- Safeguarding activity
- Policy development
- Audit planning
- Risk management

This information is accessible to Integrated Care Board (ICB) colleagues, and a quarterly ICB Assurance Report is submitted. Additionally, monthly updates containing key safeguarding data are shared with the Divisional Quality meetings.

3.3 Roles and Responsibilities

The Chief Executive of UHSussex holds overall responsibility for safeguarding children, young people, and adults at risk, with the Chief Nurse designated as the Executive Lead and SRO for safeguarding and is responsible for providing overall assurance to the Trust Board on the effectiveness and quality of the safeguarding arrangements. The Associate Director for safeguarding provides strategic direction for both adult, children and Learning Disabilities and Autism safeguarding and supports the Deputy Chief Nurse Nursing & Quality in the Executive role.

The Chief Nurse's responsibilities include:

- Providing strategic leadership on all aspects of the Trust's contributions to safeguarding.
- Ensuring the Trust is represented at Local Safeguarding Adult and Children's Partnerships.
- Ensuring that appropriate safeguarding processes are in place, complying with all legal, statutory, and best practice requirements.

3.4 Statutory Safeguarding Responsibilities

The Trust is statutorily required to maintain the following roles within the organisation in relation to safeguarding. These have been fulfilled throughout 2024/25.

Safeguarding structures are established within the Trust, including the following designated roles:

- Executive Lead
- Named Doctor for Safeguarding Children
- Named Nurse for Safeguarding Children and Children in Care
- Named Midwife for Safeguarding Children
- Named Doctor for Children in Care
- Named Lead for Safeguarding Adults
- Mental Capacity Act (MCA) Lead

Named and lead practitioners play a crucial role in promoting good professional practice within the organisation. They provide advice and expertise to fellow practitioners and ensure that safeguarding training is effectively implemented.

These practitioners collaborate closely with the UHSussex leadership team, designated safeguarding professionals from the ICB, and other statutory safeguarding partners. As senior practitioners, they are experts in advocating for the needs of children and adults at risk, responding to potential safeguarding concerns, and managing these issues within a multi-agency context.

Named Doctors offer support, guidance, and leadership to medical staff, primarily to senior paediatricians. They deliver and lead peer reviews (reflective safeguarding supervision for paediatricians) in addition to conducting safeguarding supervision sessions for other medical and multi-disciplinary teams.

The safeguarding team collaborates to:

- Identify children and adults at risk of harm and implement measures to protect them
- Ensure that the welfare of the child or adult at risk is paramount, with their voices central to all interventions
- Ensure compliance with local and national safeguarding procedures
- Implement national and local guidance related to safeguarding children and young people, children in care, and safeguarding adults
- Actively participate in the West Sussex and Brighton & Hove Safeguarding Children and Safeguarding Adults Partnerships and their subgroups
- Promote best practices throughout the Trust

4. Safeguarding Service at UHSussex

The safeguarding team work closely with staff and support them to respond appropriately to safeguarding concerns for children, young people, and adults at risk who use UHSussex services, in line with their statutory duties.

The team operates across Sussex and professionals are place based, working closely with our local safeguarding partners. The chart below shows the current structure of the Safeguarding Adults teams within UHSussex. Please note the current MCA lead for Worthing and St Richards does not provide cover for Brighton & Princess Royal Hospital. This is provided by the new HON for safeguarding Adults and The Named Nurse safeguarding Adults who also Best Interest Assessors.

During this reporting period, UHSussex successfully recruited to the Associate Director of Nursing (ADON) for Safeguarding to replace the outgoing ADON. The roles for the Head of Nursing Safeguarding Adults, Head of Nursing Safeguarding Children

and Head of Nursing for Mental Health & Dementia have all been successfully recruited to.

The Safeguarding Children team experienced significant staffing disruption in Q4, particularly at Worthing and St Richard's, where 50% absence led to a business continuity response. Staffing has now begun to recover, with further improvement expected by mid-April.

These challenges have provided an opportunity to undertake a UHSussex strategic review of team functions and resourcing. Under new leadership, the service will explore a more integrated 'One Team' model to strengthen resilience and improve delivery across the Trust.

Standardisation of processes is underway, though IT disparities and lack of electronic patient records at Brighton and PRH remain a barrier. The team is working with IT colleagues to co-design safe, sustainable solutions.

4.1 UHSussex Children Safeguarding Workforce

Whole Time Equivalent exec Lead/Head of Safeguarding		
1	ADON Safeguarding	1WTE
Named Nurses/Specialist Nurses/Practitioners Adults		
2	HON Children	0.6
3	Named Nurse	1.6
4	Specialist Nurse 7	4WTE
5	Safeguarding Practitioner	5.11 WTE
6	Named Midwife	1WTE
7	Specialist midwife	4WTE
Whole Time Project Support Children/Midwifery		
8	Safeguarding Admin	3.11
Whole Time Named Doctors Children		
9	Named Doctor R	2 PAs per week
10	Named Doctor L	2 Pas per week
11	Named Doctor J	0.5 Pas per week
12	Named Doctor	3 Pas per week

4.2 UHSussex Adults Safeguarding Workforce

Named Nurses/Specialist Nurses/Practitioners Adults		
1	HON Adults	1 WTE
2	Named Nurse	1 WTE

3	Specialist Nurse 7	1.8WTE
4	MCA Lead	1 WTE
5	Specialist Nurse 6	1 WTE
Project Support		
1	Safeguarding Admin	1.26 WTE

5. Safeguarding Policies

UHSussex Safeguarding service collaborates with and aligns practices to partnership policies across Sussex and nationally. Trust-specific policies address the needs of the organisation and are regularly updated to reflect changes in legislation as well as local and national learning. There are thirteen approved and in date safeguarding policies that can be accessed via [UHSussex Safeguarding](#) link. The Domestic Abuse Policy was updated and ratified in this reporting period.

6. Safeguarding Children & Adult Training

Safeguarding training is guided by the Intercollegiate Documents published by the Royal College of Nursing on behalf of multiple stakeholders. These documents outline the roles and responsibilities associated with safeguarding and specify the level of training required for various positions. New guidance is expected in summer 2025 for the Children's Intercollegiate Document.

[Adult Safeguarding: Roles and Competencies for Health Care Staff | Publications | Royal College of Nursing \(rcn.org.uk\)](#)

[Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing \(rcn.org.uk\)](#)

Each level of training mandates that staff complete a minimum number of training hours over a three-year period. These training hours can be fulfilled through a variety of different training interventions. Training is accessible via the IRIS learning platform.

6.1 Safeguarding training requirements Adults and MCA

Level	Staff Group	Method
Level 1	All staff	Mandatory e-learning
Level 2	All staff who have regular contact with patients, their families or carers, or the public	e-learning via the national programme
Level 3	All staff who engage in assessing, planning and intervening and evaluating the needs of adults where there are safeguarding concerns.	Blended face to face/virtual and e-learning

6.2 Safeguarding training requirements Children and young people

Level	Staff Group	Method
Level 1	All staff	Mandatory e-learning
Level 2	Clinical and non-clinical staff who have contact with children, young people or their parents/carers	e-learning via the national programme
Level 3	All clinical staff who are working with children and young people and who could potentially contribute to assessing planning intervening and evaluating the safeguarding needs of a child and their families.	Blended face to face/virtual and e-learning

Level 4	Named Professionals and safeguarding specialists	This is usually multi-agency training

6.3 UHSussex Training Needs Analysis 2024/25

The Trust's TNA in place is based on the intercollegiate document guidance. The TNA has been revised to align with the Adult Safeguarding Intercollegiate (2024). To satisfy this requirement, compliance has been linked to both work roles and the Agenda for Change banding. After revision of the TNA an additional 350 individuals now require Safeguarding Adults level 3. The TNA for level 3 will continue to be reviewed in 2025-2026 to ensure that the trust is meeting national guidance.

All safeguarding adult training content has been updated against the intercollegiate document (2024). Enhancing Level 3 safeguarding adults training provision has been earmarked as a priority for 2025-26. Safeguarding level 3 training is divided into two sections, online and face to face sessions. Staff are required to complete online learning through IRIS online learning before booking into mandatory face to face sessions which are offered across the four main hospital sites. The safeguarding team offer team-based training on request.

6.4 Children safeguarding Training Compliance

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Level 1 %	96.4%	96.7%	96.7%	96.5%	96.6%	96.2%	96.4%	96.5%	96.6%	96.6%	96.7%	96.1%
Level 2 %	93.0%	94.7%	93.6%	93.7%	93.9%	93.2%	93.5%	93.6%	93.4%	93.1%	92.8%	92.9%
Level 3 %	72.0%	74.1%	73.0%	71.8%	75.6%	78.2%	75.5%	77.1%	76.7%	80.5%	80.1%	78.5%

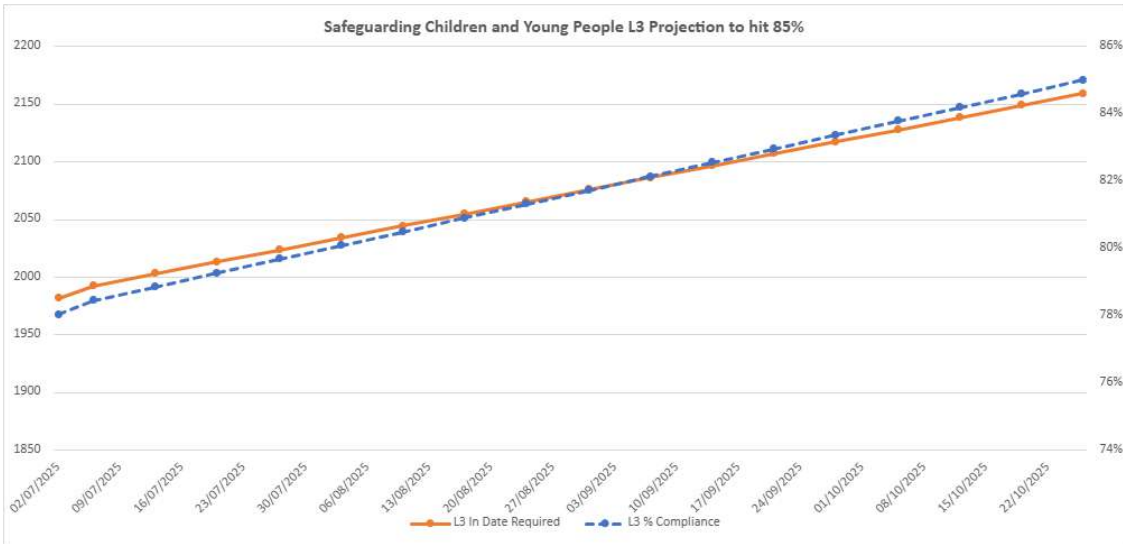
The safeguarding L1 and L2 training for Children has been consistently above the national threshold of 85%, it sits at 89.6% and 91.3 % respectively.

The below table shows the compliance for L3 for 2025 which has been steadily increasing every quarter from 71.4% at the end of 2023/24 to 78.2% of 2521 staff at year end. The number of staff who are now appropriately trained in level 3 safeguarding for children as required for their roles has increased, reducing the risk of children and young people who require safeguarding and protection being missed.

Over 100 sessions of hybrid training have been delivered in the reporting period. Analysis of bookings shows staff prefer virtual training sessions. This insight has resulted in the team converting some of the face-to-face sessions to virtual sessions to create more capacity.

Medical & Dental Staff compliance with L3 has been challenging and stands at 65.5% at year end. A focused plan to engage this group of professionals to increase compliance has been developed and being implemented for 2025/26.

For the Trust to meet its target of 85% compliance, the trajectory below was required:



To date there have been difficulties in driving up the compliance to the target of 85% The safeguarding training working group has been meeting weekly in this reporting period to review training. Factors influencing training compliance include the incorrect level assigned to role and clinical capacity to attend training delivered. There has been some improvement with targeted signposting of staff to access the available training. Delivery of an "all-age" training offer has been agreed and will be offered online and

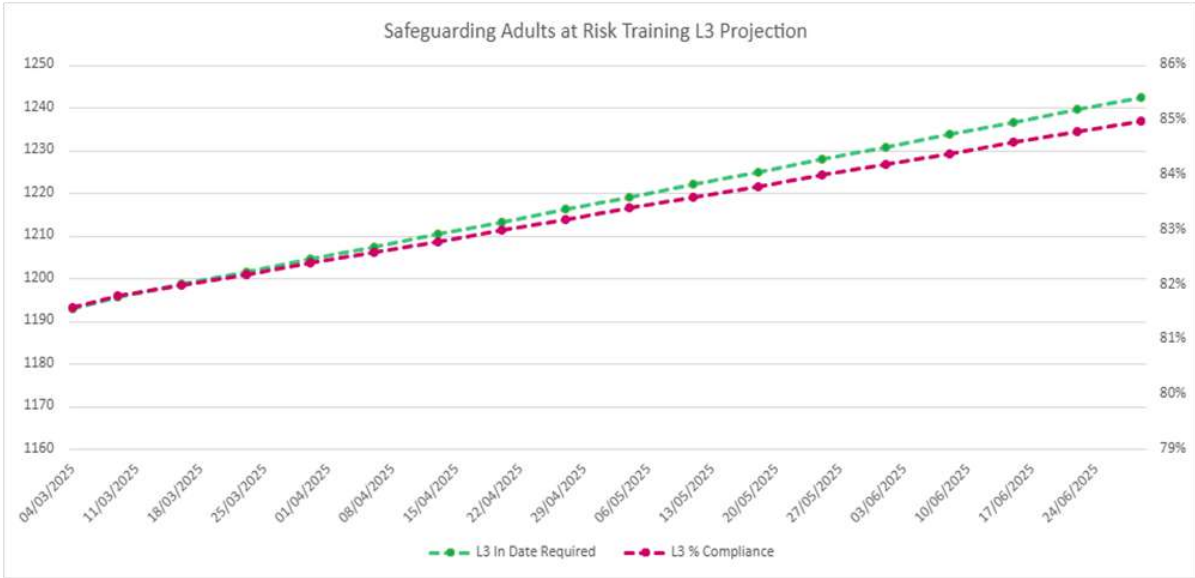
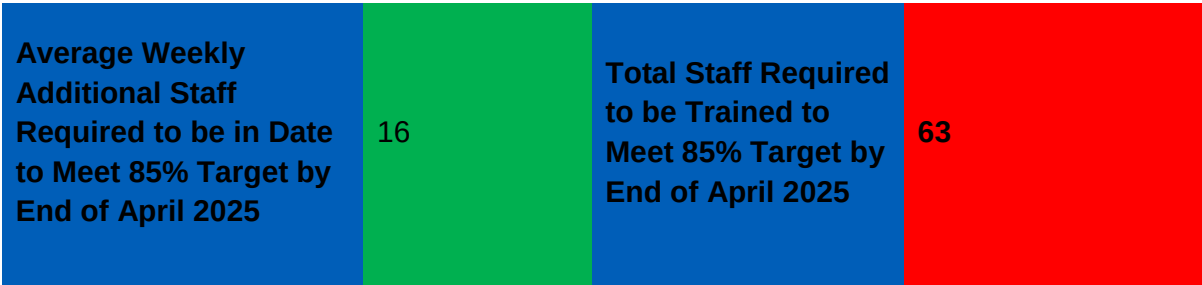
in-person in 2025/26. Divisional leads continue to be offered bespoke training which can be delivered to any group of staff, and which can be tailored to the needs of the service.

6.5 Adult Safeguarding Training compliance 2024/2025

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Level 1	94.70%	94.90%	94.30%	94.30%	94.20%	94.50%	95.60%	96.20%	96.40%	96.50%	96.30%	95.60%
Level 2	91.50%	92.80%	91.60%	91.30%	92.00%	91.00%	91.80%	92.20%	91.80%	91.90%	91.70%	91.40%
Level 3	67.20%	46.60%	46.40%	99.50%	49.70%	50.30%	54.90%	61.40%	70.70%	77.70%	80.40%	81.60%

Training compliance for Adults Level 1 and 2 remains consistently above 90%. Adults Level 3 training improved significantly from 63% at the end of 23/24 to 80% by Q4 2024/25 through increased face-to-face and virtual capacity.

For the Trust to have meet its target of 85% compliance, the following trajectories will need to be followed in the reporting period:



A bi-weekly safeguarding training working group was initiated to drive this agenda forward, with plans to review training content continually in response to local and national learning and enhance compliance monitoring and reporting processes within UHSussex. The expectation is to reach 85% compliance level by November 2025.

6.6 Oliver McGowan Training

The Oliver McGowan Mandatory Training on Learning Disability and Autism is named after Oliver McGowan, whose tragic death highlighted the urgent need for improved training for health and social care staff. The Health and Care Act 2022 introduced a statutory requirement that regulated service providers ensure their staff receive training on learning disabilities and autism appropriate to their roles.

6.7 Oliver McGowan Training Requirements

Tier 1: Tier 1 of The Oliver McGowan Mandatory Training on Learning Disability and Autism is designed for individuals who require a general awareness of the support autistic individuals and those with learning disabilities may need. This e-learning component must be completed by everyone, regardless of their role. This training has been developed by Health Education England and is available via the IRIS training portal. The uptake of this important training package has been extremely positive.

Tier 2: Tier 2 training is intended for those who may need to provide direct care and support to autistic individuals or those with a learning disability. It includes the Tier 1 training, along with a 1-day face-to-face training session co-delivered by a facilitating trainer, an autistic co-trainer, and a co-trainer with a learning disability. Trainers undergo standardised training prior to being approved to deliver the sessions.

UHSussex is currently awaiting further information from Sussex ICB regarding plans for the rollout of Tier 2 training in 2025/26.

6.8 Oliver McGowan Training Compliance

	Apr -24	May -24	Jun -24	Jul- 24	Aug -24	Sep -24	Oct -24	Nov -24	Dec -24	Jan -25	Feb -25	Mar -25
% Compliance	82.1%	84.4%	86.1%	87.4%	88.7%	89.8%	90.6%	91.2%	91.8%	92.4%	92.8%	93.1%

The Trust compliance has improved significantly and is over 90% at year end from 80% at the of 2023/24.

7. Safeguarding Children & Adult Supervision

Staff at UHSussex have access to both informal and formal supervision through various group case discussions, peer reviews, with monthly supervision sessions offered to specialist services. The safeguarding team also provides individual supervision and remains responsive to inquiries for advice and support.

Supervisor training was arranged for all safeguarding team members in this reporting period. A restorative supervision model was piloted and embedded with ICB support.

There is a standard set that requires the safeguarding teams to engage in regular supervision, with named professionals receiving supervision from the designated professionals in the local ICB.



The safeguarding supervision policy was ratified in September 2024, along with monitoring and reporting arrangements implemented and in effect. More safeguarding staff are now trained in delivering supervision to safeguard. Restorative Reflective supervision is provided to support the safeguarding team started February 2025. Further work to embed UHSussex safeguarding supervision across emergency departments and allied health professionals is a priority for the 2025/26 workplan.

8. Safe Recruitment and Allegations Management

All staff at UHSussex continue to undergo enhanced DBS checks in line with NHS Safer Recruitment standards. The Trust has a statutory duty to investigate allegations against staff working with children and with adults at risk. This includes activity relating to a staff member's conduct in their personal as well as their professional life.

Allegations are managed in accordance with the UHSussex policy, with monthly oversight led by senior safeguarding, nursing and HR leads. The response to an allegation will vary according to the nature of the allegation and may include referral to the police and/or local authority.

The Managing Allegations Policy applies when it is alleged that a person who works with children or any adult at risk has:

- Behaved in a way that has harmed a child/adult at risk .
- Possibly committed a criminal offence against or related to a child/adult at risk.
- Behaved towards a child or children/adult at risk in a way that indicates they will pose a risk of harm if they work regularly or closely with children/adults at risk.
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children/adults at risk.

Managing allegations against staff is a complex and sensitive area of the Trust's work, requiring a thorough process that involves close collaboration between the Human Resources department and the safeguarding team, as well as, when applicable, temporary staffing, the police and local authorities.

UHSussex holds a monthly allegations meeting attended by Senior Safeguarding leads, HR, Clinical Lead Temporary staffing, Deputy Chief Nurse – Workforce, ADON Safeguarding. Allegations are discussed and reviewed in accordance with UHSussex allegations policy and liaised with LADO for allegations involving or risk to children.

There were 33 allegations made against staff in 2024/25 compared to 31 allegations in 2023/24 with a total of 14 involving individuals working with children and young people. All allegations resulted in several actions which included no further action (NFA), suspension, police reporting, risk assessment, safeguarding referral, and adherence to the trust's investigation policy.

9. FGM Mandatory Reporting

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act (2003). It is classified as a form of child abuse and violence against women. Regulated health professionals in England and Wales are required to report any known cases of FGM in individuals under 18 that they identify in the course of their professional work to the police. This reporting requirement came into effect on 31 October 2015.

During the year 2024/25, there were 43 reported cases of FGM compared to 31 cases in 2023/24. There were no mandatory referrals for individuals under the age of 18 in the last 2 yrs.

10. Child Protection Medicals

Child protection medical arrangements remain on the risk register for the Chichester area. A formal arrangement for the service is under discussion with partner agencies and the ICB.

Additionally, risks associated with clinical photography support and skeletal surveys for child protection medicals continue to be monitored by the safeguarding team.

Child Protection Medicals		
	2023/24	24/25
WH	93	109
SRH	33	37
RSCH/PRH	100	97
Total	226	243

Numbers of children seen for CP medicals has increased in 2024/25.

11. Child Death Reviews

The coordination of child death information is supported by the child death administrator who is responsible for working with departments across the Trust to implement a unified reporting system.

Unexpected child deaths that could not have been anticipated in the preceding 24 hours trigger a Joint Agency Response (JAR) aimed at establishing the cause of death and ensuring support for the family. A clinical practitioner and safeguarding specialist attend the JAR to consider any safeguarding issues, including the safety of other children.

A JAR will occur if a child's death:

- 6.3.1 Is or could be due to external causes
- 6.3.2 Is sudden and there is no immediately apparent cause (including Sudden Unexpected Death in Infancy/Childhood: SUDI/C)
- 6.3.3 Occurs in custody or while the child was detained under the Mental Health Act
- 6.3.4 Raises any suspicions that the death may not have been natural due to the initial circumstances
- 6.3.5 Involves a stillbirth where no healthcare professional was present

11.1 Child Deaths 2023/24

Hospitals	Deaths overall	Children over 1 year	Neonates	Expected	Unexpected
WH & SRH	18	13	5	8	10
RSCH & PRH	20	7	13	16	4

Total	38	20	18	24	14

11.2 Child Deaths 2024/25

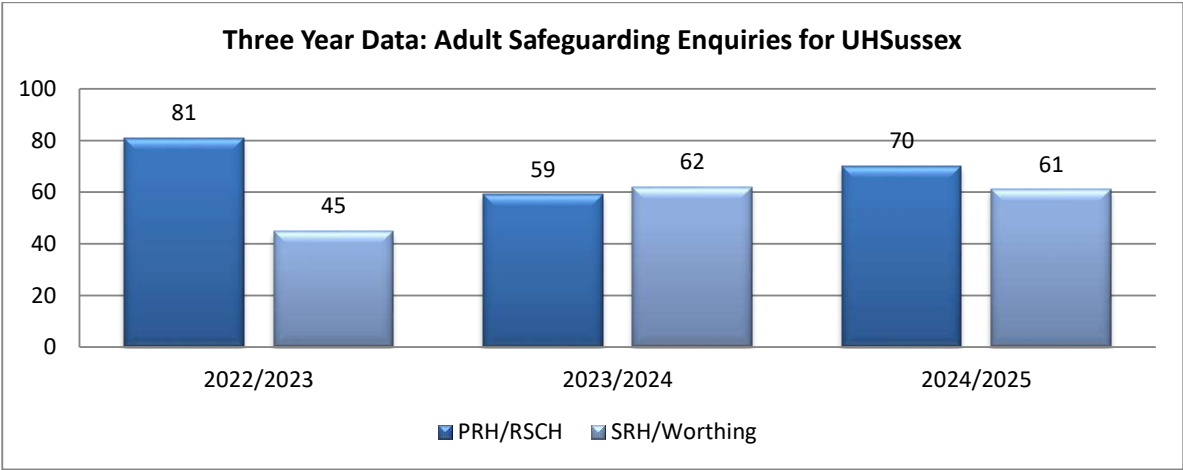
Hospitals	Deaths overall	Children over 1 year	Neonates	Expected	Unexpected
WH & SRH	8	4	4	4	4
RSCH & PRH	14	3	11	11	3
Total	22	7	15	15	7

Learning from unexpected child deaths is incorporated into the safeguarding training delivery program. Key messages on topics such as neglect, working with fathers and non-birthing partners, exploitation, safer sleeping, and child mental and emotional health are shared as part of this training.

12. Safeguarding Adults Section 42 Enquiries at UHSussex

Local authorities have a statutory duty to make enquiries, or cause others to undertake enquiry, if they believe an adult is experiencing, or is at risk of, abuse or neglect. UHSussex provides services to the population of Sussex and may be caused to undertake enquiry by any of the three Sussex local authorities if there are concerns regarding the care provided by UHSussex hospitals or outpatient services.

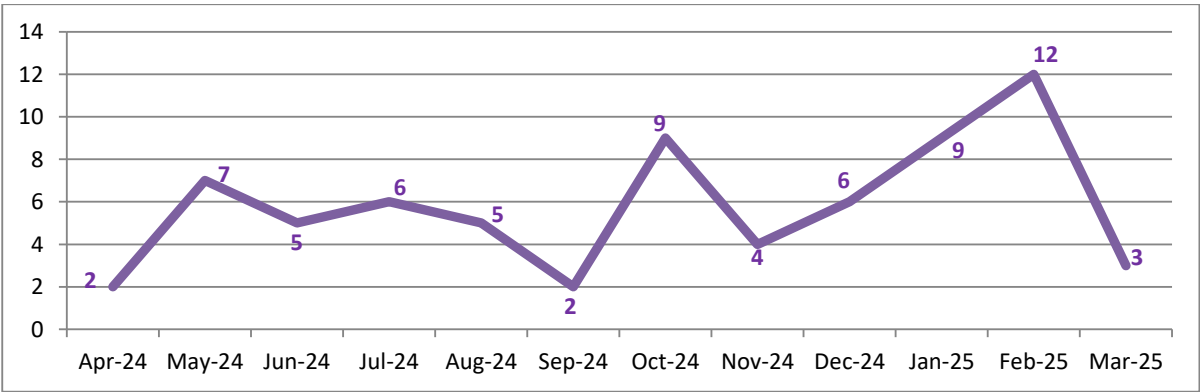
The table below shows a three-year comparison of the total number of safeguarding enquiries received across UHSussex hospitals.



As part of maintaining oversight of safeguarding activity, the safeguarding team monitor and review not just the number of safeguarding concerns but also the underlying categories and themes, to identify any trends within safeguarding.

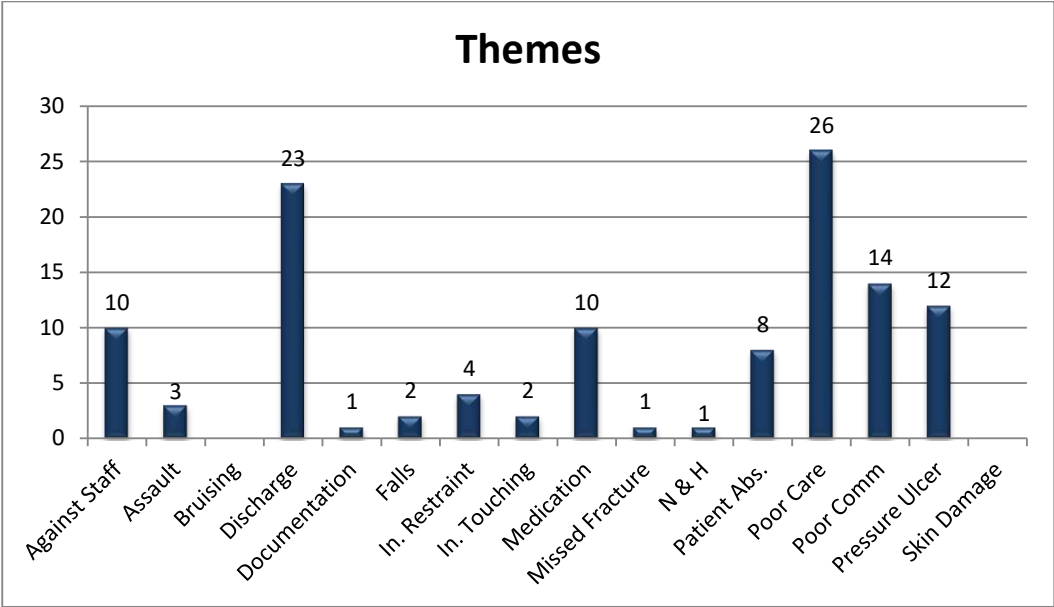
Figures 1 and 2 below show the number of safeguarding concerns and themes raised regarding the care provided by UHSussex across Newhaven, Brighton and Haywards Heath hospitals. One safeguarding concern may relate to multiple themes.

12. 1 Section 42 enquiries – RSCH & PRH - Total 70



When compared to the previous year, the data for 2024-25 shows an increase in the number of safeguarding enquiries received from the local authorities from a total of 59 incidents in 2023-24 to a total number of 70 incidents in this reporting period. We will be benchmarking our Section 42s in 2025/6/

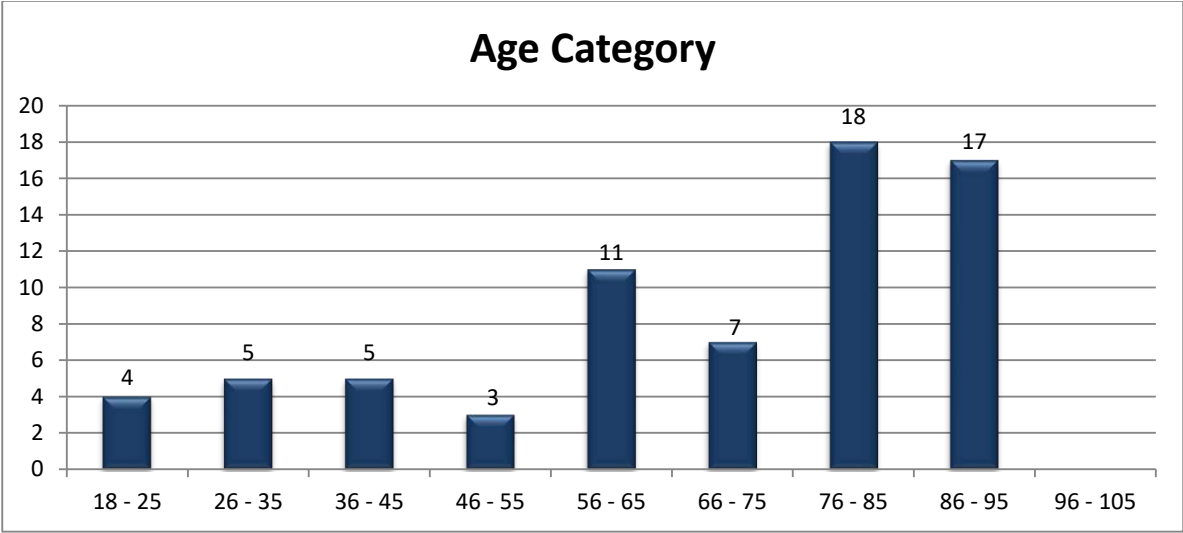
12.2 Themes raised in safeguarding enquiries - RSCH & PRH



The above data shows that discharge, remains an area of concern. There has also been an increase in medication, poor communication, and poor care concerns at UHSussex. 2024-25 has seen a slight reduction in the number of safeguarding enquiries received relating to pressure damage, bruising, skin damage in comparison to the previous year.

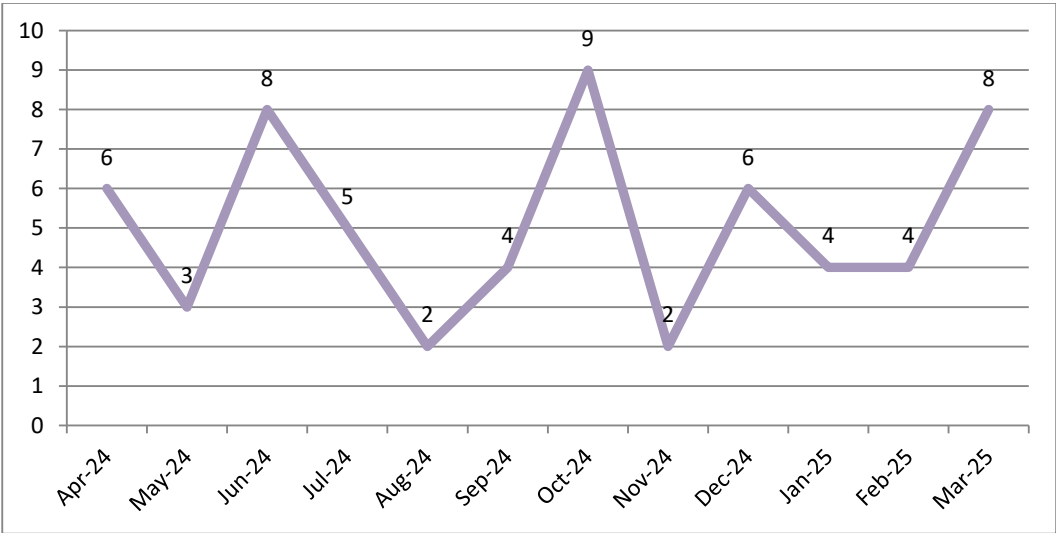
Safeguarding Adult Lead Nurses are integral members of the weekly Harm Free Care panel, collaborating with Matrons and Heads of Nursing to identify learning and improvement action plans. It is part of the forward plan in 2025/26 for the Head of Nursing for Safeguarding Adults and the Safeguarding Adults Lead Nurse to collaborate with Divisional governance teams to amalgamate learning from these incidents with insights from safeguarding enquiries, supporting the formulation of improvement plans.

12.3 S42 Enquiries Received – Age - RSCH & PRH



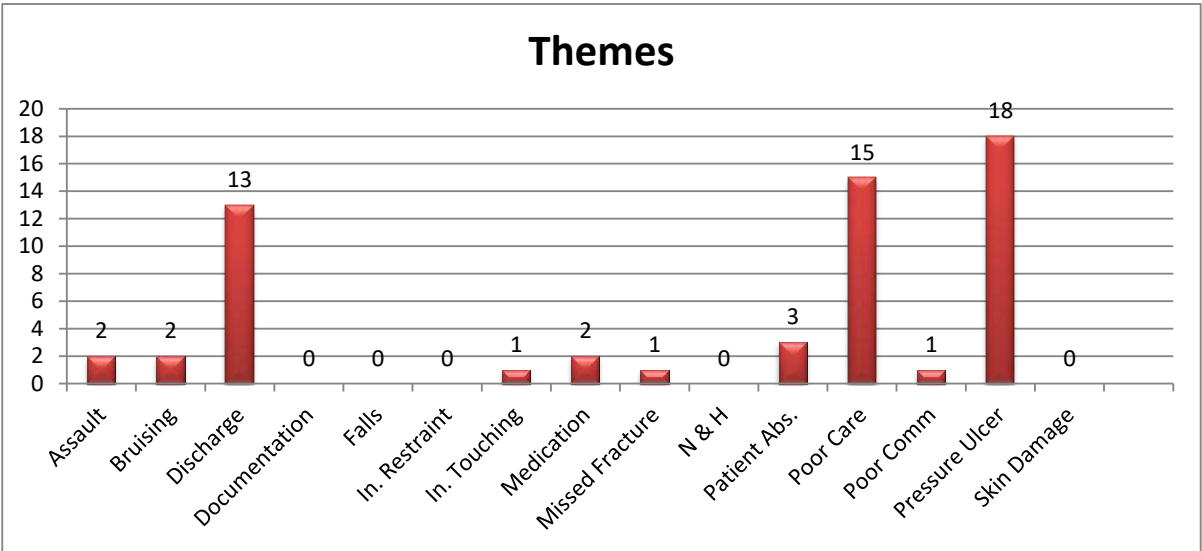
The chart above shows the number of safeguarding enquiries received by age of the patient. When compared to last year, there has been a slight increase in the number of safeguarding enquires received from local authorities for people accessing UHSussex services in each age bracket from 18 – 55 years and a slight decrease in all other age brackets. The team need to work to streamline referrals and data across UHSussex to ascertain further data to effectively scrutinise and to better understand the vulnerabilities leading to this increase e.g. were these linked to mental health or learning disability, substance use etc.

12.4 Section 42 enquiries – WH & SRH - Total 61



When compared to the previous year, the data for 2024-25 shows a broadly consistent pattern in the number of safeguarding enquiries received from the local authorities decreasing marginally from 62 to 61 in this reporting period.

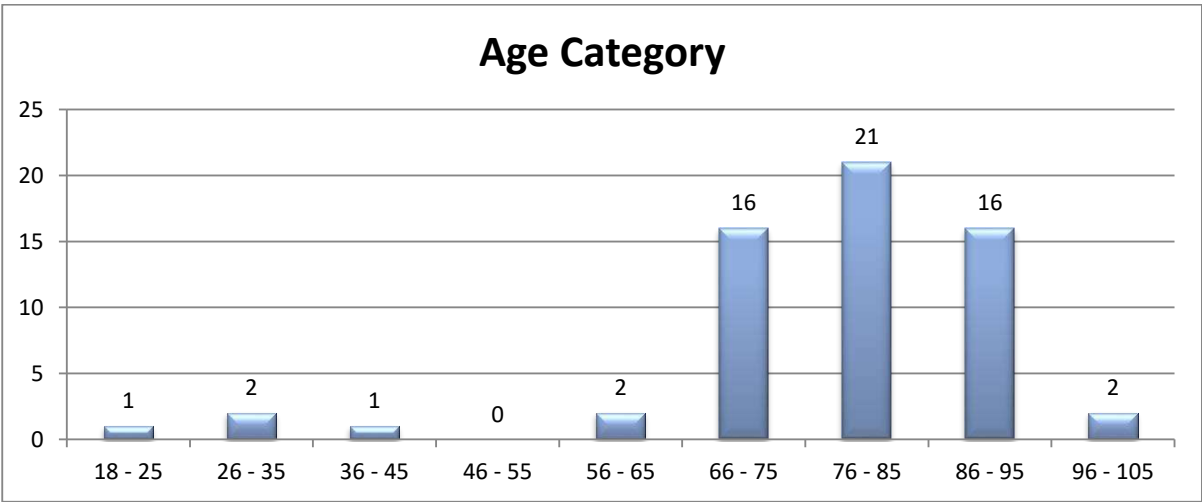
12.5 Themes raised in safeguarding enquiries - WH & SRH



Analysing safeguarding enquiries at WH & SRH for 2024/25, it appears that pressure ulcers were the most frequently cited issue, followed by poor care and discharge-related concerns. Notably, discharge related enquiries decreased from 23 last year to 13 this year, suggesting that improvements in discharge processes may be having a positive impact.

However, pressure care related safeguarding enquiries have doubled, and concerns around poor care have also increased. This highlights the continued importance of the Harm Free Care Panels and Early Learning Reviews in identifying themes, driving improvements, and maintaining patient safety across the Trust. Please note a thematic review reference Category 2 and above hospital acquired pressure ulcers was undertaken in November 2024, the results evidenced that there were not any statistically significant themes

12.6 S42 Enquiries Received – Age - WH & SRH

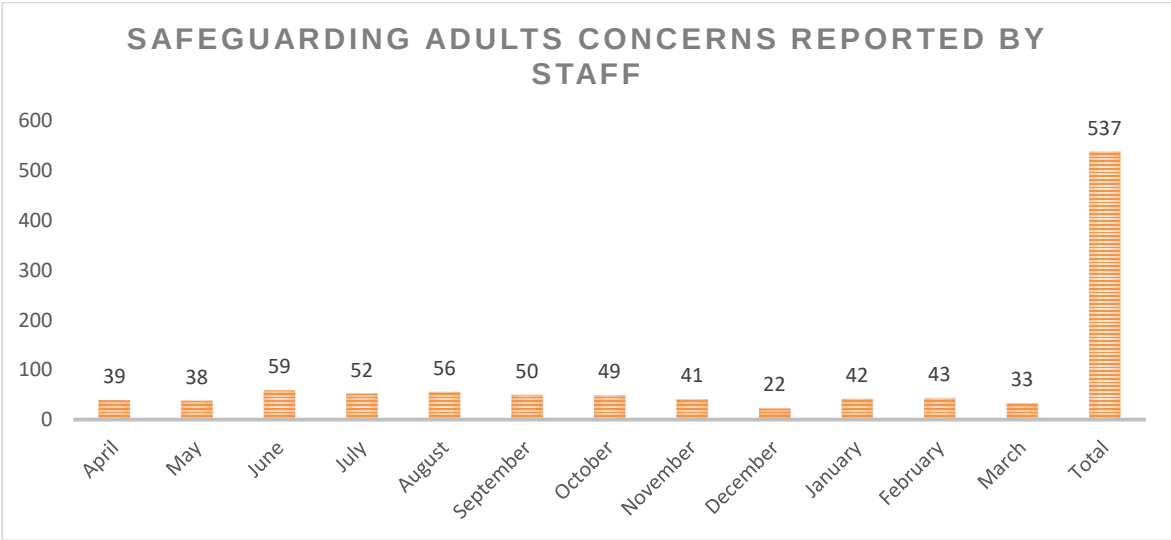


The chart above shows the number of safeguarding enquiries received by age of the patient. When compared to last year, there has been a slight increase in the number of safeguarding enquires received from local authorities for people accessing UHSussex services in each age bracket from 18 – 55 years and a slight decrease in all other age brackets. The team need to work to streamline referrals and data across UHSussex to ascertain further data to effectively scrutinise and to better understand the vulnerabilities leading to this increase e.g. were these linked to mental health or learning disability, substance use etc.

13. Safeguarding Activity Across UHSussex

The safeguarding adults team monitor safeguarding concerns raised by clinicians to the local authorities on behalf of patients accessing their services. 2024/25 has seen a decrease in the number of concerns raised regarding patients accessing our services from 620 in 2023/24 to 537. This would be consistent with the fact that the systems to refer has changed and the safeguarding team is not always cited on referrals made and there may be small discrepancies. This issue remains a priority for the Trust and is on the risk register and 2025/26 workplan to resolve as the digital and IT transformation progresses at pace in the Trust.

Medicine divisions have the highest referrals. Themes include concerns about self-neglect, psychological, substance misuse and domestic abuse.



14. Mental Capacity Act (MCA) and Deprivation of Liberty safeguards

The Mental Capacity Act (2005) is a crucial piece of legislation designed to protect individuals who may lack the capacity to make specific decisions for themselves due to conditions such as mental health issues, learning disabilities, or other impairments. The Act sets out a framework for making decisions on behalf of individuals who cannot do so with an emphasis of respecting individuals' rights and autonomy.

14.1 MCA Education and Training

A key safeguarding priority for 2024/25 has been to review and update the training for staff in relation to MCA and DoLS as part of learning from the 2023/24 Safeguarding Adult Review of Craig and DJT at Brighton Safeguarding Adult's Board.

This training is predominantly e-learning based with all clinical staff completing training as part of the Level 2 Safeguarding Adults e-learning available in IRIS. Compliance has remained above 90% in the last 2 years.

As part of the on-going work to improve the level 3 Safeguarding Adults training, a blended approach for MCA and DoLS training has been incorporated to include e-learning with an additional case study-based application to practice as part of the face-to-face component of the level 3. Compliance for 2024/25 year end is 81.6% a significant increase from 63.4% in 2023/24.

The Mental Capacity Act Lead for St Richards, Southlands and Worthing hospitals continues to provide bespoke face to face training both in person and via Teams as requested by wards / departments. Similarly, the Safeguarding Adults specialist nurses provide bespoke training for MCA and DoLS across RSCH / PRH.

15. Deprivation of Liberty Safeguards activity & data

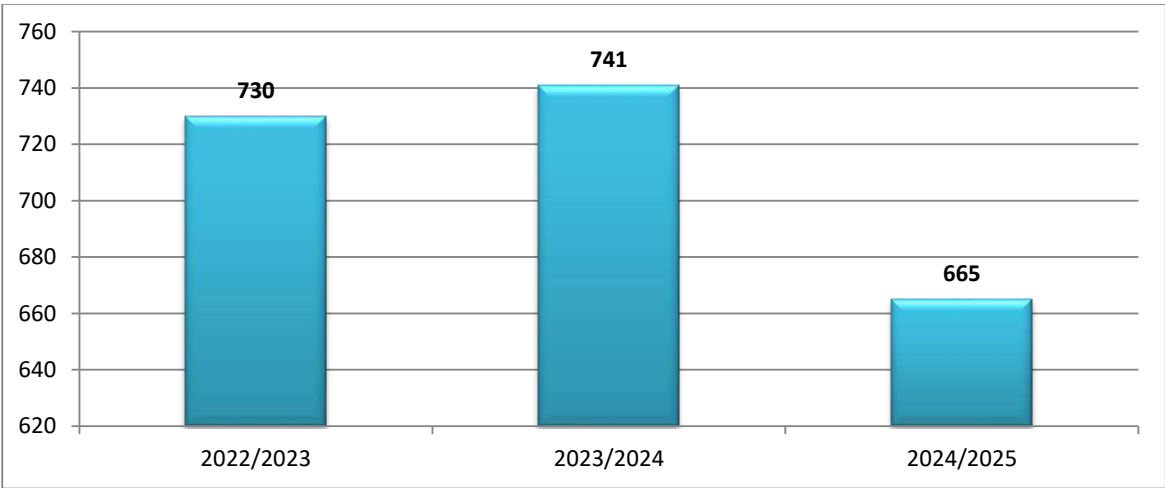
UHSussex acts as the 'Managing Authority' when depriving adults of their liberty when they lack the capacity to consent to the arrangements in place, necessary for them to access treatment and care. The trust has a statutory duty to comply with the legal processes in relation to DoLS and to seek authorisation from the appropriate local authority.

The data below illustrates the increasing number of DoLS authorisation requests made by all UHSussex hospitals to the local authorities across Sussex. As the Managing Authority, the Trust can grant itself urgent authorisation for a period of 7 to 14 days

and must still submit this to the local authority to ensure external oversight. Standard DoLS authorisation for periods longer than the urgent authorisation can only be granted by the relevant local authority.

UHSussex is also required to notify the Care Quality Commission (CQC) of all DoLS authorisations approved by the local authority, and processes are in place to facilitate this notification.

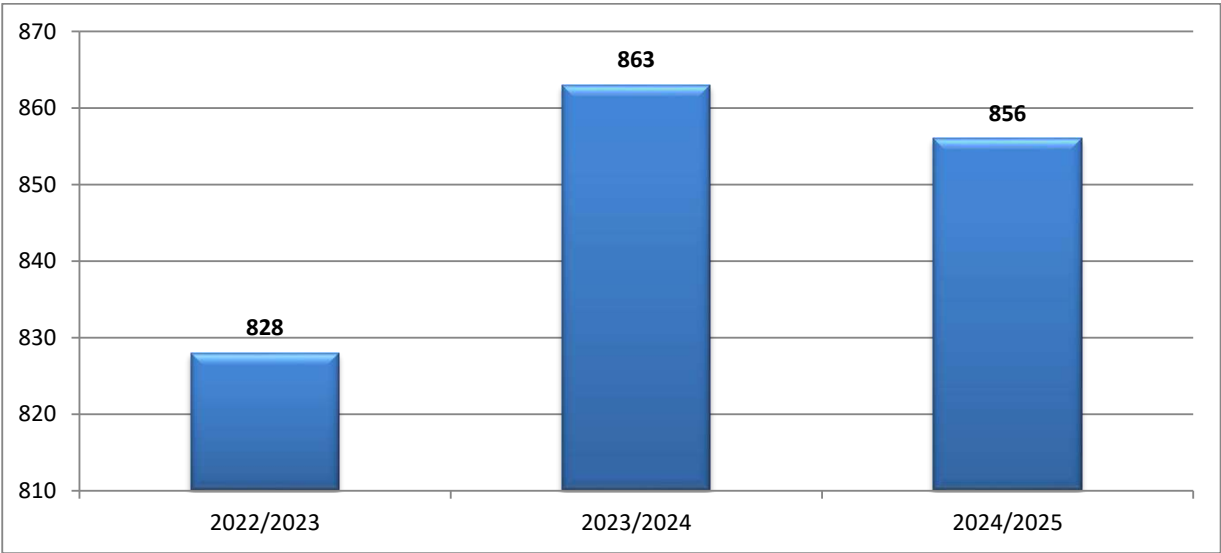
15.1 DoLS authorisation requests over last three years RSCH, PRH & Newhaven



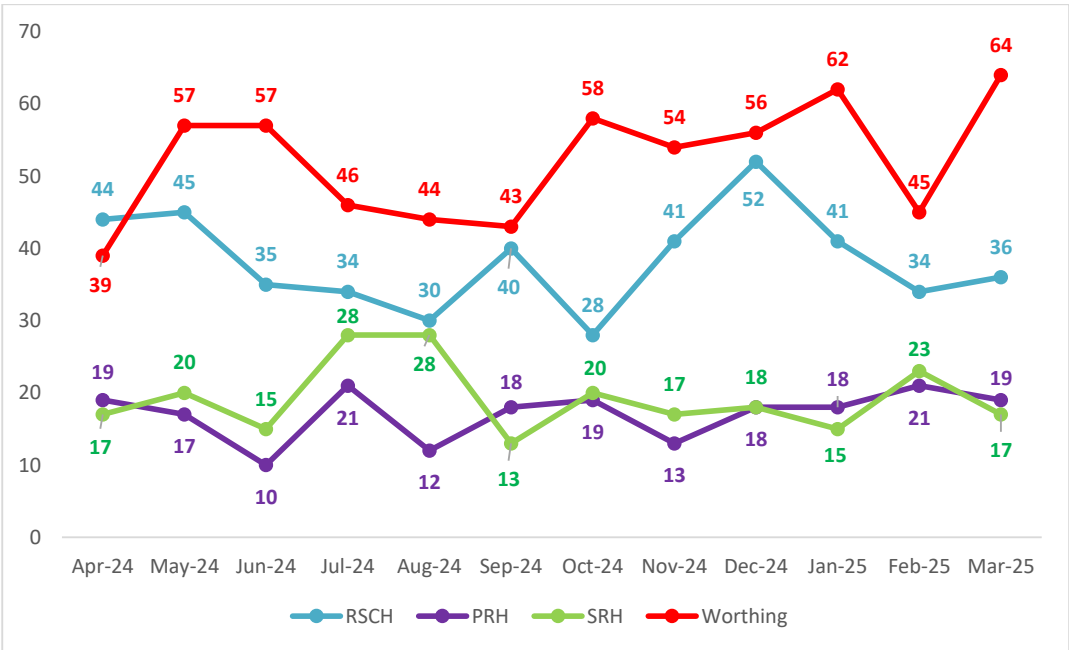
The number of standard DoLS authorisation requests made to local authorities in 2024/25 (665) has decreased compared to previous years (730 in 2022/23 and 741 in 2023/24). However, it is important to note that the number of authorisations remains significantly lower than the number of applications made.

This discrepancy is attributed to several factors as of a result of insights from the DOLS audit which is in section 21 of this report. Factors include patient discharge before assessment, regain of mental capacity, or capacity constraints within the local authority. In all cases, UHSussex must ensure continued scrutiny of restrictions in place, including regular capacity assessments and prompt notification to local authorities of any changes. These steps are essential to uphold patient rights and ensure legal compliance under the Mental Capacity Act.

15.2 DoLS Authorisation Requests for Past Three Years Worthing & SRH

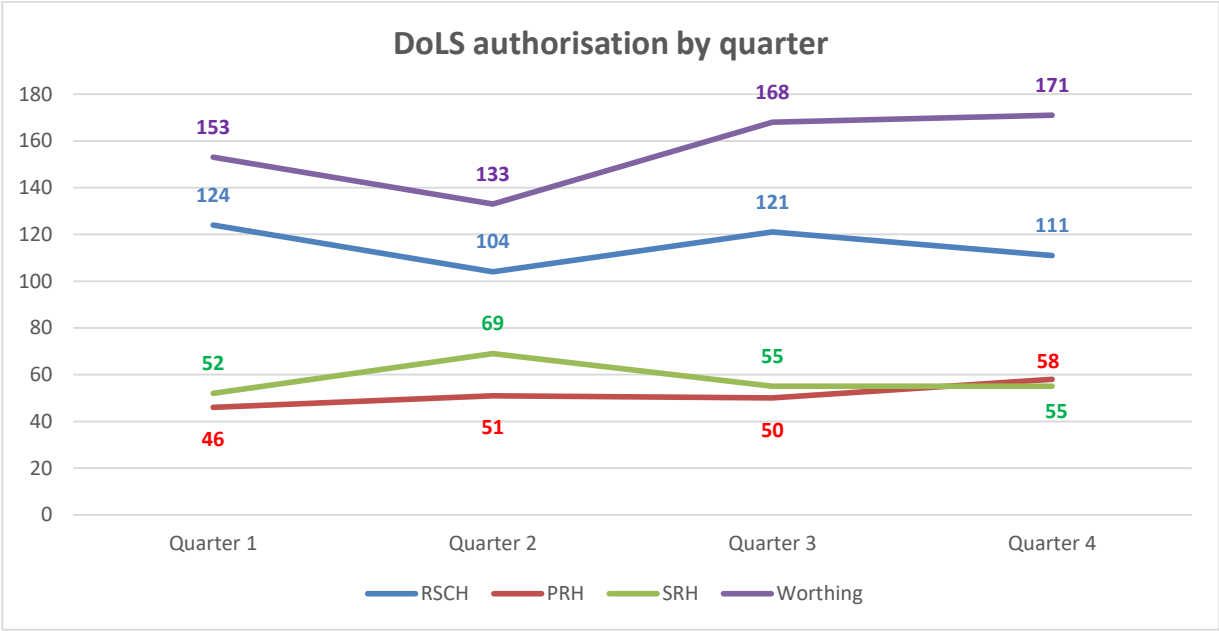


15.3 DoLS authorisation requests per month across UHSussex (2024 -25) – Total: 1521



Work to raise the profile of DOLs across RSCH and PRH is planned for 2025/26.

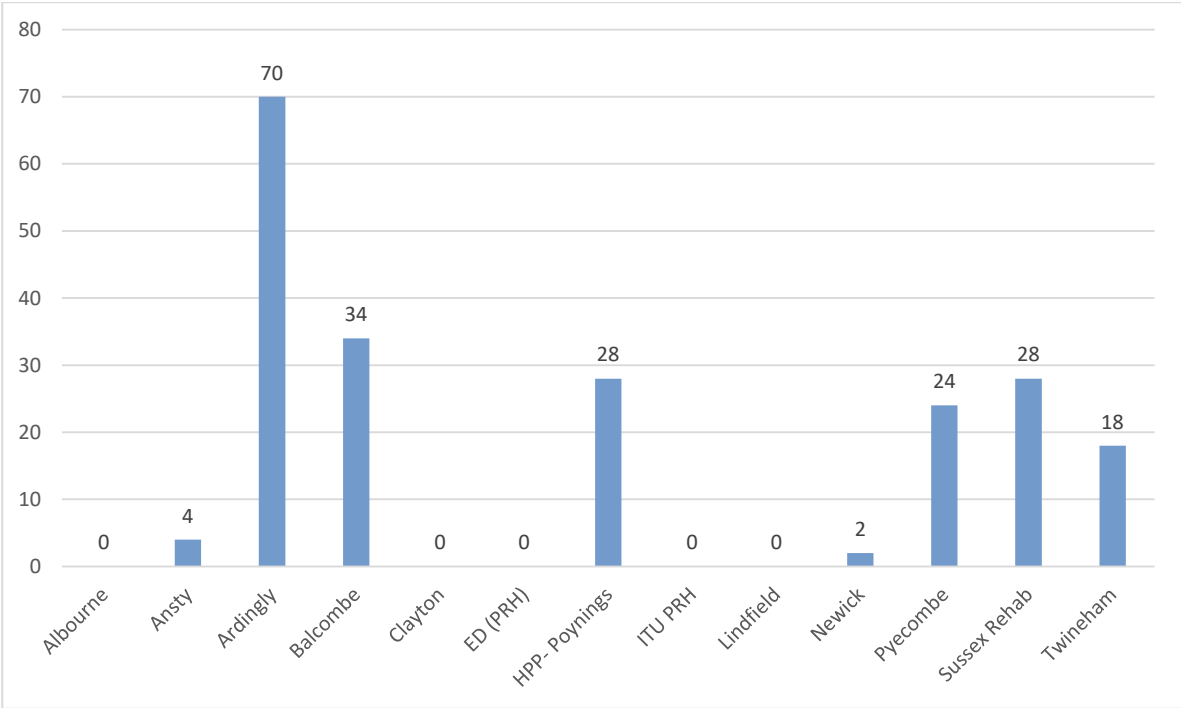
15.4 DoLS authorisation requests per quarter across UHSussex



The general picture for Dols activity shows a decreasing number of DoLS authorisation requests made by all UHSussex hospitals to the local authorities across Sussex.

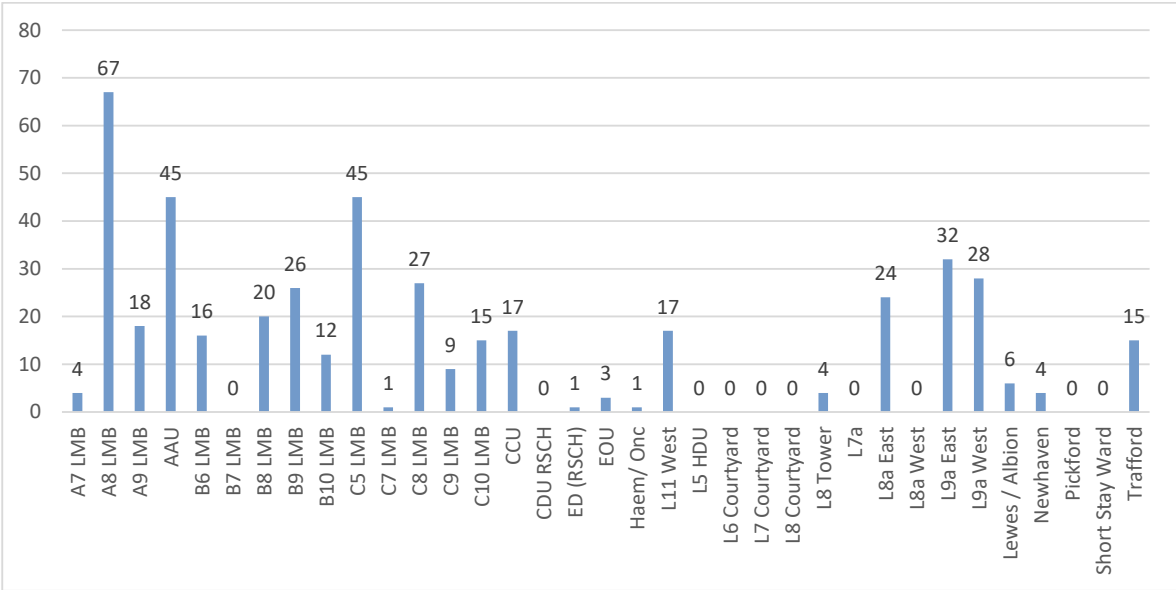
15.5 DoLS Authorisation Requests by Wards at PRH – (208)

Requests decreased from 240 in 2023/24 to 208 in this reporting period.



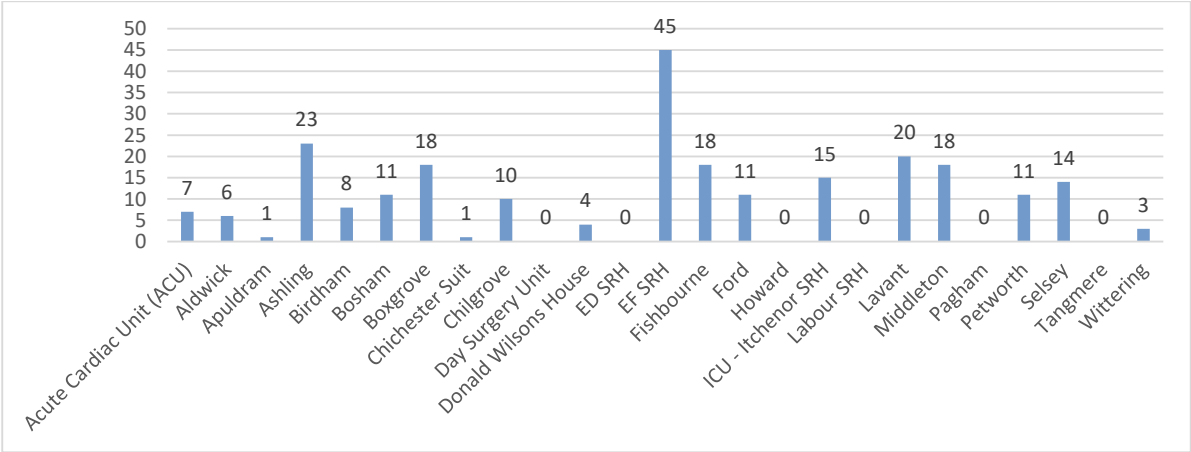
15.6 DoLS Authorisation Requests by Wards at RSCH – (457)

Requests decreased from 481 in 2023/24 to 457 in this reporting period.



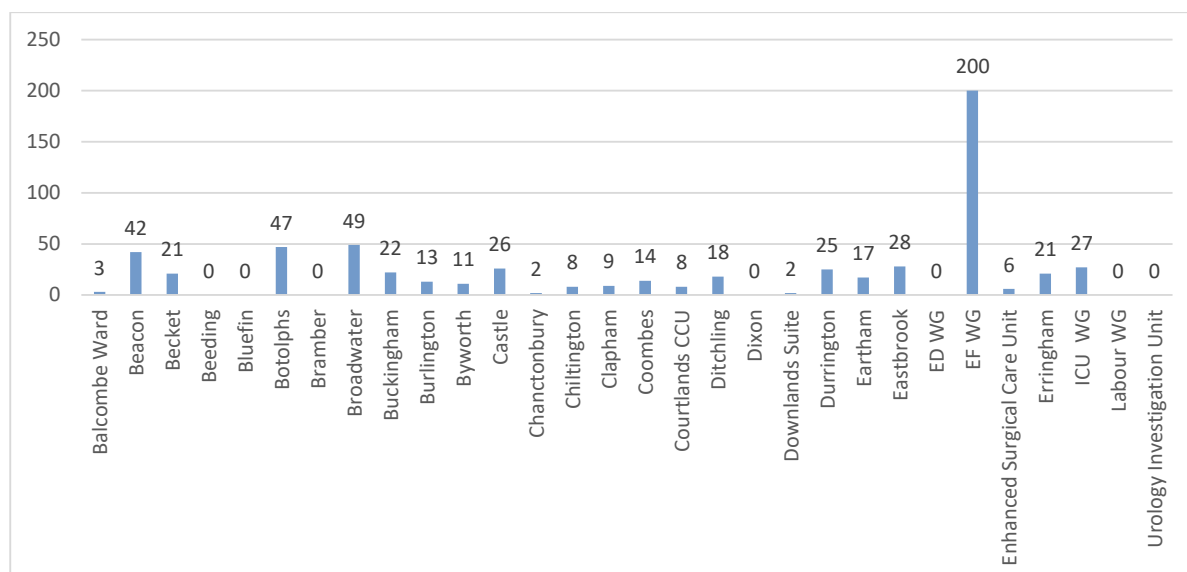
15.7 DoLS Authorisation Requests by Wards at SRH – (244)

Requests decreased from 261 in 2023/24 to 244 in this reporting period.



15.8 DoLS Authorisation Requests by Wards at WH – (619)

Requests increased from 602 in 2023/24 to 619 in this reporting period.



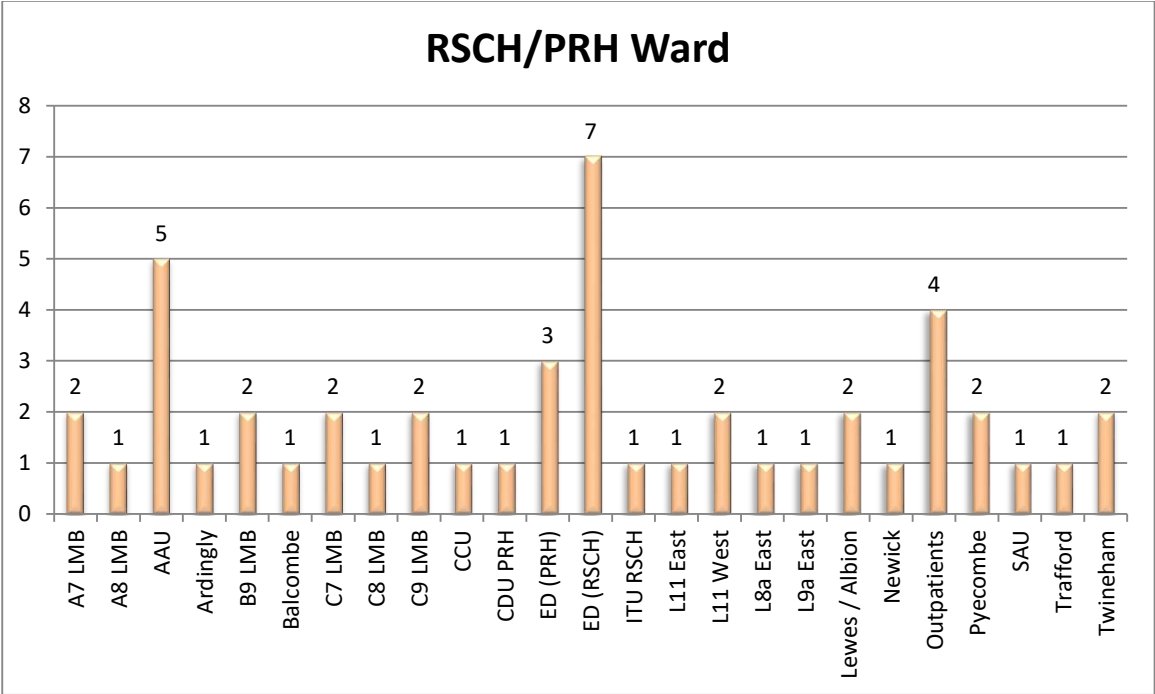
16. Domestic Abuse and Violence

Specialist domestic abuse services in Brighton are provided by Victim Support, while Worth Domestic Abuse Services delivers specialist services across West Sussex. As part of their contract with the local authority and ICB, a Health Independent Domestic Abuse Advisor (HIDVA) from Victim Support is based at the RSCH. Similarly, Worth Services provides three HIDVAs who are stationed at PRH, WH and SRH. The HIDVAs offer specialist support to both patients and staff who disclose domestic violence or abuse.

Staff can refer individuals directly to the HIDVA service; however, if the adult has additional vulnerabilities, there may be a need to raise a safeguarding concern with the local authority as well.

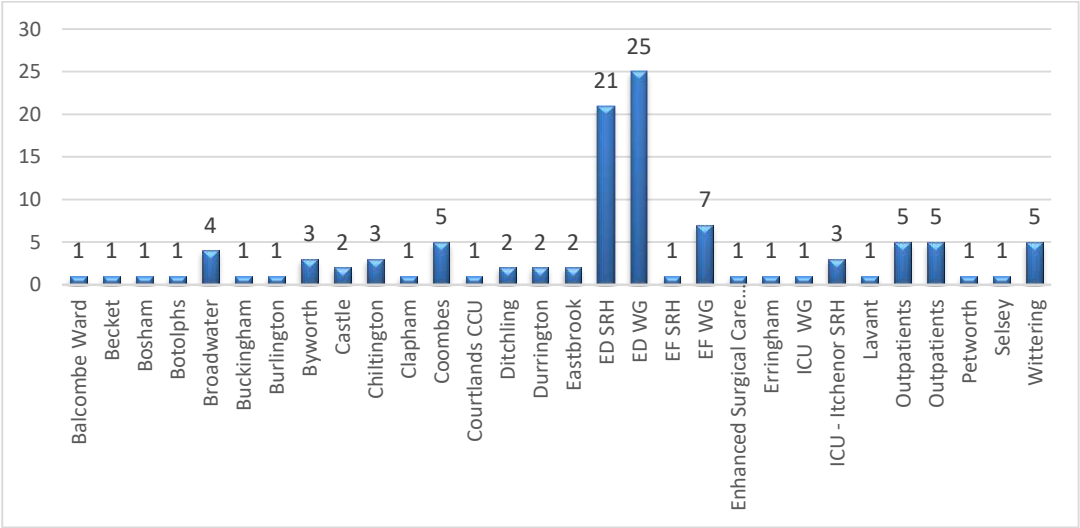
16.1 Domestic Abuse Referrals at RSCH/ PRH total – (48)

During this reporting period, UHSussex staff working across RSCH and PRH raised 48 safeguarding concerns specifically related to domestic abuse on behalf of patients accessing their hospitals compared to 56 reports in 2023/24.

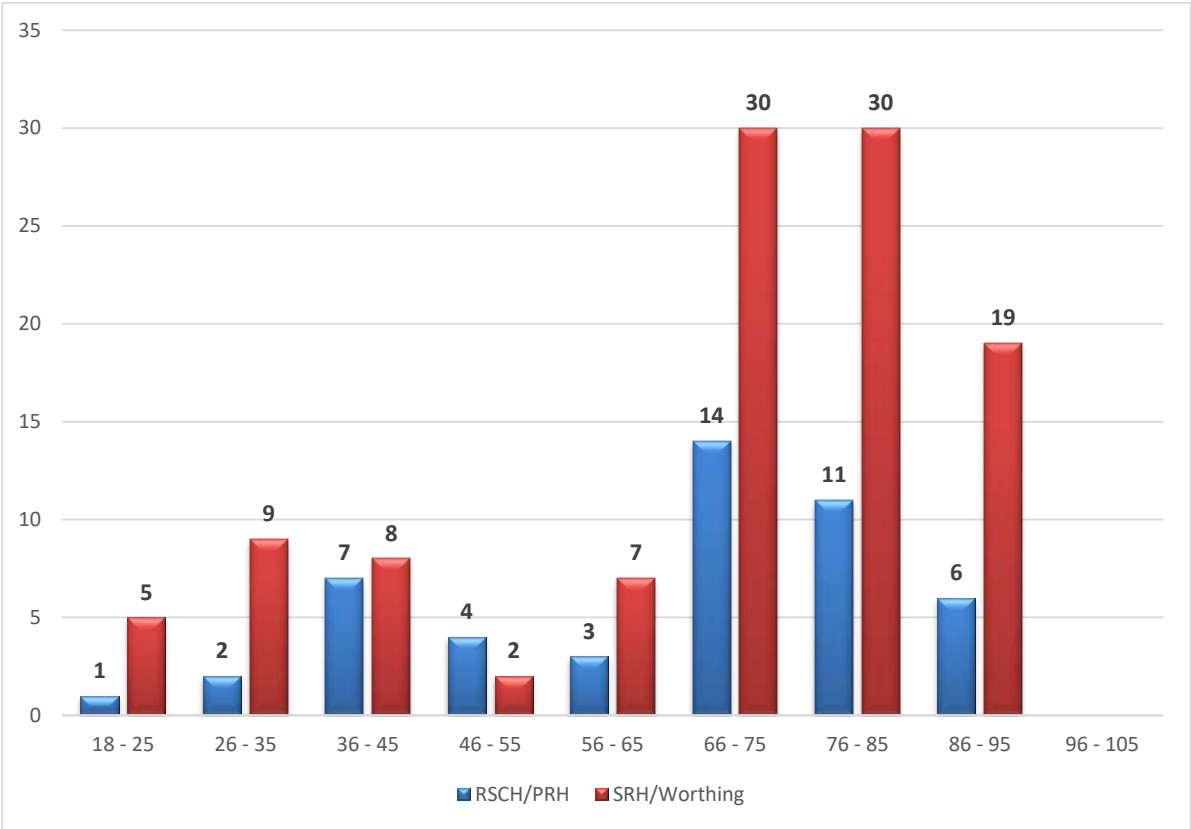


16.2 Domestic Abuse Referrals at SRH & Worthing total – (109)

During 2024/25, UHSussex staff working across SRH and Worthing raised 109 safeguarding concerns specifically related to domestic abuse on behalf of patients accessing their hospitals. There is no comparable data for 2023/24 as the data was not yet being collected at these sites.



16.3 Domestic Abuse Concerns Raised by Age across UHSussex



In this reporting period, high numbers of domestic abuse safeguarding concerns were recorded among patients aged both 76-85 and 66-75. While older patients continue to represent a significant proportion, this year has seen a marked increase in recognition and reporting among the 66-75 age group compared to 2023/24, particularly at RSCH & PRH sites. This shift may reflect improved awareness, more consistent enquiry, and the proactive role of the HIDVAs in supporting identification and response.

17. Modern slavery

UHSussex actively addresses modern slavery and supports all staff to identify and mitigate risks of modern slavery, ensuring compliance with legislation like the Modern Slavery Act 2015. It does this through:

Procurement - UHSussex incorporates modern slavery requirements into procurement policies and contracts, leveraging its buying power to influence suppliers. This includes mandatory exclusion questions regarding the Modern Slavery Act during procurement of goods and services.

Safeguarding Training and Awareness - UHSussex provides training to staff, particularly frontline healthcare workers, to recognise potential victims of modern slavery and understand how to respond.

Supply Chain Management - UHSussex ensures suppliers adhere to relevant legislation and ethical standards, including those related to modern slavery.

Reporting and Transparency - UHSussex publishes an annual statement on modern slavery, outlining steps taken to address the issue, maintain transparency and ensuring compliance with the Modern Slavery Act 2015. The annual statement is published on the UHSussex website here:

<https://www.uhsussex.nhs.uk/resources/modern-slavery-statement/>

It is also made available to all staff on the Staff intranet.

Collaboration and Partnerships - UHSussex collaborates with various agencies and organisations within the Sussex partnership to tackle modern slavery, including participating in multi-agency groups focused on exploitation and the National Referral Mechanism.

Safeguarding Adults and Children - UHSussex implements safeguarding policies and procedures to protect vulnerable individuals, including children and adults, who may be at risk of exploitation.

Freedom to Speak Up - The UHSussex "Freedom to Speak Up" policy encourages staff to raise concerns about potential harms, including modern slavery, related to healthcare service provision.

Data Collection and Monitoring - UHSussex tracks the number of concerns raised about exploitation and modern slavery to assess the effectiveness of its safeguarding efforts.

18. Prevent

The Prevent Duty under the Counter-Terrorism and Security Act 2015 requires all specified authorities to have “due regard to the need to prevent people from being drawn into terrorism”; local authorities and their partners therefore have a core role to play in countering terrorism at a local level and helping to safeguard individuals at risk of radicalisation

Under the Duty, NHS organisations are required to provide appropriate training in line with the Prevent Competency Framework; for staff to have an awareness of Prevent and radicalisation and how to spot the vulnerabilities that may lead to a person becoming radicalised. The purpose of Prevent is for staff to identify and report concerns where they believe young people or adults may be vulnerable to radicalisation or exploiting others for the purposes of radicalisation. This may include staff and/ or patients.

The Chief Nurse is the named organisational Prevent lead and is supported by the safeguarding leads in the implementation of the Prevent Duty within UHSussex. UHSussex is represented at the Brighton and Hove Prevent Board and the

safeguarding leads work in collaboration with the Designated Nurse Safeguarding Adults NHS Sussex Prevent Lead, as part of the 'health' contribution to the Counter-terrorism Local Profile and the Prevent Board action plan.

UHSussex has an internal Prevent policy accessible to all staff which outlines responsibilities for staff and the referral process for raising concerns.

Local Authority led Channel Panels, supported by Sussex Police, are multi-agency panels who meet to discuss the risk posed by vulnerable people who are believed to have become radicalised and threatening extreme violence who have been referred for multi-agency support. For any referrals made by UHSussex, the organisational Prevent Lead (or nominated replacement) will be invited to attend the Local Authority Channel panel. There have been no referrals from the Trust to the Channel panel in the last 2 years (2023-24/2024-25).

The Trust submits a quarterly return to NHS England. The data submitted monitors the key elements of the prevent duties and responsibilities which include Identification of Prevent leads, strategic and operational, delivery of training, the levels of referrals made via the Channel process, representation, and engagement with local and regional Prevent leads.

All Prevent training within the Trust is via ELFH modules available through IRIS. For Level 1 Safeguarding training this is Basic Prevent Awareness and is mandatory for all staff within the NHS. For Levels 2 & 3 Safeguarding training this is Level 3 – Awareness of Prevent. All staff who required to complete level 3 safeguarding adults and children are also required to complete Prevent level 3.

The Trust compliance for L1 and L3 Prevent is 88.2% and 91.3% respectively. This is above the national threshold of 85%.

STAM	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
STAM - Prevent Basic	52.00 %	67.20 %	72.80 %	78.00 %	82.10 %	84.60 %	88.20 %
STAM - Prevent - Level 3	68.20 %	78.00 %	81.90 %	86.00 %	87.50 %	89.10 %	91.30 %

19. Multi-agency Collaboration

Safeguarding Partnerships refer to statutory arrangements between agencies focused on protecting children and vulnerable adults from harm, abuse, and neglect. The Trust has a duty to engage with the Safeguarding Children and Safeguarding Adult Partnership arrangements in each of our local authorities and is actively involved in the work of the sub-groups.

Changes to statutory guidance, Working Together to Safeguard Children Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk), has enabled a joined up, pan-Sussex approach which has helped to streamline some activities.

19.1 Local Safeguarding Partnership Meetings

The safeguarding team contributes to West Sussex and Brighton & Hove Safeguarding Children and Adult Partnerships and are engaged in the following subgroups.

19.2 Safeguarding Children Partnership meetings

West Sussex Safeguarding Children Partnership	Frequency
Improvement and Assurance Subgroup	Bi-monthly
Child Safeguarding Liaison Subgroup	Monthly
Learning and Development Subgroup	Quarterly
Extra familial risk & Harm Subgroup	Quarterly
Partnership Group (previously Board)	Quarterly
Safer West Sussex Partnership (SWSP)	Quarterly
Domestic Violence and Sexual Abuse (DVSA) Steering Group	Quarterly
West Sussex Violence and Exploitation Board	Quarterly
Children’s Health Safeguarding Forum	Bi-monthly
MASH Health Working Group	Quarterly
Children First Board	Quarterly
Myth of Invisible Men Task & Finish group	Bi- Monthly
Partnership Group	Quarterly
Child Safeguarding Liaison Subgroup	Monthly
Learning and Development Subgroup	Quarterly

Monitoring & Evaluation Sub-Group	Bi-monthly
Community Safety Partnership Board	Quarterly
Children's Health Safeguarding Forum	Bi-monthly
MASH Health Working Group	Quarterly
Pan Sussex and or NHS Sussex	
Looked After Children Operational Group	Quarterly
Looked After Children NHS Professionals Meeting	Quarterly
Joint Targeted Area Inspection (JTAI) Health Providers Working Group	Monthly
NHS Professionals MCA Steering Group	Monthly
LMNS- Local Maternity & Neonatal System	Quarterly
Maternity Safeguarding Forum	Quarterly
ICON Forum	6 monthly
National and Regional Networks	
National Safeguarding Maternity network	Quarterly
National Network for Safeguarding Children Named Professionals	Monthly
Southeast Region Safeguarding Maternity Network	Quarterly
Southeast Named Safeguarding Professionals Network	Quarterly

19.3 Safeguarding Adult Partnership meetings

West Sussex SAB	Frequency
Safeguarding Adults Board	Quarterly
Quality and Performance Subgroup	Quarterly
Learning and Development Subgroup	Quarterly
DVSA	Quarterly
Violence and Exploitation Board	TBC
Brighton & Hove SAB	
B&H Safeguarding Adults Board	Quarterly

Learning and Development Subgroup	Quarterly
Quality Assurance Subgroup	Quarterly
PREVENT Board	Quarterly
Sussex Anti – Slavery Network	Three times per year
Sussex Safeguarding Adults Board Self-Assessment	Bi - Annual
ICB/Region	
NHS Professionals - Safeguarding	Monthly
NHS Professionals – Prevent	Bi - Monthly
MCA / LPS Network	Bi - Monthly

20. Statutory and Mandatory Safeguarding Reviews

Safeguarding Reviews are systematic evaluations conducted to examine and assess safeguarding practices and incidents involving children or vulnerable adults. The primary goal of safeguarding reviews is to improve organisational and inter-agency responses to safeguarding concerns, enhance the protection of individuals at risk, and promote learning and development within professions and organisations involved in safeguarding.

A multi-agency audit program reflects the learning from these reviews, and the Named and Lead Nurses actively participate in the Safeguarding Partnerships Learning and Development sub-groups.

There have been several requests for rapid reviews, with only a few proceeded to case review. The LCSPR Serin and LSCPR Zeta continue, and due process is being undertaken.

The tables below outline UHSussex participation during 2024/25

20.1 Safeguarding Children and Young People

Local Authority	Child Initials	Date of Review	UHSx Actions	Status
West Sussex				
Rapid Review	JS	May 2024	Strengthen Safeguarding arrangements in ED with Champion role and regular supervision	In Progress
Rapid Review	HS	July 2024	Responded to rapid review request	Complete
Rapid Review	CF	Oct 2024	Limited involvement following ED attendances at RACH. Will share wider learning from review when made available	Complete
Rapid Review	HW	November 2024	Maternity responded to rapid review request	In Progress
Rapid Review	SC	November 2024	Perplexing case and actions to be considered including supervision arrangements for AHP's (dieticians) as a group	In Progress
Rapid Review	AA	January 2025	Return submitted - Limited involvement UHSussex. Will share wider learning from review when	Complete

			made available by WSSCP	
Rapid Review	JC	February 2025	CP MEDICAL & ED attendances. Return submitted - Will share wider learning from review when made available by WSSCP	Complete
Brighton & Hove				
Rapid Review	L-JC	February 2025	Return submitted - Will share wider learning from review when made available by BHSCP	Complete
East Sussex				
Rapid Review	JM	July 2024	Some involvement of RACH CED- to provide update	In Progress

20.2 Themes from Rapid Reviews (2024/25)

Themes emerging from Rapid Reviews this year have included:

- County Lines exploitation and knife crime involving minors
- Unexplained and unexpected child deaths in the community, including one involving an infant
- Parental refusal of early help and support services
- Concerns around radicalisation and harmful behaviours in a young adult
- Death of a child with disabilities open to Children in Need (CIN)
- Neglect and suspected child sexual abuse (CSA) of a young person
- Chronic neglect of two young people

These cases have informed local learning and are being used to strengthen safeguarding responses across the Trust and with multi-agency partners. Oversight is provided at safeguarding committee.

20.3 Participation in Safeguarding Adult Reviews (SARS)

The Care Act 2014 places a statutory duty for Safeguarding Adult Boards to arrange a SAR when an adult dies because of abuse or neglect (whether known or suspected), where there is concern that partner agencies could have worked more effectively together to protect the adult. The overall purpose of a SAR is to promote learning and improve practice; it is not to re-investigate or to apportion blame.

A SAR is considered if:

- an adult has died, and the SAB (Safeguarding Adults Board) knows or suspects that the death resulted from abuse or neglect (whether it knew about or suspected the abuse or neglect before the adult died); or
- an adult has experienced serious abuse or neglect which has resulted in permanent harm, reduced capacity, or quality of life (whether it knew because of physical or psychological effects), or the individual would have been likely to have died but for an intervention; and,
- there is concern that partner agencies could have worked more effectively to protect the adult.

The below tables outline the SARS in which UHSussex was involved or where learning from the review is applicable across health organisations.

Safeguarding Adults Board	Request Received	Status
Brighton and Hove	Sept 23	Delayed report due to capacity of author. New report author commissioned.
Brighton and Hove	Jan 2024	Review Ongoing
Brighton and Hove	July 2024	Draft review circulated Feb 25. Awaiting Final report from Partnership Board.
Brighton and Hove	Jan 2025	Review ongoing

Brighton and Hove	Jan 2025	Review ongoing

UHSussex did not participate in any new West Sussex SARs in 2024/25 compared to 1 in 2023/24.

UHSussex participated in 4 new Brighton and Hove SARS including 1 carried through from 2023/24. This is comparative to last years figure (5).

20.4 UHSussex participation in Domestic Homicide Reviews (DHRs) and Domestic Abuse Related Death Reviews (DARDRs)

A Domestic Abuse Related Death Review (DARDR), formerly known as Domestic Homicide Reviews (DHR), is carried out where a person has died because of abuse, violence or neglect by a relative, intimate partner or member of the same household. DARDRs were established on a statutory basis under Section 9 of the [Domestic Violence, Crime and Victims Act \(2004\)](#).

The purpose of a DARDR is to:

- Establish what lessons can be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply those lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic abuse and domestic homicides and suicides and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

The below table outlines the DHRs and DARDRs in which UHSussex was involved or where learning from the review is applicable across health organisations.

Safeguarding Adults Board	Request Received	Status
West Sussex	Dec 2022	Panel meetings and review ongoing
West Sussex	May 2023	Awaiting final draft of report
West Sussex	July 2023	Awaiting final draft of report – action planning to follow

West Sussex	Aug 2023	Panel meetings and review ongoing
West Sussex	Sept 2023	Draft report V2 under review
West Sussex	Oct 2023	Final draft of report and action planning in progress
Brighton and Hove	Mar 2024	Review ongoing – additional agency IMR's to be requested
West Sussex	Apr 2024	Review ongoing
West Sussex	June 2024	Review ongoing
Brighton and Hove	Jan 25	Review ongoing
West Sussex	Mar 2025	Review ongoing
Brighton and Hove	Mar 25	Review ongoing

Overall, UHSussex participated in 12 DARDRs, 6 were new in the year and 9 ongoing from previous years. 3 new West Sussex DARDHRs in 2024/25. 6 were ongoing from previous years. 3 new Brighton and Hove DARDRs in 2024/25. None carried over from previous year.

20.5 Themes identified from SARs / DHR / DARDRs

- Understanding coercion and control in context of domestic abuse leading to suicidal ideation.
- Recognising and responding to substance use / self-neglect in the context of domestic abuse.
- Ensuring staff have appropriate knowledge and skills to recognise and respond to disclosures of domestic abuse.
- The importance of routine enquiry and professional curiosity
- Interface between Mental Capacity and Mental Health and the multi-agency application to practice.
- Understanding trauma and the impact on accessing healthcare / engagement with services.

- Recognising and responding to hate crime and multiagency working to safeguard adult at risk.
- Multi-agency working to safeguard people with multiple and compound needs.

21. Quality Assurance and Improvement

The safeguarding children team has contributed to 2 multi-agency audits which focused on:

- Non-accidental injury (NAI) in Pre-School age children (2-5 yrs)
- Cultural competency
- Neglect
- Harmful Practices including Honour based Abuse (HBA), Forced Marriage, Breast Ironing, Spirit Possession and Female Genital Mutilation (FGM).
- The Impact of Parental Substance Misuse
- Voice of the child
- Hidden fathers

The insights gained from each of these audits are informing the learning and supervision programs in 2025/26.

The Section 11 Audit was completed in July 2024 and is linked to the UHSussex audit plan.

There has been limited capacity within the safeguarding children's team to conduct single agency safeguarding audits and the focus has been on learning from safeguarding reviews.

The Safeguarding Adult team conducted an audit of MCA/DoLS processes in 2024-25. The planned audit took place from April- June 2024 across all four sites in UHSx by internal and external auditors (ICB and the MCA Lead, Head of Nursing for Adult Safeguarding). The purpose of the audit was to review and determine the appropriate and accurate application of the Mental Capacity Act (2005) and Mental Capacity Amendment Act (2009) legal requirements and application of Deprivation of Liberty Safeguards.

The summary of finding was presented in areas of high compliance (90-100%), acceptable compliance (70-89%) and low compliance (below 70%) as follows:

- **High Compliance:** 95% of staff identified the impairment of mind and brain and 93% accurately signed all required fields.
- **Acceptable Compliance:** 78% of patient records reviewed demonstrated deprivation of liberty was appropriate to the risks of the patient if not applied with 88% outlining care and treatment needs appropriately. 81% of staff considered advocacy appropriately and in 88% of records reviewed Advanced

decisions were considered. 81% of patient records reviewed demonstrated the rationale for use of restrictive interventions and 88% outlined care and treatment needs appropriately.

- **Low Compliance:** The uptake of capacity assessments was low with only 26% of Capacity Assessment for admission and remaining in hospital to receive care &/or treatment. 42% of DoLS applications demonstrated accurate dates of expiring legal authorisation and 58% of appropriate persons were informed of DoLS application.

Areas of Strength: The audit demonstrated that where it was appropriate to apply a deprivation to a patient to prevent serious deterioration in the patient's wellbeing most applications met this.

Most applications accurately recorded the necessary care needs, risks and restrictions.

The following high-risk areas for targeted improvement were identified and an action plan put in place for targeted improvement:

PRIORITY	
PRIORITY 1:	Appropriately documented assessments of capacity for all DoLS applications Risk: Any deprivation of liberty without evidence of a lack of capacity does not comply with the law and therefore could lead to litigation from patients on families for false imprisonment.
PRIORITY 2:	Documented evidence of informing others of DoLS Risk: Any patient deprived of their liberty must have access to an appropriate person to advocate on their behalf if they (the patient) wish to challenge the authorisation. This forms part of the legal procedure and could risk litigation against the trust and/or professional reputation.
PRIORITY 3:	Accurate recording of when the DoLS authorisation ends Risk: Trust authorisation ceased requiring alternative review to ensure DoLS remains appropriate.

ACTIONS

- Mandate assessment of capacity form across trust
- Assessment of capacity form with DoLS application on StaffNet and InfoNet
- documented consent discussion on admission to hospital (Grey Book)
- Mirroring of resources across all UHSx intranet sites
- Further inquiry with front line staff around barriers and challenges with assessments and areas of low compliance found (live questionnaire following application with follow up review)
- Liaison with Local Authority DoLS Team re: amendments to form with audit findings (previously unsuccessful request)
- Development of audit tool for quality review of capacity assessments undertaken (Divisional Review following patient from admission to discharge)
- Repeat audit within agreed timescale
- On-going monitoring via MCA Working Group

The Safeguarding Adults Boards Self-Assessment was completed in July 2024 and is linked to the UHSussex audit plan.

21.1 Audit Plan for 2025/26

There has been reduced capacity within the safeguarding team to undertake single agency safeguarding audits within UHSussex during 2024-25. The following audits have been included for 2025-26 UHSussex audit plan for all hospital sites providing services for children and young people. Some of these audits will be in partnership with local services.

The safeguarding audit plan below is designed to ensure continuous improvement in safeguarding practices across UHSussex. Each of these audits aims to identify areas for enhancement, promote best practices, and ultimately safeguard the health and well-being of children and adults at risk within the Trust. Regular reviews and updates will be conducted to monitor progress and implement necessary changes based on audit findings. The audit programme will go to the Safeguarding Committee for oversight.

Audit Focus	Description
Quality of SGC Training Delivery - Level 3	Evaluation of the quality and effectiveness of Level 3 safeguarding training delivery based on feedback from the IRIS platform.
Review of specific quality improvement projects related to	Injuries in Non-Mobile Infants Aged 12 Months and Under Assessment of reporting and responses to injuries in non-mobile infants.
	Patients Under 18 Who Abscond or Leave the ED Without Being Seen Analysis of incidents involving young patients leaving the Emergency Department before being seen.
	Appropriate Assessment of Psychosocial Risk in 12-17 Year Olds evaluation of how psychosocial risks are assessed for adolescents.
Quality of Referrals to Social Care	Examination of the quality and effectiveness of referrals made to Children and Adult Social Care services.
Was Not Brought/DNA	Analysis of missed appointments (Did Not Attend - DNA) for children and young people, including implications for safeguarding.
Child Protection Medical Standards	Audit of adherence to established medical standards for child protection assessments.
Safer Sleeping (Maternity & Neonates)	Review of the implementation of safer sleeping practices in maternity and neonatal services.
S11 Audit	Annual update and bi-annual report on compliance with Section 11 responsibilities regarding safeguarding children.
Children in Care	Assessment of services and support provided to children in care, ensuring safeguarding practices are effectively implemented.
Exploitation	Evaluation of strategies and responses to child exploitation, including contextual safeguarding considerations.
Supervision	Review of supervision practices within safeguarding teams and their effectiveness in supporting staff.

22. Risk Management

Most safeguarding risks are held and managed within the clinical divisions and the safeguarding team work with the Risk Management team to develop a risk tracker. The aim is to provide oversight of the divisional risks related to safeguarding across the Trust.

Divisional safeguarding risks for both adults and children primarily pertain to our capacity to support and maintain the safety of patients experiencing mental health crisis.

The information below details risks which are the responsibility of the safeguarding team.

22.1 Safeguarding Children and Adults Risks

Most safeguarding risks are held and managed within the clinical divisions and the safeguarding team and there is further work to do with the Risk Management team to develop a risk tracker for divisional risks pertaining to issues in divisions that may pose a safeguarding risk such as lack of equipment for medical procedures that may be required for child protection medicals including workforce capacity to support and maintain the safety of patients experiencing mental health crises.

The information in the table below details risks for children and adults which are the responsibility of the safeguarding team only and not the divisions for the purposes of this reporting period.

Datix risk record No	Date Opened	Risk	Current Grading	Target Grading
1940	04/07/2024	There is currently no specialist provision within UHSussex to support Autistic or Neuro diverse , children, young people or adults within UHSussex leading to harm	16	6
1369	20/04/2024	There is a risk of patients coming to harm, due to staff lack of knowledge to recognise and respond to signs of abuse and neglect. This is due to lack of training in relation to Safeguarding Adults at the appropriate level for their roles and responsibilities.	12	6

1436	29/03/2023	Patients in inappropriate care environment in the acute Emergency Dept when require Mental Health Bed. DOLS (Deprivation of Liberty Safeguards) and Mental Health Act does not apply in ED (Emergency Departments)	12	6
1575	12.10.2023	Insufficient Clinical Nurse Specialists in Safeguarding Adult service risks	9	6
1698	12.12.2023	Inaccurate Safeguarding Adults Level 3 training reporting leading to Risk that patients may come to harm as staff unable to recognise and respond to safeguarding concerns and develop appropriate safety plans (Linked to Risk 1369)	8	4
1909	12.06.2024	Domestic abuse victims who are at risk of abuse will not be protected through Multi agency Risk assessment conference (MARAC) because safeguarding team have limited capacity to meet the demands from increasing cases	12	4
1896	30/05/2024	There is a risk of - not having access to all relevant information because health records including relevant safeguarding information are stored in various silo systems and not one central place. Relevant Information is currently stored in eg paper health records, Symphony - notes scanned into MIDAS, PANDA, Careflow, IT teams folders - as a practitioner unable to have that holistic overview to relevant information to inform decision making - delay in accessing relevant information in a timely manner when needed - as a practitioner not knowing if you have full view of health records or not - as 'you don't know what you don't know' - various levels of permissions on systems acting as a barrier to accessing relevant information for practitioners eg different versions and level permissions	12	4

		and not aware if don't have full access to relevant information or not eg Midas on symphony - Systems are not joined up which creates silo information storage and is a risk to safeguarding children		
1902	03/06/2024	The loss of the CAIT trainers will mean that there is a reduction in the number of clinical staff able to receive CAIT training. This will increase the risk of an escalation in behaviours that challenge in people living with dementia not being appropriately managed with a likely increase in the use of security and registered mental health nurses. There is also an increased risk to staff through assaults and a rise in violence and aggression reports. Increase in staff sickness, patient length of stay, poor patient experience and distress is a risk likely with a reduction in training available.	12	6
2220	06/11/2024	Vulnerable patients for example those experiencing domestic abuse, exploitation, patients with learning disability, dementia, autism are not being appropriately supported due to lack of identification on admission. Up-to-date risk management plans are not always in place. There is a risk of missed opportunities to safeguard and make every contact count.	12	4
1557	03/10/2023	Risk that patient may come to harm is information is not shared in a timely manner. The safeguarding team and referrer will no longer automatically receive a copy of a referral or know about the referrals made. Staff will need to take multiple steps to mitigate against the risks leading to a high risk or error.	9	6

		This has the potential to delay information sharing with the wider health network for the child. This risk links to safeguarding adults risk number 2064.		
2064	30/08/2024	There is risk of missing safeguarding adults referrals which could result in harm to vulnerable patients due to lack of safeguarding plans. This is due to changes to referral process to West Sussex and Brighton and Hove Adults social care safeguarding hub. West Sussex and Brighton and Hove Adults social care safeguarding hub have moved to an online referral system which doesn't alert UHsussex safeguarding team that a referral has been made. This means the team do not always have oversight of the concerns and risk to patients and not always able to ensure appropriate safeguarding plans are in place. This risk links to safeguarding children's risk no 1557	9	2
2129	01/10/2024	Sussex Partnership have announced the closure of a 15 bedded older peoples mental health unit based within Mill view hospital in Brighton from the middle of November. The risk from this is an increase in length of stay for patients under a section awaiting an older peoples mental health bed resulting in them not receiving the correct treatment or care that they require. Being sent out of area to an older peoples mental health hospital resulting in poor patient experience and a lack of support from relatives or carers that may not be able to travel to the alternative hospital. The potential for greater admissions within the acute hospital with people with	9	6

		a dementia or older peoples mental health issue due to the lack of available beds in the immediate area and crisis point for the patient being reached.		
2484	20/03/2025	Safeguarding is a concept that aims to create a more fluid and effective response for young people, by proactively responding to their needs so they do not face a 'cliff-edge' in support. UHSussex requires a safeguarding strategy including leadership and resourcing support to safeguard the needs of young people moving between children's and adult services. Arrangements need to be in place to support and consider holistic circumstances of young people and, the vulnerabilities and risks they have given the types of abuse they may experience and includes the impact of previous abuse. Safeguarding teams, clinical services including sexual health and Youth workers need to have the capacity to support the safeguarding of young people aged 11-25 within UHSussex through engagement of services, partnership working ensuring safeguarding requirements are met to ensure their specific needs are met.	9	3
991	02/08/2022	The Mental Capacity Act 2005 provides a statutory framework for acting and making decisions on behalf of people who lack the mental capacity to do so for themselves. The Deprivation of Liberty Safeguards were added to the Act; these enable people, for their own safety and in their best interests, to be accommodated under care and treatment regimes which may have the effect of depriving them of their liberty. Following the Supreme Court judgement in March 2014, DoLS apply to	8	4

		an increasing number of patients. The impact of this judgement is that the DoLS team in the local authority are unable to assess all the DoLS authorisation requests. This means that we may refer a person and place them under an urgent DoLS for 7 days, but the local authority rarely come and assess these patients to grant a standard authorisation. The consequence is that as the person has not been formally assessed, they do not have a right of appeal against being unlawfully detained. It is possible that a patient or their family could complain against a possible unlawful detention, despite the fact that by applying for a DoLS we are adhering to the requirements of the law. The Trust can request an urgent assessment if the patient is very agitated and the DoLS team will aim to assess the patient. In addition, the DoLS team also telephone the ward soon after receiving the application to undertake a "telephone triage" of the cases, but the focus of the DoLS teamwork tends to be concentrated in Nursing and Care Homes. The current process is that an organisation does not assess patients in their own care.		
1368	20/04/23	Damage to Trust and Reputation: Failure to safeguard patients can damage trust in the healthcare system and the reputation of the Trust. Patients and their families need to feel confident that healthcare professionals are equipped to protect their well-being. Regulatory Compliance: Healthcare organisations are required to have safeguarding policies and procedures in place and to ensure that staff are trained in these protocols. Failure to comply with	8	4

		regulatory requirements can result in penalties and sanctions.		
1889	24/05/2024	Changes in the service provision with in the mental health team has led to a merged mental health team in part due to staff resignations and a reduction in the number of specialist mental health nurses now available at Worthing hospital The risk will lead to a delay in assessments, care and treatment planning.	6	4

23. Safeguarding Children Activity across UHSussex Hospitals.

The Trust's safeguarding duties include all children seen by any UHSussex service and extend to children and young people who are not patients at the Trust and may not be physically seen by the staff member or clinical team. This commonly occurs when an adult patient is receiving treatment and potential risks to children or young people are identified. For instance, if an adult presents with issues related to domestic abuse, substance misuse, or poor mental health, it triggers a consideration of the impact on their children. This is referred to as a 'Think Family' approach, and this duty applies to all Trust staff, including those who seldom or never work with children as part of their day-to-day responsibilities.

23.1 Emergency and Urgent Care Attendances

The below tables show the attendance data for 2023/24 and 2024/25. The numbers of attendance have increased by 3379 in year.

ED and Urgent Care attendances 2023/24					
	Q1	Q2	Q3	Q4	Total
WH ED/UTC	4850	4678/0	3889/1661	3990/ 1780	20,848
SRH ED/UTC	3458	3287/186	3503/ 261	3784/ 110	14,589
RACH	7010	6407	8255	8346	30,018
RSCH	282	325	272	226	1,105
SEH	428	367	315	422	1,532
PRH	1459	1335	1418	1480	5,692

Total	17,487	16,585	19,574	20,138	73,784

ED and Urgent Care attendances 2024/25					
	Q1	Q2	Q3	Q4	Total
WH ED + UTC	5596	5109	5579	5501	21785
SRH ED + UTC	3958	3733	4325	3887	15,903
RACH	7634	6774	8500	8048	30,956
RSCH	293	290	301	291	1175
SEH	419	366	376	393	1554
PRH	1549	1402	1458	1381	5790
Total	19,449	17,674	20,539	19,501	77,163

23.2 Safeguarding Children Referrals to local authority Integrated front doors (social care/early help)

UHSussex staff make a referral to children's social care, via local authority external portal systems and do not always keep a record/ copy of the referral for UHSussex health records. This remains an ongoing issue to ensure complete integrity in the data reported for these referrals.

Improvements have been noted through ongoing communication campaigns reminding staff to document and share referrals with the safeguarding team via existing systems. These systems are currently under review as part of the Trust's digital transformation programme. Despite progress, the risk remains on the UHSussex Risk Register, and further mitigation measures are in development to strengthen data accuracy and assurance.

	Total 2023/24	Q1	Q2	Q3	Q4	Total 2024/25
WH (includes CDC)	1,190	221	258	269	204	959
SRH	732	148	175	192	176	692

Crawley	29	0	2	17	0	16
Brighton	437	110	319	249	235	913
PRH	67	9	17	37	24	87
Total	2,455	488	771	769	639	2667

The number of referrals has increased. Brighton saw the most significant increase, rising from 437 to 913 referrals - more than doubling at year end. This may indicate improved recording and possibly increased safeguarding activity or visibility. Crawley referral numbers are expected as residents will naturally attend ESHT meaning referrals will be captured by ESHT. There is a plan to improve PRH referral rates and are exploring offering supervision on address safeguarding issues in areas deemed to have different demographics.

23.3 Principal Presenting Concern for Safeguarding Concerns/ Referrals

The following tables and charts provide a summary of the data which the safeguarding team were able to capture during 2024-25.

Child Mental & Emotional Health- (concerns relating to one or more of the following: mental health issues, eating disorders, self-harm, anxiety, challenging behaviour)						
	2023/24	Q1	Q2	Q3	Q4	Total
WH/Crawley	568	107	126	128	108	469
SRH	362	70	75	84	79	308
Brighton	550	28	196	119	100	443
PRH	33	0	7	7	9	23
Total	1513	205	404	338	296	1243

Physical abuse (concerns relating to one or more of the following: bruises, burns, fractures, cuts, poisoning, drowning, shaking, assault, kicking, hitting and any other method of causing non-accidental harm to a child, dog bite)						
	2023/24	Q1	Q2	Q3	Q4	Total
WH/Crawley	131	15	9	15	15	54
SRH	112	6	11	11	9	37
Brighton	16	7	11	10	9	37
PRH	1	1	3	2	2	8
Total	260	29	34	38	35	136
Neglect -concerns relating to one or more of the following; preventable injuries, lack of supervision, parenting, 'was not brought' to appointments and neglect due to persistent failure to meet a child's basic physical and/or psychological needs including emotional, depressed/passive, disorganised and severe deprivation neglect (Howe 2007).						
	2023/24	Q1	Q2	Q3	Q4	Total
WH/Crawley	134	34	46	69	26	175
SRH	253	43	40	40	22	145
Brighton	81	7	65	60	60	192
PRH	8	4	3	0	7	14
Total	476	88	154	169	115	526
Child Sexual Abuse – CSA, FGM, CSE						
	2023/24	Q1	Q2	Q3	Q4	Total
WH/Crawley	0	0	1	5	1	7
SRH	0	2	0	0	0	2
Brighton	0	2	0	0	0	2
PRH	0	0	0	0	0	0
Total	0	4	1	5	1	11

Think Family- whole family approach concerns relating to parenting capacity and/or family/environmental factors which negatively impact on the child due to one or more of the following: domestic abuse, adult mental health, adult drug and alcohol issues, dysfunctional household, care needs, housing and wider family functioning issues)						
	2023/24	Q1	Q2	Q3	Q4	Total
WH/Crawley	312	30	49	37	32	148
SRH	204	6	27	32	41	106
Brighton	90	9	12	12	16	49
PRH	12	0	0	3	3	6
Total	618	45	88	84	92	309
Contextual Safeguarding/Extra familial Harm (concerns relating to one or more of the following: contextual safeguarding, exploitation, drug and alcohol misuse, vulnerable young person and teenage pregnancy)						
	2023/24	Q1	Q2	Q3	Q4	Total
WH/Crawley	171	32	29	36	22	119
SRH	130	19	22	26	25	92
Brighton	189	15	72	45	47	179
PRH	25	0	4	3	3	10
Total	515	66	127	110	97	400

UHSussex Total	2023/24		2024/25	
Principal Concern	n	%	n	%
Child Emotional & Mental Health	1513	45%	1243	47%

Think Family	618	18%	309	12%
Risky Behaviour	515	15%	400	15%
Neglect	476	14%	526	20%
Physical abuse	260	8%	136	5%
Child Sexual Abuse	0	0%	11	0.4%

In both 2023/24 and 2024/25, the predominant safeguarding concern across UHSussex remained **child emotional and mental health**, accounting for **47%** of all referrals this year, up from **45%**. This highlights the continued high demand for safeguarding support linked to emotional distress, self-harm, and mental health presentations in children and young people.

Other notable changes include an **increase in neglect cases**, rising from 14% to 20%, which may indicate heightened practitioner awareness or increased safeguarding need in this area. A **small number of child sexual abuse concerns were** recorded (0.4%), which were not captured at all in the previous year. These changes may reflect changes in need and improved recognition and recording by staff. Continued monitoring will inform service planning and targeted training priorities.

23.4 Detentions of young people to UHSussex - 2024-25

The following table outlines the detentions for Children & Young people to UHSussex during 2024-25

	2023/24	Section 5(2)	Section 2	Section 3	Section 136	Total
Brighton Hospitals (RSCH and RACH)	35	8	16	6	11	41
St Richard's Hospital	27	1	4	2	4	11
Worthing Hospital	5	3	6	2	7	18
Total detentions	67	12	26	10	22	70

In 2024-2025 a total of 70 children and young people (<18 years old) were detained.

The work of the Safeguarding team continues to be significantly centred around children and young people presenting to hospital with poor mental health, emotional distress, or high-risk behaviours. The hospital safeguarding team provides ongoing

support to clinical areas in managing these complex cases and works closely with CAMHS liaison services and multi-agency partners to ensure coordinated care.

UHSussex is actively engaged in system-wide work to strengthen support for this vulnerable group, with strategic oversight provided by the multi-agency Children and Young People's Mental Health (CYPMH) Project Group. This group is leading service development and improvement across pathways including escalation.

23.5 Safeguarding CYP who have a delayed discharge

It is recognised that delayed discharge can have an adverse impact on the lives of children, young people, and their families, as well as on services. The reasons for delays in discharging to a safe and suitable facility for therapeutic or ongoing care can be complex and multifactorial, often resulting from system-wide challenges.

The following table details the number of days that children and young people have remained in UHSussex hospitals when they were physically medically fit, specifically those who experienced delays of 5 days or more. It also provides a summary of the discharge setting outcomes.

Delayed Discharges for Children & Young people <18 years from when medically fit						
Excess bed days Site/Qu	Total 2023/24	Q1 ≥ from Day 5	Q2 ≥ from day 0	Q3 ≥ from day 0	Q4 ≥ from day 0	Total 2024/25
WH	567	142	15	67	83	307
SRH	504	110	44	43	80	277
RACH	308	114	261	289	323	987
RSCH	40	0	0	31	71	102
Total	1,419	366	320	430	557	1673

We have seen a double increase in numbers on the RACH & RSCH site, of children and young people presenting with poor emotional and mental health and remaining for long periods in hospital waiting for either, a local authority residential placement, community package or Tier 4 mental health bed. These delays are detrimental to their health & wellbeing and a safeguarding risk.

The safeguarding risks and possible breach of deprivation of liberty (DOL) associated with delayed discharge for children & young people awaiting a suitable placement for discharge from the acute hospital remains a significant ongoing concern.

We have seen a reduction in delayed discharges on the Worthing and SRH sites where we have a paediatric lead for mental health

The Safeguarding team continue to work collaboratively with partner agencies and in supporting the wards.

23.6 Mental Capacity Act (MCA) and Court Authorised Deprivation of Liberty (DOL)

The MCA provides a framework for making decisions on behalf of individuals who may lack the capacity to make specific decisions themselves. For young people under 18, the MCA allows for the application of Deprivation of Liberty Safeguards in situations where it is necessary to deprive an individual of their liberty in order to provide care or treatment. This requires an application to the Court of Protection in cases involving young people.

During 2024/25, no applications were made to the Court of Protection to request authorisation for the Deprivation of Liberty for a child, compared to 1 application made in 2023/24.

23.7 Children in Care and Adoption

The Worthing Child Development Centre continues to provide Initial Health Assessments as part of the Sussex Community Foundation Trust (SCFT) Children in Care hub. This service consists of two appointments per week for health assessments, which are managed and monitored in collaboration with SCFT to ensure that statutory time frames are met.

Children in Care training is integrated with children's safeguarding training, emphasising an introduction to trauma-informed care. Additionally, children in care were highlighted as part of the Trust's theme of the week in quarter two.

24. Maternity Safeguarding

Safeguarding in Maternity Services is a critical aspect of healthcare that focuses on the well-being and safety of expectant mothers, newborns, and families. It involves identifying and addressing risks of abuse, neglect, and exploitation while ensuring the health and safety of both mothers and their infants.

Maternity services need to recognise and prioritise vulnerable populations, including those experiencing domestic violence, mental health issues, substance misuse, and young or unsupported parents.

The below table for maternity provides comparison of the referral rate to children's social care compared to delivery rate for Quarter 1-4 during 2024/25.

2023-2024 Q2-4 only	RSCH	PRH	WH	SRH	Total
Referrals to children social care	179	108	225	197	709
Delivery Rate	1761	1665	1480	1648	6554

2024-2025 Q1-4	RSCH	PRH	WH	SRH	Total
Referrals to children social care between	230	141	257	199	827
Delivery Rate	2255	2203	1904	2140	8502

The maternity safeguarding team have been developing as a team across site and successfully appointed an experienced safeguarding midwife to the substantive named midwife for safeguarding children cross site post..

Processes have been developed and arrangements are now in place for safeguarding case discussion meetings to support vulnerable families booked to give birth at each of the sites across the Trust. These meetings promote collaborative working and help to achieve robust plans of care and support.

Regular safeguarding supervision sessions have also been implemented across all four sites initially focusing on community staff who provide most of the antenatal and postnatal care therefore more involvement with vulnerable and complex families. Supervision sessions are led by a safeguarding midwife both in one to one and group settings with teams on a quarterly basis, staff are given protected time to attend.

Collaborative work continues between the maternity safeguarding team and the Local Authorities surrounding improving care of mother and baby within care proceedings and separation at birth based on principles from the Born into care Guidance. The Trust now provide HOPE boxes (Hold on Pain Eases) for all mothers who are within legal proceedings with a plan for separation at birth.

25. Priorities for 2025/2026

25.1 Progress on priorities for 2024/25

No	Action	Outcome
1	Welcome new leadership into the team and fully embed the new governance processes established.	New Associate Director of Safeguarding appointed April 2025. Governance processes are embedded with quarterly strategy committee oversight and ICB attendance.
2	Further improve the timeliness and quality of reporting to ensure effective oversight.	Quarterly reports are being delivered consistently; narrative quality and data integration is improving. Site-level breakdowns and trends are now regularly included.
3	Implement an annual audit plan to monitor and assess safeguarding practices and outcomes.	MCA/DoLS audits conducted across four sites; audit programme for safeguarding now in place and overseen by working groups.
4	Understand the challenges regarding the referral pathways to Children's Social Care and work collaboratively to resolve them.	Ongoing issues with external portal referrals recorded. Communications strengthened, system redesign in progress via digital transformation.
5	Work with clinical teams to improve issues raised with regards to UHSussex care.	Divisional action plans developed through Harm Free Care panels. Safeguarding involved in PSIRG for triangulation and learning.
6	Understand and address issues related to safe hospital discharge.	Safeguarding concerns related to discharge reduced (from 23 to 13). Collaborative discharge checklist review underway Trust-wide.

7	Collaborate with multi-agency and multi-disciplinary colleagues to better understand the needs of patients facing complex mental capacity issues.	Multi-agency work via MCA/DoLS working group established. Variation in DoLS application identified and targeted with training.
8	Improve child safeguarding supervision by developing creative and flexible models for delivery.	Embedding Supervision remains a priority as it is still not embedded across adults. Named professionals receive ICB-led supervision; flexibility models under review for improvement.
9	Develop and deliver a comprehensive communication plan to enhance awareness of safeguarding practices.	Improved visibility through divisional briefings, training messaging and supervision prompts. Formal communication strategy still in development.
10	Develop and implement all-age Level 3 safeguarding training for staff, ensuring inclusion of key topics.	All-age 'Think Family' training model being developed. Pilot delivery commenced late Q4 with integration of MCA and Prevent topics.
11	Ensure the voice and views of individuals at risk of abuse or neglect, as well as those who support them, are heard and considered.	Voice of the individual considered through advocacy, DoLS processes, and complaint reviews. Structured feedback mechanisms still in development.

25.2 Priorities for Safeguarding Children and Adults 2025/26

The following areas are set as priorities for 2025/26 and will form the basis of the safeguarding workplan:

- Standardise processes and data collection across UHSussex safeguarding teams.
- Agree an annual audit and quality improvement plan.
- Data collection to capture further information related to children in care.
- Focus for 2025/26 needs to be on the internal facing intranet page to improve communication.
- Work together with safeguarding adults, maternity teams and stakeholders.
- Develop an 'all age' Level 3 safeguarding children training programme which strengthens transitional safeguarding for 16- 25 years old young people.
- Work with directorates and divisions to improve safeguarding training compliance to above 85% for all levels
- Work with partner agencies to develop an exploitation and violence reduction strategy.
- Work alongside key stakeholders to strengthen provision of youth work support across UHSussex.
- Share key learning from case reviews at committee and embed into practice.
- Strengthen the voice of the child and individual including user engagement for Safeguarding.
- Implement Audit plan for 2024-26 and link to actions from S11 audit and evidence improvement.
- Develop a standard safeguarding page for communications on UHSussex intranet for cross site use.
- Standardise referral process across the trust.
- Strengthen DOLs across sites.
- Strengthen the process for monitoring and review of risks.

26. Conclusion

The Safeguarding Service is expanding across UHSussex and partner organisations to meet the statutory requirements outlined in legislation, including Section 11 of The Children's Act (2004), Working Together to Safeguard Children (2018), The Care Act (2014), Mental Capacity Act (2005), Domestic Abuse Bill (2021) and the Care Quality Commission Regulation 13.

Significant multiagency collaboration has proved the trust's commitment to working together to improve concern identification and protect children and vulnerable individuals within the trust. All the work throughout the trust and partnerships would not be possible without the dedication of our front-line staff and safeguarding team, who are professionally curious and committed to protecting our patients.

27. Supporting Documents

Working together to Safeguard Children (DfE 2023) [Working together to safeguard children 2023: statutory guidance \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/115442/Working-together-to-safeguard-children-2023-statutory-guidance.pdf)

Safeguarding Children and Young People – Intercollegiate Document (2019) [Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing \(rcn.org.uk\)](https://www.rcn.org/uk/standards/intercollegiate-document)

Section 11, Children's Act (2004)
<http://www.legislation.gov.uk/ukpga/2004/31/section/11>

Learning Together <https://www.scie.org.uk/children/learningtogether/>

Children in Care [Promoting the health and well-being of looked-after children - update note added to start in August 2022 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/115442/Promoting-the-health-and-well-being-of-looked-after-children-update-note-added-to-start-in-August-2022.pdf)

Information Sharing (DfE 2024) [DfE non statutory information sharing advice for practitioners providing safeguarding services for children, young people, parents and carers \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/115442/DfE-non-statutory-information-sharing-advice-for-practitioners-providing-safeguarding-services-for-children-young-people-parents-and-carers.pdf)

Safeguarding accountability and assurance framework 4th ed (June 2024)
[NHS England » Safeguarding children, young people and adults at risk in the NHS](https://www.nhs.uk/england/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs/)

The Care Act (2014) [Care Act 2014 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2014/18/section/1)

Mental Capacity Act (2005) [Mental Capacity Act 2005 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2005/9/section/1)

Intercollegiate Documents

[Adult Safeguarding: Roles and Competencies for Health Care Staff | Publications | Royal College of Nursing \(rcn.org.uk\)](#)

[Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing \(rcn.org.uk\)](#)



University Hospitals Sussex NHS
Foundation Trust (UHSx)

Annual Report
1 April 2024 to 31 March 2025



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Prepared by:
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Guardians
The Guardian Service Ltd.

Date: 4.6.2025



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1. Executive summary

The Guardian Service Ltd (GSL) was implemented in UHSx on 7th August 2023. This report presents the Freedom to Speak Up (FTSU) Guardians' (the Guardians) report for the year from 1st April 2024 – 31st March 2025. It provides an overview of the activity and themes in this period.

Staff raised 248 concerns to the Guardians in the period. 209 of these were closed. The average number of concerns remain consistent with the period ended March 2024.

Comparison with national data sets indicate UHSx quarterly case averages are high against the comparator sector and CQC rated peer group. However, it is also shown that there is wider variation in case numbers for larger organisations.

Other aspects of case data provide more context. 73% of cases remained confidential between staff and the Guardians, and also 73% were rated green. 57% of staff said they were seeking impartial support. Escalation rates stood at 27% of cases. Further analysis suggested that the Trust was eventually aware of 52% of cases initially raised to the Guardians.

Thematic analysis indicates the top three primary themes were Management Issues (80 concerns), System & Process (62 concerns) and Bullying or Harassment (35 concerns). Only 13 Patient Safety/ Quality concerns were reported to the Guardians, all were escalated and were/are being responded to by managers.

By Job Group, Division and Location

- Admin & Clerical and Nursing & Midwifery groups accounted for just over half of all concerns raised. The former showed a significant increase over the previous period and over representation for its share of the substantive workforce. The latter decreased and was slightly under-represented. Other under-represented groups included staff from Medical & Dental (like the national picture) and Facilities & Estates roles.
- Divisions with the largest number of concerns, most significant increases and all slightly above their share of the substantive workforce were: Corporate Services (16% of concerns, +7%); Women & Children's (13%, +3%) and Surgery (WOR SRH) (11%, +5%).
- By location most concerns were from RSCH (and associated sites) but with a reduction from the previous period. Worthing (and associated sites) showed a significant increase period on period. Workforce size may partly qualify the numbers from RSCH while Worthing has a disproportionately high share of cases.

Exploration of other speaking up pathways being used by these Groups; Divisions and Locations would provide a more complete picture. High case numbers and over representation for workforce share should not be viewed negatively. Some job groups, divisions and locations may feel engaged, more comfortable to speak up or simply have better knowledge of, and access to certain speaking up pathways.

While there were no confirmed cases of detriment there were other signifiers that fear and futility exist around speaking up.

Steps continue to be taken that improve the Freedom to Speak up Culture. Some of note include steps taken, through the induction process, to increase medical staff knowledge of speaking up; the additional Guardian capacity formalised in Q3; and managers in the Trust continuing to be receptive to requests for informal meetings with staff to listen to their concerns.

Recommendations from the Guardians previous reports have been encompassed in the Speaking Up Action Plan. This is a work in progress and reviewed and updated at regular intervals.

The Board is asked to consider the new comments and recommendations at Section 16.



2. Purpose of the paper

The purpose of this paper is to provide an activity report with further insight and narrative around the concerns raised throughout this financial year, supplementary to the monthly numerical, cumulative reports already provided.

The report provides an overview for the twelve months 1st April 2024 to 31st March 2025. The report follows the guidance from the National Guardian Office (NGO) on the content Guardians should include when reporting to their Board: Assessment of cases; Potential patient safety or worker experience issues; Action taken to improve FTSU culture and Recommendations.

3. Background to Freedom to Speak Up

Following the Francis Inquiry¹ 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

4. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries, or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the Trust as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in UHSx on 7th August 2023.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, planned and unplanned site visits, the Intranet and the distribution of flyers and posters across the Trust. All new staff will become aware of the Guardian Service when undertaking the Trust's induction programme.

5. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardian is not a UHSx employee and is external to the Trust.

6. Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours

¹ <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry>



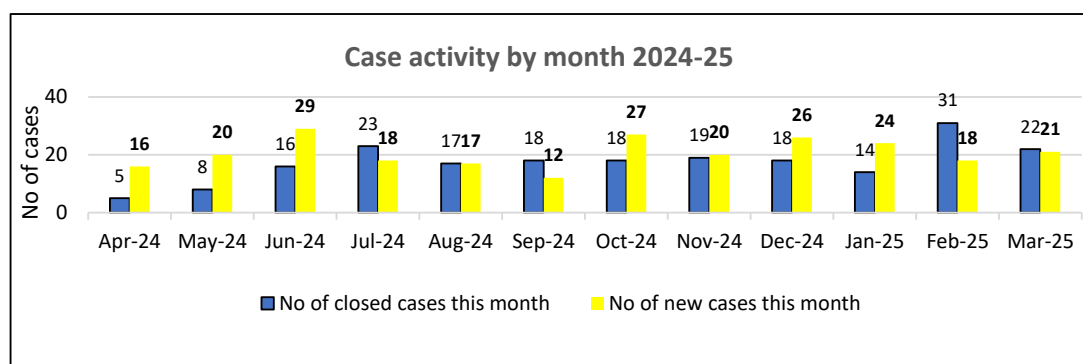
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

Open cases are continually monitored, and the Guardians maintain regular contact with members of staff who have raised a concern to establish where ongoing support is required. This can be via follow up phone calls and/or face to face meetings with staff. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks, or avoidable delays in the progress of cases that have been escalated, these would be raised with David Grantham, Chief People Officer at regular monthly meetings.

Escalated cases are those which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. Some staff choose to progress their issue themselves, and others choose no further action. There are circumstances where cases are escalated later by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. The Guardian will keep a case open and continue to support staff in such cases. In some situations, contact with the Guardian is not maintained by the staff member.

7. Number of concerns raised to Guardians this period.

Staff in the Trust may raise work related issues using a number of pathways. In the period 248 new concerns were raised to the Guardians, and 209 concerns closed.



Monthly concern numbers continued to fluctuate, peaking in June (29) and the lowest number of cases recorded in September (12). The yearly average remains consistent with the first 8 months of the service (period ended March 24).

Most initial contact with the Guardian is by email but a variety of methods are used in on going communication with staff. There are normally multiple contact points for each concern and therefore there is no direct correlation with numbers of concerns raised. Frequency of contact is agreed with the worker.

Initial Contact points with Guardians 24/25		
Emails - 1308	Telephone calls - 377	Face to face - 306

8. Confidentiality and Case Outcomes

The nature of a concern raised by staff may dictate the confidentiality status of an issue. On first speaking with the Guardian, staff are informed that issues of, safeguarding, patient or staff safety will be reported to the Trust by the Guardian. Staff will also be informed that though the issue may not remain confidential it may be possible to attempt to protect the individual's identity. The latter is never guaranteed.



Confidentiality status may change over time depending on the wishes of the person. Sometimes after a period of reflection staff may opt to move from a confidential conversation with the Guardian to looking for escalation with/ without their name.

In all cases requiring or requesting escalation it is also explained that the nature of a concern may identify an individual and, that withholding identity may be a limiting factor for resolution.

Case management by the Guardian with respect to confidentiality and escalation path is categorised and recorded as a cumulative figure. For the period this broke down as follows:

Confidentiality	24/25 No. concerns	Percentage	23/24* No. concerns	
Keep it confidential within Guardian Service remit	181	73%	119	69%
Permission to escalate with name	37	15%	28	16%
Permission to escalate anonymously	6	2%	12	7%
Permission to escalate without name	24	10%	14	8%
Total	248	100%	173	100%

*8-month period

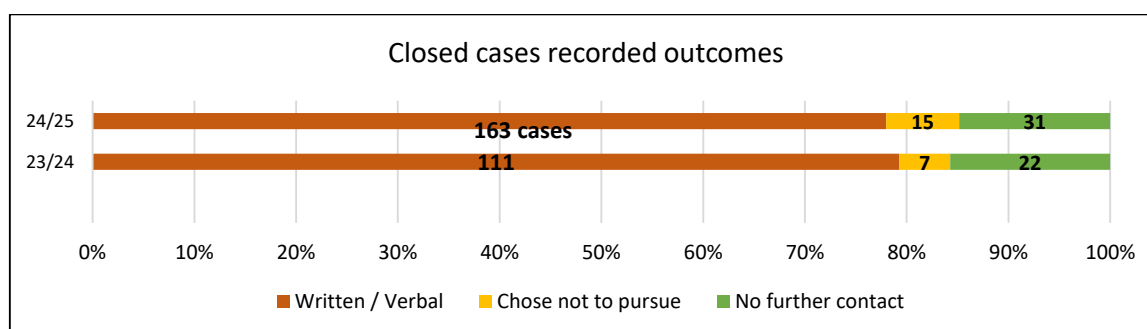
Confidentiality at 73% is not necessarily a reflection of staff lacking trust. An alternative view is that it reflects staff just needing an independent, impartial listener. Guardians may challenge staff thinking and encourage both reflection and consideration of a different perspective and so help them identify their own way forward with an issue. The analysis below illustrates how this has been achieved.

Additionally, when a concern is escalated by the Guardians on behalf of a worker, the Guardians will endeavour to ensure there is follow up and feedback i.e. a resolution. The Guardians will also ensure unexpected outcomes are accompanied with an explanation. Sometimes other pathways for speaking up in the Trust may not ensure that the “follow up/ feedback” takes place.

With one exception, escalated concerns were responded to within the agreed timeframes. In that one case, several attempts were made by a Guardian to contact the escalation manager. However, this, and further attempts to reconnect with the worker achieved no response. The case was closed as the Guardian had done everything they could. Following discussion with the Executive Lead the Guardian attended a leaders briefing to remind managers of the importance of active engagement.

There has been a slight reduction in the number of cases escalated via the Guardians versus the period ended March 24 (27% v 31%). Alongside this it is also worth considering the proportion of cases with a written/verbal outcome and, within that, what staff told the Guardians happened next.

Of 248 cases, 209 closed and 163 had a written/verbal outcome. This is consistent with the previous period.

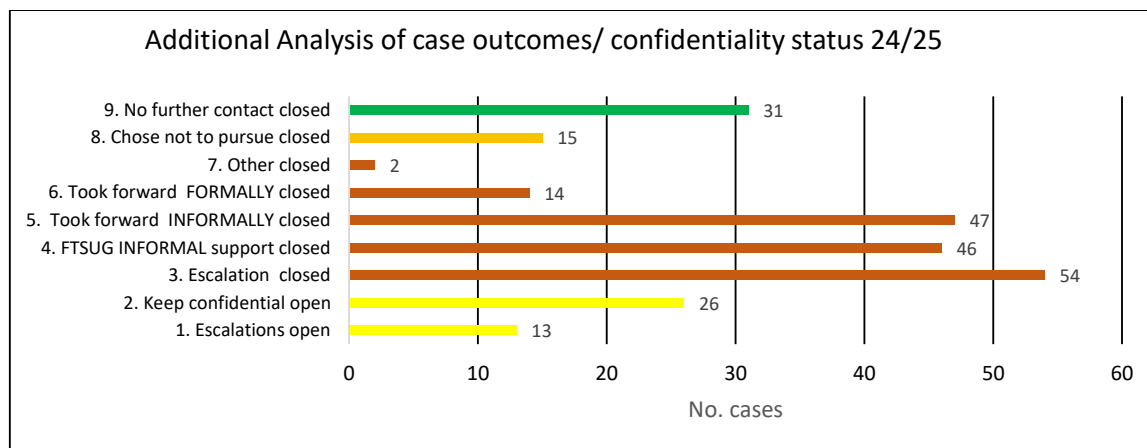




Further analysis of all 248 cases is charted below. It shows that a further 61 cases (items 5 and 6) were escalated by the staff member to the Trust as follows:

- In 47 of those cases staff reported that following a supportive conversation with the Guardians they intended escalating the issue informally themselves.
- In 14 cases staff reported they intended moving forward via a formal process.

Overall, it is reported the Trust was aware of 128 (52%) of cases initially raised with the Guardians.



In a further 46 cases (19%) staff found an informal supportive conversation with the Guardians resolved their concern. A confidential conversation with an objective and impartial listener who brings no judgement to the issue can be sufficient to resolve. The Guardians will regularly challenge, in a supportive way, with the aim of bringing clarity of perspective, reality on resolution and suitable ways of moving forward.

9. Themes and trends in themes

Concerns are categorised under themes. The table below gives an indication of what staff are speaking up to the Guardians about:

Theme	Primary themes 2024-25 12 months	All themes 2024-25	Primary themes 2023-24 8 months	All themes 2023-24
A Patient Safety / Quality	13 (5%)	25 (6%)	11 (6%)	17 (6%)
B Management Issue	80 (32%)	123 (30%)	44 (25%)	65 (23%)
C System Process	62 (25%)	85 (21%)	62 (36%)	77 (27%)
D Bullying or Harassment	35 (14%)	43 (11%)	22 (13%)	33 (12%)
E Discrimination or Inequality	22 (9%)	33 (8%)	5 (3%)	14 (5%)
F Behavioural / Relationship	18 (7%)	45 (11%)	26 (15%)	49 (17%)
G Other (Describe)	2 (1%)	3 (1%)		
H Worker Safety	16 (7%)	49 (12%)	3 (2%)	30 (10%)
Grand Total	248	406	173	285

A concern may have more than one theme. The dominant theme determines the Primary categorisation. Other themes are recorded and considered under “All themes”. The NGO data collection records cases with any element of certain themes regardless of the dominant theme. The NGO theme “Inappropriate Attitudes and Behaviours” (consists of GSL themes Management Issues; Discrimination/Inequality;



Behavioural/ Relationship). Nationally the theme System & Process is overlooked though may be considered at a local level by individual Guardians.

Primary themes

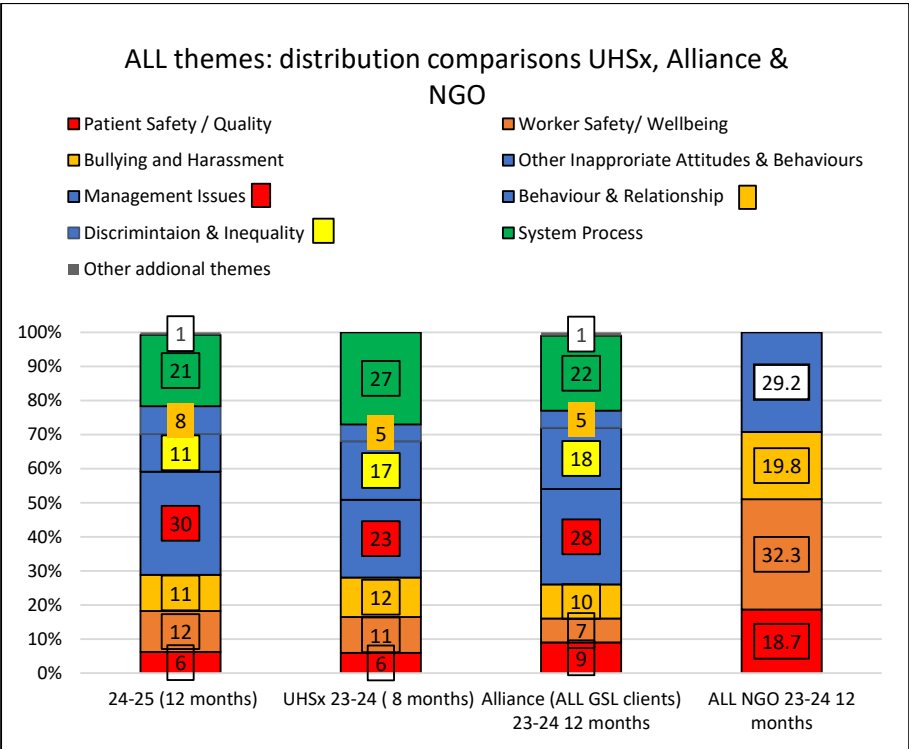
Most concerns were categorised as Management issues (32%), followed by System & Process (25%). Bullying or Harassment was the theme in 14% of cases. These were also the top three themes for the period ended March 24.

Patient Safety /Quality concerns stood at similar proportions to the period ended March 2024, and accounted for 5% of cases. There were 16 Worker Safety concerns (7%). An increase on the previous period.

All themes

Other Inappropriate Attitudes and Behaviours have been, and continue to be, a significant feature of concerns escalated to the Guardians.

The following chart compares how All themes have broken down across the main reporting periods. The chart also offers comparisons with other Alliance² clients (GSL clients base consisting largely of NHS Trusts and over 200,000 NHS staff at time of publication).



The proportions of cases by themes are similar to the reporting period ended ³March 2024. The proportion of concerns with an element of Patient Safety, Bullying or Harassment and Staff Safety / Wellbeing have remained constant period on period, and the reduction in the proportion of concerns with an element of System & Process has been matched by an increase in Management Issues.

Comparison with the available ⁴NGO Annual Report 23-24 data (the most recent available at the time of writing this report) indicates that the Trust, and the Alliance, have lower numbers of concerns with an

² [Turning data into intelligence The Guardian Service Data Report 2023-24](#)

³ UHSx FTSU Guardian Annual Report 7 August to 31 March 2024

⁴ [National Guardian Office A Summary of Speaking up to Freedom to Speak Up Guardians FTSU-Case-Data-Annual-Report-23-24](#)

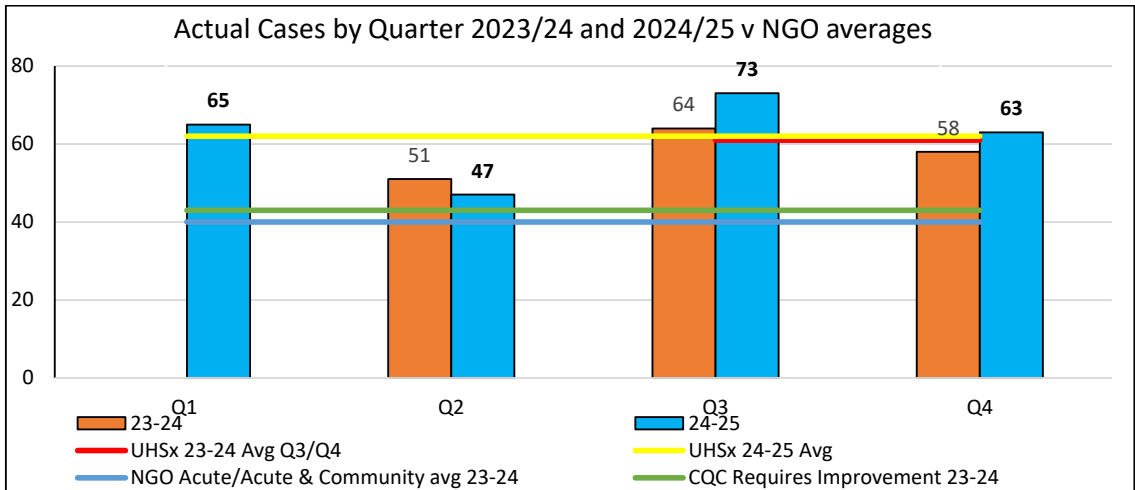


element of Patient Safety / Quality reported to the Guardians. This remains true when factoring out any differentials there may be on the Systems & Process theme.

10. Other Trends in Cases and Themes

The chart below provides the reporting period averages. These are consistent. It also gives UHSx quarterly comparisons and national trends. The service launched part way through Q2 23/24 when there was an early peak in activity possibly in part due to the corporate promotion at launch. Q3 is also considered a busy period as there is normally an increase in promotional activity due to October being “Speak Up” month.

In the 23-24 report the NGO noted a quarterly average of 40 cases for Acute/ Acute Community Trusts and 43.2 for NHS Trusts rated “Requires Improvement”. These figures include trusts of all sizes, not just larger ones. The NGO also observed that more cases were raised with Guardians in Acute/ Acute Community Trusts, but this did not necessarily correlate with the size of the work force. There was more variability in the number of cases from this group.



Cases coming to the Guardians are running at a similar rate year on year. Case numbers alone are only a measure of activity, not a reflection of speak-up culture. The Trust may triangulate this with data from other pathways for speaking up.

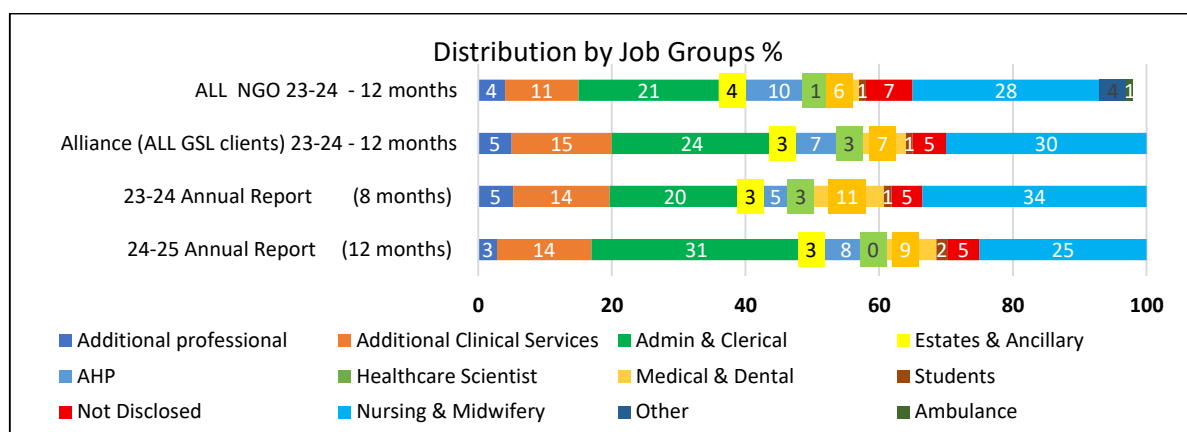
Further analysis of trends in cases coming to the Guardians shows:

RAG rating - while most concerns remain rated green (general concerns) (73% v 79% March 24) and individually present low risk of harm, there is an increase in Amber concerns (e.g., bullying, harassment and staff safety) (21% from 14%). The proportion of Bullying/ Harassment concerns remain consistent. There is an increase in Worker Safety as a primary theme (noted in Section 9).

Red Cases (largely patient safety) continue to be a relatively low, but important proportion of cases and are similar to last period.

Who is speaking up to the Guardians?

The two job groups speaking up most continue to be Nursing & Midwifery and Admin & Clerical staff. However, concerns from Admin & Clerical staff are higher (31%) than Nursing (25%) in this period. NGO, Alliance and UHSx data from the last period show the same top two job groups albeit in reverse order.

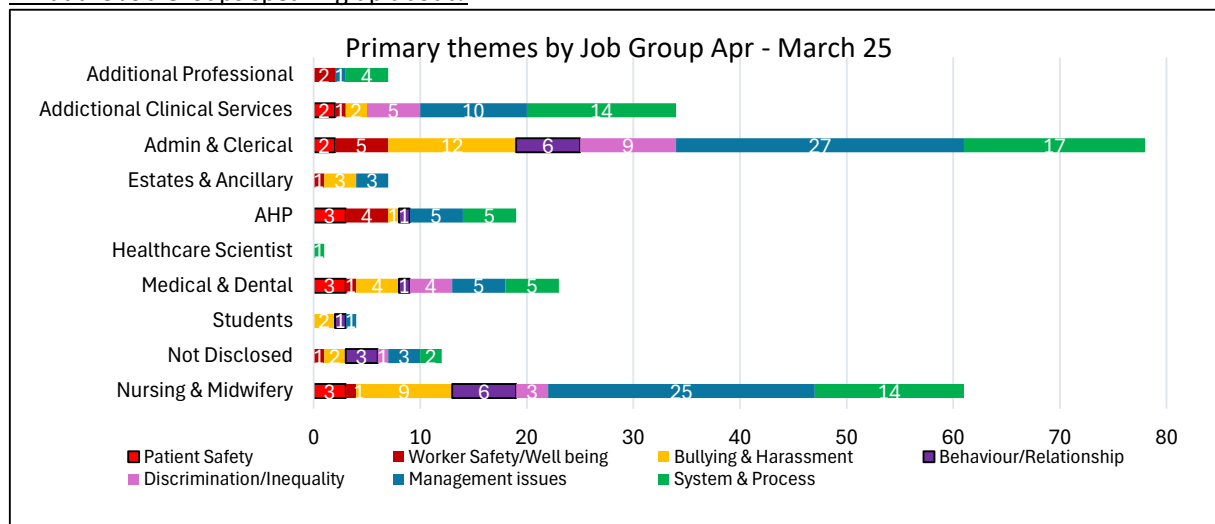


Of note:

- the proportion of concerns from Admin & Clerical has increased substantially (31% v 20%). Staff in this category represent 19% of the substantive workforce (workforce stats 01/04/25 via Workforce Services ESR). Some related factors for this could include the embedding of GSL in the Trust and this groups' ease of access to intranet and email for speaking up.
- For the period, Nursing & Midwifery staff are speaking up at both a lower rate (25%) than last period and for their proportion of the substantive workforce (30%).
- 9% of concerns were brought by Medical & Dental staff, a slightly higher proportion than the data from the NGO (6%) and the Alliance (7%). This category represents 15% of the substantive workforce at 01/04/25. Under representation is not unusual for this group. Again, consideration may be given to other speak up pathways available e.g. Doctors in training have Guardian for Safe Working Hours and their practice education team.
- Concerns from Estates & Ancillary staff remain consistent at 3% and reflect findings from Alliance and NGO. They represent about 8% of the substantive workforce. It may be helpful to consider if they are speaking up via other pathways e.g. formal routes or not at all. Also, what is the ease of access and knowledge of speaking up routes for this staff group.

Though it is acknowledged that 248 total cases is a low proportion of the substantive workforce consideration of the proportion of speak up may be useful when triangulated with other speak up routes.

What are Job Groups speaking up about?

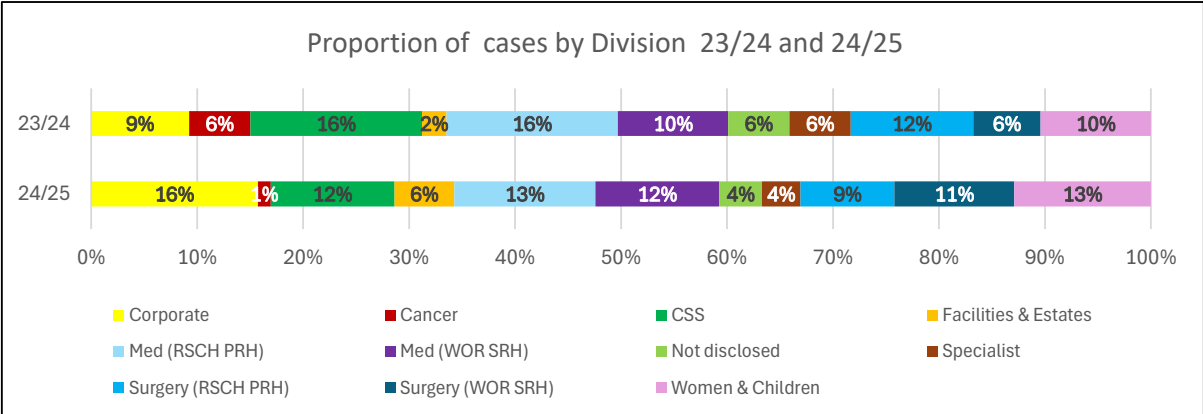




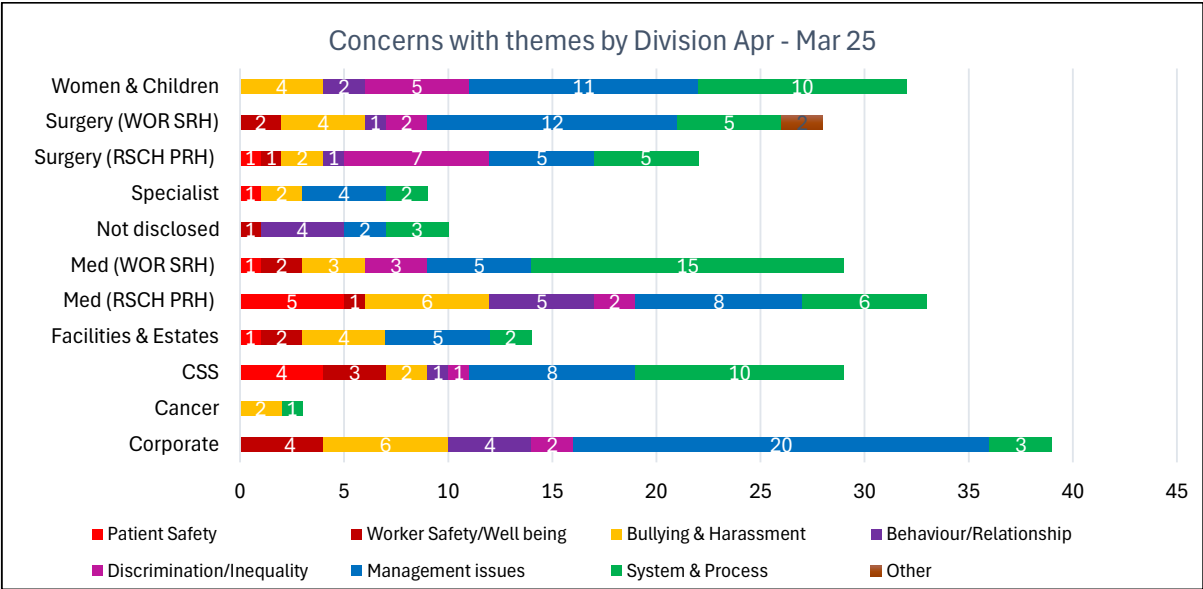
Management Issues and System & Process are the dominant themes across most Job Groups. Bullying or Harassment accounted for 15% of cases in each of the top two groups. It was the third most popular primary theme. Further assessment of cases is made in Section 11.

Where are staff speaking up from?

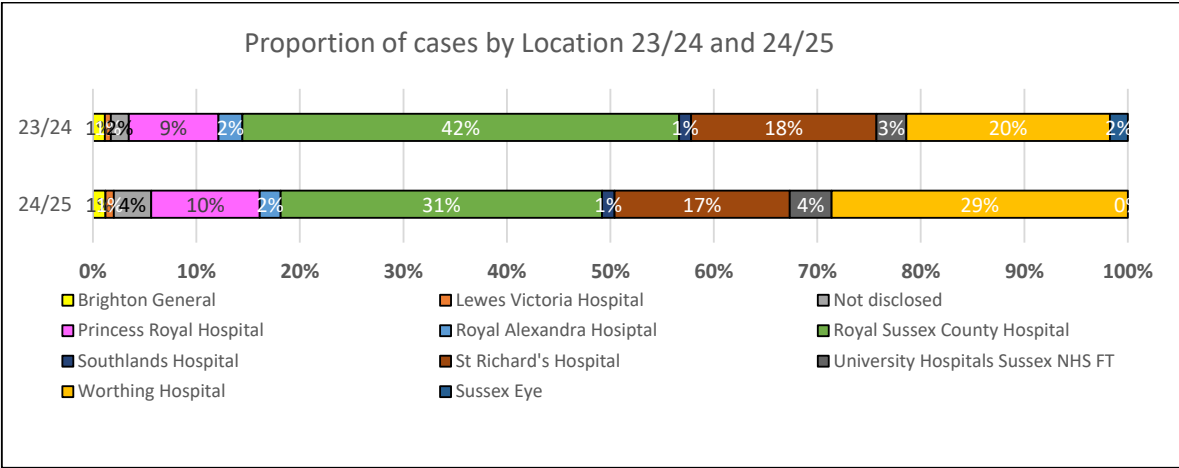
The breakdown by Division and Location gives an indication of where they are speaking up from, how that compares with previous period (an 8-month period) and what staff in those locations/divisions were speaking up about this period.



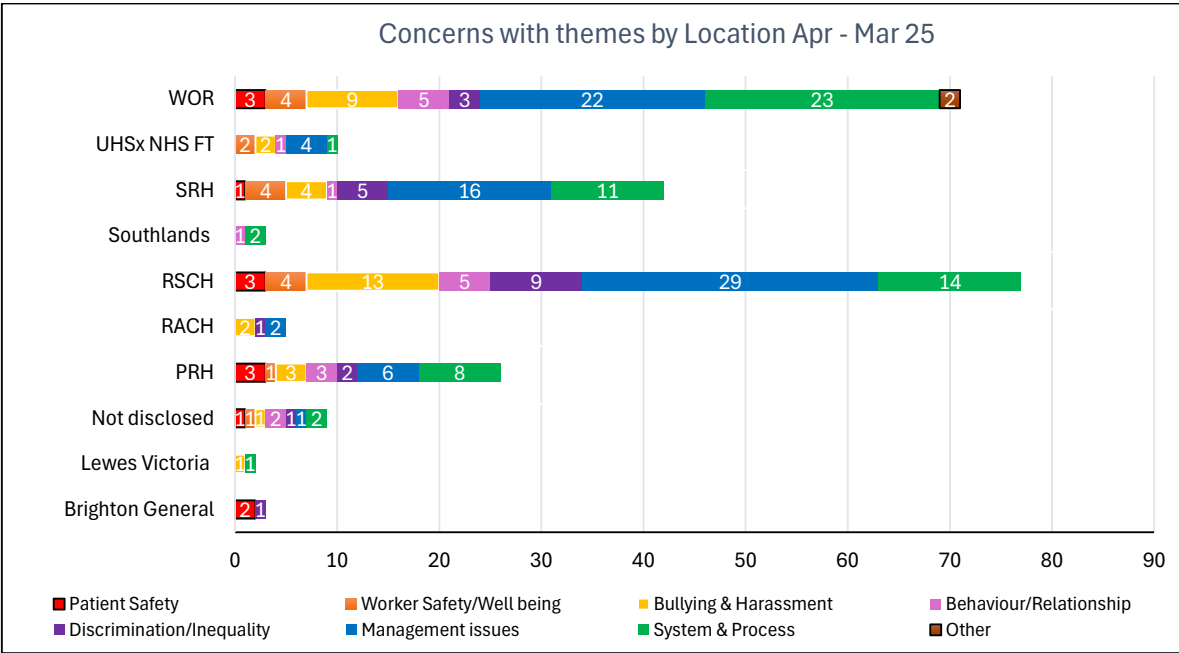
Staff in Corporate Services were speaking up more period on period (16% v 9%). Surgery (WOR/ SRH) showed a similar increase (11% v 6%). Smaller increases were apparent from Womens’ & Childrens’ (13% v 10%), and Medicine (WOR/SRH) (12% v 10%).



Again, Management Issues was a dominant theme in most Divisions, followed by System & Process. Corporate Services with a 14% share of substantive workforce accounted for most actual concerns (16%). In this division staff were also speaking up about Bullying or Harassment, Behaviour or Relationship and Worker Safety/Wellbeing, albeit at a lower rate. Med (RSCH PRH) and W&C both accounted for 13% of concerns their respective share of substantive workforce being 9% and 11%. Bullying was a notable third theme in Medicine while in W&C this was Discrimintaion or Inequality. Surgery (WOR SRH) with an 8% share of the substantive workforce accounted for 11% of cases in the period. Over 40% of cases in this division were management issues.



By location, staff were speaking up similarly to last period. Of note RSCH (and associated sites) accounted for proportionally fewer cases this period and Worthing Hospital (and associate sites) a considerably higher proportion.



Again, most concerns at larger locations were categorised as Management Issues and Systems & Process. The majority of concerns (approx. 35%) are raised from staff reporting RSCH/related sites as their location. That may be expected given their respective share of the substantive workforce. Similarly, the proportion of concerns (approx. 30%) reported from sites classed as Worthing could be considered high relative to the share of substantive workforce at 24%.

High case numbers and apparent over representation should not be viewed negatively. Some groups, divisions and locations may feel engaged, more comfortable to speak up or simply have better access to some speaking up pathways. A holistic picture on general speaking tendency by Job Group, Division or Location could involve looking at results for other pathways.



11. Assessment of Cases

This section provides additional insight to the primary themes.

Patient Safety/Quality - On receipt of a concern in this category the Guardians make immediate contact with a relevant manager in the Trust. 13 concerns were raised in the period. 10 were closed. All 13 were escalated, 4 with name. 2 concerns were anonymous.

Issues raised under this primary theme included 9 cases which can be summarised as regarding perceptions about professional behaviours, practice, or competency. A further 4 cases can be summarised as perceptions about impact of resourcing on safety or quality of care.

Management Issues - This theme reflects staff perception of issues falling under management control. This is the top primary theme and 80 concerns were raised, 68 closed. 14 were escalated, 10 escalated with name. A general summary would include professional styles and behaviours; capability; how processes are managed; management of communications; management accountability a reluctance to address poor behaviours; managing resources. Where issues were raised about professional style and behaviours this included concerns relating to all levels of management.

Examples from staff include:

- Management of policy/ processes such as annual leave, re-banding arrangements, reasonable adjustments, retirement, rostering/allocation of work, training, and supervision, change management, skills mix, additional hours worked, informal processes.
- Management of communication. This was often linked to the processes above. Staff reflections were that communications were not shared/ not shared widely, difficult to find, incomplete or, from their perspective, did not exist.
- Inability/ Reluctance to engage and to address poor behaviours. Staff reflected that managers did not manage or did not sustain activity around individual team members. Managers did not address issues raised by staff.
- Management style/ behaviours – indiscretion, gossip, lacking boundaries, hostility, verbal abuse, accusatory tone; micromanagement, lack of support, compassion, or empathy; lack of engagement from senior managers which delays progress.
- Management knowledge/ capability – lacking leadership/ leadership skills or direction
- Managing resources – staff recounted being allocated to (sometimes complex) work for which they had no experience or training and no explanation being given; supervision not being provided; allocating staff to work area outside of contract scope without discussion; resourcing inadequate.

System & Process - the second most popular primary theme with 62 concerns raised, 55 closed. 20 were escalated, 13 with name.

Some of the issues raised by staff included:

- A variety of pay related issues (approx. 20) such as incorrect pay and ongoing errors; lodging and securing a response to a pay query; repayment demands about overpayments; adjustment with deduction from pay without any communication; on-going non-payment of additional hours worked; pay banding inequality; lack of communication on proposed job re-banding; process for securing back pay around HCA re-banding when role now changed.
- Delays around - getting response to emails; informal processes; acknowledgement of formal process; responses and timelines around formal processes; access to Occupational Health and Staff psychological services; response to FOI request.
- How to get/delay in securing equipment which was part of disability related reasonable adjustment.



- Lack of Trust policy and guidance for individual managers and staff on job evaluation re-grading process.
- Lack of clarity/ poor or no communications around: new process – Datix arose; pay issues e.g. differences between substantive and bank staff and how the Covid bonus was agreed – alongside a perception of inequality.
- Lack of clarity in Maternity Pay and Sickness Leave processes.
- No cleaner having been allocated to the service area.
- Perceived lack of impartiality of mediation process
- Long breaks being taken on night shift.
- Inappropriate use of social media
- Detriment that staff believed would inevitably occur from speaking up, so staff seeking thorough exploration of the confidentiality boundaries of the FTSU service.

Bullying or Harassment - Cases are recorded in this category where the worker believes there is an element of Bullying or Harassment. It is third among the top primary themes, and 35 concerns were raised, 30 closed. 6 were escalated, 1 with the staff member's name. 23 cases were reported as manager allegedly bullying a staff member.

Of the 30 closed cases, 7 cases had no further contact, or staff chose not to pursue, and 4 cases were escalated and now closed. In the remaining 19 cases, 6 staff reported that following support from the Guardians they felt able to raise the matter directly with a manager, 2 reported finding another way forward and 7 staff felt supported by the Guardians on the issue in some other way. 4 staff reported their intention to move forward with a formal process.

A number of staff reported the perceived behaviour arose following them challenging the manager indirectly in some way e.g. a practice or decision. Reports also indicated that some of the perceived behaviour may be connected to difficult conversations relating to staff performance. Most staff were seeking impartial support from the Guardians and 6 reported having "raised the concern before but not been listened to". Two staff perceived the behaviour being related to their protected characteristic.

Some examples of issues raised in this theme include:

- micromanagement and unfair criticism
- harassment while supporting improvement
- undermining behaviours
- delivery of negative feedback lacking empathy or support
- Intimidating behaviours/language, verbal abuse, threatening behaviour
- rude, abrasive, accusatory and dismissive tones, and behaviours
- belittling, berating, and targeting staff
- belittling and failing to acknowledge or support health condition
- feeling pressured to reduce working hours due to health condition
- being isolated/ ghosted

Discrimination or Inequality - 22 concerns were raised, 17 closed. 3 were escalated, 2 with the staff member's name. As a primary theme there has been a notable increase in the proportion of concerns versus last period (9% v 3%). Over half the discrimination issues were reported as Race or Disability discrimination. Most of those cases were reported as becoming known to the Trust either through informal means or with one report of choosing a formal process and another escalated via the Guardian.

Issues perceived around inequality and unfairness included on pay bandings i.e. 2 from a group not re-banded; rota allocations; recruitment/ flexible working process; unfairness in back dating pay for one group v HCA.



Perceptions raised around discrimination include:

- different treatment from manager due to race
- how neurodiversity was addressed in a formal process
- manager taking issue with common, long term cultural language practice accepted by others
- discrimination when a group of minoritised staff did not speak in the common language of English causing isolation for staff of another minoritised group
- racism – staff reports manager applying informal process without following guidance staff believes it is due to their race
- disability discrimination arising from failure to acknowledge and adjust for staff's disability/ or to adhere to reasonable adjustments.

Behavioural / Relationship – 18 concerns were raised, 15 closed. 5 were escalated, 4 with name. The majority of the concerns related to behaviours and relationship between colleagues although several were about the behaviour of managers and senior staff

Issues raised included:

- Personality differences and styles
- Aggressive, poor behaviour of senior colleagues
- Professional behaviours and values
- Deteriorating relationships with colleagues following period of absence
- Manager lacks empathy and understanding.
- Dismissive behaviour of colleague
- Manager looking to mend relationship with team member.

Worker Safety/Wellbeing – 16 concerns were raised, 13 closed. 4 were escalated, 3 with name. Primary themes under this category were often reported as being perceived as having strong links with Behaviour, Management Issues and System & Process e.g. being able to use equipment relating to disability; managers behaviour/ unreasonable instruction impacting on wellbeing. 33 other cases reported an element of Worker Safety/ Wellbeing when considering All themes.

Issues reported by staff included:

- welfare concerns perceived as serious which were escalated and responded to the same day with welfare checks and support.
- perceived lack of H&S around manual handling
- a number of wellbeing matters arising in connection with a protected characteristic in varying contexts
- hot desking limiting use of specialised equipment which was a reasonable adjustment.
- working conditions/environment
- anxiety and wellbeing issues arising from perception that aggressive behaviour from team member was not being managed.
- wellbeing impact of what staff perceived as poor and unsafe rostering allocations
- burnout arising from perceived challenges on ward.

12. Why do staff use The Guardian Service?

Speaking up to the Guardian is one pathway for staff speaking up in the Trust. Sometimes, having considered and dismissed other pathways or where other pathways have previously been tried, staff choose instead to contact the Guardian.

As indicated in Section 8 considering why staff use GSL may be a helpful triangulation point.



Reason	No. of concerns 2024-25	Percentage	No. of concerns 2023-24	Percentage
A. Impartial Support	142	57.26%	106	61.27%
B. Fear of Reprisal	19	7.66%	18	10.40%
C. Believe they will not be listened to	10	4.03%	4	2.31%
D. Have raised concern before but have not been listened to	76	30.65%	45	26.01%
E. Other	1	0.40%	0	0
Total	248	100.00%	173	100.00%

In the table above item B relates to detriment/ fear around speaking up and Items C and D relate to futility /perceptions on futility around speaking up. The table gives the distribution of responses from staff for this period and the reporting period ended March 24.

Impartial support is cited as the most common reason for staff to use the Guardian Service and, in many cases, after impartial support, staff may be empowered to take their concerns forward by themselves. However, over 40% of those contacting the Guardians gave reasons relating to fear and futility as their reason for contact. Examples of not being listened to include (futility): having no response to an email; having had a conversation with their manager without conclusion/feedback or having raised a Datix without action/ the outcome being shared.

13. Detriment

Nationally, the NGO reports (for 23/24) that detriment for speaking up was indicated in 4 % of cases. This figure was consistent year on year against a background where case numbers had increased substantially.

In addition to cases recorded as detriment, other signifiers around fear of detriment could include staff stating “fear of reprisal” (Section 12) for speaking up as their main reason for speaking to the Guardians; and/or staff raising concerns anonymously, as well as staff withholding their name when seeking escalation of their issue.

In UHSx:

- There were no confirmed cases of detriment however,
- 8% of staff (19 cases, 10%, 18 cases last period) indicated “fear of reprisal” and
- 12 cases, (5% v 14 cases 8% last period) were raised anonymously. The majority (10 from 12 cases) had not indicated fear of reprisal.
- In 24 cases (10% v 14 cases, 8% last period) staff withheld their name for escalation. The majority (16 from 24 cases) had not indicated fear of reprisal.

Combined, it could be considered that “fear” played a part in 18% of worker decisions and experience in speaking up. Additionally, it is worth noting that only one key reason for using the Guardians is recorded. In many instances staff may indicate more than one reason (including both fear and futility) for contacting the Guardians e.g. have not been listened to already and now fear reprisal for speaking up again/escalating and wonder what the point is given the response to a first attempt at speaking up.



In Q4 the NGO issued revised guidance⁵ on detriment to clarify the position and to support Guardians and organisations in removing the barrier of fear of detriment. The guidance clarifies recording perceptions of detriment by the Guardians not just by the worker and to record detriment arising from speaking up through any pathway not just via the Guardians. With this clarity we may expect cases recorded as detriment to increase.

Detriment can be subtle and unintentional. It includes both deliberate acts but also omitting to act. Key is how its perceived by the individual and/ or the Guardians. Examples of detriment arising as a result of having spoken up may include being ostracised or experiencing bullying; being denied access to training or inadequate supervision; being overlooked for promotion and being treated as a troublemaker.

The Guardians invest considerable time with staff creating a safe space and treating them in such a way that they feel supported to share their concern. Staff may advise perceived detriments to the Guardian. Going forward perceived detriment will be recorded and staff will be supported in taking this forward to the Trust, should they wish.

It is important to be mindful that fear of reprisal for speaking up and other such signifiers include staff who may be reticent to bring forward suggestions for improvement.

14. Action taken to improve the Freedom to Speak Up Culture

The Guardian resource was formally increased from 1 to 1.5 FTE in the latter part of the reporting period, supporting an increase in reach and visibility of Guardians.

Non-medical staff continue to be introduced to the concept of Freedom to speak up and the Trust's Guardians at Corporate Induction. There is a possibility the Trust may strengthen the FTSU content subject to other priorities.

Materials on speaking up pathways and FTSU are included in onboarding and induction for Residents (Trainee medical doctors). Similarly for Consultant and SAS Doctors from Jan 25. It is hoped this work will help address some under representation of this group in speaking up (indicated in Section 10).

Trust managers and leaders have been positive in accommodating requests to meet with the Guardians and the member of staff wishing to escalate a concern.

The Trust now has a Speaking Up Action Plan, overseen by the Chief People Officer. Progress on recommendations from the Guardians' reports are monitored.

Pending a review of training priorities/capacity and STAM review there has been some promotion and voluntary completion of the NGO Speak up Listen Up eLearning modules.

As a GSL client, key staff are invited to Alliance network meetings. Attendance at one client's showcase of their work around Sexual Misconduct was helpful for the UHSx Engagement team and connections were made.

The Guardians supported staff understanding of some key policies and procedures. Clarification from an independent party helps with staff understanding and may prevent further escalation.

Guardians undertook just over 100 promotions/ briefings to staff in the period. Some of this was by invitation such as visibility at the Trust Annual conference and Black History month conference; speaking to International Medical graduates at RACH; presentations to preceptorship and student nurses/ student

⁵ [Detriment Guidance for Guardians Jan 2025](#)



midwives across the Trust; attending hospital forums; staff networks, Clinical Governance days and team meetings. Additionally, the Guardians did ad hoc visits and promotions including wards, particular teams, hard to reach areas and high traffic areas such as foyers and restaurants.

Visibility and presence are key for building both awareness of the service and professional relationships with staff. Staff may then decide if the Guardians are a route they feel both comfortable with and that they can trust. As part of the GSL network of Guardians we regularly indicate that we may be able to facilitate staff speaking to another GSL Guardian of their choice if staff feel relevant shared lived experience is critical.

The series of regular meetings continues with:

- the Chief People Officer to discuss monthly activity reports and any particular themes arising as well as any particular issues for which support is required.
- the Non-executive Director for FTSU bi-monthly (the Trust's Chair is in attendance twice yearly) when exceptions and assurance are discussed.
- the CEO to discuss quarterly activity, recent learnings and themes.
- Nursing leadership quarterly for a focus on themes being seen for the relevant cohorts; any support needed and any known hotspots.
- the Associate Director for OD, Wellbeing and Engagement to discuss progress against the Action Plan; how the service is running/ being received and any operational issues.
- with the Engagement & Wellbeing teams for discussion on any relevant developments and initiatives

There are also ad hoc meetings with Employee Relations and EDI leads as required, and ad hoc project involvement.

15. Learning and Improvements

The decision to formally increase the Guardian FTE from 1 to 1.5 provides for increased contingency over and above the contingency that GSL automatically provides through its On Call and extensive Guardian network. A second dedicated Guardian who has more intimate local knowledge of the Trust increases the quality of the cover available.

Local improvements arising from case escalation include:

- the night staffing template on a ward was increased and a programme of renewing training was arranged.
- A review of the skills mix in a team was undertaken and identified vacancies were actioned.
- A listening event was planned as well as support for a new manager around style and behaviours.
- A need for better rota management on a ward was identified and relevant support provided to ward manager and matron.
- Additional training needs for employee and their manager were actioned following issues with ESR.

The Guardians continue to develop their organisational knowledge and apply this to cases. Opportunities to do this arise from the Trust through, for example, attending events such as the workshops running at the conferences, or with individual teams by supporting work such as the Sexual Safety work. Also, by meeting with other ICB guardians on a regular basis so there is better understanding on what is happening in the wider system and impacts in UHSx.



16. Comments & Recommendations

The recommendations from previous written reports for period ended March 2024 and for the 6 months ended September 2025 remain a work in progress and are encompassed in the Speaking Up Action Plan.

New recommendations include:

Detriment, fear and futility - the FTSU Policy indicates the organisation has a clear stance on detriment. The FTSU Reflection Planning Tool acknowledged there is some additional work that can be done around detriment. Data, and anecdotal feedback from staff, also indicates fear of detriment from speaking up is real, as is futility/ perceptions of futility around doing so.

The culture transformation work streams and many of the previous recommendations e.g. upskilling of managers; improvement in communication, would help address this in part. Those are also possibly medium to longer timescales. Meanwhile, some staff will remain silent even where improvement is identified.

Recommendation: start a direct conversation with all staff around detriment, fear and futility around speaking up. Also to consider: is the detriment messaging sufficient; how else is the Trust's stance communicated to staff and, what a good response to detriment (escalated to the Trust) looks like.

Follow up and feedback (closing the loop) - staff frequently tell the Guardians they "have spoken up before and not been listened to" i.e. they did not get feedback or did not get timely and meaningful feedback. This adds to a sense of futility. The Guardians endeavour to ensure there is follow up and feedback on any escalated concern. Where resolution is not as expected the Guardians will seek an explanation as to why. Therefore the conversation loop of: speak, listen, follow up, feedback can be completed. Mandating the NGO modules Listen Up/ Follow Up is under review and voluntary completion is currently promoted. We also understand one of the culture workstreams has already picked this theme up in respect of RL Datix as a pathway.

Recommendation: to consider what other speaking up routes formal and informal (unrelated to management skills) provide opportunities to improve the process on follow up and feedback, and what can be done.

Lived experience perspective - the Guardians have the privilege of experiencing staff voice first hand. They remain impartial and non-judgemental and may challenge staff to consider another perspective. The individual's insight and particular perspective can support understanding of how and why issues arise. This leads to awareness of where solutions and resolutions lie.

Recommendation: to consider if the Board would benefit to hear directly from staff about their personal experience of speaking up in the Trust.

Relationship with Communications team - GSL and their Guardians have a direct relationship with the internal communications team for most of the Alliance clients. We would welcome similar with UHSx.

Recommendation: to consider a named contact in the internal communications team for the Guardians and GSL.

17. Staff Feedback

Staff may provide anonymous feedback about the service once a case is closed. There were approximately 54 responses to the feedback survey in the year. Examples to September 24 were provided in an earlier report. Examples of feedback for October to March 2025 follow:

Would you speak up again?



- *Yes, I think it is really important*
- *Yes, it's a great service and I had a good experience*
- *Felt it was well handled and a really useful service to speak to*
- *Useful resource to have if unsure of next steps or general advice. Was professional and safe*
- *I will always speak up because I received the best advice and follow up throughout*
- *Friendly, prompt, understanding and followed through with their actions*
- *I appreciated an impartial and empathetic listener, who really took time to explore the situation and possible solutions with me.*
- *Based on my experience FTSU provides a process but I question the value. The service unable to meet the service users expectations.*
- *I couldn't have had better support from Guardian it got me through a difficult time. Leaders take a referral seriously.*

University Hospitals Sussex NHS Foundation Trust

Guardian of Safe Working Hours (GoSW) Annual report 24/25

Author	Dr Lottie Ford Consultant Gastroenterologist and Guardian of safe working hours (GoSW) UHSussex
Contributors	Nicola Taylor and Billie Strickland (Medical workforce officers), Melanie Clay (Medical Workforce manager), Jane Berry (EWTD and rostering officer), Nick Wilson (Finance Head of Core Management Accounting), Molly Ford (HealthRota implementation lead), DRS-4 / HealthRota exception reporting data, Trainee feedback at Resident doctors fora (RDF) and local faculty group (LFG) meetings.

Executive Summary

In 24/25 there have been an overall increase in exception reports (ER) at UHSussex with 1785 in total (compared to 1394 23/24). 461 ERs at Worthing site (cf. 424 ERs 23/24) (WGH*); 460 at St Richards Hospital (SRH) (cf. 364 23/24); 795 at Royal Sussex County Hospital** sites (cf. 558 23/24) (RSCH**) and 69 at Princess Royal Hospital sites (PRH***) cf. 48 23/24.

The majority of ERs at UHSussex are submitted by trainees in medical specialties (72% at WGH, 79% at SRH, 56% at RSCH and 83% at PRH sites). Predominant themes of exception reports are workload and staffing.

Hot spots for exception reporting at WGH 24/25 include Acute medicine (18%) and Cardiology (14%). At SRH Acute medicine (24%) and Cardiology (14%). RSCH sites Cardiology (15%) and Infectious diseases & GU Medicine (11%). PRH Urology (22%) and Diabetes & Endocrinology (20%). 7 immediate safety concerns (ISC) have been submitted and agreed (2 WGH, 4 SRH, 1 RSCH).

79 Guardian fines have been issued this year across UHSussex (WGH 24, SRH 10, RSCH 44, PRH 1) resulting in a total Guardian fines allocation of £6274.63. Guardian fines fund balance is currently £31,894. 9 Resident doctors fora (RDF) have taken place in 24/25.

Exception reporting reforms agreed in March 2025 by BMA Resident doctors committee and NHS employers must be implemented by all Trusts by 12.9.25 and will have major implications for ER locally and nationally. The changes followed a BMA National exception reporting audit (Autumn 2024 >3000 respondents) which identified high numbers of unpaid additional hours worked due to under-reporting and major barriers to ER for doctors including a 'fear of backlash from departments or supervisors'. This required a cultural shift with focus on protections for those doctors with access to exception reporting.

National framework reforms will result in significant changes to the sign off process for exception reporting with emphasis on 'not exposing doctors to detriment' from ER. The vast majority of ERs will now be agreed by HR / medical workforce within 7 days with educational and clinical supervisors effectively removed from the process. Under the contractual changes challenges to claims must be by exception, not the norm and choice of remuneration (payment versus TOIL) made by the reporting doctor. New confidentiality clauses impose substantial Trust fines for 'data breaches' where individual doctors are identified or suffer detriment by ER.

Concerns from National Guardian network (who were not included in negotiations) include; practical implications for preserving resident doctors (RD) anonymity, evaporation of 'discretionary effort' within NHS culture and a reduction in the quality of training experience (especially for NROC - non-resident on call rotas). The GOSW will have expanded responsibilities, now as the only clinician with complete access and oversight of ER data, offering pastoral support to high volume reporters in addition to investigating unsafe working practices and levying new fines across the Trust. The challenges post reform will be ensuring clinical leads and budget holders can be responsive to ER trends and affect change, while safeguarding reporter anonymity. Clinical and educational supervisors and 'change makers' within clinical teams previously most likely to unlock solutions will lose real time access to ER data. The Trust must navigate and eliminate the risk of data breaches. There is a short time line for implementation.

It is easy to feel disheartened by the need for these changes especially considering the significant and hard won progress in 24/25 at UHSussex to deliver ER, support RDs and ensure supervisors and clinicians use ER informatively as a tool for change and not simply a conduit for payment. There is expectation that ER reforms will increase the numbers of ER significantly at UHSussex in 25/26 at a time of intense fiscal scrutiny. The changes at UHSussex will come at a time ER is expanded to Locally employed doctors (August 2025). UHSussex must accept and embrace ER reforms, recognising that this may be the only way to accurately remunerate 'true hours worked' and in turn meet the needs of our RD / LED workforce in delivering efficient handover, workable rotas and safe working practices to benefit patients and staff. The move to HealthRota for exception reporting in April 2025 strengthens opportunities to introduce these changes but requires immediate software modification to meet the task.

(*WGH; refers to trainees at Worthing and Southlands Hospital) (**RSCH; includes trainees at Royal Sussex County Hospital and Royal Alexandra Childrens hospital, Brighton General Hospital and Sussex Eye Hospital sites PRH*** refers to trainees at Princess Royal and at Hurstwood Park Neurosurgical Centre)

1.0 Introduction

Table 1: High level data UHSussex

Number of doctors in training posts	RSCH and PRH sites: 718	SRH and WGH sites: 401	
	F1 posts: 81 F2 posts: 75 GP 1/2/3s: 134	F1 post: 31 F2 posts: 30 GP posts: 49	F1 post: 32 F2 posts: 37 GP posts: 53
	CT /IMT posts: 156 ST posts: 289	CT /IMT posts: 90 ST posts: 79	
GoSW	2.5 PA		
Admin support provided to GoSW	2 x Band 4 ER Workforce officers		
Time for educational supervision / trainee	0.25 PA		

1.1 Implementation of HealthRota® software for exception reporting at UHSussex

UHSussex implemented HealthRota for exception reporting for approximately 1100 doctors from April 1 2025. This followed a successful pilot for HealthRota at RSCH/PRH sites with positive feedback from RDs and supervisors.

It is anticipated that Exception reporting on HealthRota will be extended to Locally employed doctors (LEDs) from August 2025.

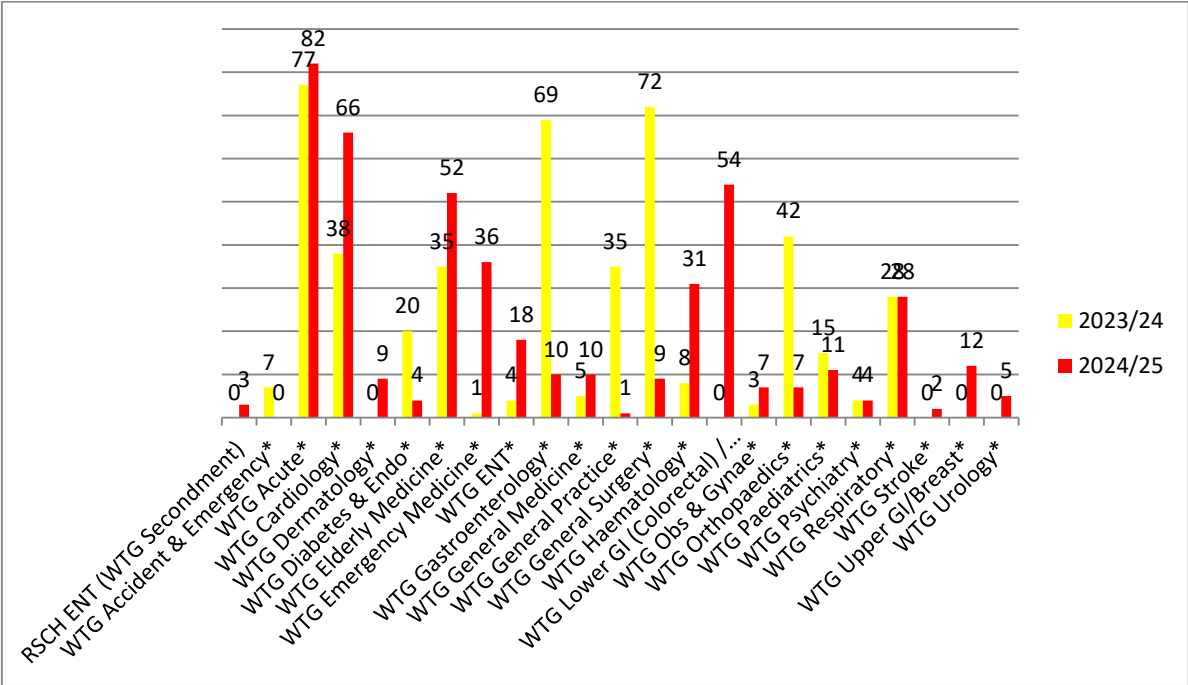
HealthRota offers a single platform for rostering, rota compliance and exception reporting ensuring greater visibility across workforce and rota teams and improve efficiency (for example of TOIL allocation). The majority of doctors at UHSussex are set up on HealthRota from the first day of employment with a single user login for accessing individual and team rotas and ready access to exception reporting. Education exception reports (for missed teaching or learning opportunities) are actioned by DMEs (director of medical education) at each site - a key requirement of new proposals. Changes required by September 2025 (to avoid financial penalties) include: removal of supervisor access to ER data and additional software modifications to include geolocation / timestamp evidence of proof of hours worked. This will ensure medical workforce can process ER within new deadlines of 7 days and rota teams allocate TOIL within a new deadline of 10 days. Thematic analysis and high quality data reporting will be essential to ensure clinical leadership teams have a clear understanding of the contributors. Budget holders will need to understand the true cost of exception reporting resulting in actions at departmental level or work schedule changes.

2.0 Exception report (ER) data. There have been a total of 1785 ERs during 24/25.

2.1 Exception reports by Division and Specialty department

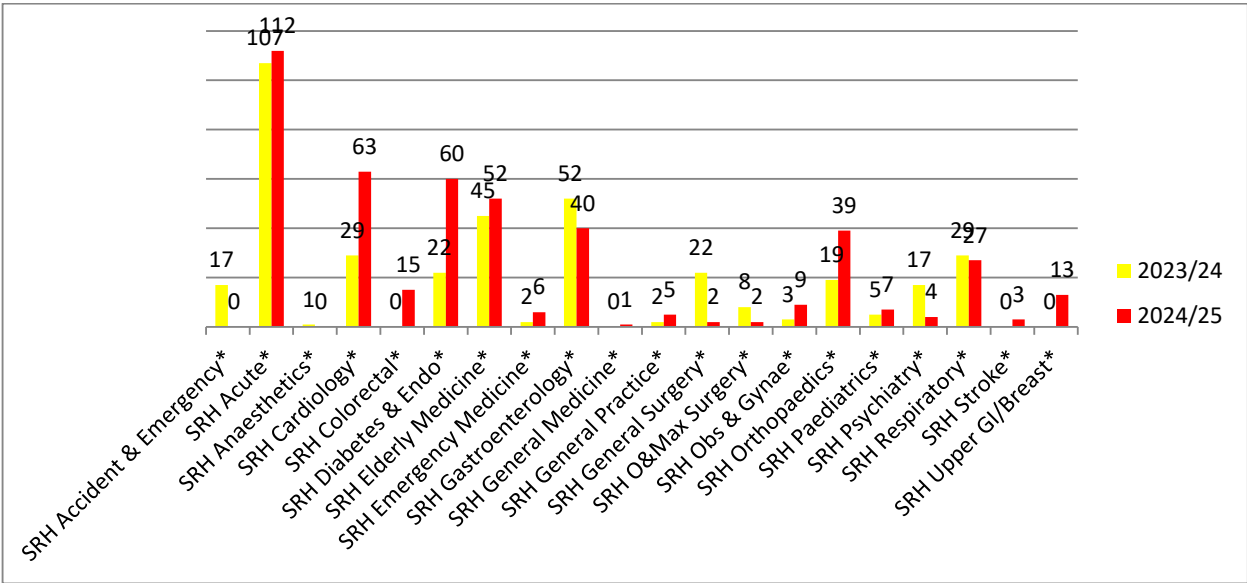
There have been in total 461 ERs at Worthing site 24/25 compared to 424 ERs in the previous financial year 23/24. Hot spots for exception reporting at WGH 24/25 include Acute medicine (18%) and Cardiology (14%).

Graph 1a: UHSussex (WGH) Total Exception reports by Specialty 24/25



Graph 1b: UHSussex (SRH) Total Exception reports by Specialty 24/25

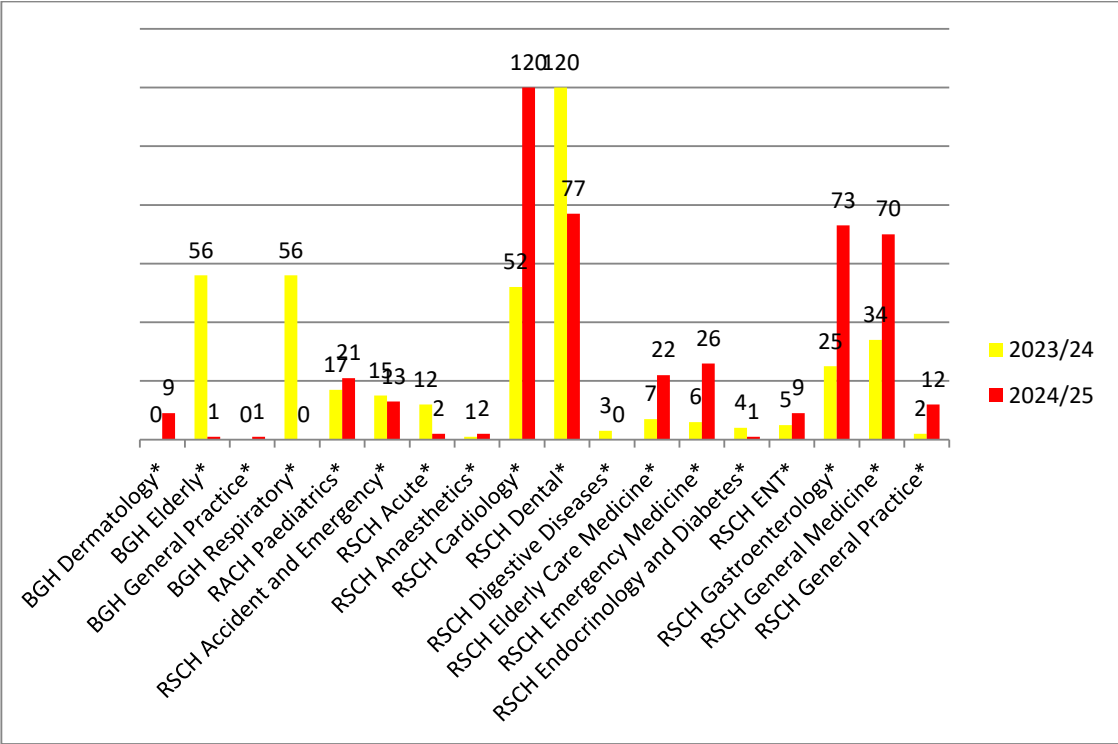
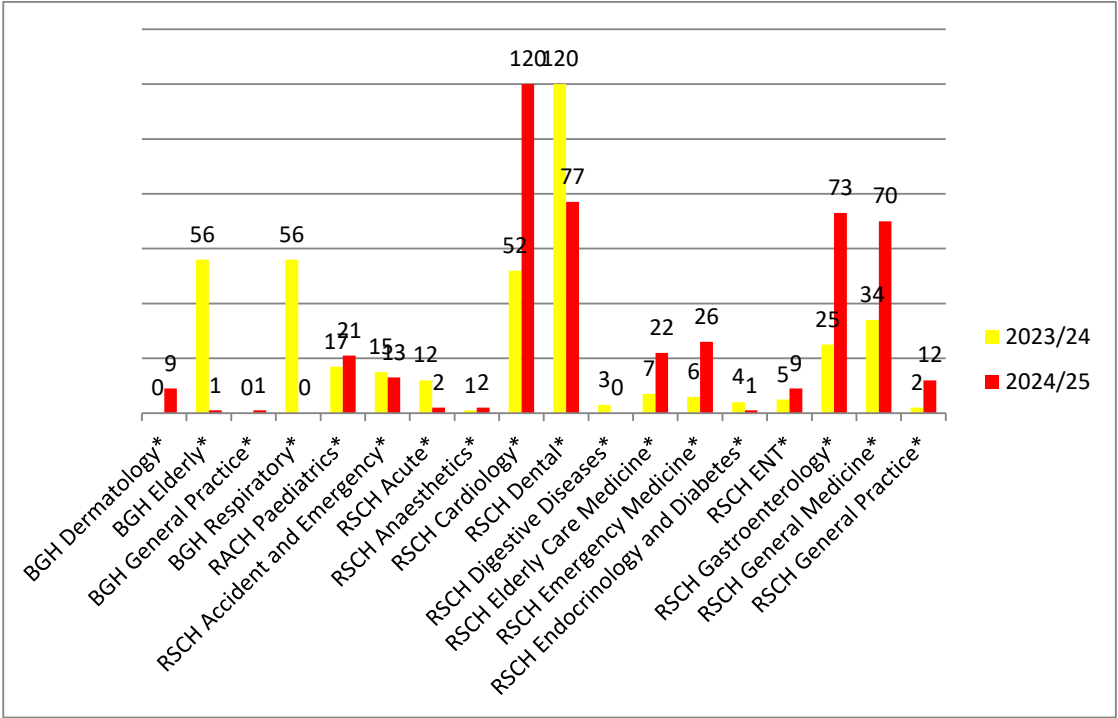
There have been in total 460 ERs at SRH site 24/25 compared to 364 ERs in the previous financial year 23/24. Hot spots for exception reporting at SRH include Acute medicine (24%) and Cardiology (14%).



There have been in total 795 ERs at RSCH sites 24/25 compared to 558 ERs in the previous financial year 23/24.

Hot spots for exception reporting at RSCH sites include Cardiology (15%) and Infectious diseases & GU Medicine (11%).

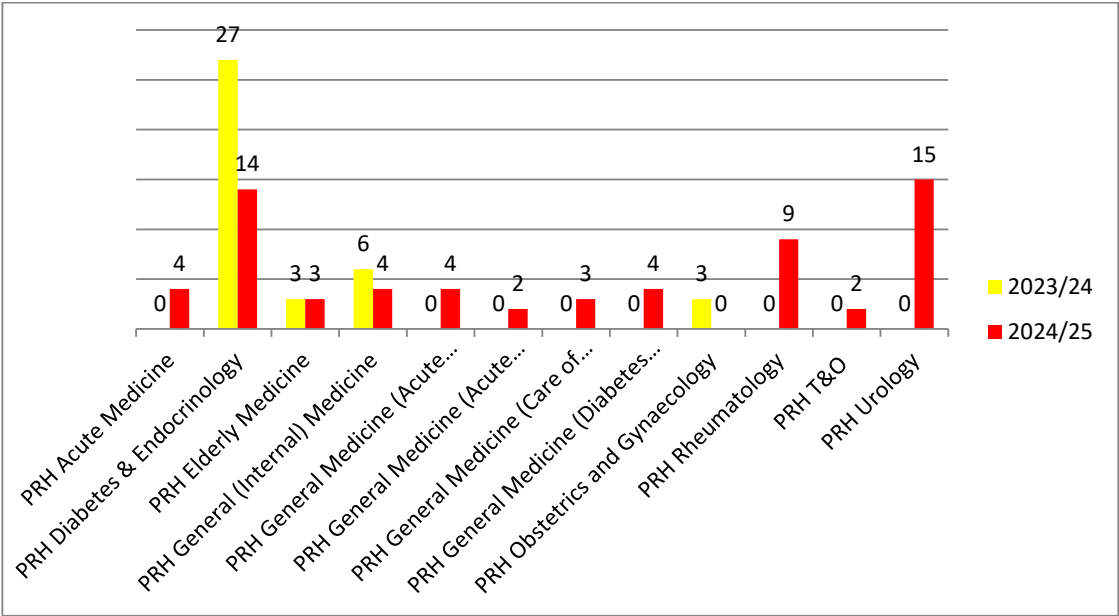
Graph 1c: UHSussex (RSCH) Total Exception reports by Specialty 24/25



There have been in total 69 ERs at PRH sites 24/25 compared to 558 ERs in the previous financial year 23/24.

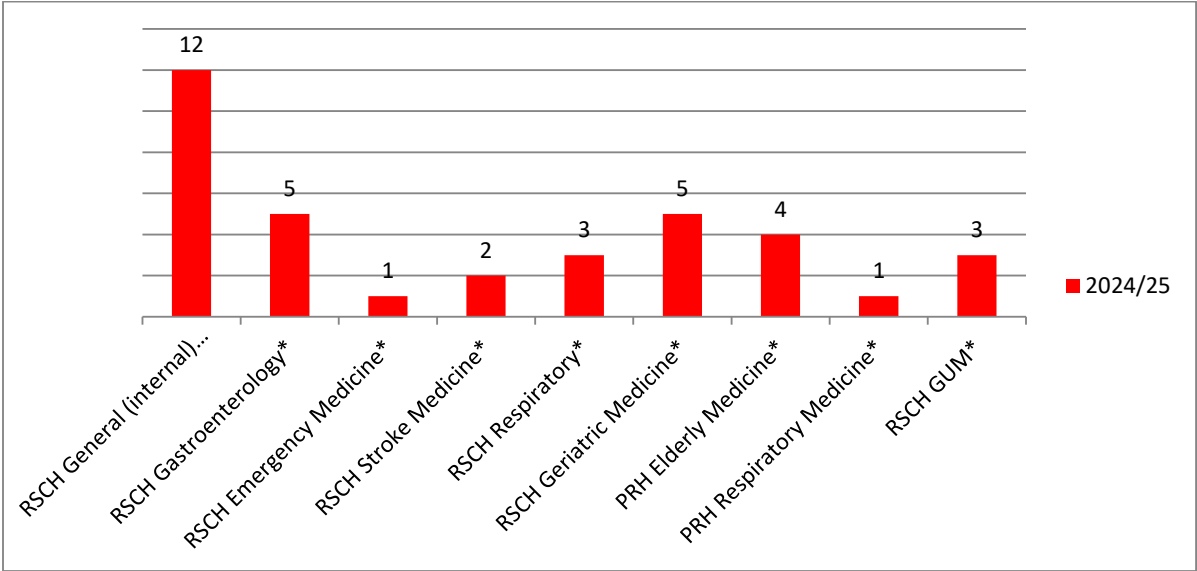
Hot spots for ER at PRH included Urology (22%) and Diabetes & Endocrinology (20%).

Graph 1d: UHSussex (PRH) Total Exception reports by Specialty 24/25



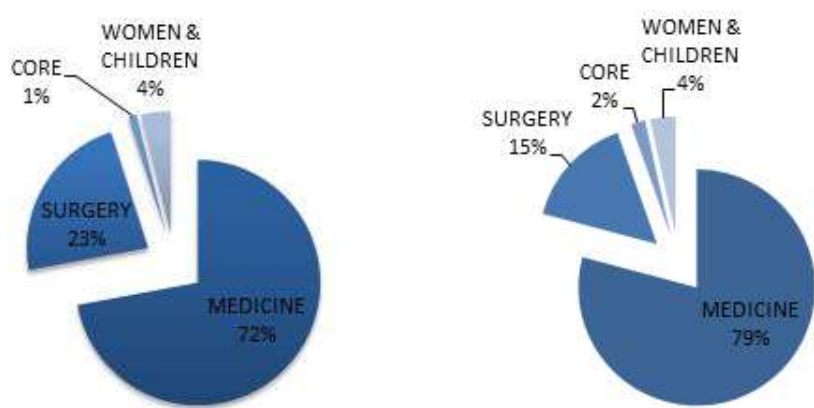
Additional ERs captured as part of HealthRota pilot for exception reporting at RSCH/PRH sites (included in total numbers reported):

Graph 1e: HealthRota pilot additional ERs 24/25

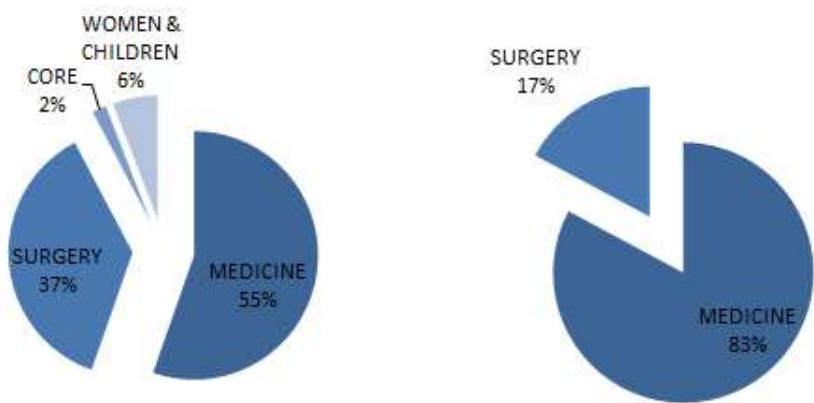


2.2 UHSussex Exception reports by Division 24/25

Graph 2a: WTG ER (n=461) by Division 24/25 Graph 2b: SRH ER (n=460) by Division 24/25



Graph 2c: RSCH ER (n=795) by Division 24/25 Graph 2d: PRH (n=68) by Division 24/25



2.3 UHSussex Exception reports by Theme 24/25

Workload and staffing are predominant themes for ER at UHSussex in 24/25

Work load: Perception by the exception reporter that the clinical workload exceeds the capacity of a full team.

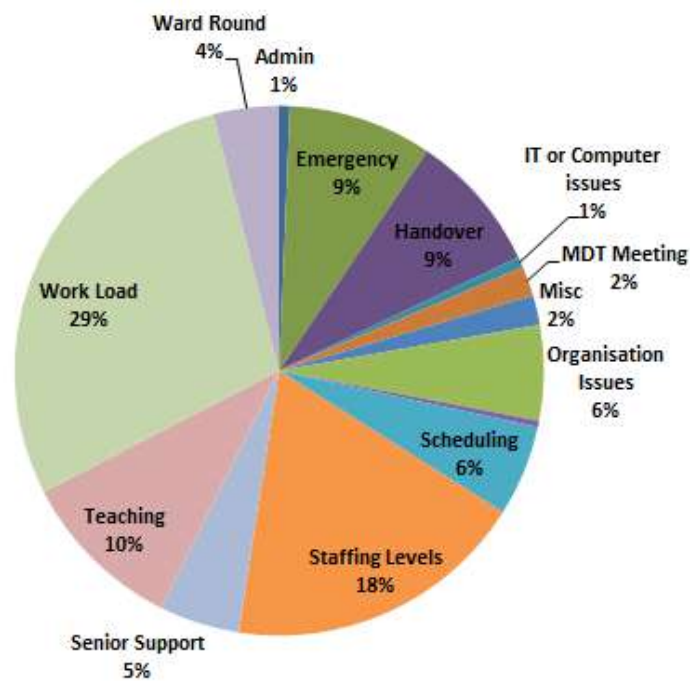
Ward staffing: Perception by the exception reporter that the team allocation was insufficient for the clinical work load.

Handover: Doctor stayed as they felt handing over tasks to another team was unsafe or inappropriate (must qualify).

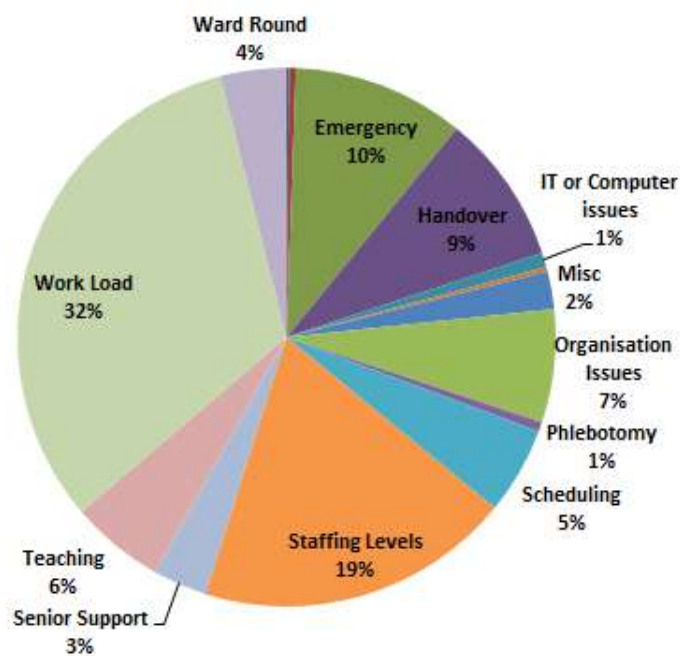
Emergency: Unpredicted clinical issue or emergency situation that occurred at the close of the shift or after normal working hours that required doctors continued presence.

Graphs 3a-d UHSussex ER Themes at WGH, SRH, RSCH and PRH note a single ER may be categorised under multiple themes.

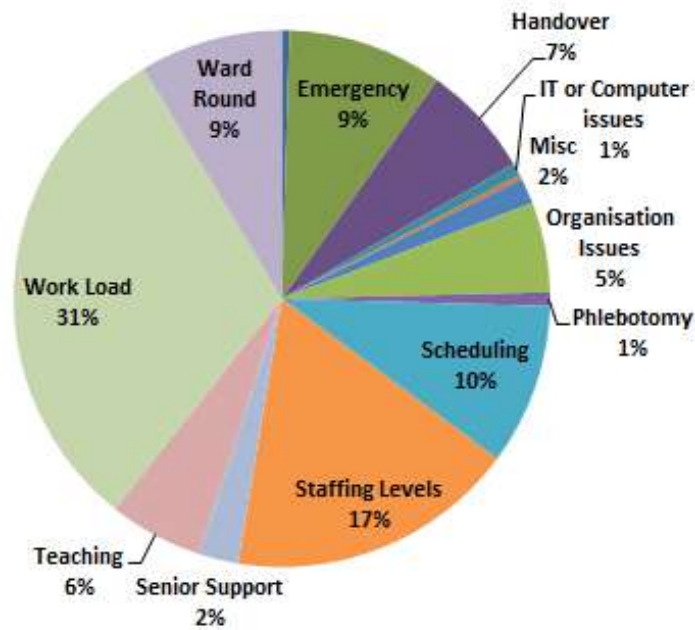
Graph 3a WTG ER by Theme 24/25



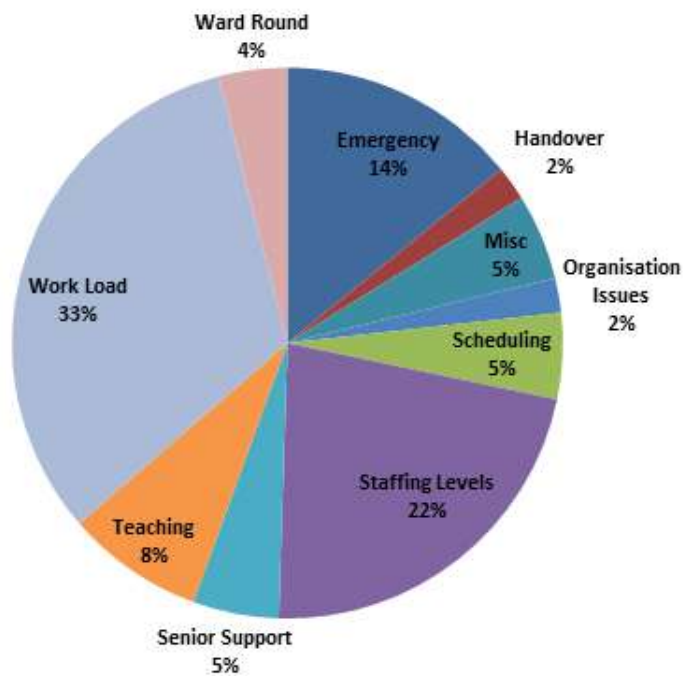
Graph 3b SRH ER by Theme 24/25



Graph 3c RSCH sites ER by Theme 24/25



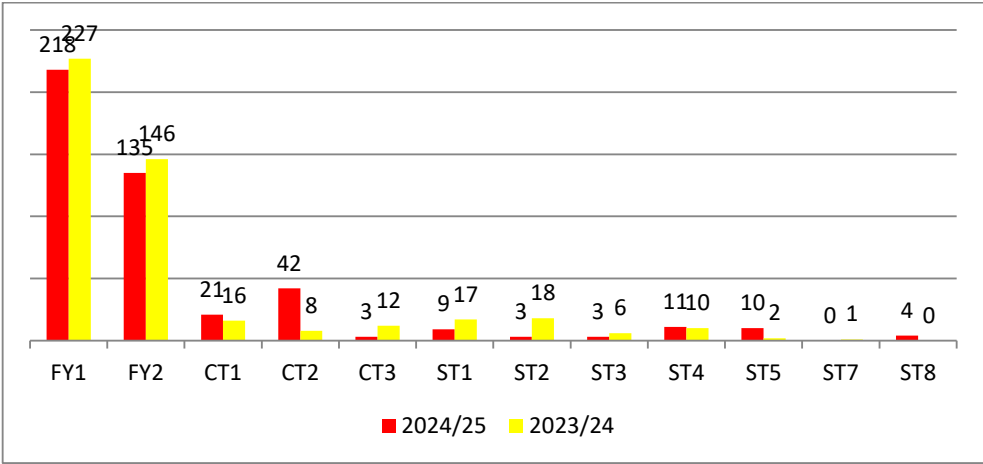
Graph 3d PRH ER by Theme 24/25



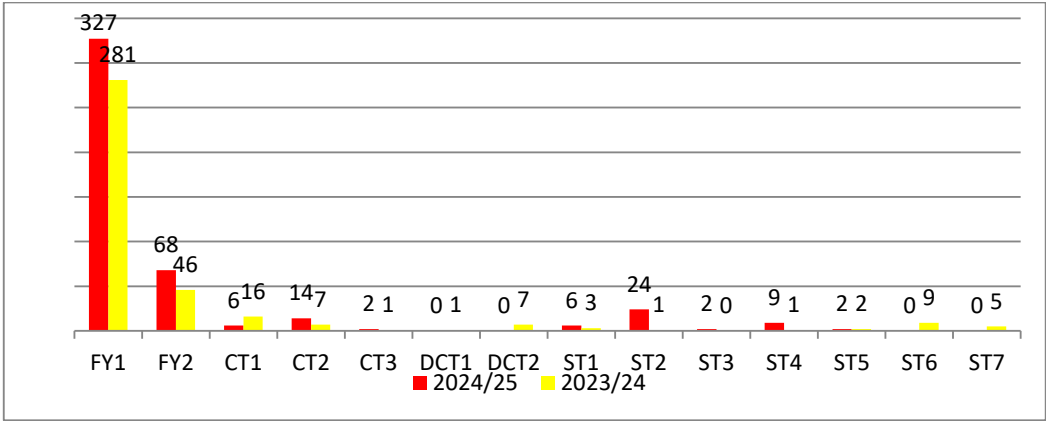
2.4 24/25 UHSussex Exception reports by Grade

Foundation grade doctors submitted the vast majority of ERs at UHSussex in 24/25.

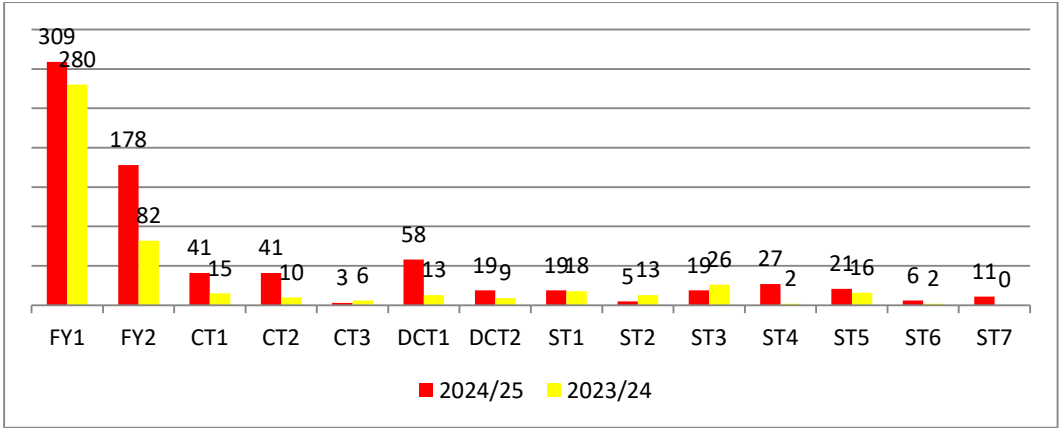
Graph 4a 24/25 WGH sites ER by Grade 24/25



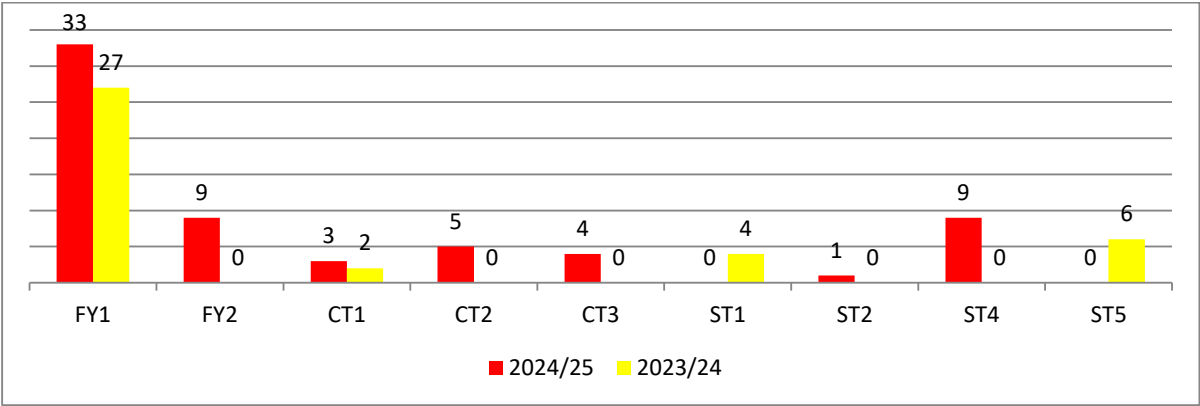
Graph 4b 24/25 SRH sites ER by Grade 24/25



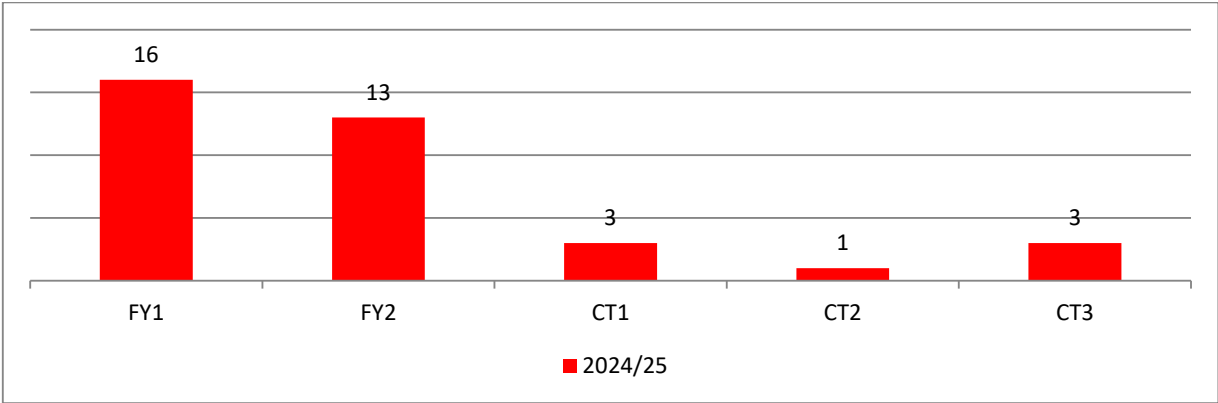
Graph 4c RSCH ER by Grade 24/25



Graph 4d PRH ER by Grade 24/25



Graph 4e HealthRota pilot ER data by Grade 24/25



2.5 Missed breaks

Under the terms and conditions of the Junior doctors contract (2016) RDs should receive;

- At least one 30 minute paid break for a shift rostered to last more than 5 hours
- A second 30 minute paid break for a shift rostered to last more than 9 hours
- A third 30 minute break when working a night shift of 12 hours or longer

No GoSW fines were incurred for missed breaks in 24/25 (fines can be levied for missing 25% of breaks across a 4 week rota cycle – no ER pattern met this criteria).

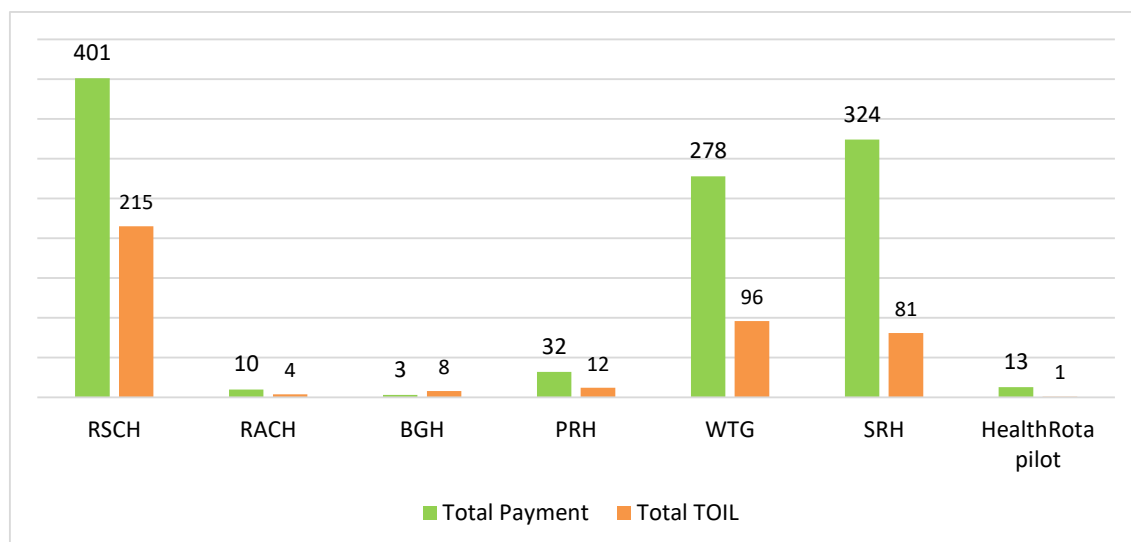
Numbers of ER for missed breaks at each site in 24/25 are reported below.

- 121 WTG sites
- 99 SRH site
- 185 RSCH sites
- 19 PRH sites

RDs are not remunerated with TOIL or payment for missed breaks since they have already received payment for these hours. This is thought to lead to under reporting. This will be unchanged under proposed reforms. In 24/25 there has been investment in rest facilities at RSCH site with Mess relocation and refurbishment. The Guardian fines fund has contributed £6,000 to garden space redevelopment at WGH site. Rest spaces across sites are well utilised and RD mess-lead activities and leisure have been supported by the GOSW fine fund (Table 3).

2.6 TOIL versus payment ER

The majority of ERs of ERs at UHSussex in 24/25 were agreed as payment (72%)

Graph 5: UHSussex TOIL v Payment by site 24/25

Key change to process National Framework reform impacting medical workforce

- **All ER <2hrs to be processed centrally by Medical workforce / HR.** RDs decision to work additional hours should not be questioned or challenged. (Graph 6 below demonstrates in 24/25 this was >90% of ER).
- RDs may be required to provide **proof of hours worked** with Geolocation time stamp (such as screen shot of Google maps at time / location hours were worked – this will not be required for non resident on call shifts).
- **ERs should be processed within 7 days** with TOIL allocated (but not necessarily taken) within 10 days
- Doctors select TOIL / payment: **TOIL and payment cannot be substituted and should be facilitated.** (Graph 5 above majority of ERs at UHSussex 24/25 agreed as Payment).

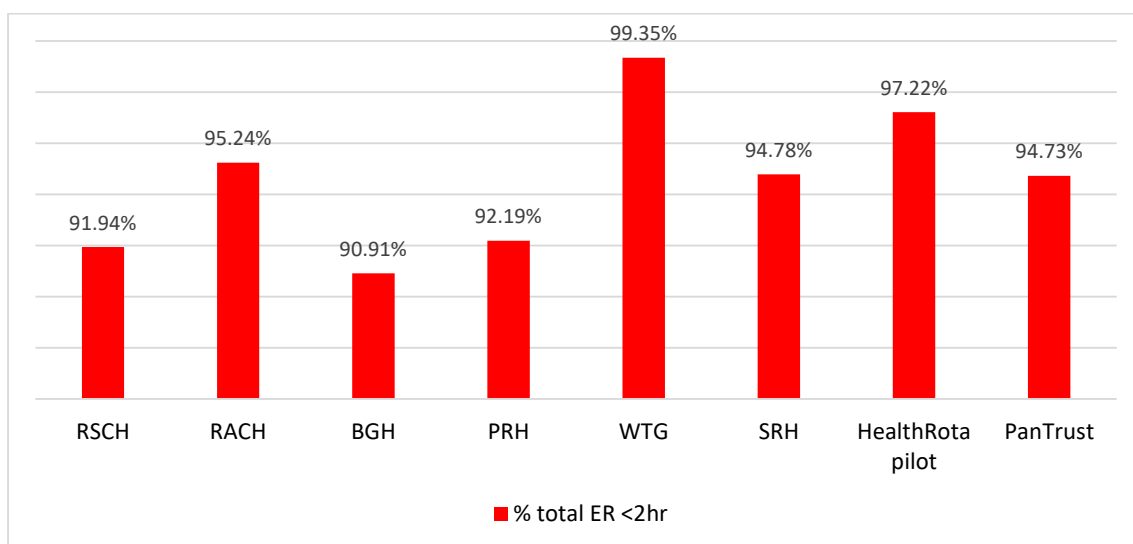
Risks

- Increased pressure on medical workforce team to deliver new contractualised changes.
- Higher number of ERs agreed as payment over TOIL leading to exhaustion in RD / LED workforce and financial pressures for budget holders.
- Increased role for GOSW to investigate unsafe working practices while ensuring no detriment and protecting confidentiality of reporter protected (substantial financial penalties for data breaches which apply per doctor affected)
- Valid ERs with insufficient detail may be 'rejected' by Medical workforce in a binary process to meet hard time line 7 days to process / 10 days to allocate TOIL. This reduces quality of the ER process without clinician involvement and support available to RD.

Actions / requirements

- Medical workforce team resourcing to meet increasing demands and arrangement to cover leave (GOSW)
- Essential HealthRota ER software modifications by 16th September 2025 to meet these changes.

Graph 6: UHSussex: % ERs under 2 hours 24/25



3.0 Exception report data: Educational supervisors closure times 24/25

Under the JDC (2016) educational supervisors have been required to action ERs within 7 days. This ensures trainees working additional hours receive timely remuneration with time off in lieu (TOIL) or payment and identified concerns can be acted upon swiftly. In 24/25 Educational supervisors (ES) have closed 46% of exception reports at UHSussex within 7 days of submission.

Delays to closing ER may result in RDs who have worked additional hours being unable to access rest / TOIL. Under the JDC (2016) at UHSussex the educational supervisor has been the 'arbiter' for the decision of ER validity and may have challenged a doctor's decision to stay late. Doctors were able to appeal decisions to 'reject ERs' via the GOSW. In the National Exception reporting survey RDs reported involvement of supervisors in this way as a major barrier to ER due to 'fear of backlash from clinical departments or supervisors'. Respondents also cited 'fear / lack of time for supervisor meetings' as a reason for non-reporting.

Key changes as result of ER reform / contractualisation framework impacting clinicians and education teams:

- Educational and clinical supervisors **removed** from ER sign off process.
- **DME manages ALL educational ER** and can take action to reinstate educational opportunities.
- **Confidentiality structure** ensures ER information is not shared directly with supervisors or clinical teams without doctors explicit agreement.
- **Significant departmental fines for confidentiality breaches (Fine £500 per doctor affected)**
- **Doctors must be able to ER within 14 days of starting work.** Doctors have to demonstrate they have access by submitting a 'test report'. **(Penalty £250 per doctor / week from Sept increasing to £500 per doctor / week from Feb 2025).**

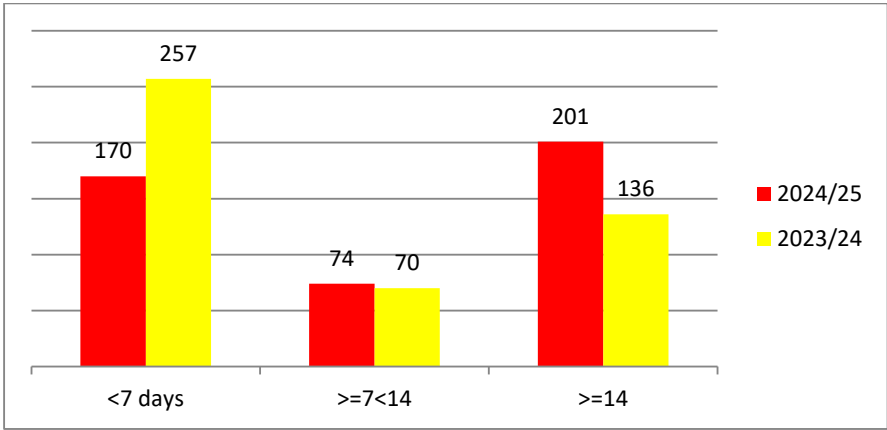
Risks

- In removing clinicians from the process 'supportive departments' will lose insight and abilities to affect change.
- Majority of ERs now processed by Medical workforce teams / non clinicians; reducing abilities to identify trainees requiring support and offer tailored pastoral care.
- Financial penalties to Trust as a result of unintentional confidentiality breaches require assessment of who has access to ER data and attention to weaknesses in the system which could lead to information leak.
- Significant financial penalties for lead employers who have not given RDs access to ER within 14 days of starting work.

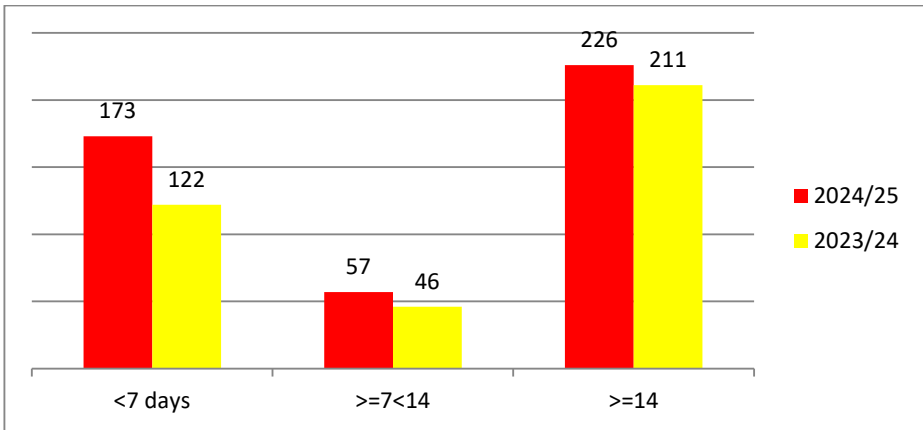
Actions/ requirements

- Access to ER incorporated into on-boarding with submission of ‘test report’. There is scope to include this in Trust wide induction (utilising ER champions and with a live smart phone ER test report submission).
- Ensuring adequate responsiveness of Medical workforce team so immediate issues can be remedied (i.e.doctors without access to ER)
- Development of high quality educational resources to support ER on HealthRota to ensure all doctors have access.
- LFG (local faculty group) meetings will have greater relevance as may be only opportunity for clinicians and supervisors to have access to ER themes (beyond quarterly Guardian reports) and impact on training. LFG action group to be briefed on changes and impact.

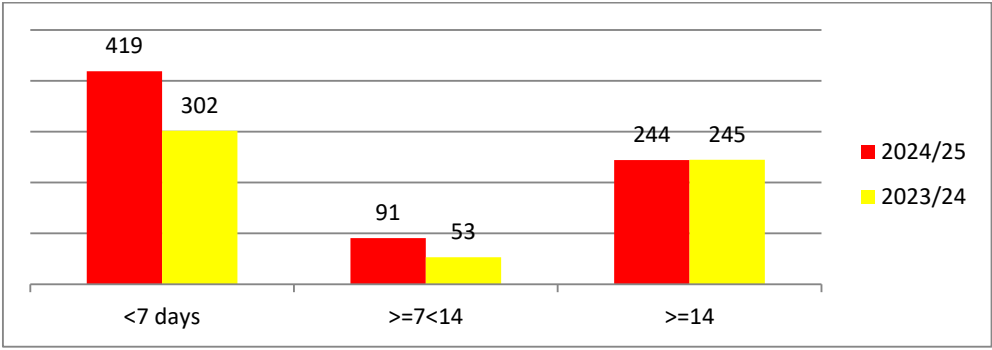
Graph 7a 24/25 Educational supervisor response times WGH site



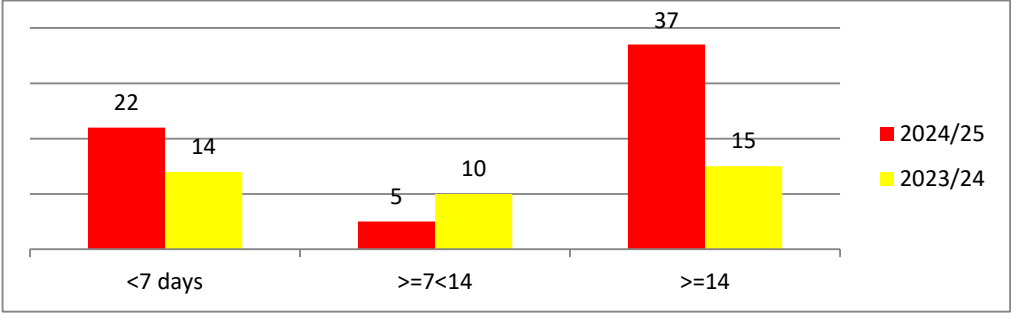
Graph 7b 24/25 Educational supervisor response times SRH site



Graph 7c 24/25 Educational supervisor response times RSCH site



Graph 7d 24/25 Educational supervisor response times PRH site



4.0 Work schedule reviews

A Level 1 work schedule review was issued as below in October 2024 for RSCH ENT trainees with agreement and involvement of ENT and GP TPDs (training programme directors), Chief of service Surgery RSCH and medical workforce leads.

Table 2: Work schedule reviews 24/25

Rota	Adjustment	Affected trainees
RSCH ENT GP ITPs	Change from 40 hours / week to 42 hours / week to reflect 0800 - 1700hrs working day	3 x GP-ITPs RSCH site who received back pay to reflect hours worked since start of post in November 2024.

5.0 Guardian fines

Although most exception reports will result in either payment for the additional hours worked or TOIL, there are circumstances where financial penalties will also be levied. When issued these are levied to the department at the following rate;

	Total hourly value (£)	Hourly penalty rate (£), paid to the doctor	Hourly fine (£), paid to the Guardian of Safe Working Hours
Basic rate	The total value of the fine is four times the <u>basic</u> hourly rate	x1.5 of the <u>basic</u> hourly locum rate	The total hourly value minus the hourly penalty rate paid to the doctor

79 Guardian fines have been issued for 24/25 (WGH 24, SRH 10, RSCH 44, PRH 1) resulting in a total Guardian fines allocation of £6274.63. Full breakdown of GOSW fines 24/25 (Appendix 1).

6.0 Immediate safety concerns

In 24/25 7 immediate safety concerns (ISC) have been submitted and agreed (2 WGH, 4 SRH, 1 RSCH). All have been escalated to divisional management and resolved with responses / actions from relevant Chief of Service included in GOSW quarterly reports including improvements to rota resilience or staffing models if compounded by sickness.

Immediate safety concern 1: Date of exception: 6.1.25 IMT Grade WGH

Trainee description:

'I was one of the Night Regs 6.1.25. Due to last minute sickness we were short of both a DOME and a Medicine clerking SHO. These shifts were put out to locum at the start of the day but [rates of pay] were not escalated until 1600hrs. As a result only one of the shifts was picked up so we had 5 doctors instead of 6 working the night. We came onto 4 patients waiting to be seen; and had a very busy night with 28 referrals made resulting in us handing over 5 to be seen for the day team.

As a result of the poor staffing and busy night I was unable to achieve any break at all and worked well above an acceptable workload. Patient care felt compromised. I would like to add that I felt very upset as I left the shift due to the poor patient care we are currently delivering. When I got home I learnt that the other night SpR had called in sick and that there was another SHO vacancy for the night. I felt hopeless and ended up crying when I got home due to how demoralised and undervalued/appreciated I feel as a doctor having to work stressful shifts with poor and frankly unsafe staffing.'

Immediate safety concern 2: Date of exception: 6.1.25 IMT Grade WGH

Trainee description:

'7.1.25 night shift there were two vacancies for a clerking SHO and Night SpR 2 that were put out to locum at the start of the morning. They escalated the rates at 12:14pm. The SpR shift was picked up after this but the clerking remained vacant meaning we worked at below minimum staffing and the doctors working were stretched and working beyond their supposed role in order to help with the take. We came onto 5 waiting and there were >20 referrals from A&E overnight; with one DOME patient waiting 4 hours 48 minutes to be seen; and another DOME patient waiting 5 hours 15 minutes to be seen. Due to how busy we were I was unable to achieve a meaningful break; and managed approximately 20 minutes in the EF office. We continue to deliver suboptimal patient care and doctors are feeling burnt out and demoralised.'

Immediate safety concern 3: Date of exception: 22.06.24 Maxillofacial surgery ST grade SRH

Trainee description:

[The SHO grade doctor] due to be on shift called in sick at 7am. Start time due was 8am. No SHO/first on call/resident on site cover for my NROC (non-resident on call) shift therefore I was asked to step down and work as resident on call for the full 24hr shift. No breaks [were] taken and [there was] no NROC cover for this period. [I] was covering both registrar and SHO level for the full 24 hour period.

Immediate safety concern 4: Date of exception: 12.7.24 ST grade SRH

Trainee description:

I was the day registrar on the 12.07.2024. It was a short staffed day with no Day 1 SHO (which rota knew from the previous afternoon) and due to last minute sickness - I had no day 1 F1 as well. There was no clerking team. Rotas managed to get one Day 1 F1 who could only clerk in the morning but by afternoon had to go on PTWR (post take ward round) with consultant. I had no twilight registrar as well. One twilight SHO but was told to 'go do procedures' and could not clerk.

I was alone trying to handle take and clerk. Heavy workload with no full team - I was unable to achieve any breaks. Despite escalation and insisting rota to incentivise with escalated rates (which was not agreed) this was a very unsafe level of staffing and overwhelming to deal with - unfortunately not an uncommon situation in SRH.

Immediate safety concern 5 and 6: Date of exception: 5.8.24 and 6.8.24 F1 grade SRH

Trainee description:

I'm creating this exception report to highlight understaffing which led to compromised patient safety. The only staffing for the day was myself (F1); a PA and a consultant cross covering 2 elderly care wards.

I was also on-call that day carrying the crash bleep which meant that I would be leaving my ward staffed with only a PA when I went to MET calls / arrests. A patient became very unwell towards the end of my shift and I began to manage the situation by myself before I realised I needed help. The patient was eventually managed by myself and the on-call SHO but on reflection of the situation we realised the patient had missed 4 days of important medication.

It was not picked up that morning that the patient had not been receiving her medication for 4 days and that the patient should have been for consultant review that day. Further to this; we were 'down' an F1 on the met call team and I was asked to hold another bleep. The situation was explained to the rota team not just by me but by the consultant covering and we were assured that we would receive help from another ward but no help came.

Trainee description

Similar to my previous exception report; I would like to clarify that this is because of understaffing. I was the only person who rota'd to be on this day along with a PA. Again I was on the met call team which meant I would be leaving the ward empty in the event of a met call.

We were also down 2 people on the met call team. None of these shifts were advertised as escalated rates despite the last minute nature of these shifts. Despite consultants raising this with management this did not get approved. Further to this; two F1s were asked by the rota team to carry the crash bleeps for the whole day.

Immediate safety concern 7: Date of exception: 1.1.25 F1 grade / Stroke Medicine RSCH**Trainee description**

Only doctor on ward covering 47 patients on list. Unable to take breaks constantly being bleeped to review patients; plus have to see patients with consultant in the morning for some outliers. Then bleeped to see outliers all day. Unmanageable workload. I felt that I couldn't safely provide care for all of these patients and question the appropriateness of an F1 being the only doctor covering this many acute patients just because it's a bank holiday. I didn't take a break all day and had to finish an hour late to safely hand over to night team. I have raised my concerns with Consultant today.

7.0 UHSussex Agency and Locum Expenditure 24/25 (Appendix 2)**8.0 UHSussex Medical Workforce: Vacancy data and forward plan 24/25 (Appendix 3)****9.0 UHSussex Rota compliance (Appendix 4)****10.0 Resident doctors fora**

There have been 9 Resident doctors in 24/25. At the request of the RD / LED representatives the meeting has moved to a monthly format on MS Teams with invited speakers. Speakers have included the Freedom to speak up Guardian and Guest Speaker (Health & Wellbeing Engagement Programme Manager) discussing 'Sexual Safety Charter in Healthcare' / speaking up in the workplace on sexual misconduct.

This year there has been RDF trainee representation across specialties and sites. Meetings have been attended by medical workforce, educational leads and RD well-being senior nurse educational fellows.

Topic for discussion have included:

- ER trends
- Escalating staffing concerns / escalation of rates of pay for bank and locum shifts
- HealthRota implementation for exception reporting and Protected development time for doctors in training
- STAM (statutory and mandatory training) requirements prior to booking study leave
- Rest facilities – relocation of RSCH doctors mess, facilities at SRH and essential equipment provision at WGH.
- Distribution of Guardian fines (Appendix 5)

Unresolved issues via RDF requiring focus in 25/26:

- There is currently **no UHSussex trust wide 'too tired to drive'** standard operating policy (SoP) to meet the JDC (2016) and ensure doctors are provided suitable accommodation or the cost of a return taxi home if they declare themselves too tired to drive following an on call shift. At present responsibility rests with clinical site teams. Without an agreed SoP site teams lack awareness of contractual obligations. Doctors are 'put off' requesting accommodation; even if this is available and the lack of a formal process leads to delay. Doctors at risk include those working high intensity shifts (ED / acute specialties) and those at rotational placements far from home. Trainees have been advised to submit ISCs in all instances where they feel their safety is at risk.
- Despite projects being agreed and voted on by a quorate RDF of appointed BMA and trainee representatives, changes to the procurement process 24/25 have significantly **delayed allocation of funds generated by Guardian fines some of >90 days**. The process is currently under review by medical workforce management and outstanding bids investigated. A clear process which facilitates transfer of funds within 28days (to benefit affected RD cohort incurring safety breaches / working additional hours) is required.
- Exception reporting reform will mean **greater focus on Guardian fines disbursement** with emphasis on granularity i.e. fines not dispersed on Trust wide basis but proportionately to high ER volume departments / specialties.
- Key changes to ER as part of National framework will have major impact for RDs/LEDs which can be monitored via RDF. There will increased emphasis on **demonstrating RDs/ LEDs exception reporting at UHSussex do not experience any actual or perceived detriment from exception reporting**. This will require 'pulse surveys' of exception reporting to be included in quarterly Guardian reports. There will also be changes to quarterly Guardian report format following an agreed National template which allows centralised data collection and regional comparison. NHS employers place emphasis on the 'magnitude of the task' for GOSW and medical workforce teams in implementing contractualised ER reform by 12.9.25.

APPENDIX 1: UHSUSSEX GoSW Fines 24/25

- Breach A: Exceeding 13 hr shift length
- Breach B: Unable to achieve the minimum 11 hours rest between resident shifts
- Breach C: Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC)

WTG GoSW Fines 24/25

Department / Specialty	Grade	Exception Date	Doctor receives X1.5	GOSWH receives x 2.5	Breach
WTG General Surgery	FY1	08/05/2024	65.28	108.88	A
WTG General Surgery	FY1	12/05/2024	65.28	108.88	A
WTG General Surgery	FY2	13/05/2024	75.58	125.98	B
WTG General Surgery	FY2	14/05/2024	37.79	62.99	B
WTG General Surgery	FY2	15/05/2024	75.58	125.98	B
WTG General Surgery	FY2	17/05/2024	37.79	62.99	B
WTG General Surgery	FY2	19/05/2024	37.79	62.99	A
WTG Lower GI	FY2	02/08/2024	28.34	47.24	A
WTG General Surgery	FY1	10/08/2024	48.96	81.66	A
WTG General Surgery	FY1	11/08/2024	16.32	27.22	A
WTG Haematology	CT2	16/08/2024	44.72	74.53	A
WTG Urology	CT2	22/08/2024	67.08	111.80	A
WTG Paediatrics & Neonates (Unscheduled Care)	ST8	14/10/2024	65.01	108.33	A, B
WTG Lower GI (Colorectal) / Emergency (Planned Care & Cancer)	FY2	28/10/2024	27.59	45.97	A
WTG Lower GI (Colorectal) / Emergency (Planned Care & Cancer)	FY2	30/10/2024	51.59	85.98	A
WTG Lower GI (Colorectal) / Emergency (Planned Care & Cancer)	FY2	07/11/2024	56.69	94.49	A
WTG Urology (Planned Care & Cancer)	CT2	07/11/2024	113.36	188.92	A
WTG Lower GI (Colorectal) / Emergency (Planned Care & Cancer)	FY1	07/11/2024	32.64	54.44	A, B
WTG General Practice	GPST3	13/11/2024	41.38	68.94	B
WTG General Surgery	FY1	14/12/2024	32.64	54.44	A
WTG General Surgery	FY1	18/01/2025	16.32	27.22	A
WTG General Surgery	FY1	19/01/2025	16.32	27.22	A
WTG Paediatrics & Neonates (Unscheduled Care)	ST8	12/02/2025	97.52	162.50	A, B
WTG General Surgery	FY1	19/02/2025	16.32	27.22	A

SRH WTG GoSW Fines 24/25

Department / Specialty	Grade	Exception Date	Doctor receives X1.5	GOSWH receives x 2.5	Breach
SRH Orthopaedics	FY2	12/04/2024	113.37	188.97	A
SRH O&Max Surgery	ST3	19/06/2024	170.04	283.38	C
SRH General Surgery	FY2	13/08/2024	37.79	62.99	A
SRH General Surgery	FY2	24/08/2024	56.69	94.49	B
SRH General Surgery	FY2	22/08/2024	37.79	62.99	B, A
SRH Upper GI/Breast Surgery	FY2	22/09/2024	28.34	47.24	A

SRH Upper GI/Breast Surgery (Planned Care & Cancer)	FY2	04/11/2024	94.48	157.48	A
SRH Upper GI/Breast Surgery (Planned Care & Cancer)	FY2	05/11/2024	75.58	125.98	A
SRH Obs & Gynae	ST1	11/03/2025	32.64	54.40	A, B
SRH Cardiology	FY1	11/03/2025	16.32	27.22	A, B

RSCH, RACH, BGH, SHE WTG GoSW Fines 24/25

Department / Specialty	Grade	Exception Date	Doctor receives X1.5	GOSWH receives x 2.5	Breach
RSCH Gastroenterology	FY1	12/04/2024	24.48	40.83	A
RSCH Gastroenterology	FY1	03/05/2024	16.32	27.22	A
RSCH Stroke	FY2	09/05/2024	32.69	54.48	B, A
RSCH Gastroenterology	FY2	19/05/2024	89.38	148.97	A
RSCH Gastroenterology	FY1	23/05/2024	16.32	27.22	A, B
RSCH O&G	FY2	23/05/2024	13.80	22.99	A
RSCH Gastroenterology	FY1	27/05/2024	16.32	27.22	A
RSCH Gastroenterology	FY2	31/05/2024	70.48	117.47	A
RSCH Gastroenterology	FY1	03/06/2024	23.83	39.73	A, B
RSCH Gastroenterology	FY2	04/06/2024	89.38	148.97	A
RSCH O&Max Surgery	DCT1	07/06/2024	153.82	256.36	A
RSCH Gastroenterology	FY2	13/06/2024	42.14	70.23	A
RSCH Geriatric Medicine	FY1	23/06/2024	54.27	90.49	A, B
RSCH Geriatric Medicine	FY1	02/08/2024	36.40	60.70	A
RSCH GUM	FY1	02/08/2024	40.15	66.95	A
RSCH GUM	FY1	03/08/2024	23.83	39.73	A
RSCH Geriatrics	FY1	08/08/2024	28.24	47.09	A
RSCH Cardiology	FY1	22/08/2024	16.32	27.22	A
RSCH Cardiology	FY1	27/08/2024	8.16	13.61	A
RSCH Cardiology	FY2	22/08/2024	27.59	45.97	A
RSCH Gastroenterology	FY1	29/08/2024	28.24	47.09	A
RSCH Orthopaedics	FY2	05/09/2024	32.69	54.48	B
RSCH General Surgery	FY1	20/09/2024	28.24	47.09	A
RSCH Cardiology	FY1	19/09/2024	32.64	54.44	A
RSCH Orthopaedics	FY2	22/09/2024	46.49	77.47	A
RSCH General Surgery	FY1	08/10/2024	28.24	47.09	A
RSCH Cardiology	FY1	16/10/2024	32.64	54.44	D, A
RSCH Cardiology	FY1	28/10/2024	8.16	13.61	A
RSCH Cardiology	FY1	03/11/2024	32.64	54.44	A
RSCH Cardiology	FY1	22/11/2024	32.64	54.44	A
RSCH Stroke	FY2	23/11/2024	32.69	54.48	A
RSCH General Surgery	FY1	14/12/2024	15.73	26.22	B
RSCH General Medicine (Internal)	FY1	19/12/2024	28.24	47.09	A
RSCH General Medicine (Internal)	FY1	20/12/2024	28.24	47.09	A
RSCH Renal Medicine	FY2	28/12/2024	75.58	125.98	A, B
RSCH Cardiology	FY1	02/01/2025	60.88	101.53	A

RSCH Cardiology	FY1	06/01/2025	60.88	101.53	A
RSCH Cardiology	FY1	11/01/2025	44.56	74.31	A, B
RSCH Cardiology	FY1	19/01/2025	11.92	19.87	A
RSCH GUM	FY2	31/01/2025	32.69	54.48	A
RSCH Dental (Oral and MaxFax Surgery)	DCT1	03/02/2025	142.64	237.73	A
RSCH General Surgery	FY1	17/02/2025	35.75	59.60	A, B
RSCH Cardiology	FY1	24/02/2025	32.64	54.44	A
RSCH Cardiology	FY1	15/03/2025	44.56	74.31	A
RSCH Gastroenterology	FY1	19/02/2025	28.24	47.09	B, A
RSCH Gastroenterology	FY1	21/02/2025	36.40	60.70	B, A
RSCH Stroke Medicine	FY2	27/02/2025	51.59	85.98	B, A
RSCH General (internal) Medicine	FY2	10/03/2025	23.24	38.73	B, A

PRH WTG GoSW Fines 24/25

Department / Specialty	Grade	Exception Date	Doctor receives X1.5	GOSWH receives x 2.5	Breach
PRH General (internal) Medicine	FY1	19/12/2024	20.08	33.48	A

APPENDIX 2: UHS Sussex Agency and Locum Expenditure

TABLE 5A - Summary of Medical & Dental Spend 2024-25

	2024-25 Medical & Dental Staff Spend (Figures in £000s)												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Ave
Medical Locum Spend	£2,838	£3,872	£5,805	£5,053	£3,399	£3,545	£3,451	£3,157	£3,066	£2,998	£3,780	£4,411	£3,781
Medical Agency Spend	£591	£632	£711	£818	£799	£789	£535	£532	£473	£1,566	£633	£473	£713
Total Medical & Dental Spend	£24,520	£26,461	£27,895	£27,363	£26,511	£27,063	£40,218	£27,349	£28,519	£29,149	£28,786	£30,777	£28,718
Agency/Locum Spend as a % of Total Medical Pay	13.98%	17.02%	23.36%	21.46%	15.84%	16.02%	9.91%	13.49%	12.41%	15.66%	15.33%	15.87%	15.86%

2024-25 Comparison Data

Quarter 1	Quarter 2	Quarter 3	Quarter 4
Average	Average	Average	Average
£4,171	£3,999	£3,225	£3,730
£708	£619	£514	£891
£31,264	£31,544	£32,029	£29,571
13.92%	13.14%	11.94%	15.62%

TABLE 5B: Medical & Dental Agency Spend by Division

	2024-25 Medical & Dental Staff Spend (Figures in £000s)												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Ave
Cancer Division	£38	£178	£108	£164	£169	£125	£98	£254	£160	£325	£160	£155	£161
Surgery (RSCH & PRH) Division	£120	£160	£173	£186	£138	£149	£116	£108	£35	£206	£60	£98	£129
Surgery (WOR & SRH) Division	-£9	£44	£51	£82	£93	£73	-£1	-£10	£26	£98	£17	£36	£42
Women & Children Division	£71	£94	£29	£87	£60	£21	£71	-£3	-£7	£38	£46	£1	£42
CSS Division	£65	£138	£76	£83	£46	£62	£144	-£48	£65	£187	£62	£50	£77
Medicine (RSCH & PRH) Division	-£0	£7	£0	£0	£16	£14	£12	£4	£16	£13	£1	£26	£9

2024-25 Comparison Data

Quarter 1	Quarter 2	Quarter 3	Quarter 4
Average	Average	Average	Average
£108	£153	£171	£213
£151	£158	£86	£121
£29	£83	£5	£50
£65	£56	£20	£28
£93	£64	£54	£99
£2	£10	£11	£13

Medicine (WOR & SRH) Division	£197	-£129	£167	-£74	£219	£121	£2	£38	£135	£260	£132	£145	£101	£78	£88	£58	£179
Specialist Division	£96	£125	£92	£279	£51	£213	£81	£175	£31	£426	£145	-£48	£139	£104	£181	£95	£175
Corporate	£13	£14	£14	£11	£6	£11	£12	£13	£14	£13	£12	£11	£12	£14	£9	£13	£12
TOTAL	£591	£632	£711	£818	£799	£789	£535	£532	£473	£1,566	£633	£473	£713	£644	£802	£514	£891

TABLE 5C: Medical & Dental Locum Spend by Division

2024-25 Comparison Data

	2024-25 Medical & Dental Staff Spend (Figures in £000s)													Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Ave	Average	Average	Average	Average
Cancer Division	£70	£30	£131	£129	£102	£144	£147	£104	£117	£145	£184	£186	£124	£77	£125	£123	£172
Surgery (RSCH & PRH) Division	£413	£674	£1,319	£1,254	£710	£983	£1,078	£818	£786	£617	£904	£1,137	£891	£802	£982	£894	£886
Surgery (WOR & SRH) Division	£362	£369	£728	£598	£612	£541	£388	£383	£374	£172	£402	£485	£451	£486	£584	£381	£353
Women & Children Division	£478	£403	£681	£455	£504	£455	£465	£379	£449	£586	£473	£378	£475	£521	£471	£431	£479
CSS Division	£262	£451	£340	£389	£367	£314	£401	£389	£296	£376	£492	£467	£379	£351	£357	£362	£445
Medicine (RSCH & PRH) Division	£262	£400	£664	£594	£201	£212	£85	£189	£215	£282	£243	£267	£301	£442	£336	£163	£264
Medicine (WOR & SRH) Division	£699	£1,283	£1,460	£1,209	£618	£591	£783	£705	£520	£651	£789	£940	£854	£1,147	£806	£669	£793
Specialist Division	£280	£253	£480	£416	£278	£304	£95	£186	£297	£160	£282	£547	£298	£337	£333	£192	£330
Corporate	£11	£11	£2	£8	£7	£1	£9	£4	£14	£9	£12	£4	£8	£8	£5	£9	£8
TOTAL	£2,838	£3,872	£5,805	£5,053	£3,399	£3,545	£3,451	£3,157	£3,066	£2,998	£3,780	£4,410	£3,781	£4,171	£3,999	£3,225	£3,730

TABLE 5D: Agency & Locum Spend as a % of Total Medical Pay

2024-25 Comparison Data

	2024-25 Agency & Locum Spend as a % of Total Medical Pay													Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Ave	Average	Average	Average	Average
Cancer Division	9.5%	17.0%	23.5%	22.7%	21.8%	20.5%	13.6%	25.1%	17.7%	31.6%	24.2%	22.7%	20.8%	16.7%	21.7%	18.8%	26.2%
Surgery (RSCH & PRH) Division	11.4%	16.3%	26.2%	25.5%	16.5%	20.2%	14.3%	16.7%	14.4%	14.5%	17.0%	19.5%	17.7%	18.0%	20.7%	15.1%	17.0%

Surgery (WOR & SRH) Division	11.2%	12.5%	21.4%	18.6%	19.7%	17.6%	7.8%	10.7%	11.2%	8.4%	11.8%	14.3%	13.8%	15.0%	18.6%	9.9%	11.5%
Women & Children Division	16.1%	14.3%	19.5%	15.6%	15.7%	13.1%	9.9%	10.5%	11.4%	15.6%	13.6%	9.2%	13.7%	16.6%	14.8%	10.6%	12.8%
CSS Division	17.6%	25.6%	19.8%	22.5%	19.6%	18.0%	17.8%	16.0%	16.1%	23.0%	24.0%	21.2%	20.1%	21.0%	20.0%	16.6%	22.7%
Medicine (RSCH & PRH) Division	9.5%	13.6%	21.7%	20.2%	8.0%	8.0%	2.1%	6.2%	7.6%	8.9%	7.6%	8.9%	10.2%	14.9%	12.1%	5.3%	8.5%
Medicine (WOR & SRH) Division	29.4%	33.1%	41.4%	33.4%	24.7%	21.8%	15.0%	21.1%	18.2%	22.6%	24.0%	26.9%	26.0%	34.6%	26.7%	18.1%	24.5%
Specialist Division	15.6%	14.8%	20.6%	24.4%	13.1%	19.0%	5.2%	14.7%	12.3%	21.1%	15.6%	16.9%	16.1%	17.0%	18.8%	10.7%	17.8%
Corporate	1.2%	1.2%	0.8%	1.0%	0.6%	0.5%	0.6%	0.8%	1.2%	1.0%	1.1%	0.6%	0.9%	1.1%	0.7%	0.9%	0.9%
Agency/Locum Spend as a % of Total Medical Pay	14.0%	17.0%	23.4%	21.5%	15.8%	16.0%	9.9%	13.5%	12.4%	15.7%	15.3%	15.9%	15.9%	18.1%	17.8%	11.9%	15.6%

APPENDIX 3: UHSussex Medical Workforce: Vacancy data and forward plan 24/25

Site	Department	Gaps for Q4 (Jan - Mar)	WTE	Duration	Challenge and forward plan for this period

WTG	Acute Medicine	1 x F1	1	4 months	Deanery vacant post. Filled from April 2025
WTG	Acute Medicine	1 x CT1	1	6 months	Ongoing recruitment
WTG	Gastroenterology	1 x F2	1	2 months	Trainee completed training. Post filled from April 2025
WTG	Respiratory Medicine	1 x ST4+	1	4 months	Deanery vacant post. Filled from June 2025
WTG	Geriatrics	1 x ST1	1	4 months	Filled from April 2025
WTG	Geriatrics	1 x Trust Dr (CT1)	1	4 months	Filled from April 2025
WTG	Geriatrics	1 x Trust Dr (CT1)	1	6 months	Resignation. Ongoing recruitment
WTG	Geriatrics	1 x CT3	1	2 months	Filled from April 2025
WTG	Dermatology	1 x ST4+	1	6 months	Deanery vacant post. Trainee withdrew
WTG	Diabetes and Endocrinology	1 x Trust Dr (CT1)	1	3 months	Maternity leave. Filled from May 2025
WTG	Cardiology	1 x Trust Dr (CT1)	1	2 months	Filled from March 2025
WTG	Cardiology	1 x Trust Dr (CT1)	1	2 months	Filled from April 2025
WTG	General Medicine	1 x Trust Dr (CT1)	1	12 months	Ongoing recruitment
WTG	Paediatrics	1 x Trust Dr (ST4+)	2	8 months	Ongoing recruitment. To be replaced by training post from October 2024
WTG	Paediatrics	1 x Clinical Fellow	1	8 months	Ongoing recruitment. To be replaced by training post from October 2024
WTG	Paediatrics	1 x Trust Dr (CT1)	1	6 months	Being reviewed by department
WTG	Intensive Care Medicine	1 x ST4+	1	6 months	Deanery vacant post - approval to recruit until May 2025
WTG	Anaesthetics	1 x Trust Dr	1	12 months	Being reviewed by department
WTG	Trauma & Orthopaedics	1x Trust Dr (ST3+)	1	6 months	Unpaid leave. Ongoing recruitment
WTG	Trauma & Orthopaedics	1x Trust Dr (CT1)	1	6 months	Ongoing recruitment

Site	Department	Gaps for Q4 (Jan - Mar)	WTE	Duration	Challenge and forward plan for this period
SRH	Stroke Medicine	1 x GPST	1	2 months	Deanery vacant post. Filled from April 2025

SRH	Diabetes and Endocrinology	1 x Trust Dr (CT1)	1	8 months	Ongoing recruitment
SRH	Geriatrics	1x Trust Dr (CT1)	1	8 months	Resignation. Ongoing recruitment
SRH	Geriatrics	1x Trust Dr (CT1)	1	1 month	Resignation. Filled from April 2025
SRH	General Medicine	1x Trust Dr (CT1)	1	4 months	Filled from April 2025
SRH	Respiratory Medicine	1x Trust Dr (CT1)	1	4 months	Filled from April 2025
SRH	Emergency Medicine	1x ST4+	1	12 months	Deanery vacant post. Partially filled (0.5 WTE) by Fixed Term Specialty Doctor
SRH	Emergency Medicine	1x Clinical Fellow	1	12 months	Maternity leave
SRH	Emergency Medicine	1 x GPST	1	5 months	Filled from April 2025
SRH	Oral Surgery	1x ST3+	1	12 months	Deanery vacant post
SRH	Orthodontics	1x ST3+	1	12 months	Deanery vacant post
SRH	Trauma & Orthopaedics	1x ST3 +	1	12 months	Deanery vacant post. Filled - start date TBC
SRH	Trauma & Orthopaedics	1 x Trust Dr (CT1)	1	12 months	Ongoing recruitment
SRH	Rheumatology	1x ST4+	1	12 months	Deanery vacant post
SRH	Microbiology	1xHST	1	6 months	Deanery vacant post - trainee on OOP. Filled from March 2025
SRH	Paediatrics	1 x GPST	1	4 months	Maternity leave
SRH	Paediatrics	1 x Clinical Fellow	1	8 months	Ongoing recruitment. Post to be replaced by a trainee post in September 2025
SRH	Paediatrics	1x ST4+	1	6 months	Deanery vacant post - filled from March 2025

Site	Department	Gaps for Q4 (Jan - Mar)	WTE	Duration	Challenge and forward plan for this period
RSCH	Emergency Medicine	5 x ST4+	5	6 months	Vacant deanery posts. Ongoing recruitment.
RSCH	Emergency Medicine	1 x ST4+	1	6 months	Maternity leave
RSCH	Emergency Medicine	1 x ST4+	1	6 months	HEMS doctor. Deanery vacant post
RSCH	Emergency Medicine	2 x CT3	2	6 months	Vacant deanery posts. Ongoing recruitment
RSCH	Emergency Medicine	1 x Clinical Fellow	1	6 months	Resignation. Filled from April 2025
RSCH	Emergency Medicine	1 x Clinical Fellow	1	4 months	Resignation. Ongoing recruitment
RSCH	Diabetes & Endocrinology	1 x ST4+	1	6 months	Deanery vacant post
RSCH	Genito-Urinary Medicine	3 x ST4+	3	12 months	Deanery vacant posts
RSCH	Acute Medicine	1 x F1	1	4 months	Deanery vacant post. Filled from April 2025

RSCH	Elderly Medicine	2 x F1	2	4 months	Deanery vacant post. Filled from April 2025
RSCH	Elderly Medicine	1 x GPST	1	2 months	Trainee rotated to General Practice. Filled from April 2025
RSCH	Respiratory Medicine	2 x Clinical Fellow	2	8 months	Ongoing recruitment
RSCH	Respiratory Medicine	1 x CT1	1	4 months	Deanery vacant post. Filled from April 2025
RSCH	Gastroenterology	1 x CT1	1	4 months	Deanery vacant post. Filled from April 2025
RSCH	Gastroenterology	1 x ST4+	1	6 months	Resignation
RSCH	Respiratory Medicine	1 xST4+	1	12 months	Deanery vacant post
RSCH	Anaesthetics	11x Clinical Fellow	11	12 months	Ongoing recruitment
RSCH	Anaesthetics	3 x Clinical Fellow	3	12 months	Ongoing recruitment
RSCH	Intensive Care	1 x ST3+	2	6 months	Deanery vacant post
RSCH	Intensive Care	1 x Clinical Fellow	1	6 months	Ongoing recruitment
RSCH	General Surgery	1x Clinical Fellow (ST3)	1	12 months	Filled from April 2025
RSCH	General Surgery	1 x F1	1	4 months	Deanery vacant post. Filled from April 2025
RSCH	ENT	1 x Clinical Fellow	1	6 months	Ongoing recruitment
RSCH	Orthodontics	1 x ST3+	1	12 months	Deanery vacant post
RSCH	Radiology	3 x ST1	3	6 months	Deanery vacant posts
RSCH	Vascular Surgery	1 x CT2	1	6 months	Deanery vacant post
RSCH	Vascular Surgery	2 x Clinical Fellow	2	6 months	
RSCH	Cardiology	1 x F1	1	4 months	Deanery vacant post. Filled from April 2025
RSCH	Cardiac Surgery	1x ST3+	1	12 months	Deanery vacant post
RSCH	Trauma and Orthopaedics	2 x ST1	2	6 months	Deanery vacant post. Filled from March 2025
RSCH	Trauma and Orthopaedics	1 x Clinical Fellow	1	1 month	filled from March 2025
RSCH	Trauma and Orthopaedics	2 x Senior Clinical Fellow	2	6 months	Filled - 1 in April 2025 and 1 start date TBC
RSCH	Renal Medicine	1x Clinical Fellow	1	12 months	Ongoing recruitment
RSCH	Neurology	1 x Clinical Fellow	1	6 months	Resignation. Filled from April 2025
RSCH	Haematology	1 x Clinical Fellow	1	6 months	Filled from April 2025
RSCH	Gastroenterology	1 x Clinical Fellow	1	12 months	Ongoing recruitment
RSCH	Genito-Urinary Medicine	1 x Clinical Fellow	1	12 months	
RSCH	Neurosurgery	1 x Clinical Fellow	1	12 months	Awaiting advertising approval

RSCH	Obstetrics and Gynaecology	1 x F2	1	2 months	Parental leave. Filled from April 2025
RACH	Paediatrics	1x Clinical Fellow (St1)	1	12 months	Ongoing recruitment
RACH	Paediatrics	1x ST4+	1	6 months	Maternity leave
RACH	Paediatrics	1x ST4+	1	6 months	Deanery vacant post. Filled from March 2025
RACH	Neonatology	1x ST4+	1	12 months	Deanery vacant post. Filled from March 2025
RACH	Neonatology	1 x ST3+	1	6 months	Maternity leave. Filled from March 2025
RACH	Neonatology	1 x ST1	1	12 months	Deanery vacant post. No recruitment
RSCH	Haematology	1x ST3+	1	12 months	Deanery vacant post. Filled from March 2025
RSCH	Histopathology	2 x ST1	1	12 months	Deanery vacant post
RSCH	Histopathology	2 x ST4	1	6 months	Deanery vacant post
RSCH	Nuclear Medicine	2x ST3+	2	12 months	Deanery vacant posts

Site	Department	Gaps for Q4 (Jan - Mar)	WTE	Duration	Challenge and forward plan for this period
PRH	Acute Medicine	1x ST3+	1	6 months	Vacant deanery post. Ongoing recruitment
PRH	Acute Medicine	1 x CT2	1	4 months	Deanery vacant post. Filled from April 2025
PRH	Acute Medicine	1 x F2	1	4 months	Deanery vacant post. Filled from April 2025
PRH	Diabetes and Endocrinology	1 x F2	1	4 months	Deanery vacant post. Filled from April 2025
PRH	Rehabilitation Medicine	1 x F2	1	8 months	Deanery vacant post
PRH	Respiratory Medicine	1 x F1	1	4 months	Deanery vacant post. Filled from April 2025
PRH	Acute Medicine	1 x F1	1	8 months	Deanery vacant post
PRH	Elderly Medicine	2 x Clinical Fellow	2	4 months	Filled from April 2025
PRH	Diabetes and Endocrinology	1 x Clinical Fellow	1	4 months	Ongoing recruitment
PRH	Rehabilitation Medicine	1 x Clinical Fellow	1	4 months	Filled from March 2025
PRH	Obstetrics and Gynaecology	1 x Clinical Fellow	1	6 months	Filled from March 2025
PRH	Neurology	1 x Clinical Fellow	1	12 months	Maternity leave
PRH	Neurology	1 x Clinical Fellow	1	12 months	Resignation. Ongoing recruitment
PRH	Neurosurgery	1 x ST4+	1	12 months	Deanery vacant post.
PRH	Trauma & Orthopaedics	1 x FY1	1	4 months	Filled from April 2025

PRH	Rheumatology	1 x HST	1	4 months	Maternity leave. Filled from May 2025

APPENDIX 4: UHSussex Rota compliance 24/25

	Non compliance	Proposed solution
Microbiology SpR x WGH	No more than 3 on call duty periods in 7 days unless agreed at local level.	Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota. 48hour rest period after 7 day on call.
Microbiology SpR x SRH	No more than 3 on call duty periods in 7 days unless agreed at local level.	Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota of low intensity.
St Wilfrid's Hospice SHO x 6 SRH	No more than 3 on call duty periods in 7 days unless agreed at local level.	Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota of low intensity
ENT (Otolaryngology) SpR RSCH	No more than 3 on call duty periods in 7 days unless agreed at local level.	Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota of low intensity.

APPENDIX 5: Agreed bids for JDF GoSW fines 24/25

Bid/ Project overview in trainees words	Trainee cohort	Total amount
May 24 SRH Camping trip	SRH (all grades)	£700
August 24 SRH Mess Bell Tents x 3	SRH (all grades)	£1107
Dec 24 SRH Pottery painting event	SRH (all grades)	£500
Dec 24 Worthing Mess coffee machine	Worthing RD (all grades)	£300
Dec 24 RSCH Mess sports activities and crafts	RSCH RD (all grades)	£474

Jan 25 Worthing Mess Garden renovation project	Worthing RD (all grades)	£6000
Feb 25 SRH Mess Nintendo switch controllers	SRH (all grades)	£55
Feb 25 WGH Mess dartboard	WGH (all grades)	£22
March 25 SRH Electronic keyboard	SRH (all grades)	£1000
March 25 RSCH Pottery painting event	RSCH F2 grades	£500

Annual Workforce Equality Report 2025

If you would like this report in another format (e.g. large print) please contact uhsussex.equality@nhs.net

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Executive Summary

The Annual Workforce Equality Report 2025 presents findings from a range of analytical methods to identify differential outcomes and experiences within the Trust's workforce between demographic groups and characteristics. These included measures of relative likelihood and disparity ratios (for example comparing the chances of progression, appointment or representation between groups), mean and median pay gap analysis, and percentage point differences in NHS Staff Survey responses. The information helps support identifying issues which can then be addressed, supporting the Trust to meet its statutory equalities duties.

Summary findings

In 2024-25, UHSussex had a diverse workforce, with women, minoritised ethnic groups, and LGBUO (lesbian, gay, bisexual, undecided or other sexual orientation) staff, all well represented compared to the Sussex population. Recruitment outcomes were broadly fair for most protected characteristics, except for minoritised ethnic staff and for staff who shared a religious belief. Staff confidence in reporting incidents of bullying, harassment and discrimination had broadly improved but continued to affect groups differentially.

The most important disparities in outcome or experience are pulled out below for 2024-25. A red octagon (●) represents a finding of concern where targeted action will be taken to try and address this through the Workforce Inclusion Plan 2025-26 or wider workplace initiatives. An amber diamond (◆) indicates a change that affects one group more than another, with a watching brief recommended. A green circle (●) indicates an area of relative improvement or workforce strength:

- **Black and mixed ethnic staff** were significantly underrepresented in senior roles, particularly in clinical roles, and reported higher rates of bullying, harassment and discrimination from patients, colleagues and managers.
- ◆ Minoritised ethnic staff were half as likely than white staff to enter formal disciplinary processes, reversing historic patterns from previous years.
- **Disabled staff** reported worse perceptions of career progression. This does not accord with actual progression rates for disabled staff, potentially supporting the under-sharing by staff of their disability on their staff records. This is particularly noticeable at Non-Consultant Career Grade representation.
- Disabled staff reported improved satisfaction with access to workplace adjustments.
- **Female staff** make up most of our workforce yet remained disproportionately affected by harassment. At St Richards Hospital, female staff were under-represented in clinical Agenda for Change (AfC) pay bands 8a+ and in non-clinical AfC bands 6-7. Across the Royal Sussex County Hospital campus, females were under-represented in non-clinical AfC bands 8a+.

- **Male staff** reported experiencing more discrimination in the NHS Staff Survey (9.4%) than female staff (8.6%), particularly on the grounds of ethnicity, religion and sexual orientation. Male staff were under-represented in clinical AfC bands 6-7.
- ◆ Female staff were more likely to agree the organisation respects individual differences (68%) than male staff (66.5%).
- **Trans and gender-diverse staff** experienced some of the highest relative levels of unwanted behaviour, including harassment, as well as poorer access to flexible working, and lower confidence in fair career progression.
- **Muslim, Sikh and Hindu staff** reported improved perceptions of health and well-being support and continued to have some of the lowest burnout and harassment rates.
- **Younger staff** (aged under 30) reported the highest levels of burnout, stress, and unwanted sexual behaviour, especially from patients and the public.
- **Carers** reported slightly higher stress and musculoskeletal (MSK) problems than people without caring responsibilities.
- Broadly similar experiences in flexible working and career progression as people without caring responsibilities.

Priorities for 2025-2026

The lived experience of staff reported from the Niche Well-Led Developmental Review (July 2025), from Freedom to Speak Up cases, and from other staff feedback were used alongside the report's statistical findings to shape priorities for the year ahead. These will be responded to through the Workforce Inclusion Plan 2025-26 or through wider workplace initiatives. These include:

- ▶ **Race:** Target career progression interventions for Black and mixed ethnic groups, focusing on addressing under-representation in senior clinical and leadership roles and tackling higher levels of harassment and discrimination using a proactive, evidence-based, targeted approach.
- ▶ **Sex:** Target career progression interventions for female staff in Agenda for Change (AfC) bands 6-7 in clinical roles, or in bands 2-5 in non-clinical roles, at St Richards Hospital; or in AfC bands 6-7 in non-clinical roles at the RSCH campus. Continue to tackle the high levels of harassment female staff experience. Target career progression interventions for male staff in AfC band 2-5 clinical roles.
- ▶ **Gender identity:** Implement further support for trans and gender-diverse staff and managers, ensuring inclusive workplace practices.
- ▶ **Younger staff:** Target health and wellbeing support to address higher reported levels of burnout, stress, and harassment.

- ▶ **Data quality:** Improve recording of disability, caring responsibilities and armed forces data in Electronic Staff Records (ESR), and ethnicity data quality from the recruitment management system (TRAC).

For any queries, or to give feedback on this report, please contact uhsussex.equality@nhs.net

Introduction

Welcome to our Annual Workforce Equality Report 2025

This detailed report highlights both our areas of strength or improvement in equalities and the significant work that remains to ensure we deliver on our strategic ambition of providing 'excellent care everywhere' with an inclusive workforce representative of our communities. Our Workforce Inclusion Plan (WIP) will underpin this ambition by setting out how we will deliver our equality objectives, as part of our wider work to support our workforce.

This report includes a summary followed by eight sections covering: race, disability, gender (inclusive of sex, and gender identity), sexual orientation, religion and belief, age, caring responsibilities and armed forces equality within employment.

- ▶ Each section begins with a plain language summary of key findings.
- ▶ Each section is then organised into measures of equality aligned with the High Impact Actions (HIA) numbered 1-6 from the national NHS Equality, Diversity & Inclusion (EDI) Improvement Plan, which correspond with the first six commitments in the Year 3 graphic in the 'Governance' section below.

Terminology

In addressing the sometimes contentious nature of statistical groupings such as 'BAME' or 'BME', it is noted that these terms may imply a homogeneous grouping and highlight specific pan-ethnicities, such as 'Black' and 'Asian,' raising issues of exclusion and divisiveness (Aspinall, 2021).

They may imply indiscriminately combining people from different geographical, behavioural, social, and cultural backgrounds (Khunti et al., 2020). Such a grouping can mask disparities between different ethnic groups and create misleading interpretations of data.

This report uses the term *minoritised* group, including when also referring to underrepresented groups or marginalised groups, and aims to break the data further down into ethnic groups or specific ethnicities wherever possible. The use of the acronym BAME is only used in application to the staff network whose membership adopted the term in 2024.

Please refer to the 'Technical Notes' in the appendix for further information about compliance, privacy, scope, data quality, ratios, target ranges and rating definitions.

Analysis

This is a statutory report, with the analyses for Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and the Pay Gap reporting required at national level. The same statistical approaches have also been applied to other protected characteristics, including carers, to ensure a consistent methodology.

As in last year's report, analysis has been presented at both divisional and site level, supported by the enhanced analytical capacity and capability established in 2024. We can only analyse recruitment outcomes at a Trust level due to limitations in our recruitment management system which mean that data below this level is not readily available and affects our ability to delve beneath the headline figures.

While the recruitment management system can provide data for individual sites, divisions or occupational groups, it only allows one level to be extracted at a time. Producing breakdowns below Trust level would therefore require extensive manual work, which has not been feasible to date.

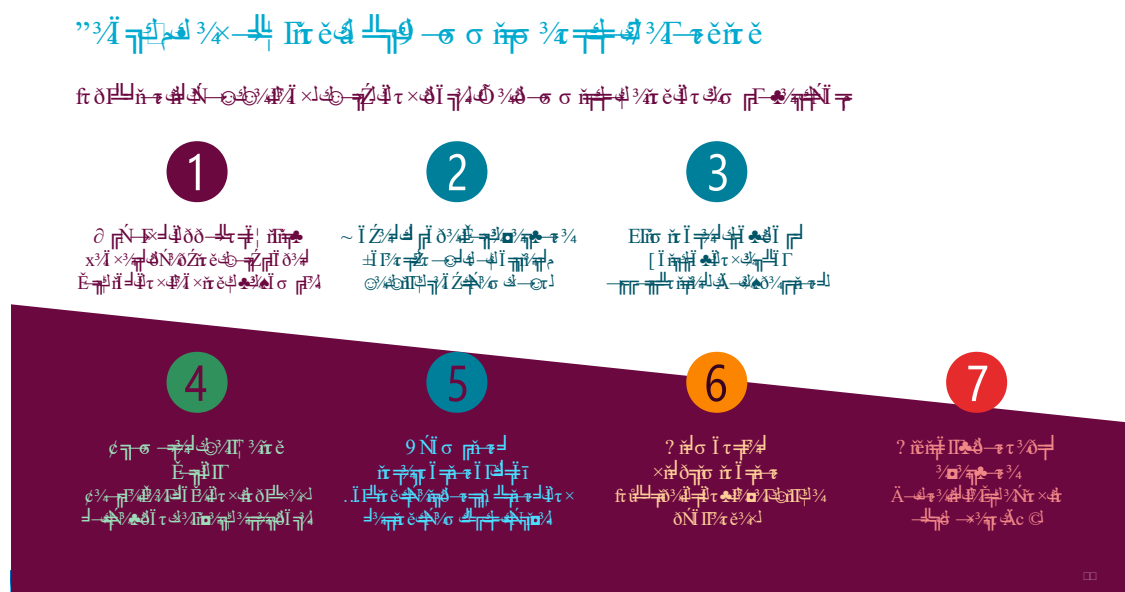
The Annual Workforce Equality Report uses a mixed-methods approach to establish differential outcomes. Quantitatively, it applies relative likelihood and disparity ratios, mean and median pay gap analysis, and percentage point differences in NHS Staff Survey responses, alongside representation and progression data drawn from ESR and TRAC (the Trust's electronic HR record and recruitment systems). These measures are presented with both absolute numbers and proportions and tracked across time (where possible) to identify trends.

Relative likelihood (disparity ratios) is a way to compare how likely different groups, events, or explanations are by looking at their chances side by side – if one group is twice as likely to experience something as another, its relative likelihood is two; it helps spot differences simply, but doesn't show whether those differences are truly important or if more careful testing is needed to be sure. To mitigate this, we use a practical significance test used by our regulators when judging workforce equality performance, commonly called the "four fifths rule".

Qualitatively, the analysis is strengthened by findings from the Niche Well-Led Review, Freedom to Speak Up cases, and staff engagement feedback, ensuring that lived experience about cumulative or persistent impacts, life stage effects, and broader context inform the priorities set, alongside the statistical disparities.

Governance

In December 2022 the Trust approved a Three-Year Equality, Diversity & Inclusion (EDI) Strategy with five key areas of focus: (i) de-bias recruitment and selection processes, (ii) reduce harassment, (iii) equitable career progression and pay, (iv) workforce health inequalities, (v) community engagement & participation. The EDI Strategy work was realigned in 2023 to reflect the high impact actions in the national NHS EDI Improvement Plan. A Workforce Inclusion Plan 2025-26 updates the strategy in its third year with aligned findings and actions in this report.



Niche Review – Equality, Diversity and Inclusion Findings

This section summarises the key equality, diversity and inclusion points from the Niche Well-Led Developmental Review and how they have informed action incorporated into the Trust's Workforce Inclusion Plan 2025-26.

The July 2025 Well-Led Developmental Review of UHSussex undertaken by Niche consulting provided valuable insights into equality, diversity and inclusion across the Trust. Through its own engagement activities, Niche heard accounts from staff about sexism, misogyny and exclusionary behaviours, as well as concerns about sexual safety and gender-based discrimination, which it noted were pronounced at this Trust and uncommon from their experience in undertaking similar reviews elsewhere.

These findings align with the higher incidence of behaviour of an unwanted sexual nature – from both patients/public and managers/colleagues – reported in the 2024 NHS Staff Survey when benchmarked against other Trusts. While the prevalence has reduced compared with 2023, it remains a significant concern requiring sustained action.

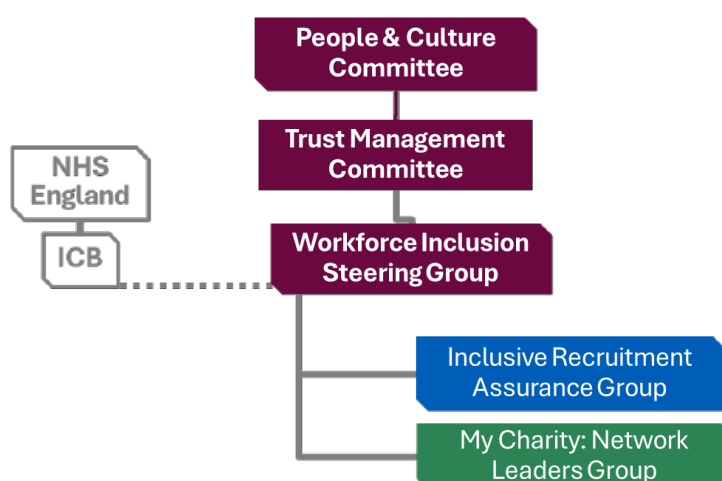
The review also considered evidence from existing Trust reporting, including the Workforce Inclusion Plan, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data, and the Annual Workforce Equality Report. While there have been some improvements in specific indicators, certain areas continue to present significant challenges that require focused and sustained action. These are identified within this annual equality report.

In producing the Workforce Inclusion Plan following publication of the Niche report, we have triangulated Niche’s qualitative findings with our existing datasets,

alongside other evidence sources such as NHS Staff Survey results, workforce disparity ratios, and feedback from key partners including Trade Unions (Staffside) and Staff Networks. This combined approach enables us to respond to the lived experiences and quantitative trends together, strengthening leadership accountability, enhancing governance and infrastructure, and targeting improvements for all groups affected by inequality – addressing sexual safety and gender-based discrimination alongside the wider disparities identified.

Reporting

On the 30 April 2025, the Trust's People & Culture Committee approved the establishment of a Workforce Inclusion Steering Group as a sub-committee of the Trust Management Committee. Progress against the WIP is reported every two months, and quarterly to the People & Culture Committee.



In addition, the following reporting is regularly undertaken:

- ▶ QSIP Quality Assurance Meetings NHS Sussex / NHSE (quarterly)
- ▶ NHS EDI Improvement Plan to NHS England (via ICB) (quarterly)
- ▶ Sussex Race Equality Strategy to Sussex ICB (ad hoc)
- ▶ Annual Workforce Equality Report (yearly)
- ▶ Trust Annual Report equality section (yearly)
- ▶ WRES and WDES data submissions to NHS England (yearly)
- ▶ Pay gap data submission to Cabinet Office (yearly)

1. Race

Race Equality Summary

At UHSussex, staff from minoritised ethnic backgrounds are under-represented in senior roles compared to white staff, especially in clinical jobs. This gap is more noticeable in higher pay bands and consultant posts. There are also fewer minoritised ethnic staff on the Trust Board compared to their overall workforce presence, though the data quality on this is improving. Representation gaps are especially marked in certain divisions and sites, including specialist services, nursing and midwifery, and at PRH and St Richard's Hospital.

In recruitment, white applicants are almost twice as likely to be appointed from shortlisting than minoritised ethnic applicants, with black candidates experiencing the largest gap, although there is a data quality issue in 2024-25 that needs addressing. Fewer minoritised ethnic staff feel they have equal opportunities for career progression, although access to non-mandatory training appears equal across groups.

Pay differences remain, with staff from Black ethnicities earning less on average than white British staff, while some Asian and 'other' ethnicities earn more. Bonus pay shows the largest gap, with Black staff receiving substantially less than all other groups.

Experiences of bullying, harassment, and discrimination remain a concern. Minoritised ethnic staff are more likely than white staff to experience these behaviours from patients, the public, and colleagues. Internationally recruited staff report particularly high levels of harassment and discrimination, though there have been some small improvements in certain areas.

On a positive note, minoritised ethnic staff are now less likely than white staff to enter formal disciplinary processes, reversing the pattern seen in previous years. Reports of discrimination from managers and colleagues have also reduced for minoritised ethnic staff, narrowing the gap between groups.

However, members of mixed ethnic groups stand out as experiencing the highest rates of harassment, bullying, and sexual harassment across multiple measures, with some indicators worsening since last year.

HIA 1: Leadership and Accountability (Race)

Staff voice

The Trust has a [Black, Asian and Minoritised Ethnic \(BAME\) Staff Network](#) sponsored by the Chief Executive Officer.

The BAME Networks key highlights from the past year include:

- ▶ New Chairs, Pam Stephens and the deputy Gerthy Albano
- ▶ Forward plan and meetings/events calendar in place
- ▶ Senior leaders and external speakers
- ▶ Sponsorship programme commenced
- ▶ Networking with other BAME Network chairs
- ▶ Philippines independency Day Celebrations sponsored by the charities

Challenges the BAME Network encountered include:

- ▶ Growing the membership and raising awareness about the network
- ▶ Insufficient administrative capacity.

In January 2025, dedicated funding was secured for all staff networks through My University Hospitals Sussex Charity, agreeing a 20-month funding programme (starting April 2025) to expand network activity, deliver staff-facing events, and enhance engagement in line with agreed plans. The BAME Network plan priorities for 2025/26 include:

- ▶ Linking with surrounding similar groups or platforms
- ▶ Getting more BAME members on the sponsorship programme
- ▶ An external and senior leaders' speaker programme
- ▶ Increased administrative capacity
- ▶ Increasing membership and raising awareness.



1 - BAME Network: Roger Kline and Michelle Cox at UHSussex Black History Month Conference 2024



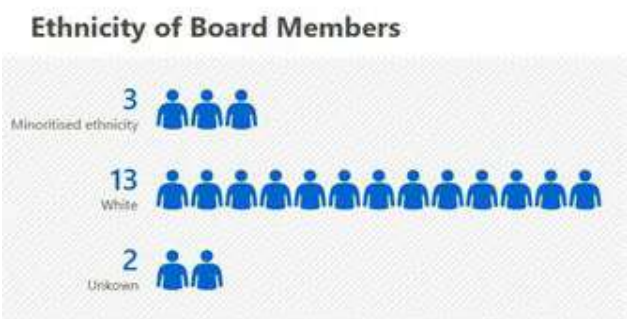
2 - BAME Network: Stalls and Celebrations for Philippine Independence 2025

Board ethnicity composition (WRES 9)

As of the snapshot date at 31 March 2025, three Board members (17%) identified as belonging to a minoritised ethnic group. This compares to 9% of the population in Sussex and 28% of the Trust’s overall workforce.

Two executive directors (11% of all board members) did not indicate their ethnicity on their staff record. The remaining seven executive Board members (39% of all board members, 78% of executive board members) identified as white.

Of those with voting rights on the Board, six (35% of all voting board members) indicated they were white, three (18% of all voting board members) identified as being from a minoritised ethnic group, and one individual did not disclose their ethnicity.



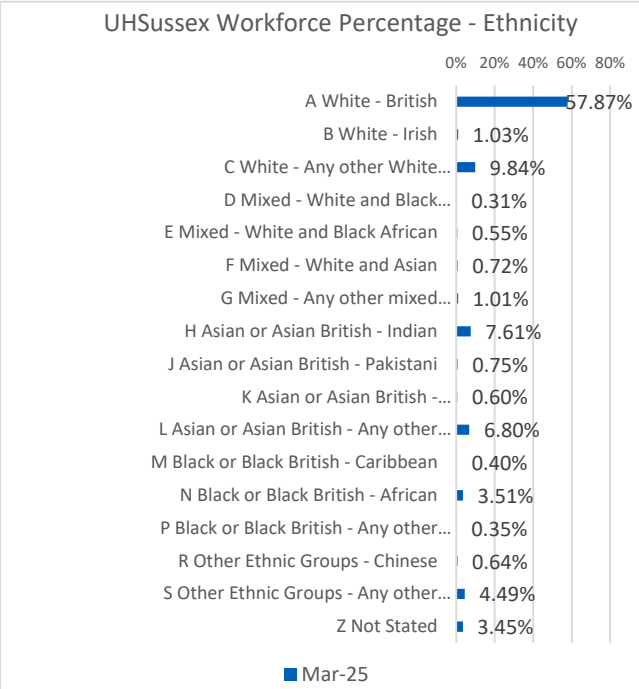
Overall, the comprehensiveness of data has improved considerably since last year.

HIA 2: Inclusive Talent (Race)

Ethnicity workforce representation (WRES 1)

The number of people from minoritised ethnic groups in the workforce on 31 March 2025 was 4,980, or 27.7% of the permanent workforce overall (17,979) compared to 19% of the population in England and 9% across East Sussex, West Sussex and Brighton and Hove combined (Census 2021, ONS)¹. This represents an increase of nearly three percentage points compared to the previous year (2024 = 25%)

In the 2024 NHS Staff Survey, responses were received from 1260 (15.56%) Asian staff, 267 (3.30%) black staff, 206 (2.54%) staff from mixed ethnic groups, 138 (1.70%) staff from other ethnic groups, and 6,068 (74.95%) white staff at UHSussex.

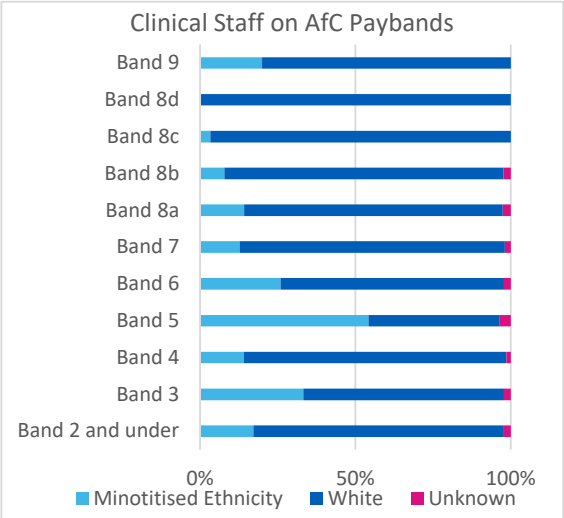


¹ [Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

Clinical Agenda for Change Staff

Out of 10,638 clinical staff on Agenda for Change (AfC) terms and conditions:

- ▶ 570 staff were in upper bands (AfC 8a+) out of which 12.1% were from minoritised ethnic groups.
- ▶ 4,025 staff were in middle bands (AfC 6-7) out of which 20.8% were from minoritised ethnic groups.
- ▶ 6,043 staff were in lower bands (AfC 1-5) out of which 40.2% were from minoritised ethnic groups.



White staff were **5 times more likely** to be in senior clinical roles (AfC bands 8+) than minoritised ethnic staff, compared to their representation in support or newly qualified roles (AfC bands 1-5). This is **worsened** (up) marginally, up from 4.8 times in 2024.

White staff were **2.6 times more likely** to be in specialist or advanced clinical roles (AfC bands 6-7) than minoritised ethnic staff, compared to their representation in support or newly qualified roles (AfC bands 1-5). This is the **same** likelihood as reported last year and still above the acceptable equality range (target between 0.8-1.25).

Representation Disparity Ratio	2023	2024	2025
Disparity ratio – lower (Bands 1-5) to middle (Bands 6-7)	2.77	2.59	2.62
Disparity ratio – middle (Bands 6-7) to upper (Bands 8a-VSM)	1.73	1.84	1.91
Disparity ratio – lower (Bands 1-5) to upper (Bands 8a-VSM)	4.78	4.76	4.99

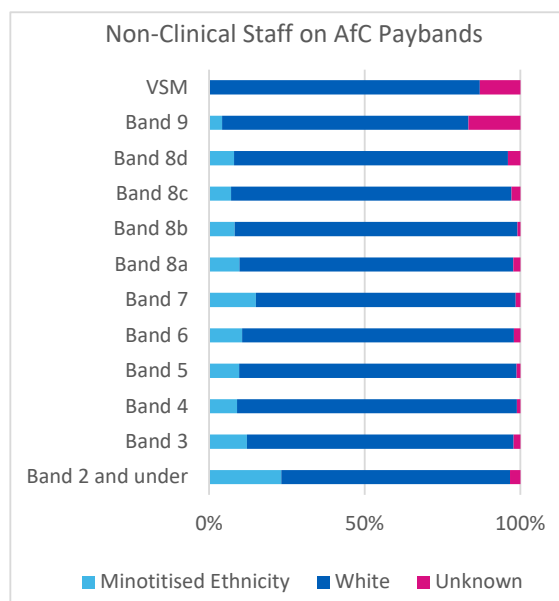
Non-Clinical Agenda for Change Staff

Out of 4,662 non-clinical staff on Agenda for Change (AfC) terms and conditions:

- ▶ 428 staff were in upper bands (AfC 8a+) out of which 7.9% were from minoritised ethnic groups.
- ▶ 499 staff were in middle bands (AfC 6-7) out of which 12.4% were from minoritised ethnic groups.
- ▶ 3,719 staff were in lower bands (AfC 1-5) out of which 15.6% were from minoritised ethnic groups.

White staff were **2.1 times more likely** to be non-clinical senior managers (AfC bands 8+) than minoritised ethnic staff, compared to support and entry level roles (AfC bands 1-5). This is **worse** (up) from 1.7 times in 2024 and remains above the acceptable equality range (target between 0.8-1.25).

White staff were **1.6 times more likely** to be non-clinical senior managers (AfC bands 8+) than minoritised ethnic staff, compared to junior managers roles (AfC bands 6-7). This has **worse** (up) from 1.3 times in 2024 and remains above the acceptable equality range (target between 0.8-1.25).

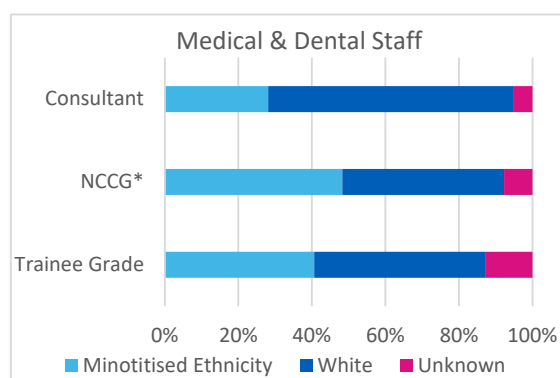


Representation Disparity Ratio	2023	2024	2025
Disparity ratio – lower (Bands 1-5) to middle (Bands 6-7)	1.59	1.33	1.31
Disparity ratio – middle (Bands 6-7) to upper (Bands 8a-VSM)	1.22	1.30	1.61
Disparity ratio – lower (Bands 1-5) to upper (Bands 8a-VSM)	1.94	1.72	2.12

Medical & Dental Staff

Out of 2,647 staff on medical and dental contracts:

- ▶ 987 were consultants, out of which 28.1% were from minoritised ethnic groups.
- ▶ 116 were non-consultant career grades (NCCGs) out of which 48.3% were from minoritised ethnic groups.
- ▶ 1,544 were trainees, out of which 40.6% were from minoritised ethnic groups.



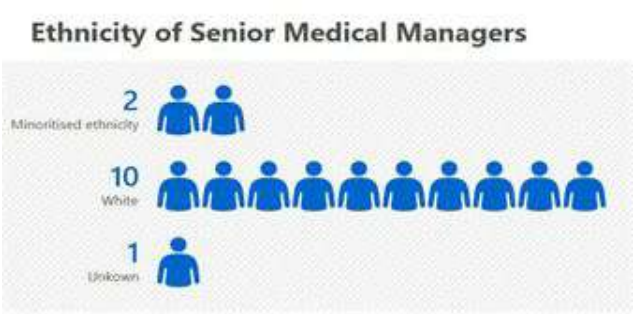
White staff were **2.6 times more likely** to be consultants than minoritised ethnic staff compared to their proportions in NCCGs. This is **improved** (down) from 3.5 times in 2024 but remains above the acceptable equality range (target between 0.8-1.25).

White staff were **2.1 times more likely** to be consultants than minoritised ethnic staff compared to their proportions in trainee grades. This is **worse** (up) from 1.8 times in 2024 and continues to remain above the acceptable equality range (target between 0.8-1.25).

Representation Disparity Ratio	2023	2024	2025
Disparity ratio - Trainee to NCCG	0.68	0.52	0.79
Disparity ratio - NCCG to Consultant	2.92	3.54	2.61
Disparity ratio - Trainee to Consultant	1.97	1.84	2.07

Senior Medical Managers

From all consultants, 13 were identified as ‘senior medical managers’ a category defined in technical reporting guidance from NHS England as an employee who works as a medical consultant and who is either a medical director, or a deputy medical director or who reports directly to a medical director or deputy medical director.

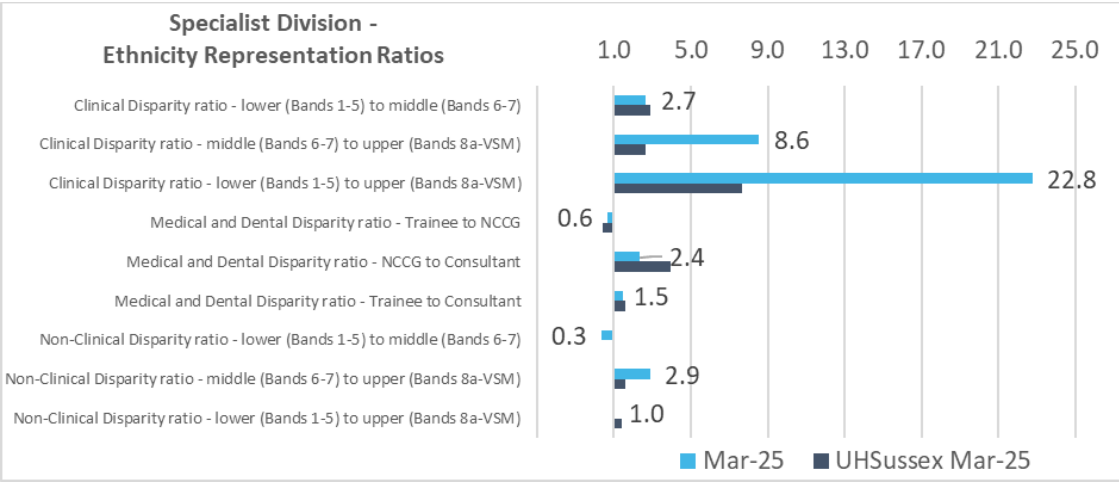


Of senior medical managers, two (14.3%) were from minoritised ethnic groups and one (7.1%) did not share their ethnicity.

Career Progression Disparities by Division

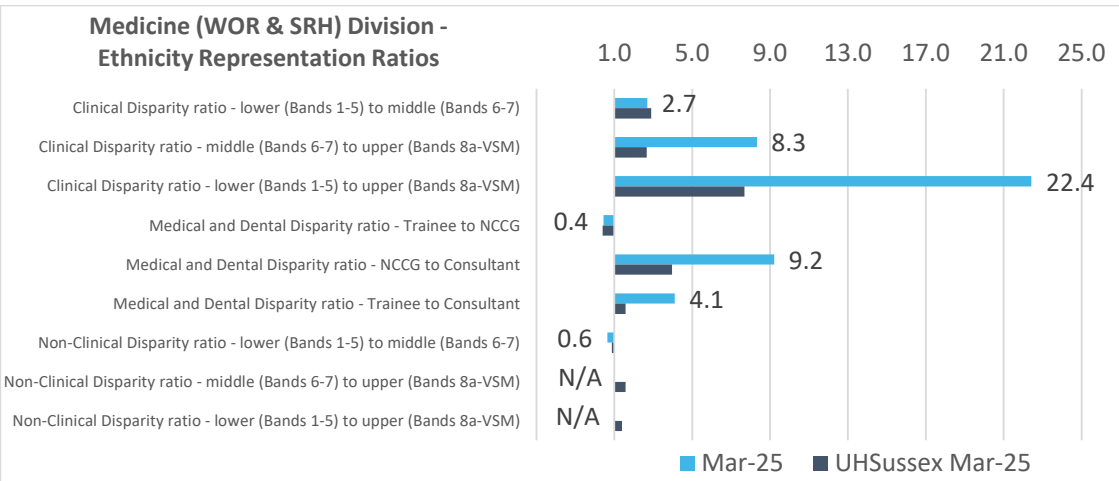
Specialist Division

This division shows the highest career progression disparity for clinical staff between broad ethnic groups. White staff are 23 times more likely than minoritised ethnic staff to hold Bands 8a-VSM roles compared to Bands 1-5, an increase from 15 times last year. For Bands 6-7 to senior roles, the ratio is nearly 9 times.



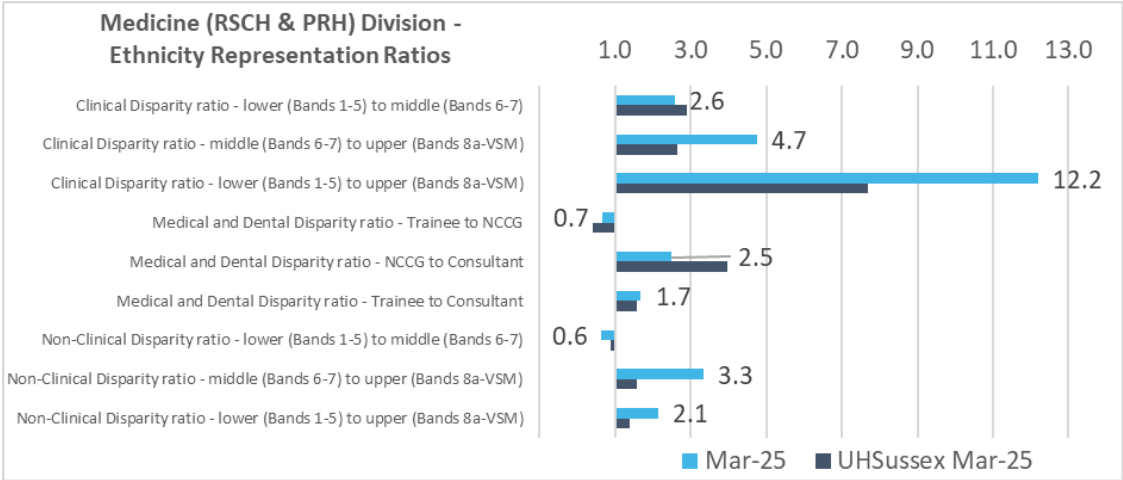
Medicine (WOR & SRH)

White clinical staff are 22 times more likely than minoritised ethnic staff to hold Bands 8a-VSM roles compared to Bands 1-5, and 8.3 times more likely compared to Bands 6-7.



Medicine (RSCH & PRH)

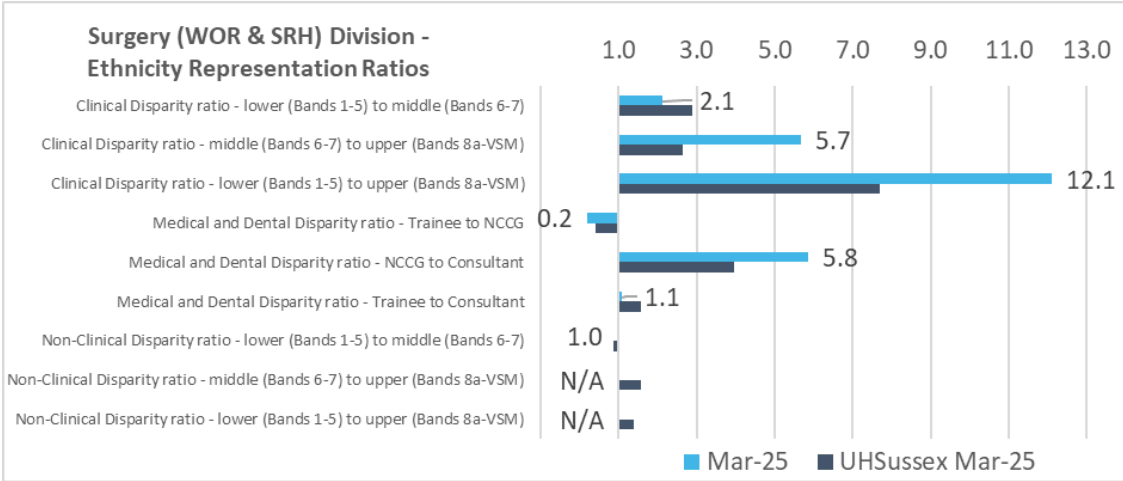
White clinical staff are 12 times more likely than minoritised ethnic staff to hold senior roles at Bands 8a-VSM compared to Bands 1-5, and 4.7 times more likely at Bands 6-7.



Surgery (WOR & SRH)

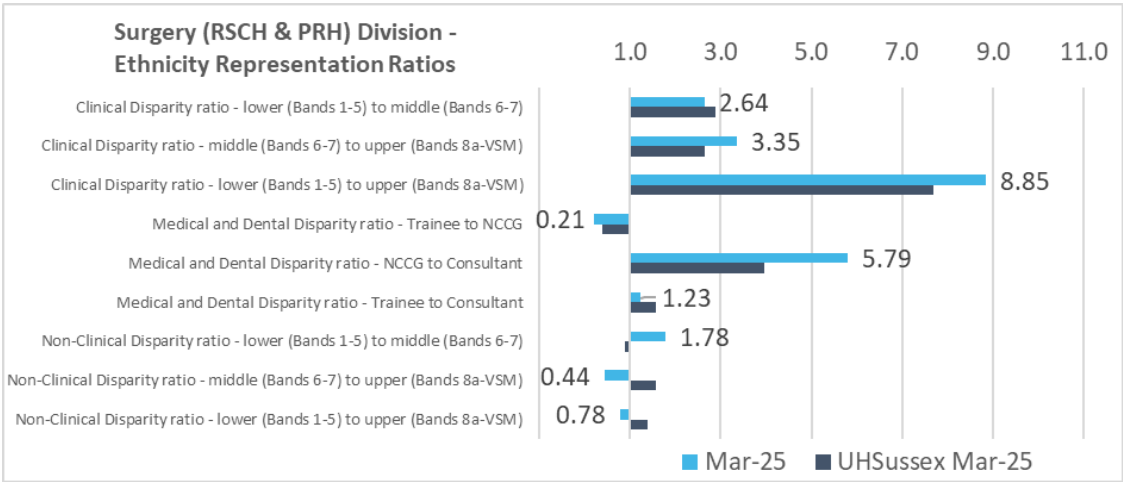
White clinical staff are over 10 times more likely than minoritised ethnic staff to hold Bands 8a-VSM roles compared to Bands 1-5. Among medical and dental staff, white doctors are over 5 times more likely to hold consultant roles compared to NCCGs.

Other notable mentions include Surgery (WOR & SRH) division, where clinical white staff were 12 times more likely to be represented in bands 8-VSM roles than in bands 1-5 compared to minoritised ethnic staff.



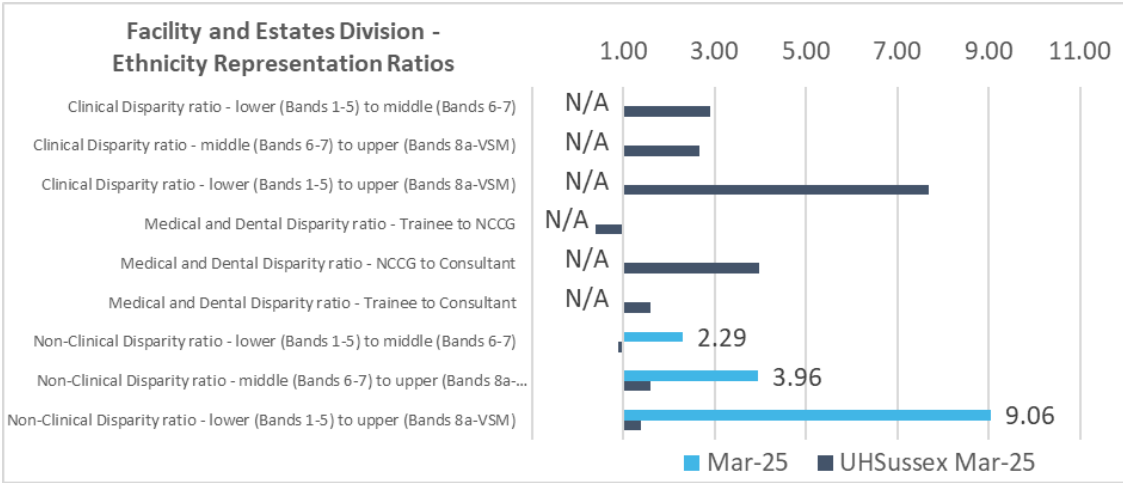
Surgery (RSCH & PRH)

White clinical staff are 8.9 times more likely than minoritised ethnic staff to hold senior roles at Bands 8a-VSM compared to Bands 1-5. For medical and dental staff, white doctors are 5.8 times more likely to hold consultant roles.



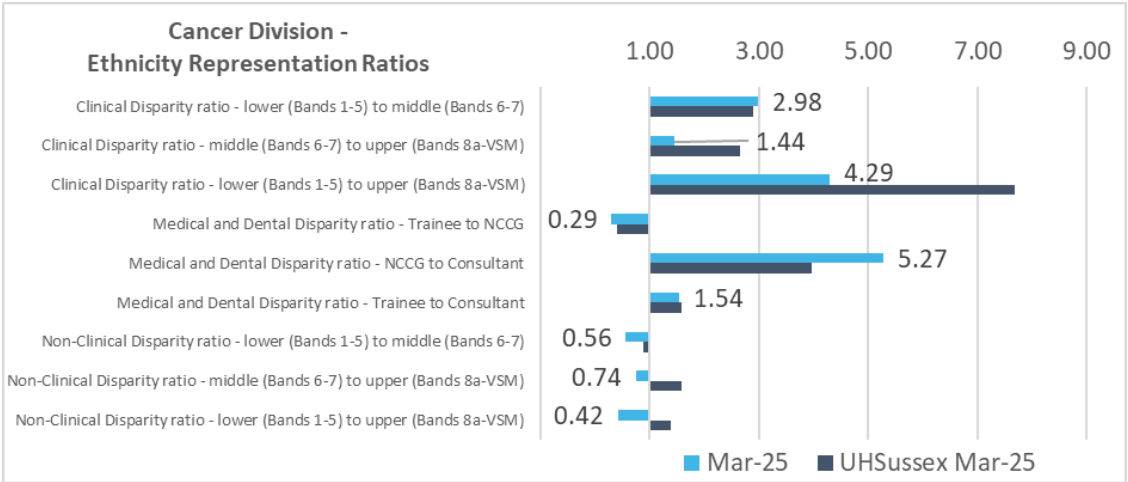
Facilities and Estates

This division shows the highest disparity for non-clinical staff. White staff are 9 times more likely than minoritised ethnic staff to hold senior roles compared to Bands 1-5 and 4 times more likely compared to Bands 6-7.



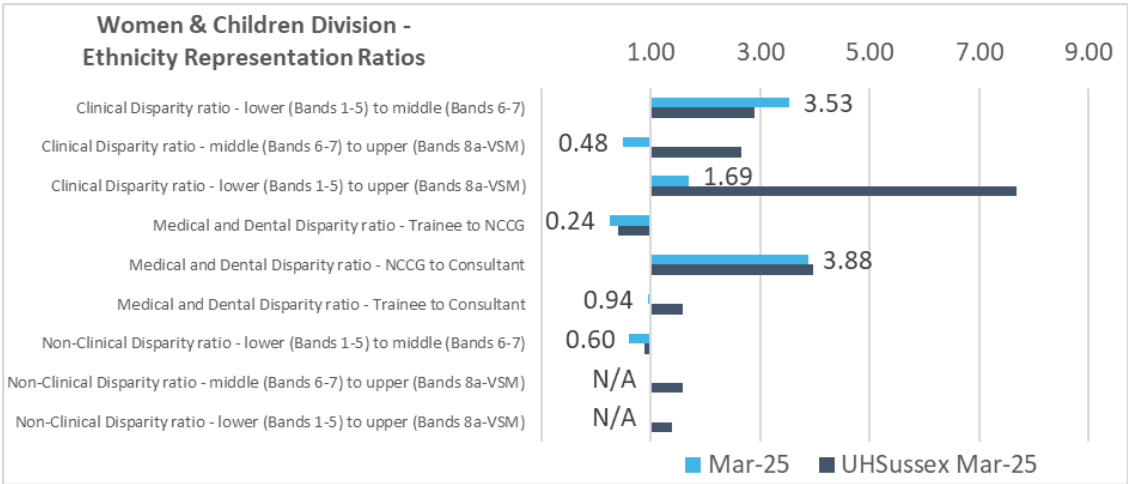
Cancer Division

White clinical staff are 4.29 times more likely than minoritised ethnic staff to hold senior roles. Among medical and dental staff, white doctors are 5.27 times more likely to hold consultant roles compared to NCCGs.



Women & Children Division

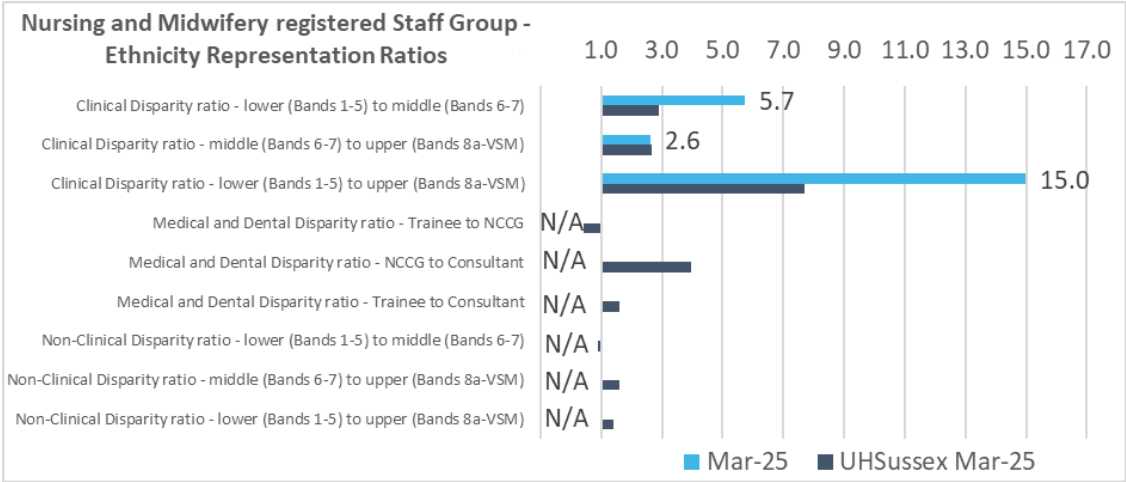
For medical and dental staff, white doctors are 3.88 times more likely than minoritised ethnic staff to hold consultant roles compared to NCCGs. For clinical staff, white colleagues are 3.53 times more likely than minoritised ethnic staff to hold senior roles. This represents a substantial increase from last year, when this division had the highest parity. Notably, progression from trainee to NCCG is reversed (ratio 0.2), with minoritised ethnic staff more represented at this stage.



Career Progression Disparities by Staff Group

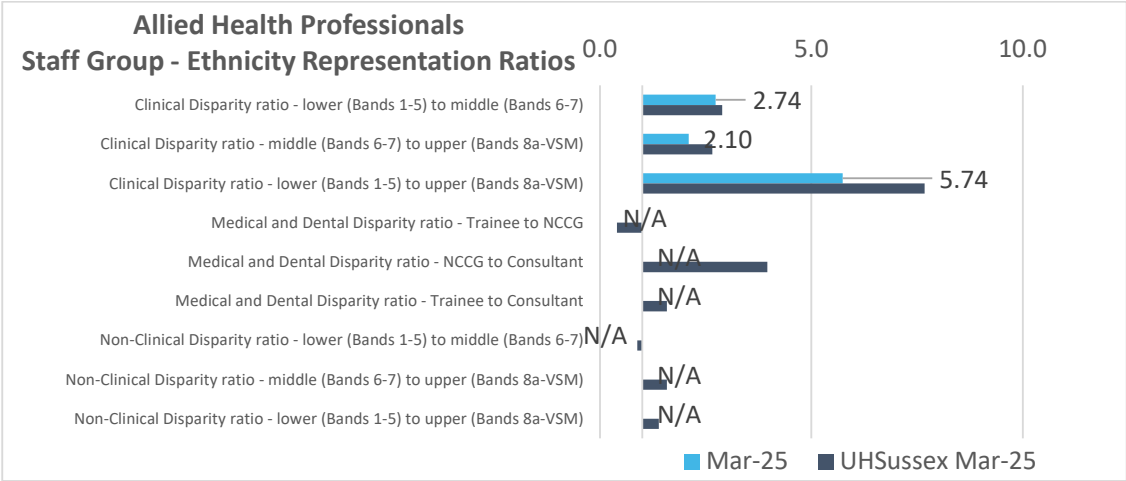
Nursing and Midwifery (registered)

White staff are 15.0 times more likely than minoritised ethnic staff to hold senior roles (Bands 8a-VSM) compared to Bands 1-5.



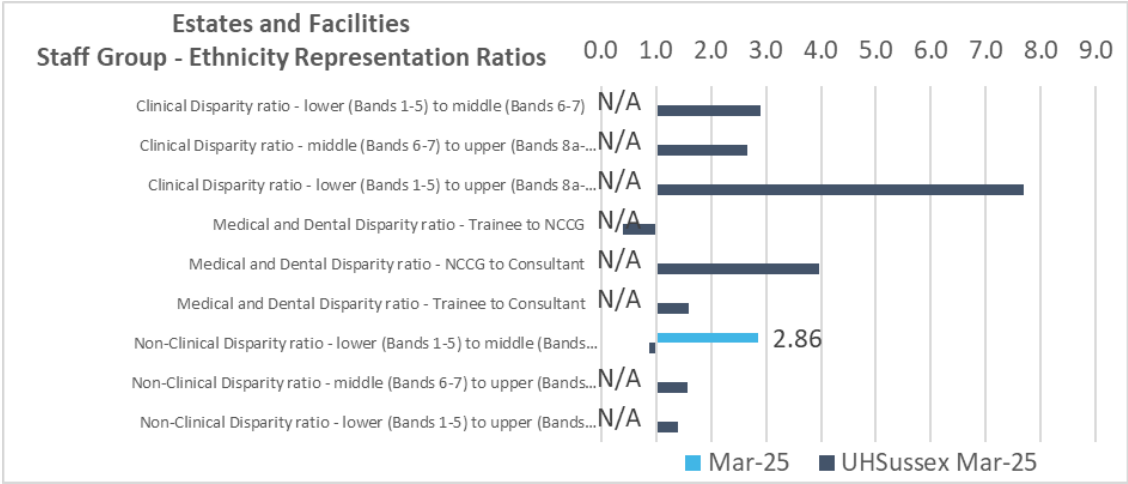
Allied Health Professionals

White staff are 6.1 times more likely than minoritised ethnic staff to hold senior roles (Bands 8a-VSM) compared to Bands 1-5.



Estates and Facilities

White staff are over 2.86 times more likely than minoritised ethnic staff to hold middle-grade roles (Bands 6-7) compared to Bands 1-5.



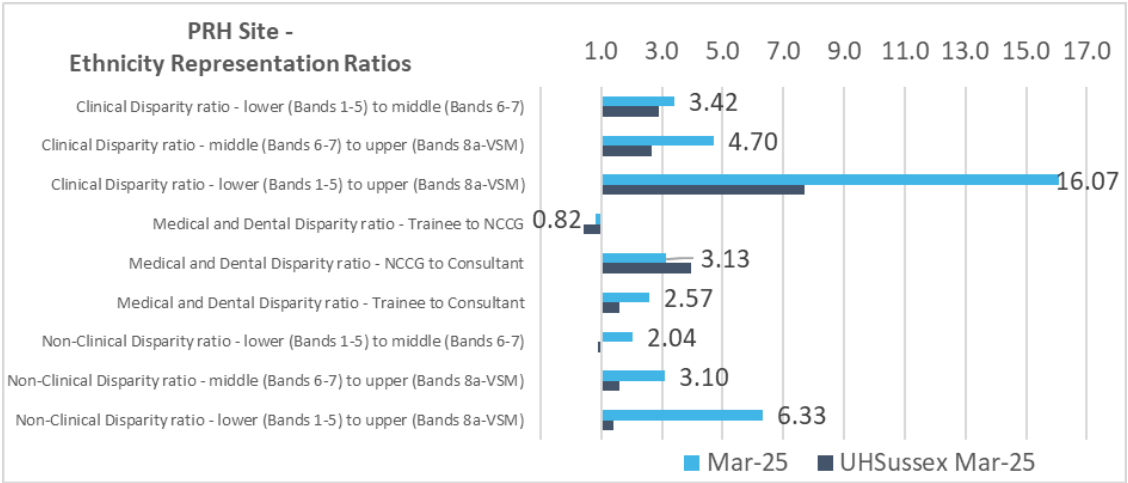
Career Progression Disparities by Site

Princess Royal Hospital (PRH)

Clinical staff: White staff are 16.1 times more likely than minoritised ethnic staff to hold senior roles (Bands 8a-VSM) compared to Bands 1-5, and under 4.7 times more likely from Bands 6-7 to senior roles.

Non-clinical staff: White staff are 6.3 times more likely to hold senior roles from Bands 1-5, and 3.10 times more likely from Bands 6-7.

Medical and dental staff: White doctors are 3.1 times more likely to hold consultant roles compared to NCCGs, and 2.6 times more likely to hold consultant roles compared to trainees.

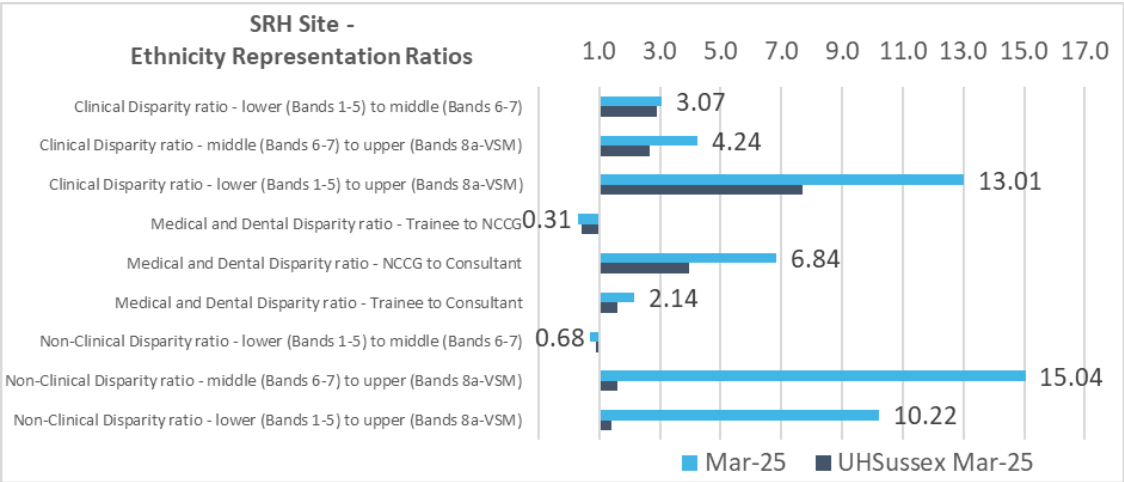


St Richard’s Hospital (SRH)

Clinical staff: White staff are 13.0 times more likely to hold senior roles from Bands 1-5, and 4.2 times more likely from both Bands 6-7 and Bands 1-5 to middle-grade roles.

Non-clinical staff: White staff are 10.2 times more likely to hold senior roles from Bands 1-5, and 15.0 times more likely from Bands 6-7.

Medical and dental staff: White doctors are 6.84 times more likely to hold consultant roles compared to NCCGs.



Royal Sussex County Hospital (RSCH)

Clinical staff: White staff are over 5 times more likely than minoritised ethnic staff to hold senior roles from Bands 1-5.

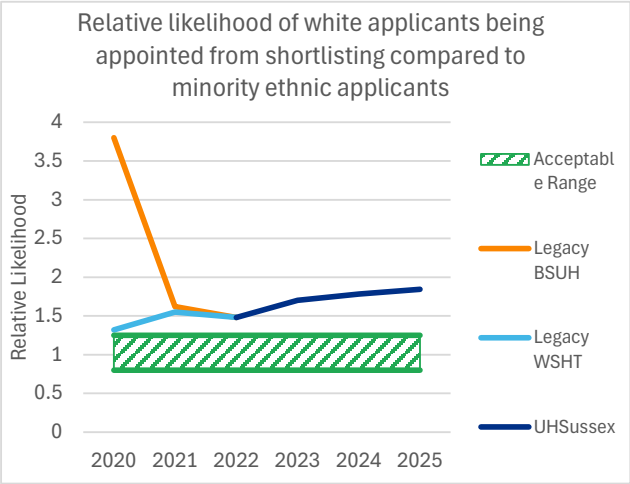
Worthing Hospital (WOR)

Clinical staff: White staff are 7.0 times more likely than minoritised ethnic staff to hold senior roles from Bands 1-5.

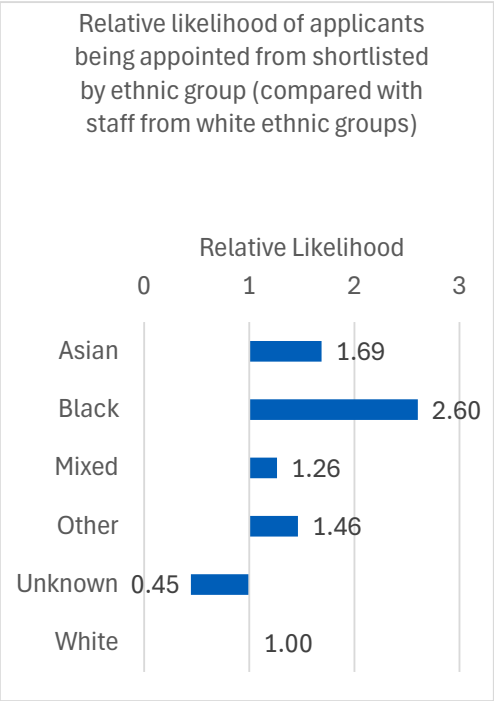
Medical and dental staff: White doctors are 3.5 times more likely to hold consultant roles compared to trainee roles.

Ethnicity shortlisting-to-appointment relative likelihood (WRES 2)

In the 2024/25 financial year UHSussex appointed 1,020 minoritised ethnic applicants and 1,900 white applicants. White applicants were 1.8 times more likely to be appointed from shortlisting than minoritised ethnic applicants. This falls above the upper limit of the acceptable equality range (target between 0.8-1.25), which suggests further work to remove barriers within recruitment.



Compared to previous years (2021-2024), the shortlisting to appointing likelihood between minoritised ethnic and white applicants has gradually increased (**worsened**) since 2022 (see graph below).



When investigating the relative likelihood of appointment from shortlisting for staff from different ethnic groups, staff from white groups are more likely to be appointed compared to staff from all other ethnic groups, with all relative likelihoods falling outside the equality target range (target between 0.8-1.25).

However, appointment rates for both white and BAME staff have decreased since 2024. It stands out that staff with unknown ethnicity status are more likely to be appointed, with people with an unknown ethnicity being almost twice as likely to be appointed from shortlisting than white people. The number of unknowns has increased substantially since the previous year, with data quality affecting reliability.

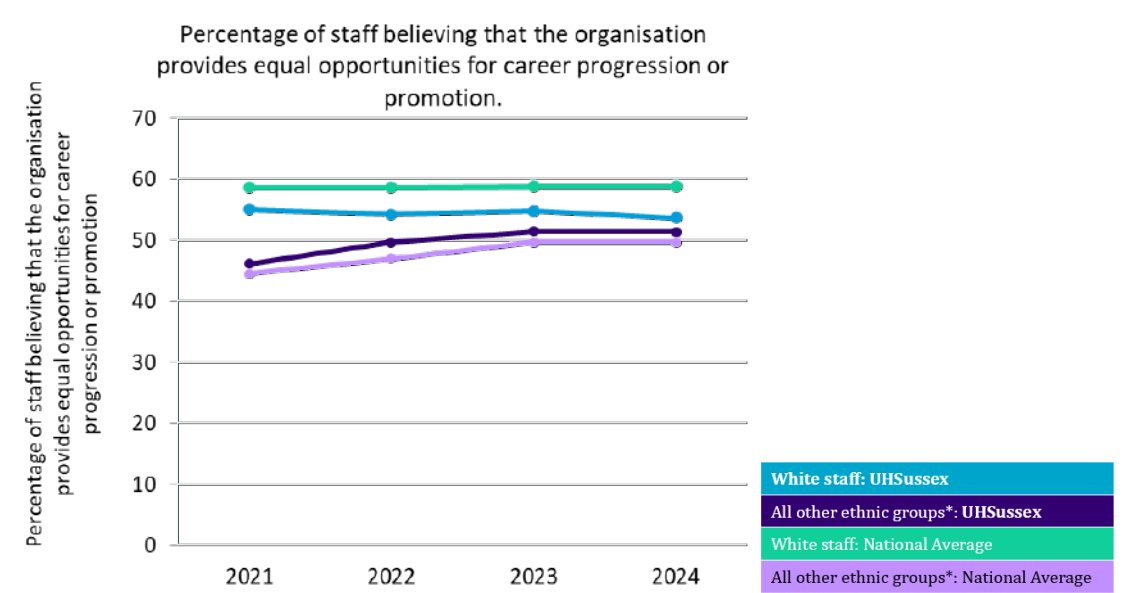
There have been various initiatives to debias recruitment policies and processes delivered through the Trust’s Inclusive Recruitment & Selection plan since Q4 of 2023/24 and over the course of the last financial year (2024/25). Changes have been managed through the Trust’s Inclusive Recruitment and Selection Action Plan. A renewed focus will be made to address the data quality issues.

Equality of opportunity for career progression/promotion (WRES 7)

51.4% of minoritised ethnic staff and 53.7% of white staff reported believing the Trust provides equal opportunities for career progression or promotion in the NHS staff survey 2024. This is largely unchanged year-on-year for ethnic minoritised staff (51.5%) and decreased (worsened) marginally for white staff (54.8%).

The gap between minoritised ethnic and white staff on this indicator has continued to narrow from 2022 and 2023 (**improvement**).

The gap between minoritised ethnic staff and white staff at UHSussex is smaller (**better**) than the gap between the national averages on this indicator.



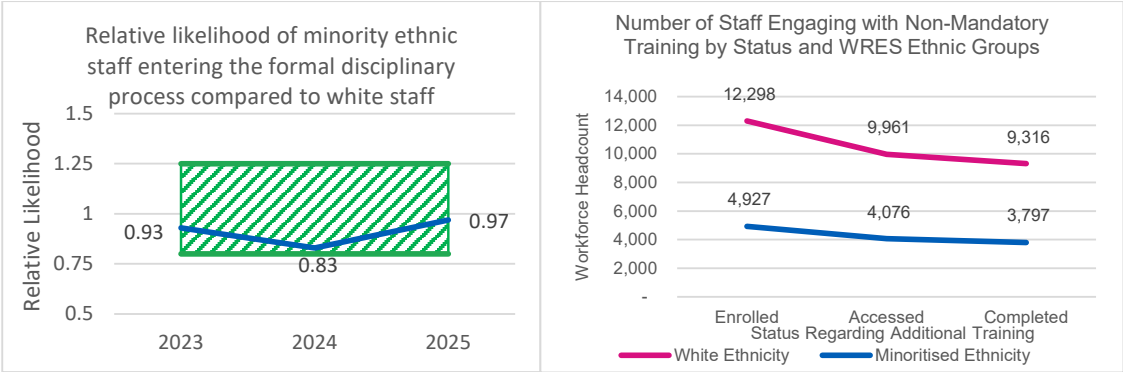
UHSussex Response Numbers	2021	2022	2023	2024
White staff	6,538	5,795	6,227	5,998
All other ethnic groups*	1,375	1,424	1,884	1,864

*Staff from all other ethnic groups combined

Non-mandatory training by ethnicity (WRES 4)

White staff (9,961) were just as likely (0.97 times) to access non-mandatory training as staff from minoritised ethnic groups (4,076), compared to their representation at Trust level.

This is similar to the last two years (2024 = 0.83; 2023 = 0.93) and continues to remain within the acceptable equality range (target between 0.8-1.25).



HIA 3: Eliminate Pay Gaps (Race)

Ethnicity Pay Gap

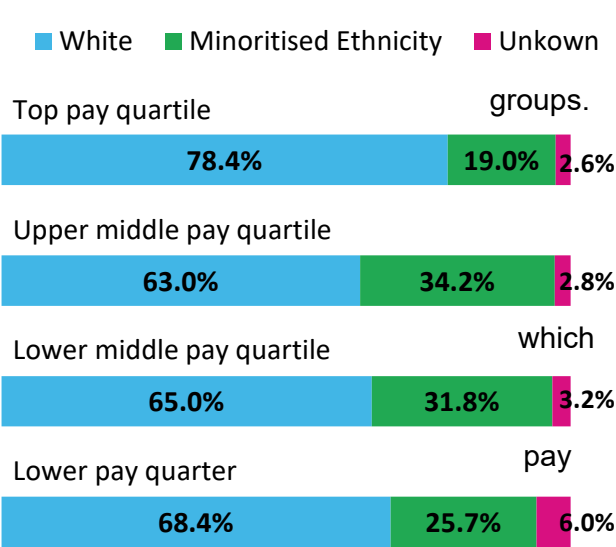
Ethnicity pay gap reporting shows the difference in average hourly pay and bonus payments between different ethnic groups. The Trust analyses the information to find:

- ▶ Pay quarters that measure the representation of employees in different ethnic groups at different levels of pay in an organisation.
- ▶ Mean and median pay gaps that measure the difference between average earnings and bonus pay in an organisation for different groups.

Ethnicity workforce representation

Out of a total workforce of 18,257 whole-time equivalent staff:

- ▶ 4,567 staff were in the top pay quartile, out of which 19.0% were from minoritised ethnic groups.
- ▶ 4,567 staff were in the upper middle pay quartile, out of which 34.2% were from minoritised ethnic groups.
- ▶ 4,567 staff were in the lower middle pay quartile, out of which 31.8% were from minoritised ethnic groups.
- ▶ 4,556 staff were in the lower pay quarter, out of which 25.7% were from minoritised ethnic groups.



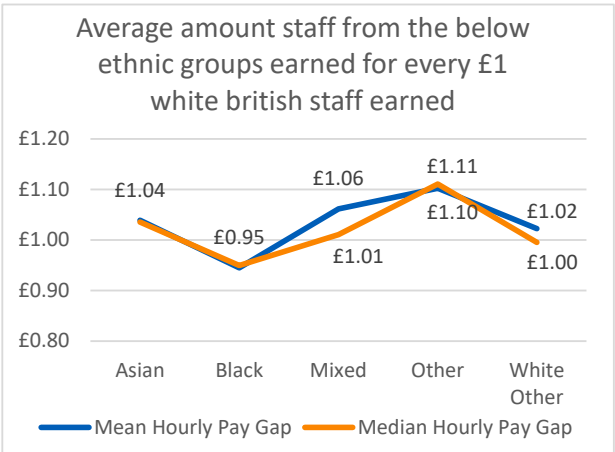
Staff from minoritised ethnicities were 2.2 times more likely to be represented in the lower-middle pay quartile than white staff compared to their representation in the lowest pay quartile. This is the same as in 2024.

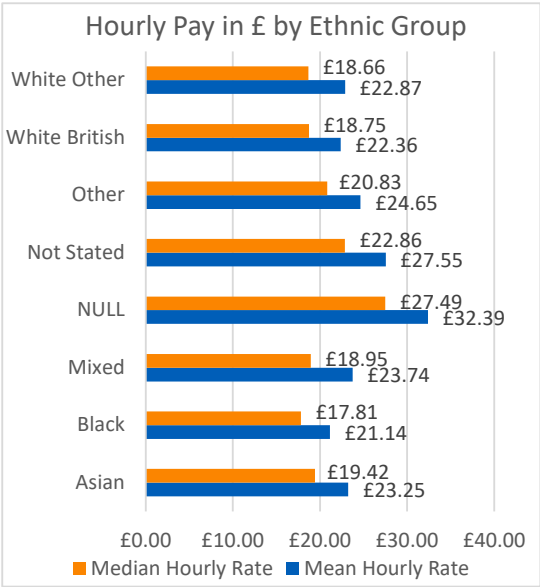
Staff from minoritised ethnicities were 1.5 times more likely to be represented in the top pay quartile than white staff compared to their representation in the lowest pay quartile. This is down marginally (**better**) from 1.7 times in 2024.

Ethnicity Ordinary Pay Gap

Comparing mean (average) and median (accounting for the effect of outliers) hourly wages, it was found that:

- ▶ Staff from black ethnic groups earned ninety-five pence for every £1 white British staff earned, this has **decreased** from 2024 (mean £0.97, median £1.00).
- ▶ Staff from ‘other’ ethnic groups earned more (£1.10 / £1.11) than white British staff, this has increased from 2024 (mean & median £1.08).
- ▶ Staff from the Asian ethnic group earned more (£1.04) than white British staff. While the mean remains the same, the median has increased marginally from 2024 (median £1.02).





For staff from mixed and 'White Other' ethnic backgrounds, median earnings are broadly in line with those of White British staff (approximately £1 for every £1 earned). However, the higher mean earnings suggest a skewed pay distribution, likely influenced by a small number of individuals earning significantly more, which raises the average.

It is important to note that staff with unknown (NULL or 'Not stated') ethnicity may influence the overall pay gap analysis. As shown in the workforce

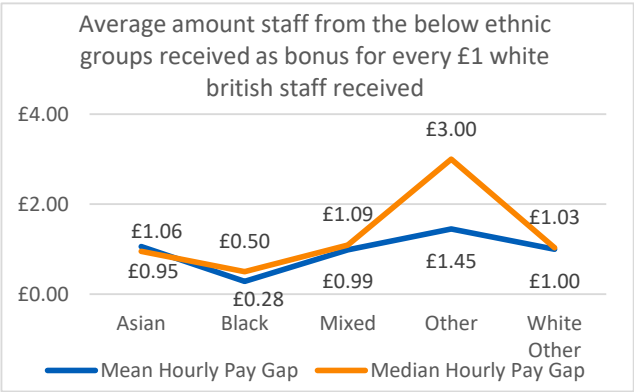
representation chart, the majority of staff with unself-identified ethnicity are concentrated in the lowest pay quartile. However, the mean (average) pay for this group is marginally higher than that of many other ethnic groups. This apparent discrepancy is likely driven by a small number of high earners within the group, which elevates the mean despite the broader concentration of individuals in lower-paid roles.

Ethnicity Bonus Pay Gap

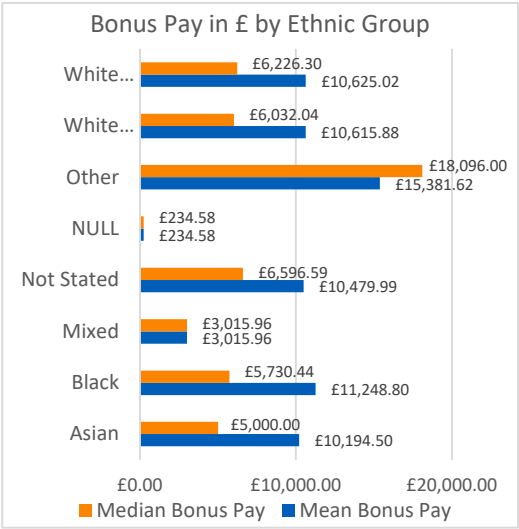
225 staff received a bonus payment between the 1 April 2024 and 31 March 2025, inclusive of 35 staff from Asian ethnicities, 3 staff from Black ethnicities, 3 staff from mixed ethnicities, 3 staff who indicated to be from an 'Other' ethnic group, 148 staff who indicated to be white British and 24 staff who indicated to be from another white ethnicity.

Comparing mean (average) and median (accounting for the effect of outliers) hourly wages, it was found that:

- ▶ Staff from black ethnic groups received the least across all ethnic groups, receiving only £0.28 (mean) and £0.5 (median) for every £1 bonus white British staff received. This has further **decreased** from 2024 (mean £0.74, median £1.00).
- ▶ Staff from 'other' ethnic groups received the most, with £3 (mean) and £1.45 (median) for every £1 bonus white British staff received.



This has substantially **increased** from 2024 (mean £0.78, median £1.00).



► Staff from Asian, mixed and ‘white other’ ethnic group earned on average the same (£0.95 to £1.09) as white British staff. This mean (average) for these groups has **increased** from 2024 (£0.77 for Asian, £0.58 for mixed, £0.81 for white other groups).

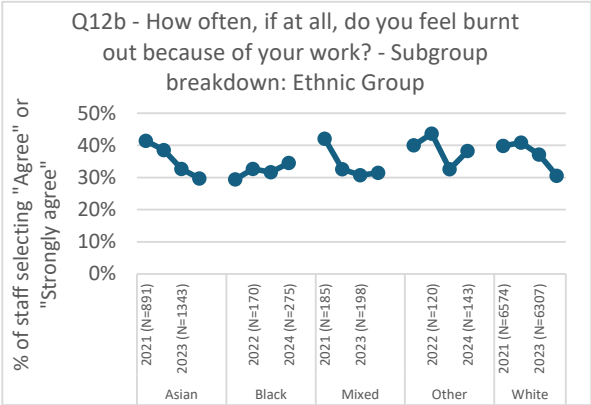
These increases are due to changes nationally in the distribution of bonus Clinical Excellence Awards (CEAs) for doctors.

HIA 4: Workforce Health Inequalities (Race)

Burnout (NSS – Q12b)

Reviewing the question on burnout from the NHS Staff Survey it can be shown that:

- There has been a continuous reduction in the percentage of staff from Asian and white ethnic groups who reported feeling burnout.
- There was an increase in the percentage of staff from black, mixed and ‘other’ ethnic groups who reported feeling burnout.
- In 2024, black members of staff and staff from ‘other’ ethnic groups reported feeling burnout the most, compared to all other ethnic groups.

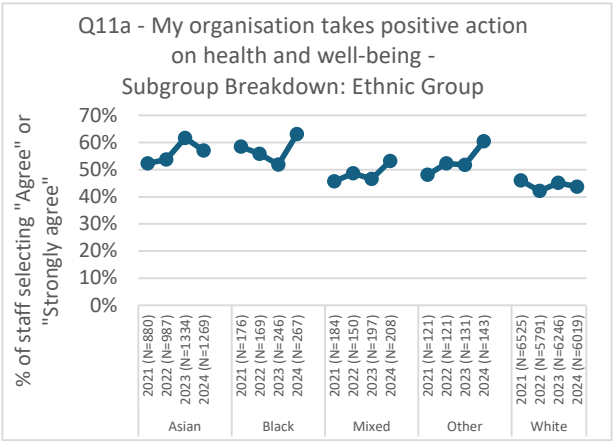


Positive action on health and wellbeing (NSS – Q11a)

Reviewing the question “My organisation takes positive action on health and well-being” from the NHS Staff Survey it can be shown that:

- More members of staff from Asian, black, and ‘other’ ethnic groups agreed with the statement in 2024 compared to members of staff from other ethnic groups.

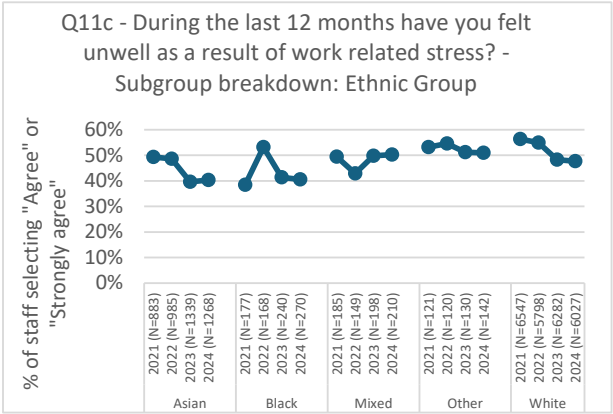
- ▶ The percentage of staff who agreed with the statement in 2024 increased for staff from black, mixed and ‘other’ ethnic groups, compared to 2023, and remained largely unchanged for white staff and decreased for staff from Asian ethnic groups.



Work related stress (NSS – Q11c)

Reviewing the question on whether staff had felt unwell because of work related stress in the last 12 months from the NHS Staff Survey it can be shown that:

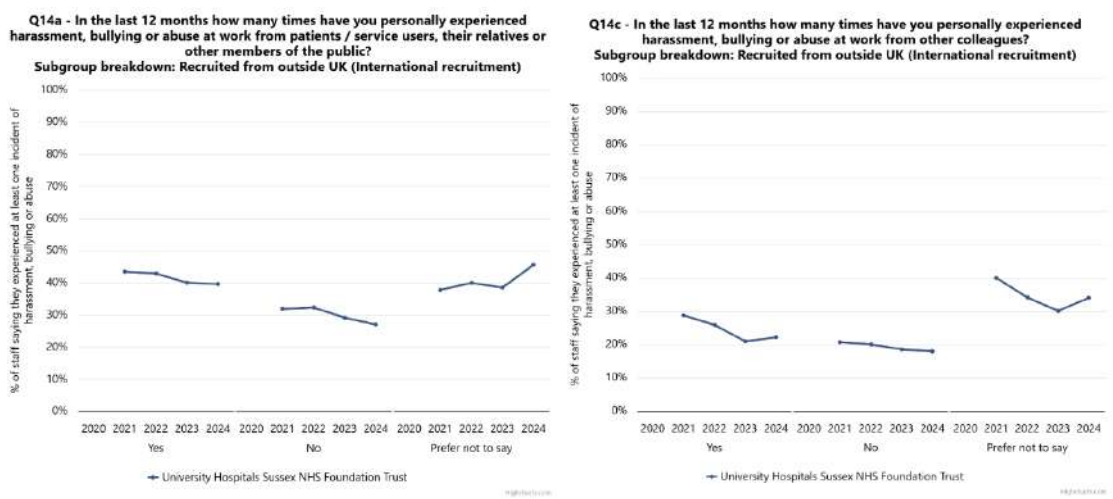
- ▶ More members of staff from mixed and ‘other’ ethnic groups reported feeling unwell because of work related stress in 2024.
- ▶ Most scores saw minor changes in comparison to 2023.
- ▶ In 2024, staff from other Asian and black ethnic groups reported the least experiences of feeling unwell because of work related stress compared to staff from all other ethnic groups.



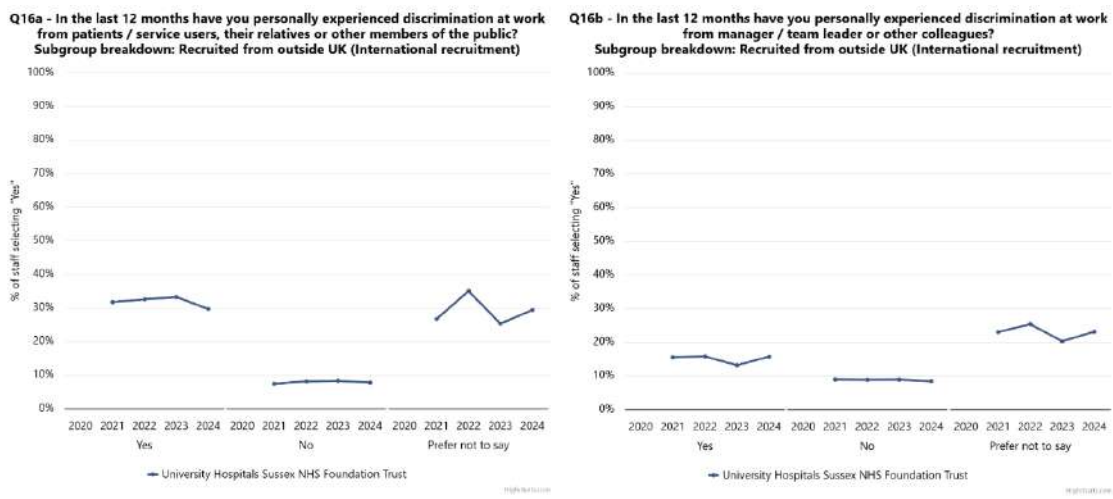
HIA 5: Internationally Recruited Staff

658 (8.13%) staff who completed the NHS staff survey reported having been recruited from outside of the UK when they joined the Trust.

- ▶ Internationally recruited staff (39.67% of 663 respondents) reported more incidence of harassment, bullying or abuse from the public (Q14a) than non-internationally recruited staff (27.06% of 6,788 respondents). This has decreased (**improved**) from previous years but remains higher (**worse**) than the national average for internationally recruited staff (35.13%).
- ▶ Internationally recruited staff (22.22% of 657 respondents) reported more incidence of harassment, bullying or abuse at work from colleagues (Q14c) than did non-internationally recruited staff (18% of 6,743 respondents). This has further increased (**deteriorated**) from previous years but is marginally lower (**better**) than the national average for internationally recruited staff (23.78%).

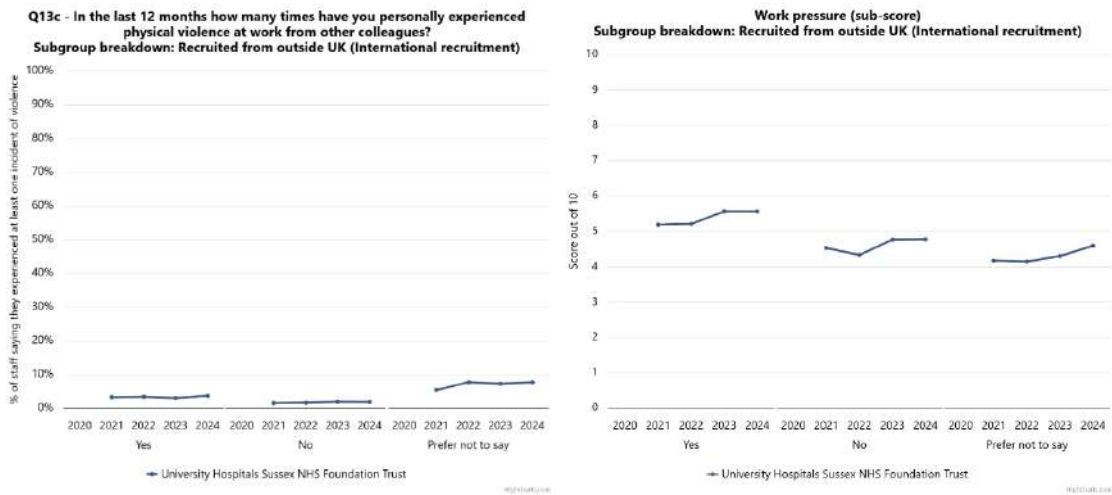


- ▶ Internationally recruited staff (29.65% of 661 respondents) reported more experiences of discrimination from the public (Q16a) than non-internationally recruited staff (7.75% of 6,774 respondents). This has decreased (**improved**) from last year but remains higher (**worse**) than the national average for internationally recruited staff (26.25%).
- ▶ Internationally recruited staff (15.63% of 659 respondents) reported more experiences of discrimination from managers/team leaders or colleagues (Q16b) than non-internationally recruited staff (8.40% of 6,717 respondents). This has increased (**deteriorated**) from last year but is marginally lower (**better**) than the national average for internationally recruited staff (16.53%).



- ▶ Internationally recruited staff (3.67% of 654 respondents) reported more experiences of physical violence from other colleagues (Q13c) than non-internationally recruited staff (1.85% of 6,720 respondents). This has increased (**deteriorated**) from last year but is marginally lower (**better**) than the national average for internationally recruited staff (4.10%).
- ▶ Internationally recruited staff (5.56 for 659 respondents) reported higher scores for the sub-theme 'Work Pressure' than non-internationally recruited

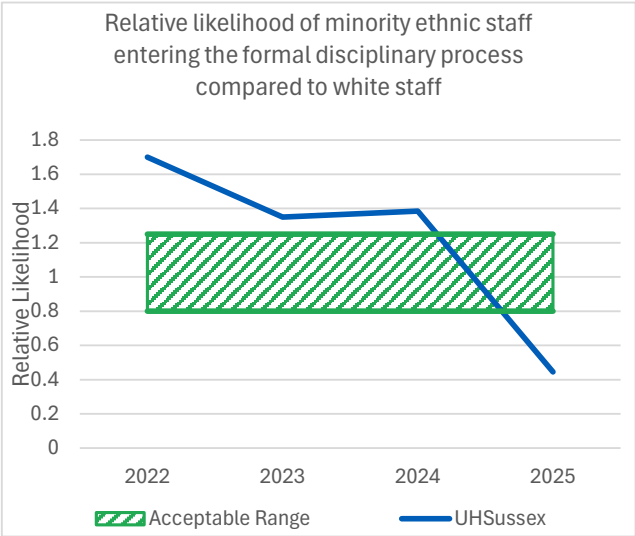
staff (4.77 for 6,809 respondents). This has increased (**deteriorated**) from last year but is marginally lower (**better**) than the national average for internationally recruited staff (5.87).



HIA 6: Eliminate Discrimination (Race)

Formal disciplinary likelihood by ethnicity (WRES 3)

Six staff from minoritised ethnic groups were formally disciplined and 34 white staff across 2024/25, as well as three members of staff who did not indicate their ethnicity. When comparing this to the overall workforce, minoritised ethnic staff were half as likely (0.44 times) to enter the formal disciplinary process than white staff. This is reversed from previous years, where minoritised ethnic staff were more likely to enter the formal disciplinary process compared to white staff (relative likelihood 2024 = 1.38) and remains outside of the acceptable equality range (target between 0.8-1.25) shown in green stripes on the graph.

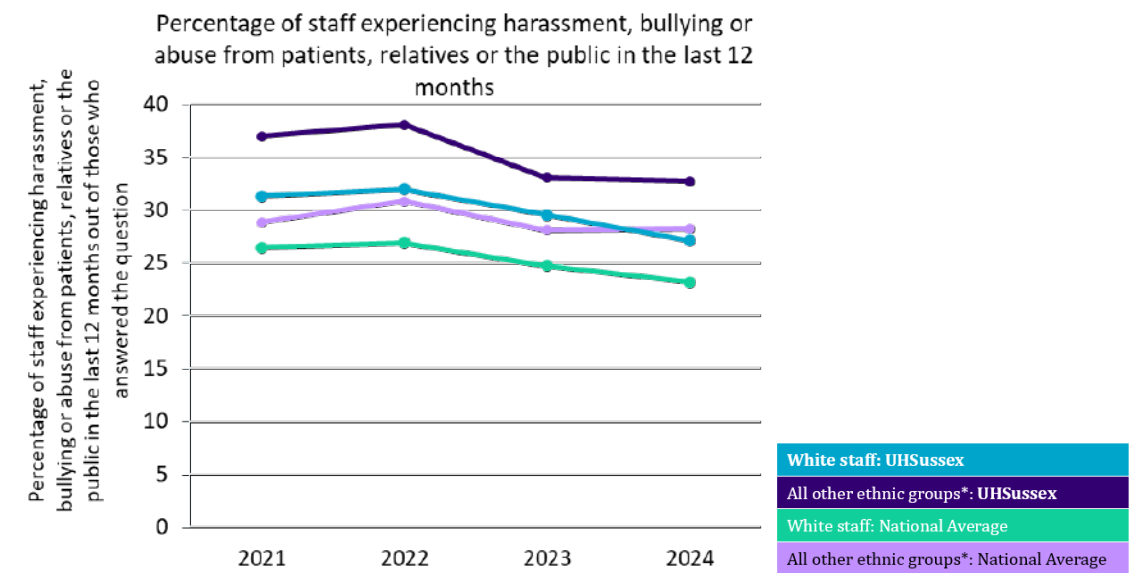


Harassment, bullying or abuse from patients or public by ethnicity (NSS – Q14a; WRES 5)

Results from the National Staff Survey (NSS) 2024 revealed that 32.7% of minoritised ethnic staff at UHSussex experienced harassment, bullying or abuse from patients, relatives, or the public; 0.4 percentage points (pp) less (**improved**) from 2023.

27.1% of white staff at UHSussex reported experiences of harassment, bullying or abuse from patients, relatives, or the public in 2024; 2.4 points less (**improved**) from last year.

Whilst both groups have improved, they have improved more for white people. The gap between white and minoritised ethnic staff on this indicator has marginally widened from 2023 (**worse**).

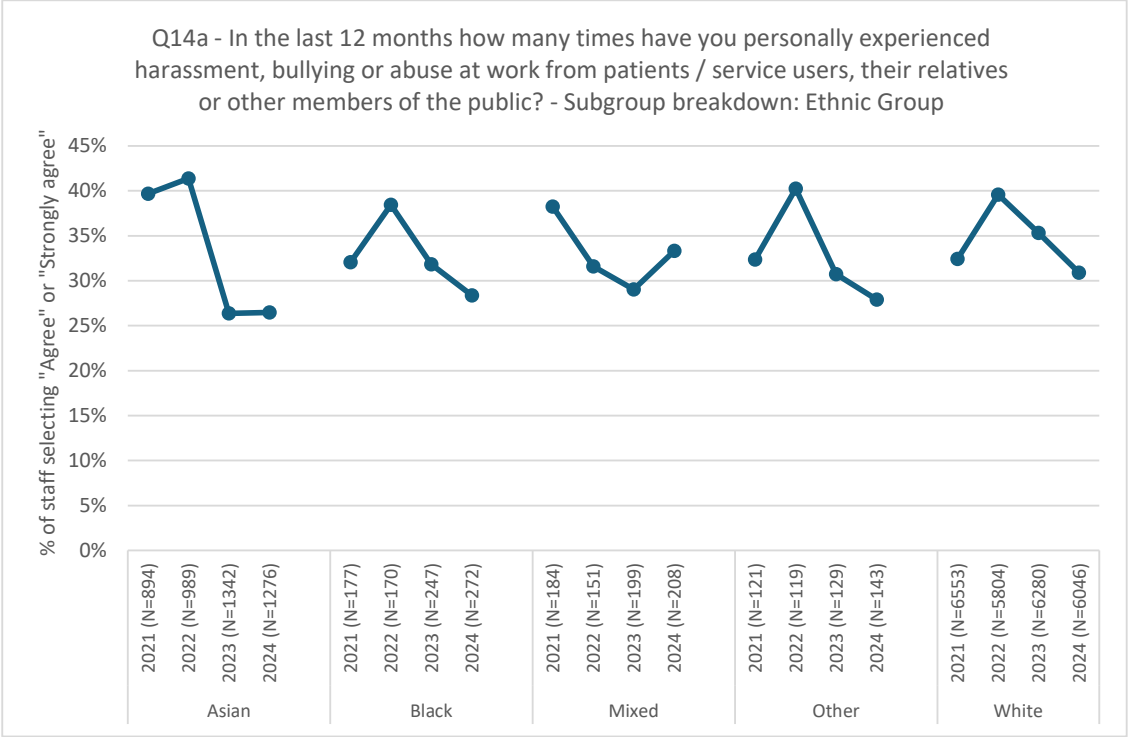


Response Numbers	2021	2022	2023	2024
White staff	6,556	5,807	6,288	6,055
All other ethnic groups*	1,376	1,429	1,917	1,899

*Staff from all other ethnic groups combined

Reviewing the data on harassment, bullying and abuse from patients or the public in more detail it can be shown:

- ▶ Members of staff from mixed ethnic groups report the most experiences of harassment, bullying and abuse from patients or the public compared to staff from all other ethnic groups.
- ▶ Members of staff from mixed ethnic groups reported an increase (worsening) in experiences of harassment, bullying and abuse from patients or the public, while there was a decrease (improvement) for staff from black, other, and white ethnic groups.



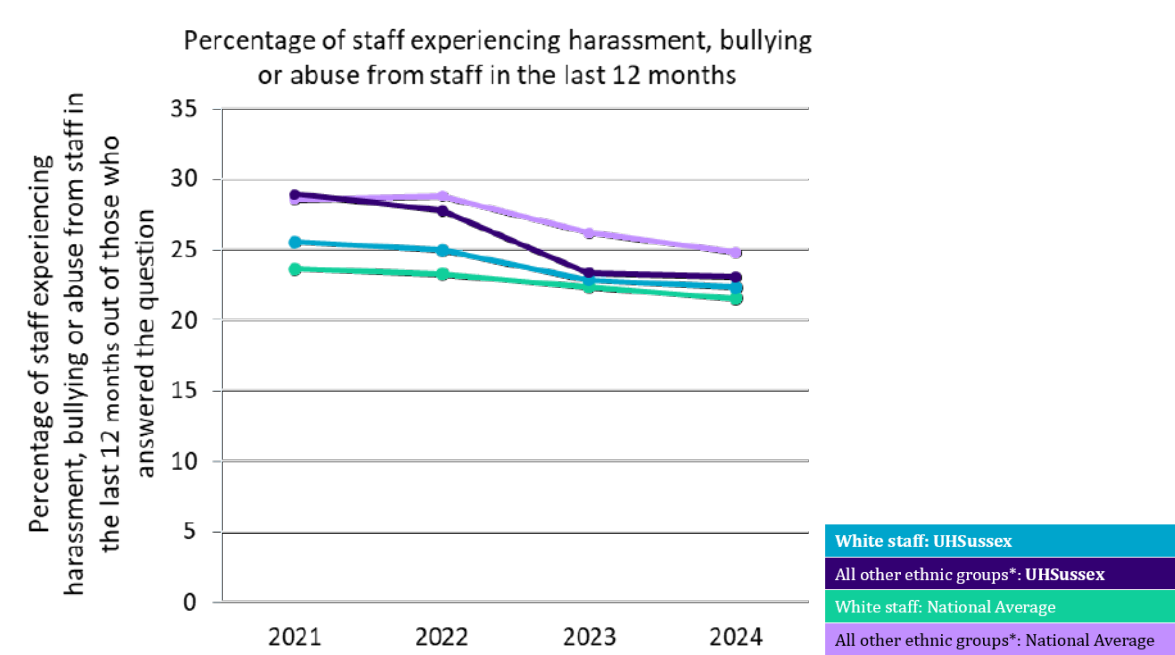
Harassment, bullying or abuse from staff by ethnicity (NSS – Q14b-c; WRES 6)

23.1% of minoritised ethnic staff reported experience of harassment, bullying or abuse from staff in the NHS staff survey 2024; 0.3 percentage points less (**improved**) than in 2023.

22.3% of white staff in the Trust also reported experiences of harassment, bullying or abuse from managers or other colleagues in 2024; 0.6 percentage points less (**improved**) than last year.

The gap between minoritised ethnic and white staff on this indicator has stayed largely like 2023.

The gap between minoritised ethnic staff and white staff at UHSussex is smaller (**better**) than the gap between the national averages.



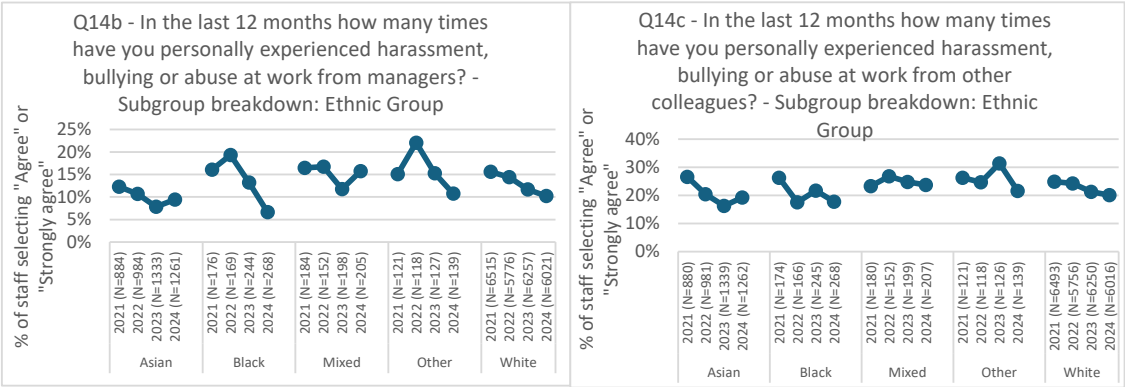
UHSussex Response Numbers	2021	2022	2023	2024
White staff	6,558	5,814	6,287	6,055
All other ethnic groups*	1,369	1,429	1,914	1,885

*Staff from all other ethnic groups combined

Reviewing the data on harassment, bullying and abuse from other staff in more detail it can be shown:

- ▶ Members of staff from mixed ethnic groups report the most experiences of harassment, bullying and abuse by managers compared to staff from all other ethnic groups.

- ▶ Members of staff from Asian and mixed ethnic groups reported an increase (worsening) in experiences of harassment, bullying and abuse from managers, while there was a decrease (improvement) for staff from black, other, and white ethnic groups.
- ▶ Members of staff from mixed ethnic groups report the most experiences of harassment, bullying and abuse from other colleagues compared to staff from all other ethnic groups.
- ▶ Members of staff from Asian ethnic groups reported an increase (worsening) in experiences of harassment, bullying and abuse from managers, while there was a decrease (improvement) for staff from black, mixed, other, and white ethnic groups.



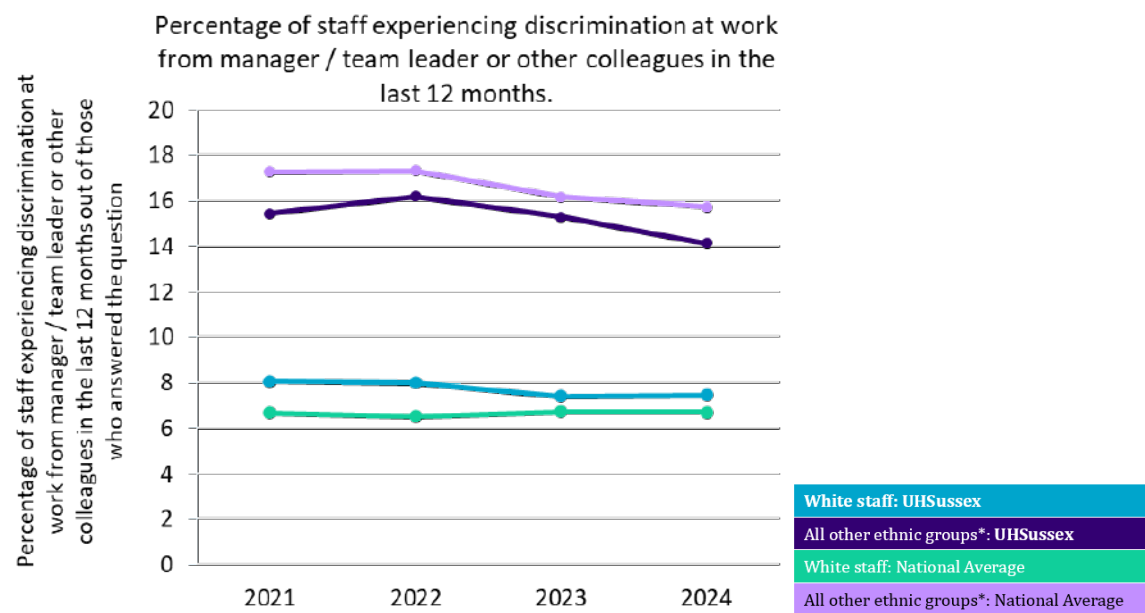
Discrimination from managers or colleagues (NSS – Q16b; WRES 8)

14.1% of minoritised ethnic staff experienced discrimination at work from their manager, team leader or colleagues in the NHS staff survey 2024; over one point less (**improved**) than in 2023.

7.5% of white staff experienced discrimination at work from their manager, team leader or colleagues in 2024; largely unchanged year-on-year.

This indicator displays a smaller difference in scores between minoritised ethnic and white staff at UHSussex compared with the national average (**better**).

Scores from minoritised ethnic staff were further reduced from 2022 and 2023 (**improvement**), decreasing the gap in scores between both groups.

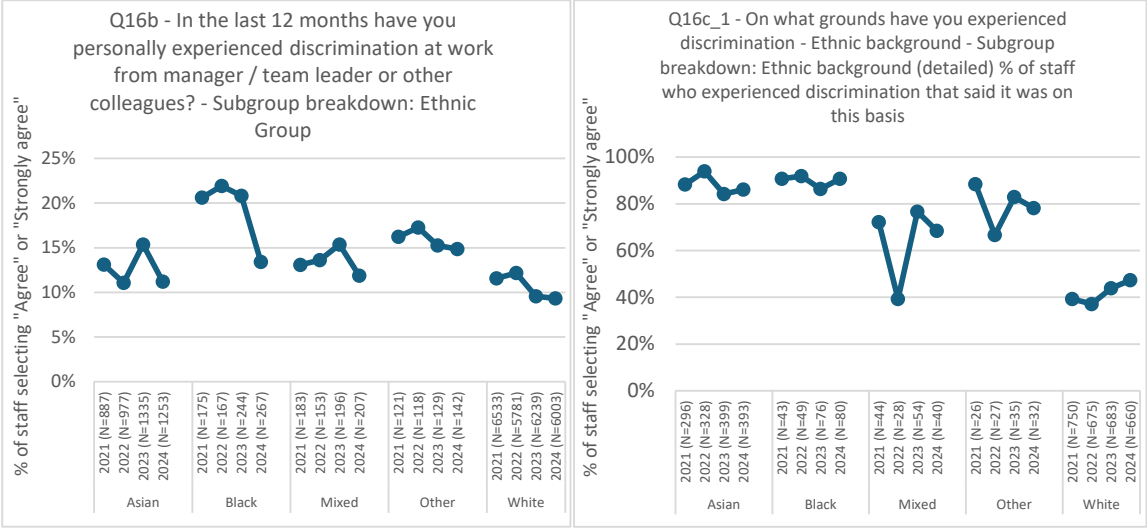


UHSussex Response Numbers	2021	2022	2023	2024
White staff	6,536	5,785	6,247	6,003
All other ethnic groups*	1,366	1,415	1,904	1,869

*Staff from all other ethnic groups combined

Reviewing the data on discrimination in more detail it can be shown that:

- ▶ White members of staff report the least experiences of discrimination from managers, team leaders or other colleagues compared to staff from Asian, Black, mixed, and other ethnic groups.
- ▶ There was a decrease (improvement) in experiences of discrimination from managers, team leaders or other colleagues for staff from all ethnic groups, with the largest improvements in 2024 scores from the previous year recorded for staff from Asian, black and mixed ethnic groups.
- ▶ A large majority of minoritised ethnic staff who had experienced discrimination felt this was on the grounds of their ethnic background (86% of Asian staff, 91% of black staff, 68% of staff with mixed ethnicity, 78% of staff from other ethnic backgrounds).



Discrimination by Race: Raising Concerns About Inequality

Out of twenty-two discrimination cases raised through the [Freedom to Speak Up Guardian Service](#) (FTSUG) during the 2024/25 financial year, 8 (36.4%) included race as either a primary or contributing theme, with 6 (27.3%) identifying race as the primary theme. Two cases (9.1%) did not specify a primary or other theme, suggesting some gaps in reporting detail.

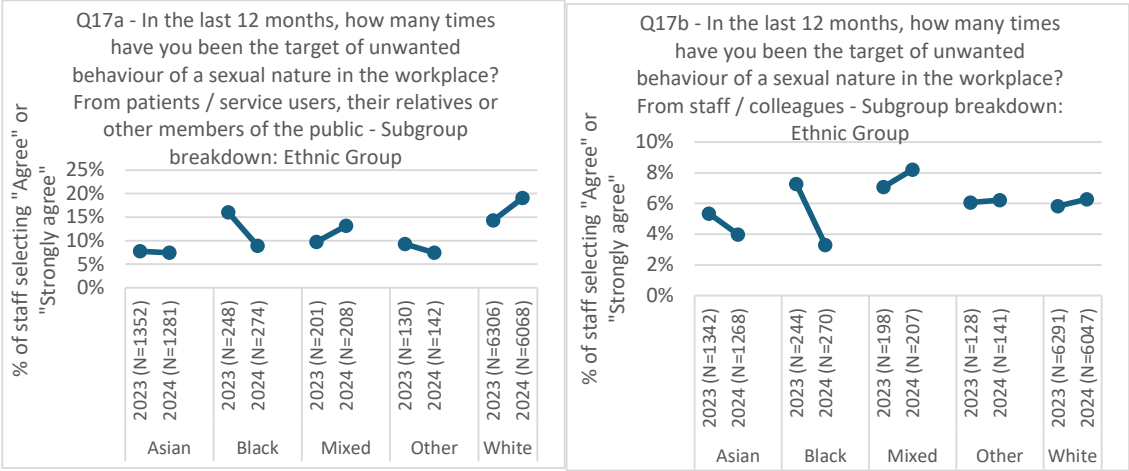
In comparison, during the 2023/24 financial year, 2 out of 14 (14.3%) cases raised through FTSUG mentioned race. However, 9 (64.3%) did not specify any primary or other theme, limiting the ability to fully understand the nature of concerns raised. It is furthermore important to note that only eight months of data were available for the 2023/24 reporting period.

Sexual harassment by ethnicity (NSS – Q17a-b)

Analysis of NHS Staff Survey responses shows that staff from racially minoritised backgrounds report higher rates of experiencing sexual harassment from colleagues and patients compared to white staff. Reviewing the data on sexual harassment in more detail it can be shown that:

- ▶ Members of staff from mixed and white ethnic groups report the most experiences of sexual harassment from patients or the public compared to staff from all other ethnic groups.
- ▶ Mixed and white ethnic groups further saw an increase (worsening) in experiences of sexual harassment from patients, or the public compared to last year, while members of staff from Asian, black and other ethnic groups reported a decrease (improvement).
- ▶ Members of staff from mixed ethnic groups report the most experiences of sexual harassment from other staff or colleagues compared to staff from all other ethnic groups.

- Members of staff from Asian and black ethnic groups reported a decrease (improvement) in experiences of sexual harassment from other staff or colleagues, while there was a increase (worsening) for staff from mixed ethnic groups.



2. Disability

Disability Equality Summary

At UHSussex, staff who have self-identified a disability remain under-represented in senior roles, particularly in higher clinical grades and senior management posts. This gap has stayed largely unchanged from last year, with some small improvements in data quality about disability at Board level. Differences in representation are particularly marked in the Chief Nurse, Chief People Officer, and specialist divisions, and at PRH and St Richard's Hospital.

Disabled staff are slightly less likely than non-disabled staff to believe the Trust provides equal opportunities for career progression, and this gap has widened compared to last year. Recruitment outcomes are now broadly equal for disabled and non-disabled applicants, reflecting steady progress in this area.

Burnout and stress remain significant concerns, with disabled staff reporting substantially higher levels than their non-disabled colleagues. Reports of work-related musculoskeletal problems and feeling pressured to work while unwell are also higher among disabled staff. There have been some improvements, such as more staff reporting that workplace adjustments meet their needs, and these scores are now slightly above the national average.

Disabled staff experience higher rates of bullying, harassment, and discrimination, particularly from colleagues and managers, although there have been small reductions in these behaviours over the past year. Reports of sexual harassment have also decreased for disabled staff, though they remain higher than for non-disabled colleagues.

On a positive note, no disabled staff entered a formal capability process for the fourth year running, and gaps in some areas, such as experiences of harassment from patients, have narrowed. However, in other areas, like feeling valued by the organisation, disabled staff still score lower than non-disabled staff, though there has been some improvement.

HIA 1: Leadership and Accountability (Disability)

Staff voice (WDES 9.2)

The Trust has a [Disabled Staff Network \(DSN\)](#) sponsored by the Chief People Officer. The DSN has achieved several significant milestones throughout 2024–25. Membership grew to 232 active members of the Disabled Staff Network, an increase of 45% since last year (March 2024 = 160).

The Disabled Staff Network meet online every month, led by a staff Chair. A range of topics were covered during these including disability awareness and pride, personal journeys and stories, inclusive workplace practices (e.g. Access to Work, reasonable

adjustments), health and wellbeing (e.g. menopause, financial health, staff checks), leadership roles within the network, external organisation presentations, and planning for UK Disability History Month and other future events.

Developments have included the launch of a new 'Disability at Work' policy, and a review of the Trust's Disability Confident status is underway. The network has also co-hosted a joint event with the Armed Forces Community and My University Hospitals Sussex charity, as part of Disability History Month. The DSN network chair opened 'Singing the Pavilion Blues' exhibition at the Heritage Space, Louisa Martindale building. The DSN was represented at key Trust events including Carers Week, Induction Days, and the All-Staff Conference with stalls to raise awareness and connect with staff.

The DSN plan priorities for the 20-month charity programme 2025/26 include:

- ▶ Delivering educational awareness and development sessions, including a seminar focused on workplace issues linked to long-term health conditions and disabilities, and a Trust-wide 'Disability Summit' to raise awareness and drive forward inclusive practice.
- ▶ Establishing site-based DSN link roles to provide local points of contact and strengthen cross-site engagement.
- ▶ Launching a membership survey to better understand support needs and explore opportunities for peer skill-sharing.
- ▶ Supporting the Trust to sign up to the Disability Employment Charter, aligning with national best practice.
- ▶ Increasing DSN membership across UHSussex to ensure wider representation and impact.



3 – (left) Disabled Staff Network: Stalls at Doctor's Induction July 2024



4 – (right) Disabled Staff Network: Stalls at Carers Week 2024

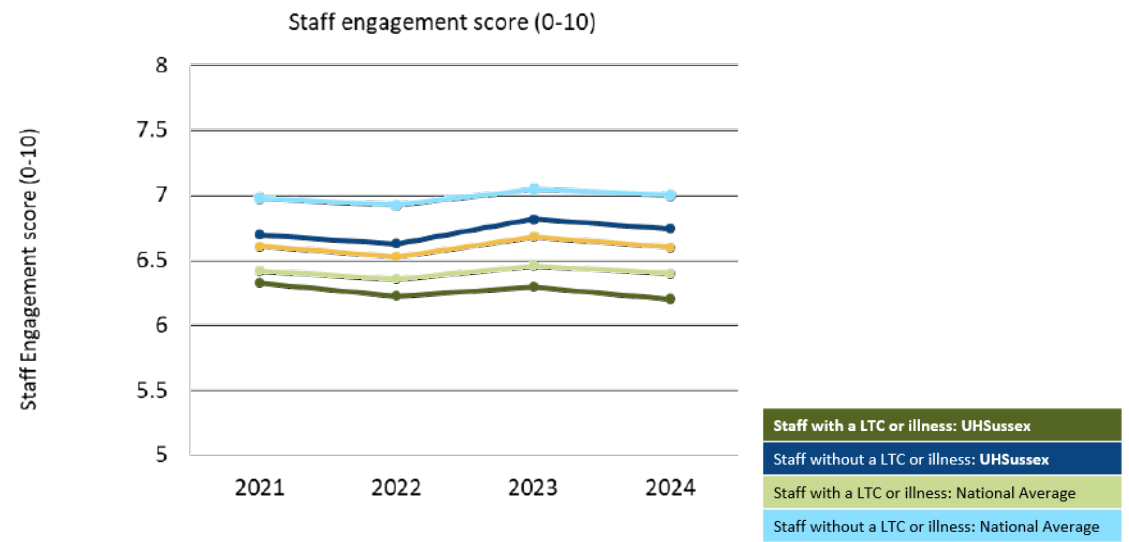


5 – Disabled Staff Network: Marce opening the Disability Awareness Conference 2024

WDES 9.1 NSS staff engagement score

Disabled staff had a lower score (6.20) for the staff engagement theme in the NHS staff survey 2024 than staff without a disability (6.74). Scores for both groups decreased marginally from 2023, a similar trajectory to national benchmarks.

The gap between disabled and non-disabled staff at UHSussex on this indicator has remained largely like previous years. UHSussex consistently scores lower than the national average for both staff with and without a disability.



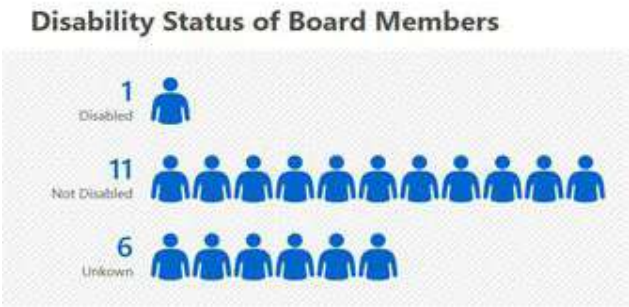
UHSussex Response Numbers	2021	2022	2023	2024
Staff with a LTC or illness: Responses	1,853	1,735	2,099	2,011
Staff without a LTC or illness: Responses	6,093	5,551	6,166	5,974

Board disability composition (WDES 10)

As of the snapshot date in March 2025, 6% of the Board indicated a disability, the same as in 2024. This is in-line with the Trust’s overall workforce (6.63% disabled).

The proportion of Board members not stating their disability status (33%) has decreased from 2024 (40%) but remains considerably higher than in the overall workforce (8.6%).

11% of executive directors indicated they were disabled. 33% of executive directors did not state their disability status, and the remaining stated they were not disabled.



66% of all non-executive directors indicated they were not disabled, 33% of all non-executive directors did not state their disability status.

6% of voting board member indicated they were disabled, 65% of board members with voting rights indicated they were not disabled, and 29% of all voting board members did not state their disability status.

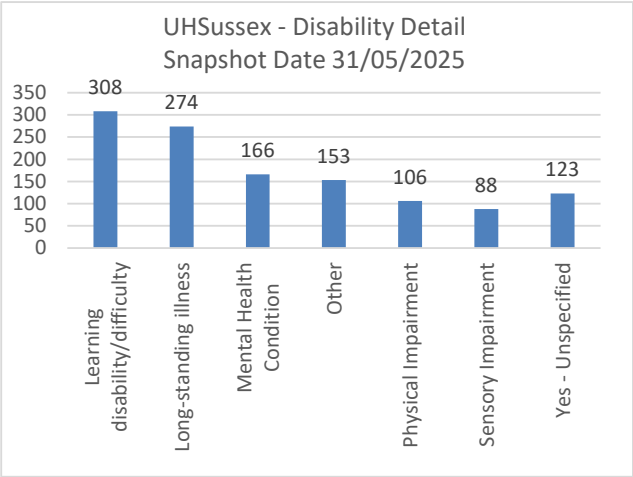
Overall, the comprehensiveness of Board level disability data has improved considerably since last year.

HIA 2: Inclusive Talent (Disability)

Disability workforce representation (WDES 1)

The number of disabled staff in the workforce on 31 March 2025 was 6.65% (1,201) of the permanent workforce overall (18,059), compared to 18% of the population in across East Sussex, West Sussex, and Brighton & Hove combined (Census 2021, ONS). This has saw minor changes compared to the previous year (2024 = 6%).

Of those with a disability, a quarter (25.3%) reported a learning disability or difficulty (N = 308), followed by 22.5% who reported a long-standing illness (N = 274), and 13.6% reported a mental health condition (N = 166), and a combined 22.7% reported 'other' disabilities or did not specify the type of disability on ESR.



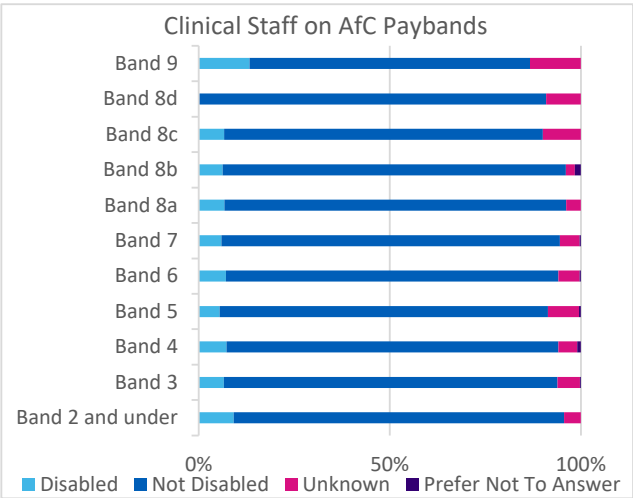
In the 2024 NHS Staff Survey, responses were received from 2,003 (24.74%) staff who indicated to have a long-lasting health condition or illness (disabled), as well as 5933 (73.28%) staff who indicated to not have a long-lasting health condition or illness at UHSussex.

Clinical Agenda for Change Staff

Out of 10,638 clinical staff on Agenda for Change (AfC) terms and conditions:

- ▶ 3,361 staff were in Cluster 1 (Bands 1-4) out of which 6.9% were disabled
- ▶ 6,707 staff were in Cluster 2 (Bands 5-7) out of which 6.2% were disabled
- ▶ 514 staff were in Cluster 3 (Bands 8a-8b) out of which 6.6% were disabled

56 staff were in Cluster 4 (Bands 8c-VSM) out of which 7.1% were disabled.



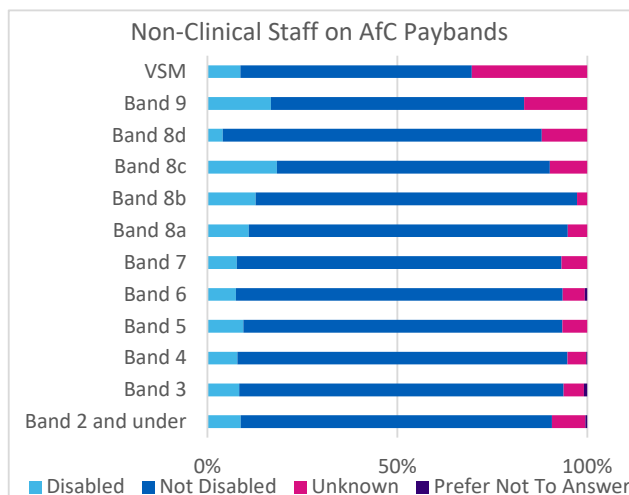
Disabled staff were similarly likely to be represented across all clinical agenda for staff pay bands as staff without a disability.

Representation Disparity Ratio	2023	2024	2025
Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 2 (Bands 5-7)	1.29	1.18	1.12
Disparity ratio - Cluster 2 (Bands 5-7) to Cluster 3 (Bands 8a & 8b)	0.90	1.11	0.96
Disparity ratio - Cluster 3 (Bands 8a & 8b) to Cluster 4 (Bands 8c - VSM)	0.45	0.61	0.85
Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 4 (Bands 8c - VSM)	0.52	0.81	0.91

Non-Clinical Agenda for Change Staff

Out of 4,646 non-clinical staff on Agenda for Change (AfC) terms and conditions:

- ▶ 3,306 staff were in Cluster 1 (Bands 1-4) out of which 8.4% were disabled.
- ▶ 912 staff were in Cluster 2 (Bands 5-7) out of which 8.4% were disabled.
- ▶ 285 staff were in Cluster 3 (Bands 8a-8b) out of which 11.6% were disabled.
- ▶ 143 staff were in Cluster 4 (Bands 8c-VSM) out of which 14% were disabled.



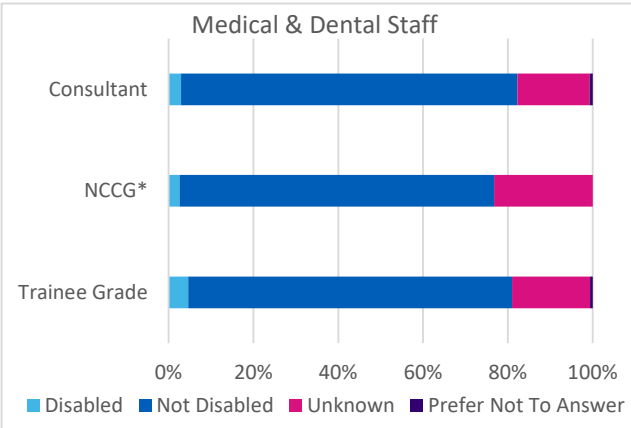
Non-disabled staff were half as likely to be represented in Cluster 4 (Bands 8c – VSM) senior career grades than disabled staff, compared to staff in Cluster 1 (Bands 1 – 4). However, the proportion of staff with unknown disability status is significantly higher in AfC bands 8c and above, compared to the lower bands, which may influence the relative likelihoods reported for these grades.

Representation Disparity Ratio	2023	2024	2025
Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 2 (Bands 5-7)	1.40	1.04	1.01
Disparity ratio - Cluster 2 (Bands 5-7) to Cluster 3 (Bands 8a & 8b)	0.62	0.76	0.72
Disparity ratio - Cluster 3 (Bands 8a & 8b) to Cluster 4 (Bands 8c - VSM)	1.23	0.87	0.70
Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 4 (Bands 8c - VSM)	1.07	0.69	0.51

Medical & Dental Staff

Out of 2,730 staff on medical and dental contracts:

- ▶ 1,544 were trainees, out of which 4.7% were disabled.
- ▶ 116 were non-consultant career grades (NCCGs) out of which 2.6% were disabled.
- ▶ 987 were consultants, out of which 2.9% were disabled.



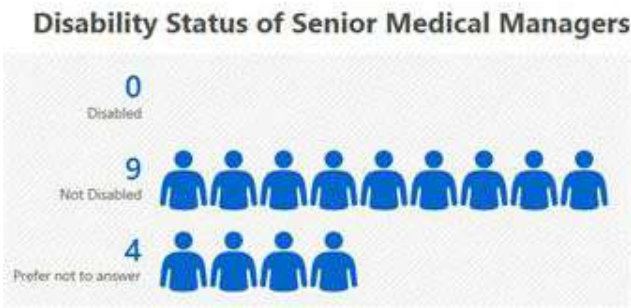
Disabled staff were 1.8 times less likely to be represented in medical and dental non-consultant career grades than staff without a disability compared to staff in trainee grades. This is higher (**worse**) than in 2023 (1.7) and in 2022 when disabled staff were just as likely as non-disabled staff.

Disabled staff were 1.7 times less likely to be represented in medical and dental consultant career grades than staff without a disability, compared to staff in trainee grades. This is lower (**better**) than in 2023 but remains outside of the acceptable equality range (0.8-1.25).

Representation Disparity Ratio	2023	2024	2025
Disparity ratio - Trainee to NCCG	0.99	1.66	1.75
Disparity ratio - NCCG to Consultant	2.20	1.40	0.94
Disparity ratio - Trainee to Consultant	2.19	2.32	1.65

Senior Medical Managers

From all consultants, 13 were identified as ‘senior medical managers’ a category defined in technical reporting guidance from NHS England as an employee who works as a medical consultant and who is either a medical director, or a deputy medical director or who reports directly to a medical director or deputy medical director.

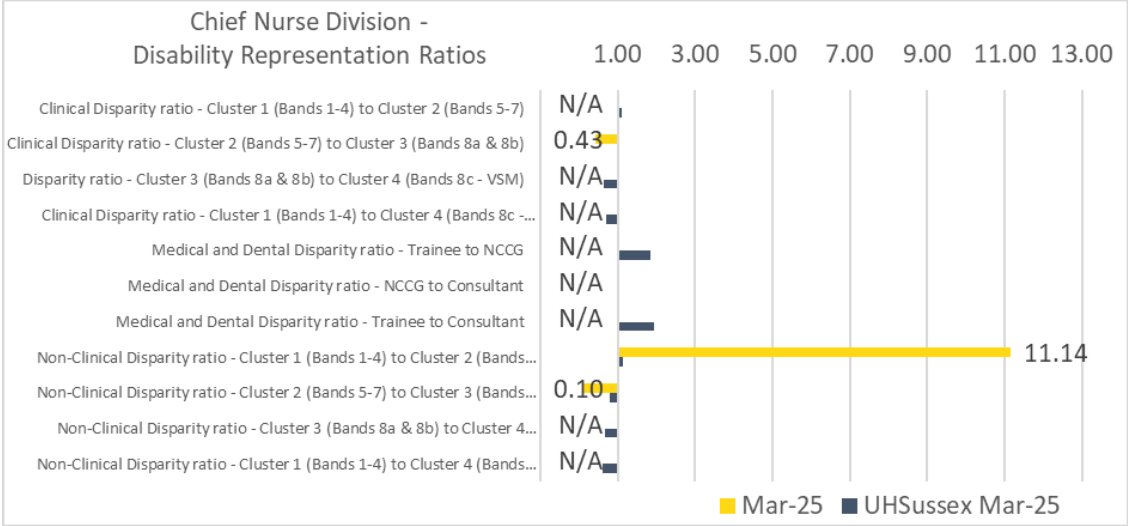


None of the senior medical managers indicated to be disabled. Four (31%) chose to not share their disability status.

Career Progression Disparities by Division

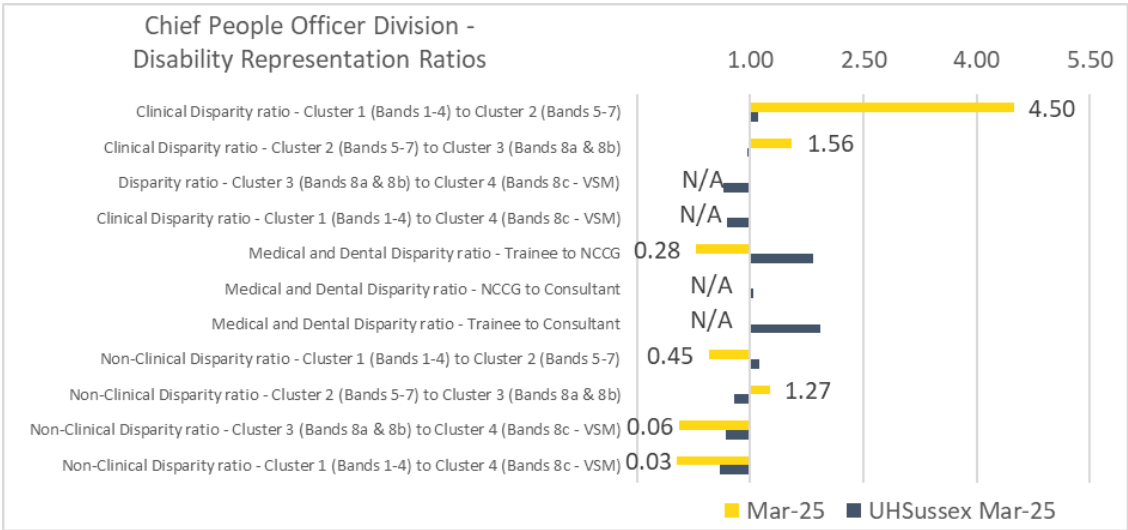
Chief Nurse Division

Non-clinical staff: Staff with no self-identified disability are 11.1 times more likely than staff with a self-identified disability to hold roles at Bands 5-7 compared to Bands 1-4. At senior levels (Bands 8a-8b), staff with a self-identified disability are over-represented (ratio 0.1).



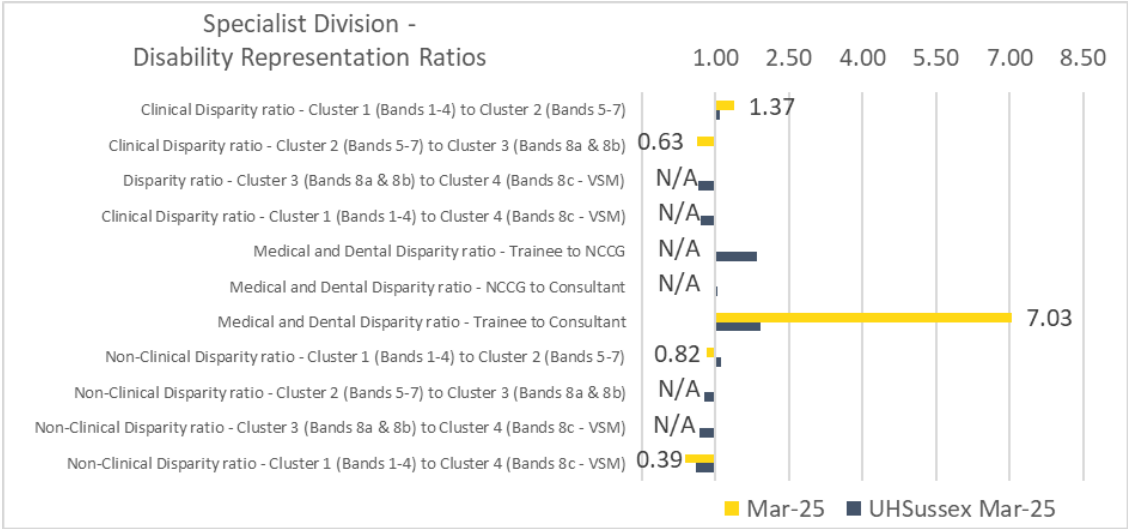
Chief People Officer Division

- ▶ Clinical staff: Staff with no self-identified disability are 4.5 times more likely to hold roles at Bands 5-7 compared to Bands 1-4.
- ▶ Non-clinical staff: At the most senior levels (Bands 8c-VSM), staff with a disability are over-represented, with disparity ratios of 0.05 (Bands 8a-8b to Bands 8c-VSM) and 0.03 (Bands 1-4 to Bands 8c-VSM).



Specialist Division

- ▶ Medical and dental staff: Staff with no self-identified disability are 7.0 times more likely to hold consultant roles compared to trainees.
- ▶ Non-clinical staff: From Bands 1-4 to Bands 8c-VSM, staff with a self-identified disability are under-represented (ratio 0.3).



Surgery (Worthing & St Richard's Hospitals)

- ▶ Non-clinical staff: From Bands 1-4 to Bands 5-7, staff with no self-identified disability are 5 times more likely to hold senior roles.
- ▶ Medical and dental staff: Staff with no self-identified disability are 3.1 times more likely to hold NCCG roles compared to trainees.
- ▶ Clinical staff: Staff with no self-identified disability are 2 times more likely to hold roles at Bands 5-7 compared to Bands 1-4.

Chief Operating Officer Division

- ▶ Non-clinical staff: Staff with no self-identified disability are 4.5 times more likely to hold roles at Bands 5-7 compared to Bands 1-4.

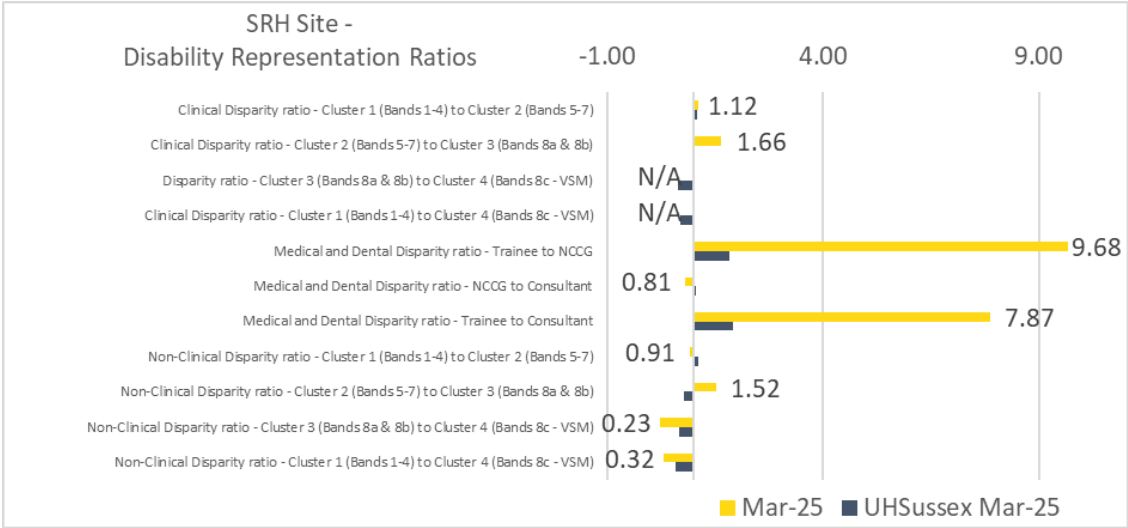
Surgery (RSCH & PRH)

- ▶ Medical and dental staff: Staff with no self-identified disability are 2.4 times more likely to hold NCCG roles compared to trainees.
- ▶ Non-clinical staff: From Bands 5-7 to Bands 8a-8b, staff with no self-identified disability are 2 times more likely to hold senior roles.

Career Progression Disparities by Site

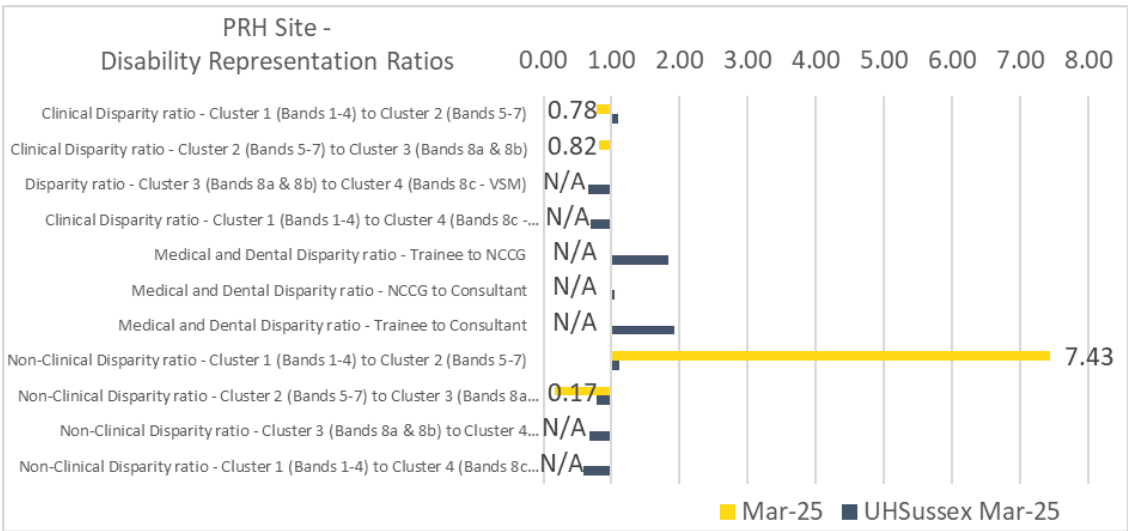
St Richard’s Hospital (SRH)

- ▶ Medical and dental staff: Staff with no self-identified disability are 9.7 times more likely than staff with a self-identified disability to hold NCCG roles compared to trainees. For consultant roles, they are 7.9 times more likely than their disabled colleagues compared to trainees.
- ▶ Non-clinical staff: At senior levels (Bands 8c-VSM), staff with a self-identified disability are over-represented (ratios 0.2 and 0.3).



Princess Royal Hospital (PRH)

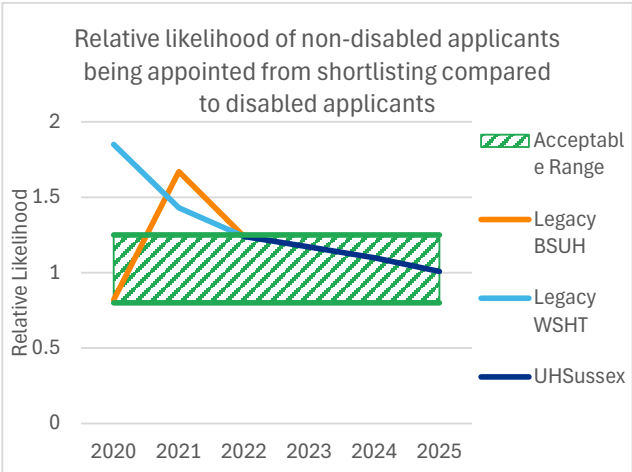
- ▶ Non-clinical staff: Staff with no self-identified disability are 7.4 times more likely than staff with a self-identified disability to hold roles at Bands 5-7 compared to Bands 1-4.
- ▶ Clinical staff: Disparity from Bands 1-4 to Bands 5-7 and Bands 5-7 to Bands 8a-8b is equitable.



Disability shortlisting-to-appointment relative likelihood (WDES 2)

In the 2024/25 financial year UHSussex appointed 233 disabled applicants and 2,652 non-disabled applicants. The Trust was almost as likely to appoint non-disabled people from short-listing as disabled people (1.01). This falls within the acceptable equality range (0.8-1.25).

Compared to previous years, the shortlisting to appointment likelihood between disabled and non-disabled applicants has continued to **improve** since 2021.

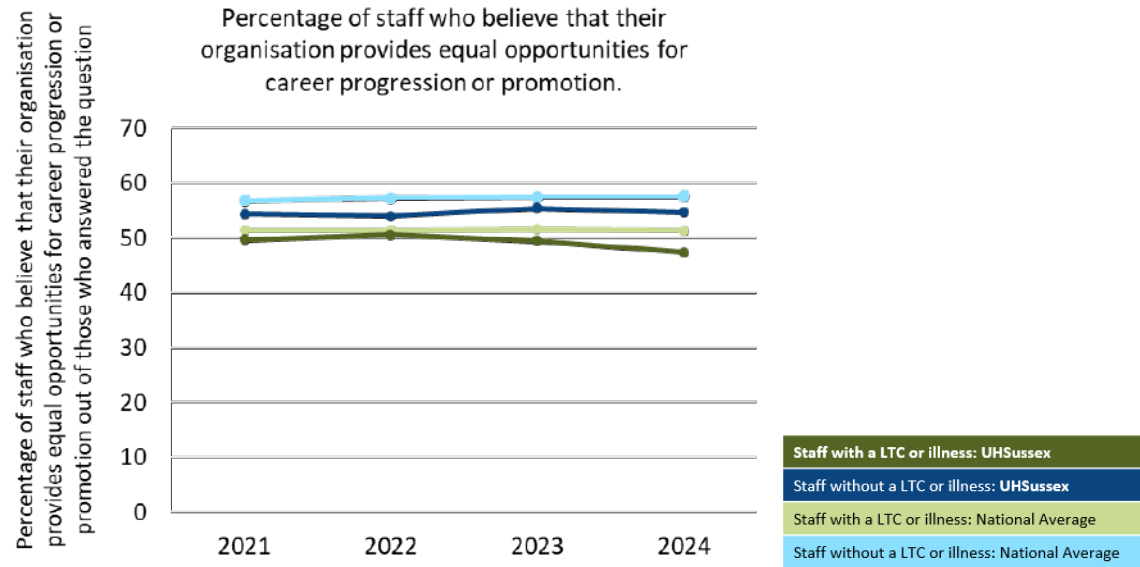


Equality of opportunity for career progression/promotion (NSS – Q15; WDES 5)

47.4% of disabled staff felt the Trust provided equal opportunities for career progression and promotion in the NHS staff survey 2024 (just under 2 percentage points less than in 2023), compared to 54.6% of non-disabled staff (0.8 percentage points less than in 2023).

The gap between disabled and non-disabled staff at UHSussex on this indicator has widened from 2023 (**worse**).

The gap between disabled and non-disabled staff at UHSussex is in-line with the gap between disabled and non-disabled staff for the national averages.



UHSussex Response Numbers	2021	2022	2023	2024

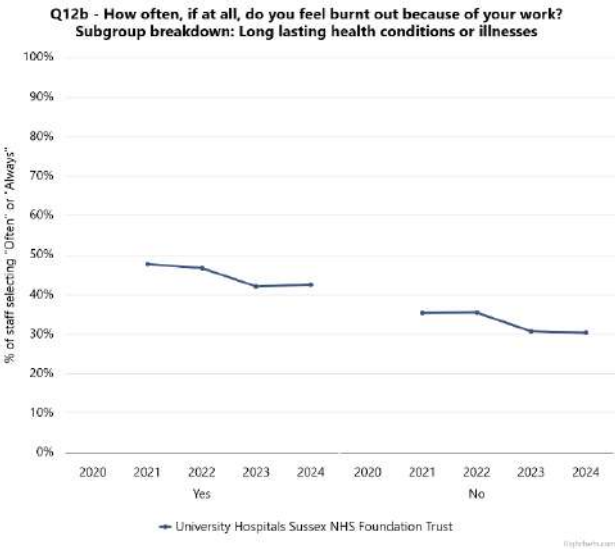
Staff with a LTC or illness: Responses	1,841	1,726	2,073	1,993
Staff without a LTC or illness: Responses	6,046	5,518	6,052	5,879

HIA 4: Workforce Health Inequalities (Disability)

Burnout (NSS – Q12b)

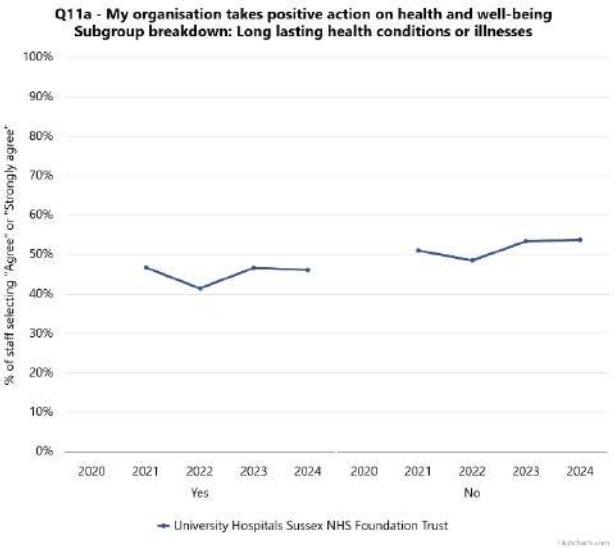
Analysis of NHS Staff Survey responses shows that disabled members of staff report substantially higher rates of burnout because of work (42.53% of 2,015 respondents) compared to members of staff who are not disabled (30.39% of 5,966 respondents).

The proportion of disabled and not disabled members of staff reporting burnout has remained largely unchanged from last year (2023), following a reduction (improvement) from 2022 scores.



Positive action on health and wellbeing (NSS – Q11a)

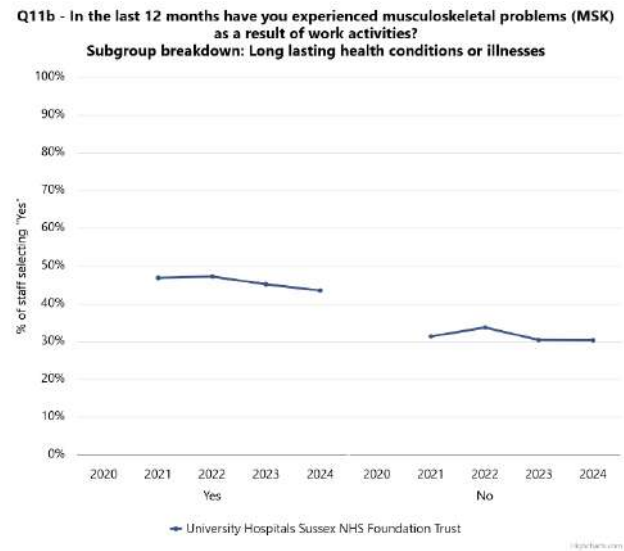
Analysis of NHS Staff Survey responses shows that disabled members of staff report less agreement (46.16% of 1,993 respondents) with the statement “My organisation takes positive action on health and well-being” compared to members of staff who are not disabled (53.80% of 5,913 respondents).



The proportion of disabled and not disabled members of staff agreeing with the statement remained largely unchanged from last year (2023), following an increase (improvement) from 2022 scores.

Musculoskeletal (MSK) problems (NSS – Q11b)

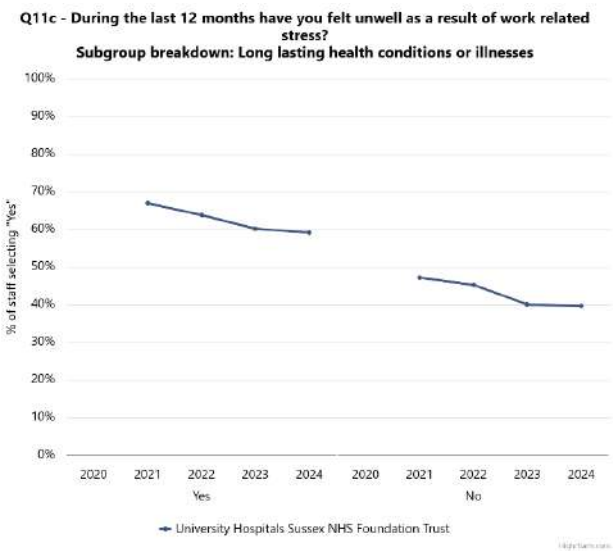
Analysis of NHS Staff Survey responses shows that disabled members of staff report substantially higher rates of musculoskeletal (MSK) problems (43.50% of 2,000 respondents) compared to members of staff who are not disabled (30.30% of 5,940 respondents).



The proportion of disabled members of staff reporting MSK problems has decreased (improved) from previous years (2023 = 45.12% of 2,090 respondents, 2022 = 47.19% of 1,725 respondents) yet remained largely unchanged from last year (2023), for not disabled staff (6,133 respondents).

Work related stress (NSS – Q11c)

Analysis of NHS Staff Survey responses shows that disabled members of staff report substantially higher rates of feeling unwell as a result of work-related stress (59.14% of 2,002 respondents) compared to members of staff who are not disabled (39.63% of 5,928 respondents).

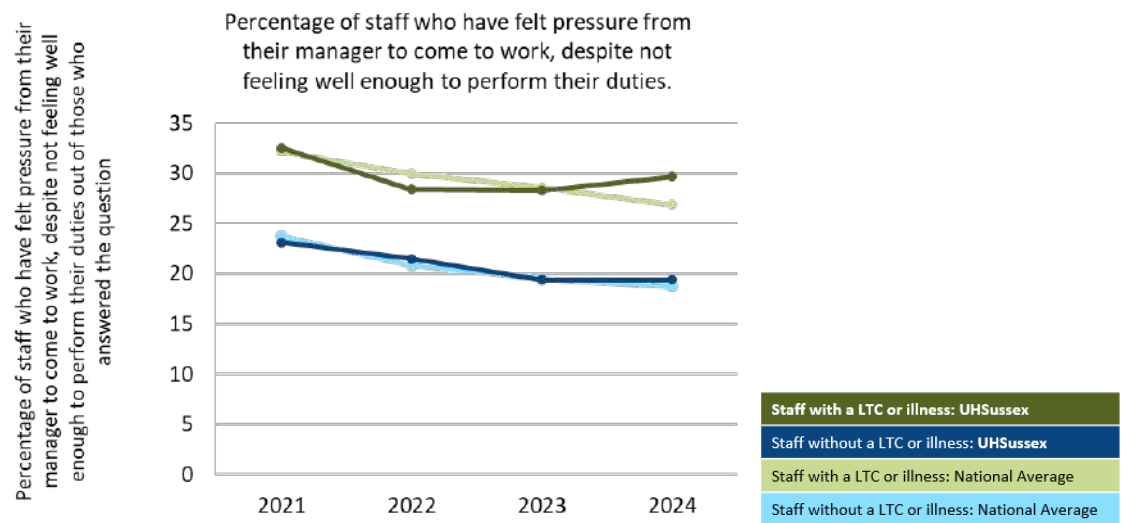


The proportion of both disabled and not disabled members of staff feeling unwell as a result of work-related stress has continued to decrease (improve) from previous years.

Pressure to work from manager when unwell (NSS – Q11e; WDES 6)

29.7% of disabled staff reported having felt management pressure to come to work when not feeling well enough in the NHS staff survey 2024 (over one percentage points more than in 2023), compared to 19.4% non-disabled staff (the same as in 2023).

The gap between disabled and non-disabled staff at UHSussex on this indicator has continued has widened from 2023 (**worse**). The gap between disabled and non-disabled staff at UHSussex is larger (**worse**) than the gap between the national averages on this indicator.

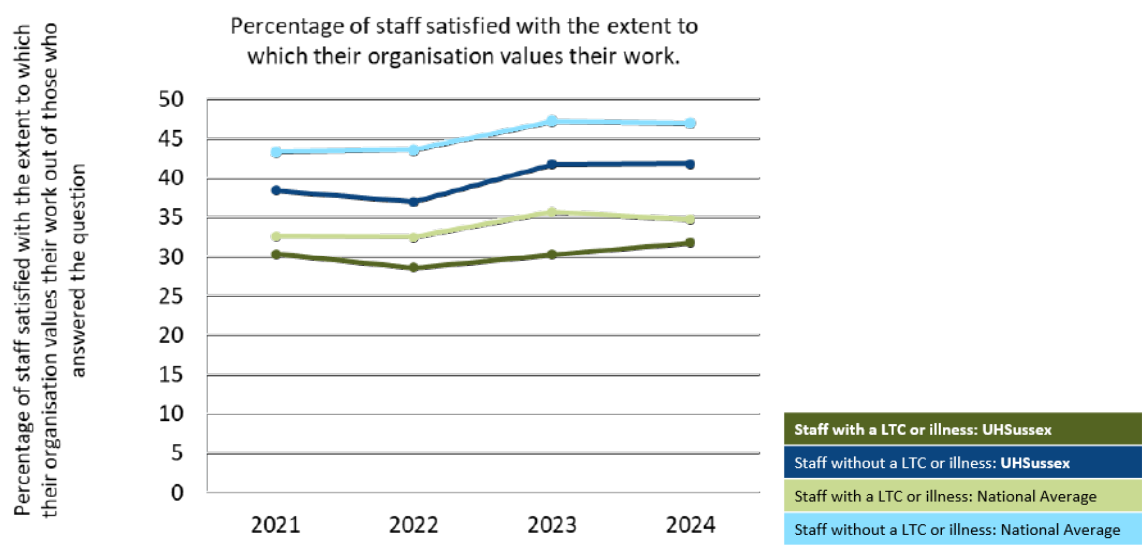


UHSussex Response Numbers	2021	2022	2023	2024
Staff with a LTC or illness: Responses	1,298	1,257	1,448	1,402
Staff without a LTC or illness: Responses	3,050	2,936	3,041	2,929

Staff satisfaction that Trust values their work (NSS – Q4b; WDES 7)

31.8% of disabled staff felt the Trust valued their work in the NHS staff survey 2024 (over one and a half percentage points more than in 2023), compared to 41.8% of non-disabled staff (the same as in 2023).

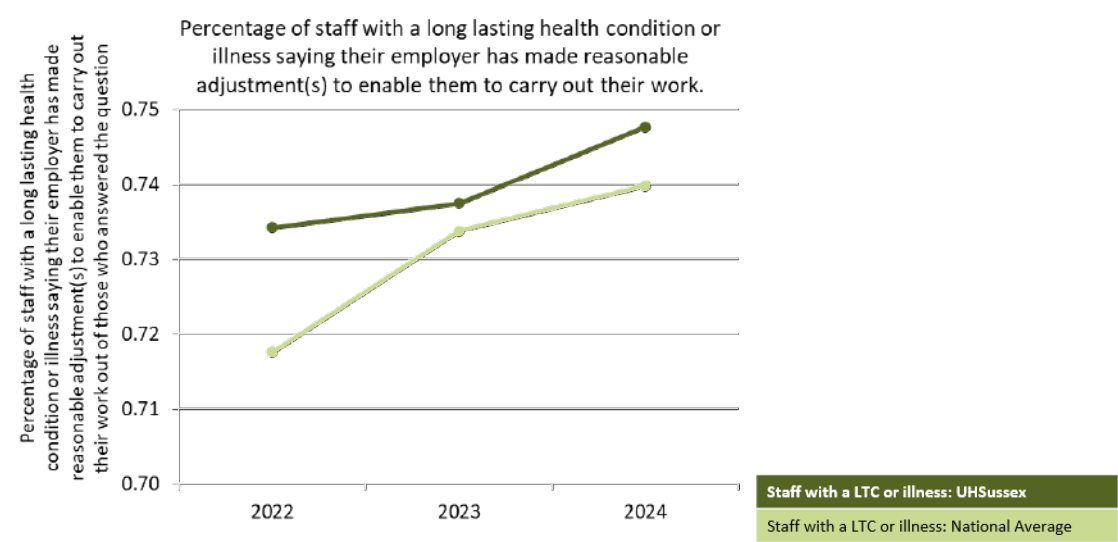
The gap between disabled and non-disabled staff at UHSussex on this indicator has narrowed from 2023 (**improvement**). The gap between disabled and non-disabled staff at UHSussex is in-line with the gap between disabled and non-disabled staff for the national averages.



UHSussex Response Numbers	2021	2022	2023	2024
Staff with a LTC or illness: Responses	1,836	1,723	2,092	1,999
Staff without a LTC or illness: Responses	6,051	5,516	6,133	5,952

Adequate adjustments for disabled people (NSS – Q31b; WDES 8)

74.8% of disabled staff report having adequate workplace adjustments in the NHS staff survey 2024; one percentage points more (**improvement**) than in 2023. This is above the national benchmark (74.0%) which has improved since last year.



UHSussex Response Numbers	2022	2023	2024
Staff with a LTC or illness: Responses	1,046	1,257	1,213

HIA 6: Eliminate Discrimination (Disability)

Formal capability likelihood by disability (WDES 3)

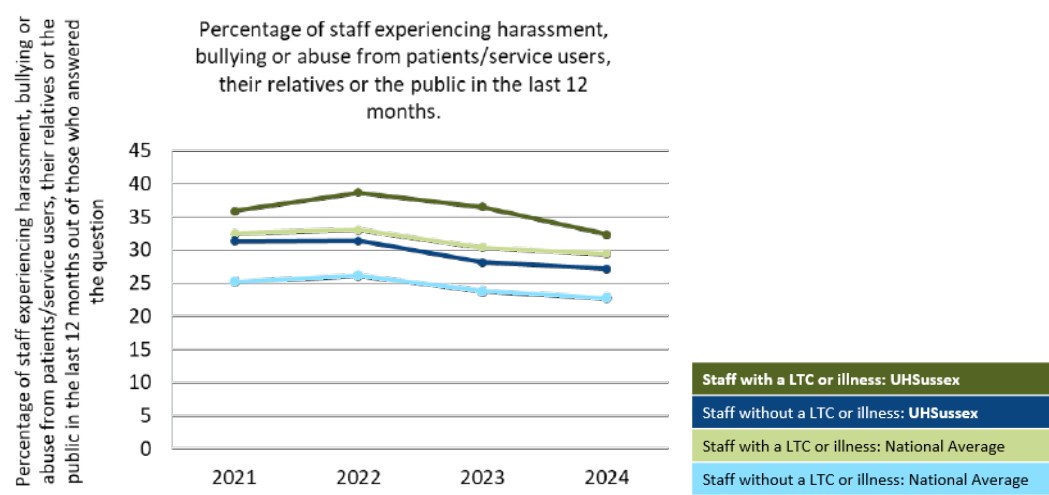
In the 2024/25 financial year no disabled people entered a formal capability process (the same as in the previous three years), compared to seven staff without a disability. As such, it was not possible to calculate the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process.

Harassment, bullying or abuse by disability status (NSS – Q14a-d; WDES 4)

WDES 4.1 Harassment, bullying, or abuse from the public

32.4% of disabled staff reported experiencing harassment, bullying, or abuse from patients, relatives, or members of the public in the NHS staff survey 2024; over 4 percentage points less (**improved**) than in 2023. 27.2% of non-disabled staff reported the same; just under one percentage point less (**improved**) than in 2023.

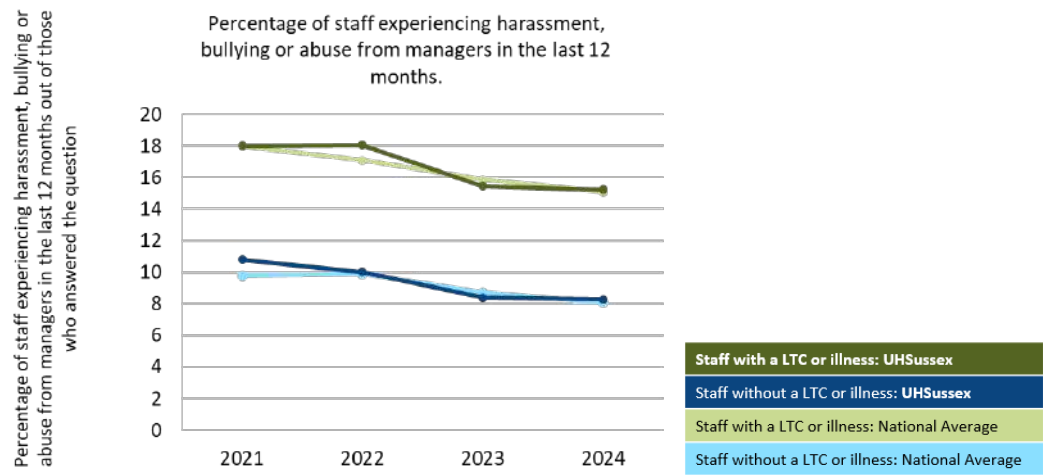
The gap between disabled and non-disabled staff at UHSussex on this indicator has continued to narrow from 2022 and 2023 (**improvement**). The gap between disabled and non-disabled staff at UHSussex is smaller (**better**) than the gap between the national averages on this indicator.



UHSussex Response Numbers	2021	2022	2023	2024
Staff with a LTC or illness: Responses	1,838	1,721	2,089	2,006
Staff without a LTC or illness: Responses	6,068	5,534	6,125	5,952

WDES 4.2 Harassment, bullying, or abuse from managers

15.2% of disabled staff reported experiencing harassment, bullying, or abuse from managers in the NHS staff survey 2024, 8.3% of non-disabled staff reported the same. Both these scores remain largely unchanged from 2023. The gap between disabled and non-disabled staff at UHSussex is in-line with the gap in national averages.

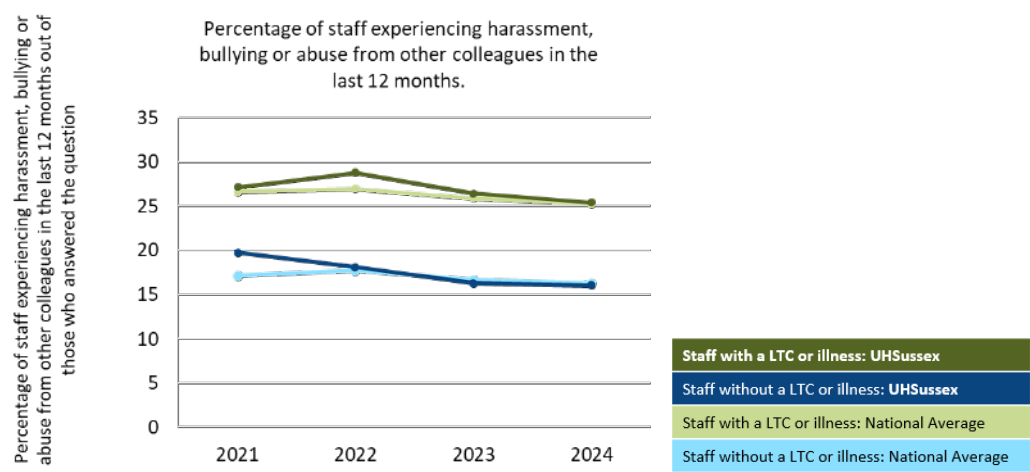


UHSussex Response Numbers	2021	2022	2023	2024
Staff with a LTC or illness: Responses	1,827	1,717	2,082	1,996
Staff without a LTC or illness: Responses	6,033	5,504	6,096	5,910

WDES 4.3 Harassment, bullying, or abuse from colleagues

25.4% of disabled staff reported experiencing harassment, bullying, or abuse from colleagues in the NHS staff survey 2024; one percentage points less (**improved**) than in 2023. 16.0% of non-disabled staff reported the same; largely unchanged from 2023.

The gap between disabled and non-disabled staff at UHSussex on this indicator has narrowed from 2023 (**improvement**). The gap between disabled and non-disabled staff at UHSussex is in-line with the gap in national averages on this indicator.

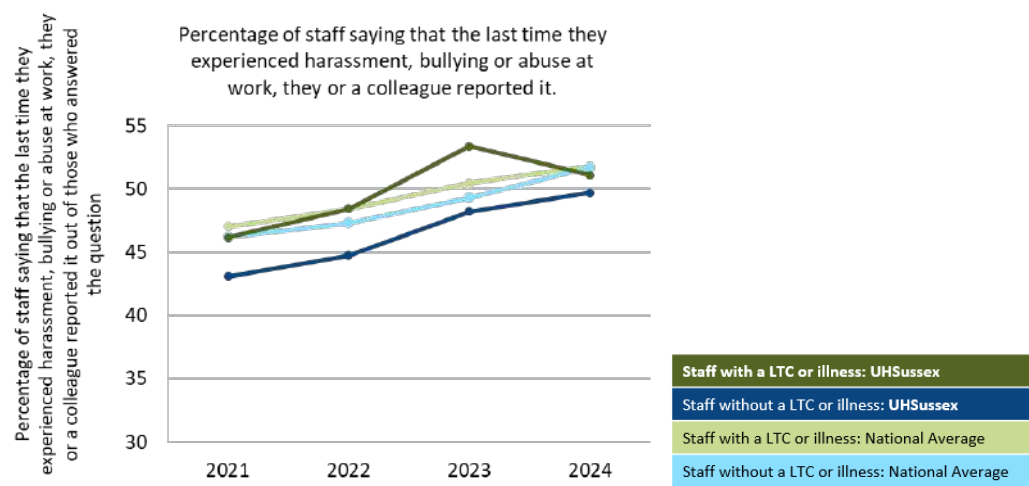


UHSussex Response Numbers	2021	2022	2023	2024
Staff with a LTC or illness: Responses	1,815	1,703	2,080	1,993
Staff without a LTC or illness: Responses	6,011	5,489	6,098	5,906

WDES 4.4 Reporting harassment, bullying, or abuse

51.1% of disabled staff identified that they, or a colleague, reported harassment, bullying or abuse in the NHS staff survey 2024; over two percentage points less (**worsened**) than in 2023. 49.7% of non-disabled staff reported the same; one and a half points more (**improved**) than in 2023.

The gap between disabled and non-disabled staff at UHSussex on this indicator has narrowed from 2023. This indicator displays a larger difference in scores between disabled and non-disabled staff at UHSussex compared with the national average (**worse**).



UHSussex Response Numbers	2021	2022	2023	2024
Staff with a LTC or illness: Responses	845	847	969	926
Staff without a LTC or illness: Responses	2,205	1,966	2,072	1,974

Discrimination by Disability: Raising Concerns About Inequality

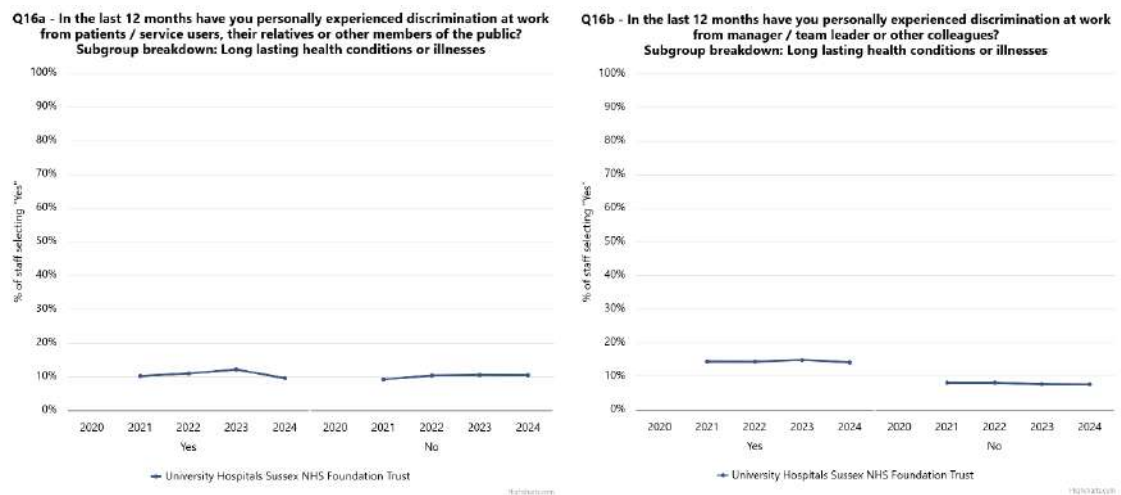
Out of 22 discrimination cases raised through the [Freedom to Speak Up Guardian Service](#) (FTSUG) during the 2024/25 financial year, 9 (40.9%) included disability as either a primary or contributing theme, with 6 (27.3%) identifying disability as the primary theme. Two cases (9.1%) did not specify a primary or other theme, suggesting some gaps in reporting detail.

In comparison, during the 2023/24 financial year, 2 out of 14 (14.3%) cases raised through FTSUG mentioned disability. However, 9 (64.3%) did not specify any primary or other theme, limiting the ability to fully understand the nature of concerns raised. It is furthermore important to note that only eight months of data were available for the 2023/24 reporting period.

Discrimination from the public, managers or colleagues by disability status (NSS – Q16a-b)

Analysis of NHS Staff Survey responses shows that disabled staff report higher rates of discrimination from colleagues compared to not disabled staff. Reviewing the data in more detail it can be shown that:

- ▶ Disabled members of staff report substantially more experiences of discrimination from managers, team leaders or other colleagues (14.05% of 1,986 respondents), than members of staff who are not disabled (7.50% of 5,890 respondents), this has remained largely unchanged from previous years.
- ▶ Disabled staff members (9.50% of 1,999 respondents) report a similar percentage of experiences of discrimination from patients or the public, as members of staff who are not disabled (10.38% of 5,942 respondents).
- ▶ The proportion of disabled members of staff reporting discrimination from patients or the public has decreased (improved) compared to last year (2023 = 12.06% of 2,090 respondents).

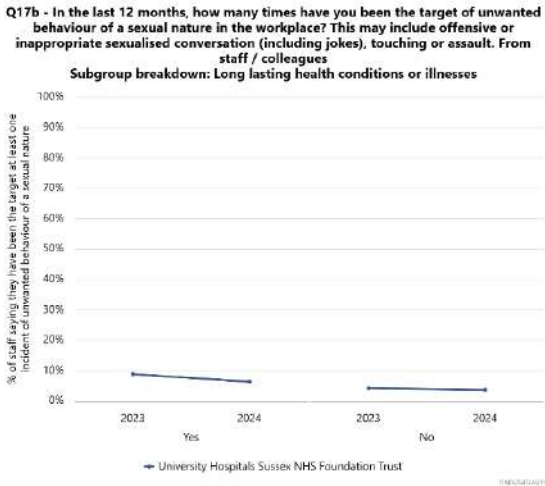
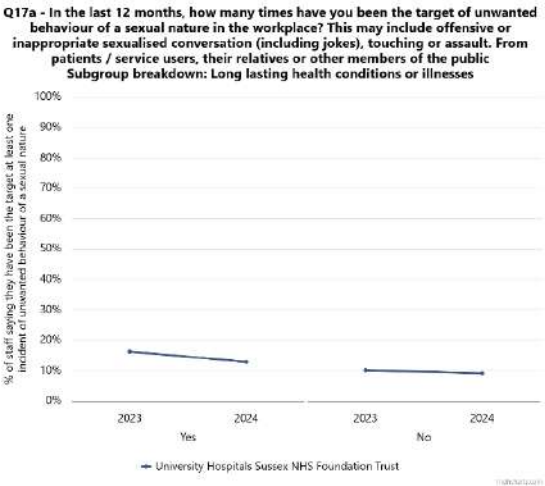


28.01% of disabled staff who had experienced discrimination felt this was on the grounds of disability (382 respondents). Notably, disabled were also similarly likely to attribute discrimination to ‘other’ reasons (24.87% of 382 respondents).

Sexual harassment by disability status (NSS – Q17a-b)

Analysis of NHS Staff Survey responses shows that disabled staff report higher rates of experiencing sexual harassment from colleagues and patients compared to not disabled staff. Reviewing the data on sexual harassment in more detail it can be shown that:

- ▶ Disabled members of staff report more experiences of sexual harassment from patients or the public (12.88% of 2,011 respondents), than members of staff who are not disabled (9.14% of 5,966 respondents).
- ▶ The proportion of disabled members of staff reporting sexual harassment from patients or the public has decreased (improved) compared to last year (2023 = 16.19% of 2,106 respondents).
- ▶ Disabled members of staff report more experiences of sexual harassment from managers, team leaders or other colleagues (6.33% of 2,005 respondents), than members of staff who are not disabled (3.68% of 5,930 respondents).
- ▶ The proportion of disabled members of staff reporting sexual harassment from managers, team leaders or other colleagues has decreased (improved) compared to last year (2023 = 8.84% of 2,092 respondents).



3. Gender

Gender Equality Summary

At UHSussex, women make up the majority of the workforce but are under-represented at Board level and in senior medical roles. Male staff are more likely to hold senior non-clinical management posts and senior medical grades, including consultant and non-consultant career grades. In contrast, women are more likely to be in senior clinical roles within AfC pay bands. These gender imbalances are particularly noticeable in divisions such as Chief Operating Officer, Medicine and Women & Children, and in the Estates and Facilities staff group.

Recruitment outcomes are broadly equal, with men and women being appointed from shortlisting at similar rates. Women are slightly more likely than men to feel the Trust acts fairly in career progression, though agreement has fallen slightly across all genders since last year. Staff who identify as non-binary or whose gender differs from their sex registered at birth report much lower confidence in fair career progression and promotion.

A gender pay gap remains, with women earning less than men on average. While this gap has narrowed slightly for regular pay, the gap in bonus pay has widened, predominantly due to changes agreed to the consultant contract to settle the 2023 pay dispute and consolidating CEA payments into pay. Recorded data on flexible working is very limited, but among the small number of cases available, most instances involve women. A new ESR rollout is expected to give a clearer picture of uptake across the workforce in the future. Satisfaction with flexible working arrangements is lowest among non-binary, transgender, and self-described staff.

Non-binary, transgender, and staff who prefer to self-describe their gender consistently report higher levels of burnout, stress, and lower satisfaction with health and well-being support. These groups also experience the highest levels of bullying, harassment, and discrimination from patients, managers, and colleagues. Reports of sexual harassment are notably higher among non-binary and transgender staff, and these incidents have increased for staff who self-describe their gender.

Given that women make up the majority of our workforce, the high levels of reported discrimination and harassment signal an urgent need for further targeted action.

HIA 1: Leadership and Accountability (Gender)

Staff voice

The Trust has a [Women's Network](#) which was established in March 2024, sponsored by the Chief Medical Officer. The Women's Network hosts 1.5-hour long meetings for members every other month, hosted by a staff chair and sponsored by the Chief Medical Officer. Network meetings have presented a wide variety of topics presented

included safeguarding women and girls against violence and abuse, financial wellbeing for women, wellbeing for women (including menopause cafe's, breastfeeding room information, cervical smear test information and mental health training), and discussions about sexual safety and safety in general at work.

We have also discussed future events and what network members want to see in future meetings.

Developments within the network have included the hosting of an International Women's Day event on 12th March, where students being mentored through [The Girls' Network](#) were invited to participate in workshops and talks focusing on basic life support, NHS career pathways, and how women can support and uplift each other in the workplace, in keeping with the event theme of accelerating action.

The network has also been active in promoting mentorship opportunities for staff members to participate in, to create pathways for women to share expertise and build confidence.

We use every session to create awareness and a safe space for women to discuss current affairs and issues impacting on them as well as looking at organisational, regional and national issues affecting women's rights and equality.

The Women's Network 20-month charity programme plan priorities for 2025/26 include:

- ▶ Creating mentorship opportunities for girls in the community, in partnership with [The Girls' Network](#).
- ▶ Expanding membership of the Women's Network by 30%.
- ▶ Hosting more speakers within network meetings, with topics including advocacy skills, looking after health and wellbeing, how to access support and work/life balance.
- ▶ Hosting on-site recruitment days to introduce and provide information on the Women's Network to staff across the Trust.
- ▶ Plan and deliver an event where staff can highlight their achievements within the NHS, fostering a supportive and inclusive community.



6 – (all above) Women's Network: Information stand at the International Women's Day Event - with inspiring and empowering quotes for the girls to read.



7 - Women's Network: Tori Cooper with the Practice Development Workshop Leads at the International Women's Day Event 2025

The Trust has a [Trans & Non-Binary \(TNB\) Group](#) sponsored by the Chief Operating Officer. There are approximately 100 members of the Trans Non-Binary (TNB)

Network at UHSussex, and a membership survey (which will be repeated annually) highlighted the connections with other networks e.g., LGBTQI +, Disability, etc.

There have been a number of social activities and greater focus on engaging across the Trust’s large geography and with other NHS organisations. The Supreme Court’s judgement on Trans rights has caused great concern across the Network as well as the TNB patients that we serve (conservative estimate of 10,000) and the TNB network has engaged at a local, regional and national level to both influence decision making and try and provide reassurance for members.

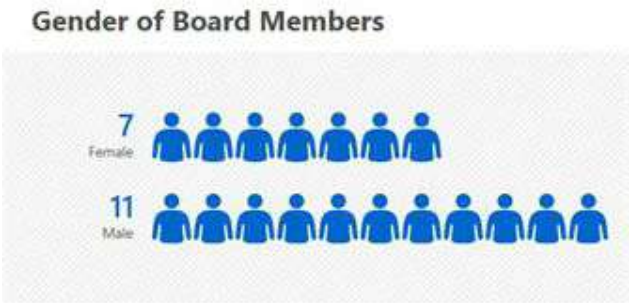
This judgement will influence activity over the next period, but in addition there will be a strong focus on helping reduce social isolation, education and development activities and providing a safe space for members many of whom feel very worried at this moment in time.

Board gender composition

Seven females (39%) and eleven males (61%) were on the Trust Board.

Four females (44.4%) and five males (55.6%) were executive directors, while three (33.3%) females and six (66.6%) males were non-executive directors.

Six females had voting rights (35.3%) and eleven males (64.7%). This was a decrease of two females (-9.1% points) since 2024 (44.4%).



HIA 2: Inclusive Talent (Gender)

Gender workforce representation

Out of a permanent workforce of 17,972 in March 2025, 12,944 were recorded as women on ESR* (72.02%), with the rest (27.98%) recorded as male. This compares to females representing 51% of the population in England and 52% across East Sussex, West Sussex and Brighton and Hove combined (Census 2021, ONS).

While there is no data on gender identity available in ESR, 0.88% of UHSussex staff who responded to the NHS Staff Survey in 2025 reported that their gender is different to the sex registered at birth. This compares to 0.5% of the population in England and 0.37% across East Sussex and West Sussex (Census 2021, ONS).

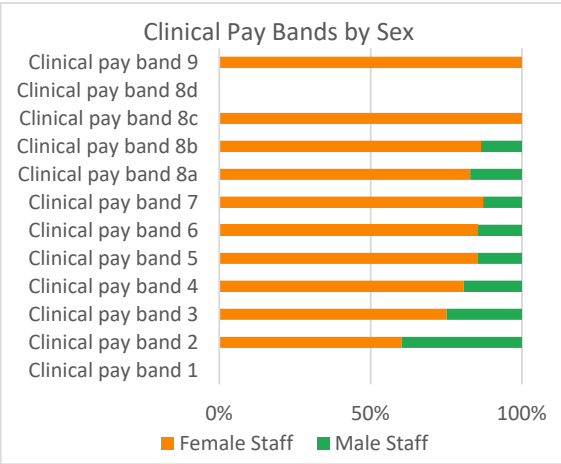
In the 2024 NHS Staff Survey, responses were received from 5,820 (71.76%) female staff, 1,849 (22.79%) male staff, 34 (0.42%) non-binary staff, 20 (0.25%) staff who preferred to self-describe their gender, and 273 (3.37%) staff who preferred not to disclose their gender at UHSussex. In terms of gender identity, 7,026 (86.63%) staff

whose gender aligns with their sex registered at birth, 65 (0.80%) reported that it is different, and 264 (3.26%) preferred not to say.

Clinical Agenda for Change Staff

Out of 9,635 clinical staff on Agenda for Change (AfC) terms and conditions:

- ▶ 384 staff were in upper bands (AfC 8a+) out of which 84.1% were female.
- ▶ 3,569 staff were in middle bands (AfC 6-7) out of which 86.0% were female.
- ▶ 5,682 staff were in lower bands (AfC 1-5) out of which 79.2% were female.



Female staff were proportionally more likely than male staff to be employed in senior clinical roles (AfC bands 8 and above), as well as in specialist or advanced clinical roles (AfC bands 6-7), relative to their representation in support or newly qualified roles (AfC bands 1-5).

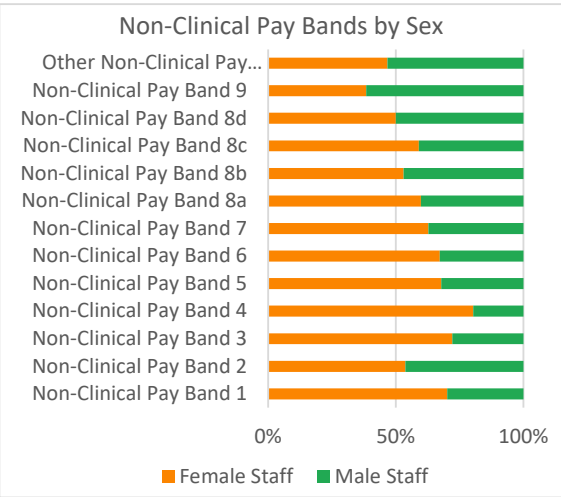
This pattern appears to be driven by a significantly higher concentration of male staff in the lowest clinical pay bands (AfC bands 2 and 3), and by the underrepresentation of men in the upper clinical pay bands, particularly above band 8b.

Representation Disparity Ratio	2025
Disparity ratio – lower (Bands 1-5) to middle (Bands 6-7)	0.62
Disparity ratio – middle (Bands 6-7) to upper (Bands 8a-VSM)	1.16
Disparity ratio – lower (Bands 1-5) to upper (Bands 8a-VSM)	0.72

Non-Clinical Agenda for Change Staff

Out of 5,637 non-clinical staff on Agenda for Change (AfC) terms and conditions:

- ▶ 588 staff were in upper bands (AfC 8a+) out of which 56.5% were female.
- ▶ 942 staff were in middle bands (AfC 6-7) out of which 65.0% were female.
- ▶ 4,107 staff were in lower bands (AfC 1-5) out of which 66.5% were female.



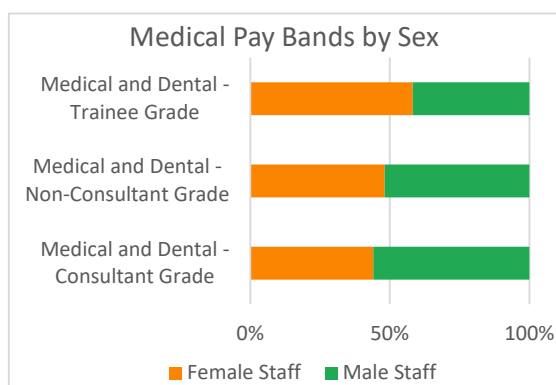
Male staff were **1.5 more likely** than female staff to be non-clinical senior managers (AfC bands 8 and above), and in junior managers roles (AfC bands 6-7), relative to their representation in compared to support and entry level roles (AfC bands 1-5). This falls outside of the acceptable equality range (0.8-1.25).

Representation Disparity Ratio	2025
Disparity ratio – lower (Bands 1-5) to middle (Bands 6-7)	1.07
Disparity ratio – middle (Bands 6-7) to upper (Bands 8a-VSM)	1.43
Disparity ratio – lower (Bands 1-5) to upper (Bands 8a-VSM)	1.53

Medical & Dental Staff

Out of 2,627 staff on medical and dental contracts:

- ▶ 962 were consultants, out of which 44.1% were female.
- ▶ 573 were non-consultant career grades (NCCGs) out of which 48.7% were female.
- ▶ 1,092 were trainees, out of which 58.7% were female.



Male staff were **1.8 times more likely** to be consultants than female staff compared to their proportions in trainee grades. This falls outside of the acceptable equality range (0.8-1.25).

Male staff were **1.5 times more likely** to be NCCGs than female staff compared to their proportions in trainee grades. This falls outside of the acceptable equality range (0.8-1.25).

Representation Disparity Ratio	2025
Disparity ratio - Trainee to NCCG	1.50
Disparity ratio - NCCG to Consultant	1.20
Disparity ratio - Trainee to Consultant	1.80

Senior Medical Managers

From all consultants, 13 were identified as 'senior medical managers' a category defined in technical reporting guidance from NHS England as an employee who works as a medical consultant and who is either a medical director, or a deputy medical director, or who reports directly to a medical director or deputy medical director.

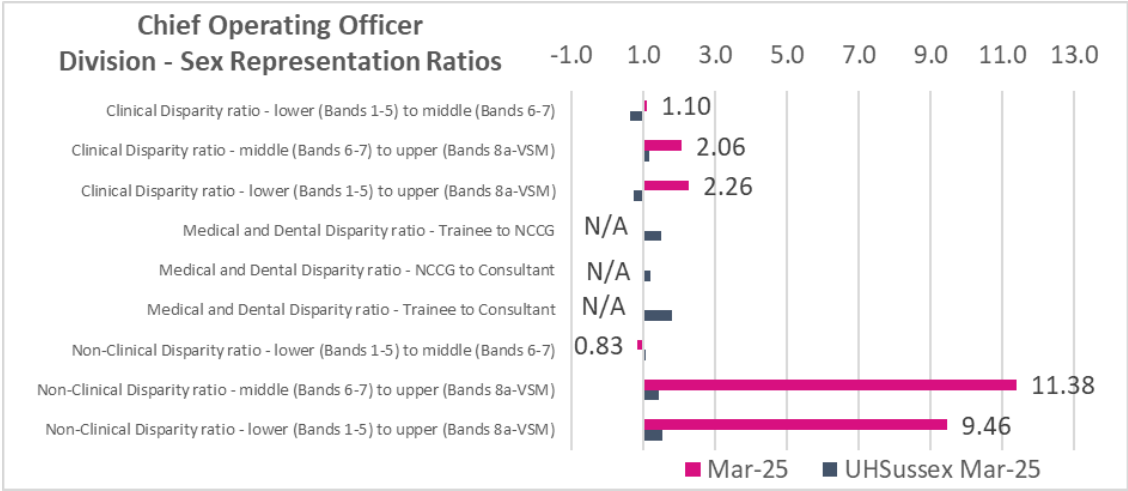


Of senior medical managers, four were female (30.8%).

Career Progression Disparities by Division

Chief Operating Officer

Non-clinical staff: Male staff are 11.4 times more likely than female staff to hold senior roles (Bands 8a-VSM) from Bands 6-7, and 9.5 times more likely from Bands 1-5.

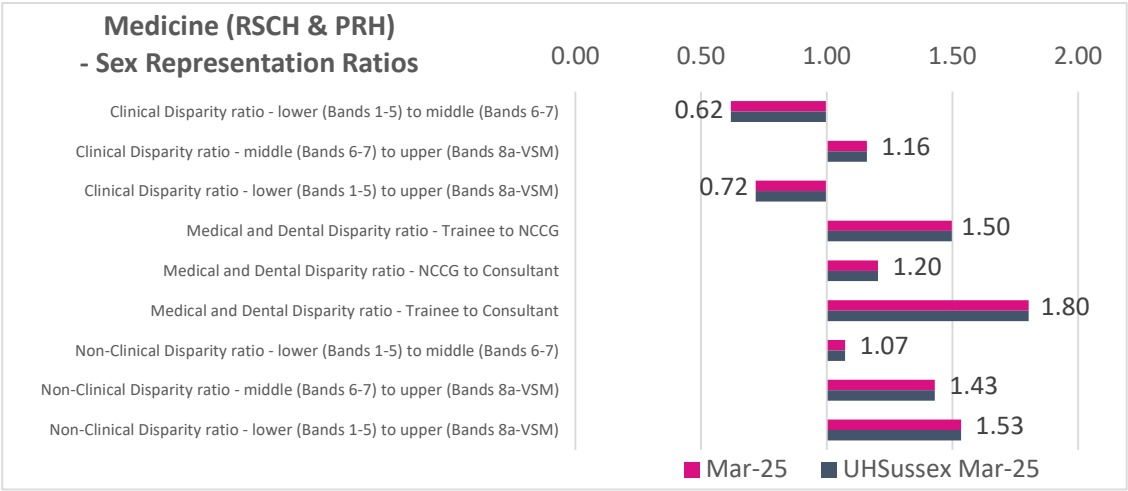


Medicine (WOR & SRH)

Non-clinical staff: Male staff are 10.3 times more likely to hold senior roles from Bands 1-5 and 4.1 times more likely to hold middle-grade roles (Bands 6-7).

Medicine (RSCH & PRH)

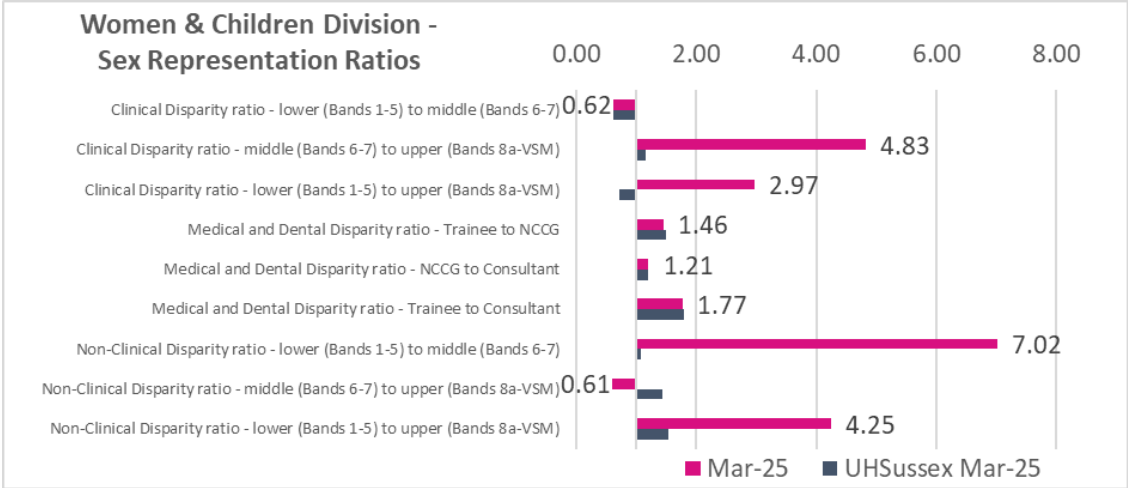
Non-clinical staff: Male staff are 6.8 times more likely to hold senior roles from Bands 1-5. From Bands 1-5 to Bands 6-7, and from Bands 6-7 to senior roles, ratios remain over two.



Women & Children Division

Non-clinical staff: Male staff are 7 times more likely to hold middle-grade roles and 4.3 times more likely to hold senior roles from Bands 1-5.

Clinical staff: At senior levels (Bands 8a-VSM), male staff are 4.8 times more likely than female staff.



Deputy Chief Executive Officer

Non-clinical staff: Male staff are 5 times more likely to hold senior roles from Bands 1-5 and 3.1 times more likely to hold middle-grade roles.

Cancer Division

Non-clinical staff: Male staff are 5.3 times more likely to hold senior roles from Bands 1-5, 2.3 times more likely from Bands 1-5 to Bands 6-7, and 2.4 times more likely from Bands 6-7 to senior roles.

Chief Executive

Non-clinical staff: Male staff are 4 times more likely to hold senior roles from Bands 6-7.

Chief Nurse

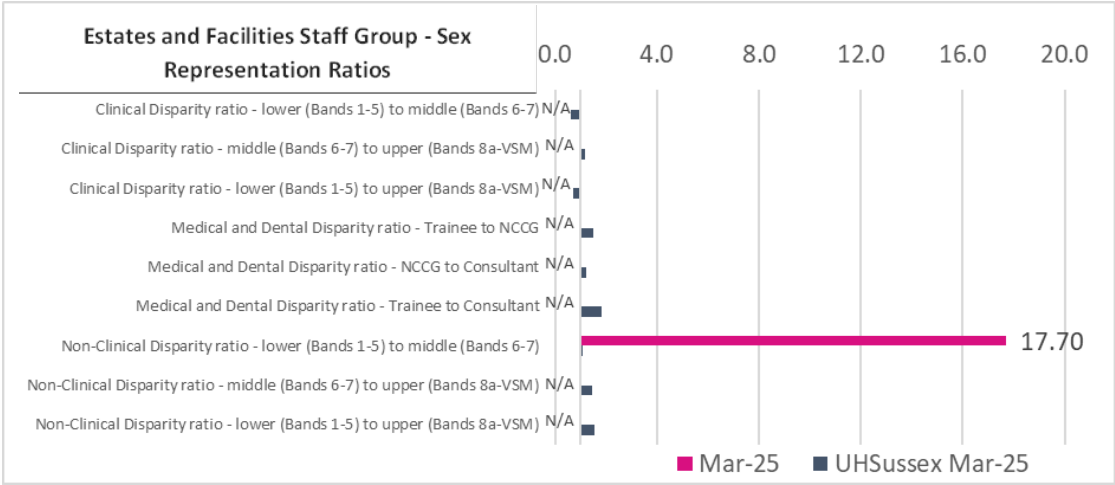
Non-clinical staff: Male staff are 4.2 times more likely to hold middle-grade roles from Bands 1-5.

Clinical staff: From Bands 6-7 to senior levels, male staff are 3.9 times more likely than female staff.

Career Progression Disparities by Staff Group

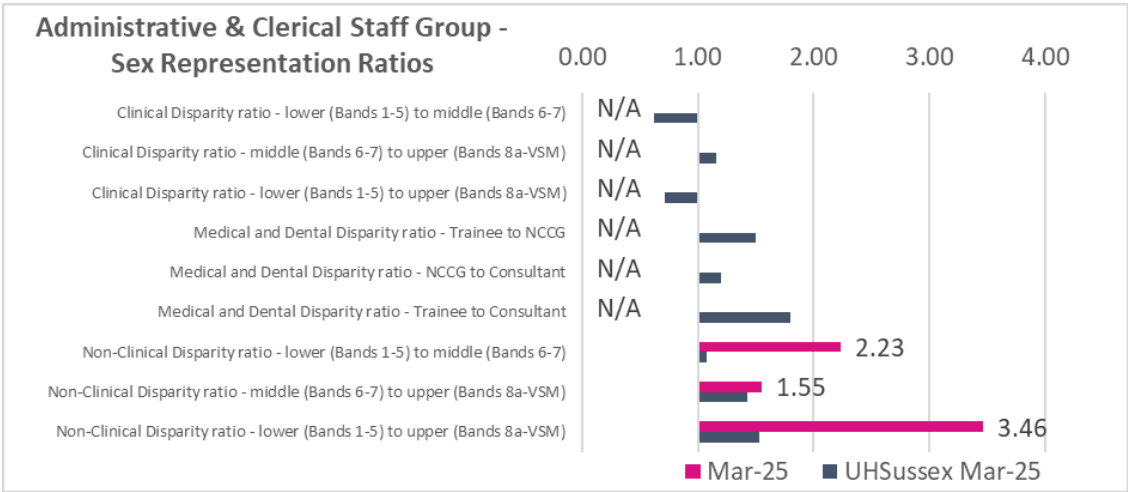
Estates and Facilities

Non-clinical staff: Male staff are 17.7 times more likely than female staff to hold middle-grade roles (Bands 6-7) compared to Bands 1-5.



Administrative & Clerical

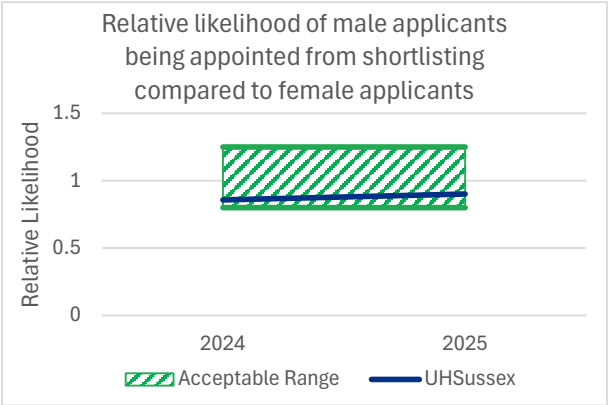
Non-clinical staff: Male staff are over 2.2 times more likely to hold middle-grade roles (Bands 6-7) compared to Bands 1-5, and over 1.6 times more likely to hold senior roles (Bands 8a-VSM) from Bands 6-7. Across the full range (Bands 1-5 to Bands 8a-VSM), male staff are over 3.5 times more likely than female staff to hold senior roles.



Gender shortlisting-to-appointment relative likelihood

In the 2024/25 financial year UHSussex appointed 2,538 female applicants and 1,146 male applicants.

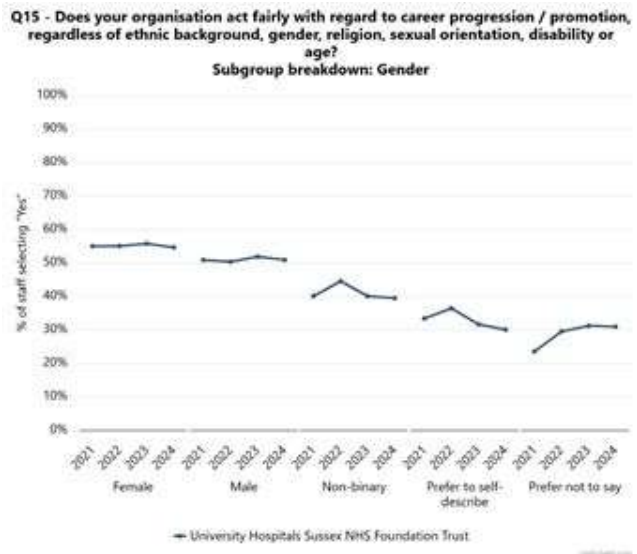
The Trust was as likely (0.9 times) to appoint males from short-listing as females. This falls within the equality target range (0.8-1.25), this has remained stable from last year (fy 2023/24)



Equality of opportunity for career progression / promotion (NSS – Q15)

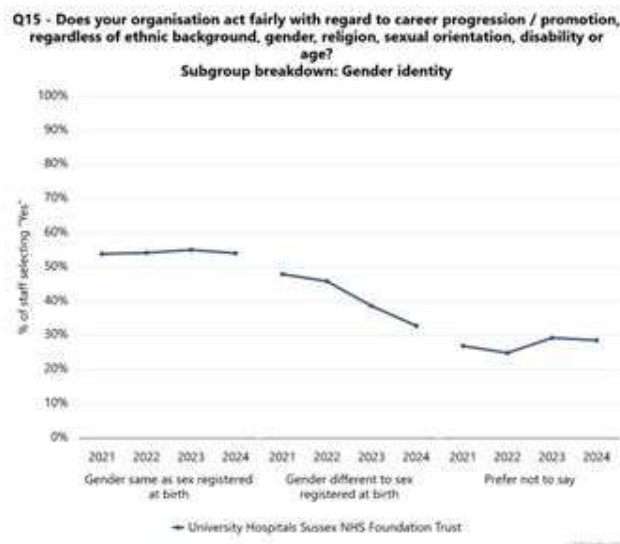
Analysis of NHS Staff Survey responses by gender shows that female staff agree the most that the Trust acts fairly with regards to career progression or promotion, compared to staff from all other genders. Reviewing the data in more detail it can be shown that:

- ▶ Across all genders, less staff members agreed that the Trust acts fairly with regards to career progression or promotion in 2024 compared to 2023.
- ▶ 54.6% of female staff (5,780 respondents) and 50.9% of male staff (1,817 respondents) agreed that the Trust acts fairly with regards to career progression or promotion in 2024.



- ▶ Less than a third (30%) of staff who prefer to self-describe (20 respondents) or preferred to not share their gender (272 respondents) agree that the Trust acts fairly with regards to career progression or promotion.

Analysis of NHS Staff Survey responses by gender identity shows that staff whose gender aligns with their sex registered at birth continue to report the highest agreement that the Trust acts fairly on career progression and promotion (54.0% of 6,973 respondents in 2024, with little year-on-year change). In contrast, agreement among staff whose gender differs from their sex registered at birth has declined markedly in recent years, falling to 32.8% (of 64 respondents).



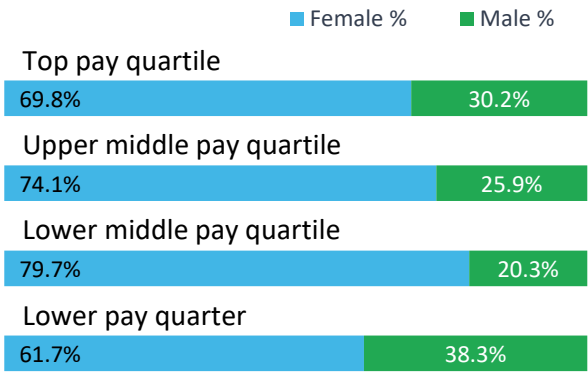
HIA 3: Eliminate Pay Gaps (Gender)

Gender Pay Gap

Gender quartile representation

Out of 18,257 whole-time equivalent staff included in the gender pay gap analysis:

- ▶ 4,567 staff were in the top pay quartile, out of which 62.7% were female.
- ▶ 4,568 staff were in the upper middle pay quartile, out of which 79.7% female.
- ▶ 4,567 staff were in the lower middle pay quartile, out of which 74.1% female.
- ▶ 4,556 staff were in the lower pay quartile, out of which 69.8% female.



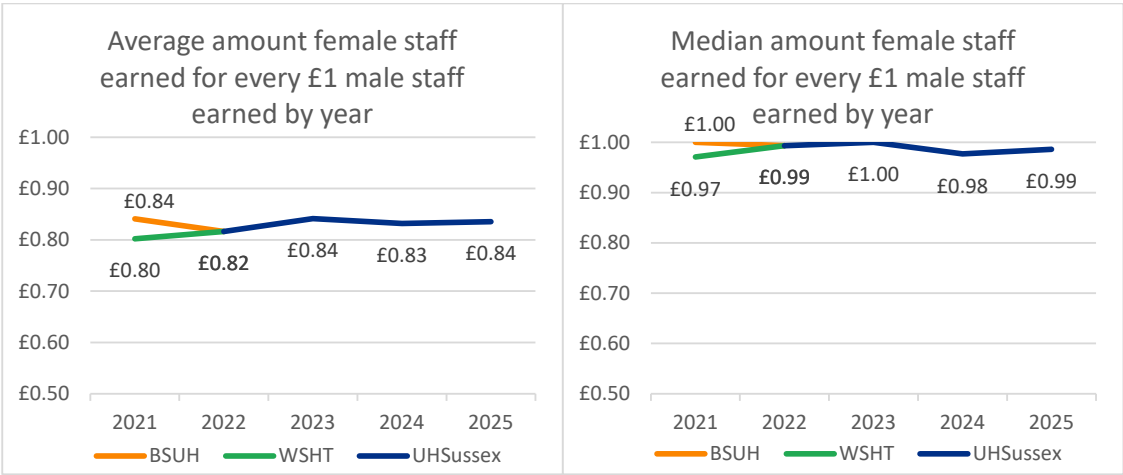
Male staff were 2.4 times more likely to be in the top pay quartile than female staff, compared to their representation in the upper middle pay quarter. This is up (**worse**) from 2.2 times in 2024.

Male staff were 1.4 times more likely to be in the top pay quartile than female staff, compared to their representation in the lower pay quarter. This is down (**better**) marginally from 1.5 times in 2024.

Gender Ordinary Pay Gap

Comparing mean (average) hourly wages, women earned eighty-four pence for every £1 men earned, one penny more (**better**) than in 2024.

Comparing median hourly wages (accounting for the effect of outliers), women earned ninety-nine pence for every £1 men earned, one penny more (**better**) than in 2024.

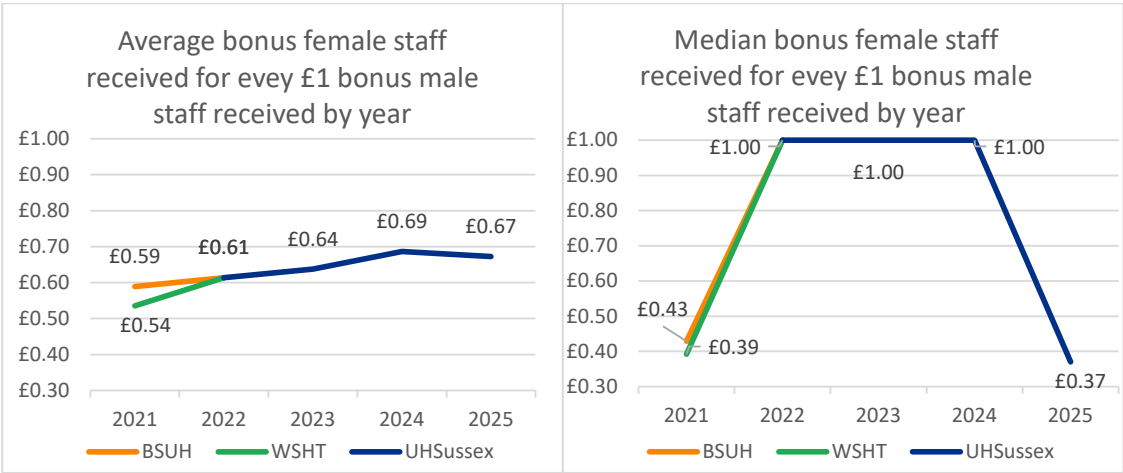


Gender Bonus Pay Gap

221 staff received a bonus payment between the 1 April 2024 and 31 March 2025, inclusive of 76 Women and 145 men.

When comparing mean bonus pay, women earned sixty-seven pence for every £1 men earned, two pence less (**worse**) than last year.

Women’s median bonus pay was 63.0% lower than men’s – this means they earned 37p for every £1 that men earn when comparing median bonus pay. This is 63p larger than in 2024. when the gap reported was 0%. This increase (**worse**) is due to changes nationally in the distribution of bonus Clinical Excellence Awards (CEAs) for consultant medical staff. Note from April 2024 no further local CEAs are distributed but existing consultants retain any awards made before 2018 until they leave NHS service.



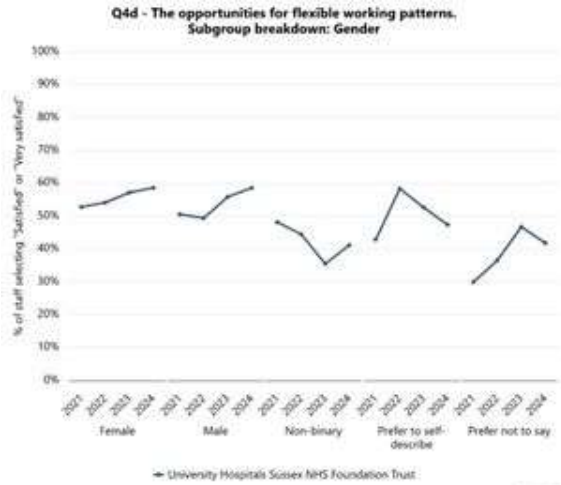
Flexible working opportunities (NSS – Q4d; Q6d)

While flexible working is recorded in ESR in only a small number of cases, it is not currently used systematically to capture such arrangements. However, among the limited records available, all instances of job sharing (N = 2) and all, but one flexible working pattern (total N = 44) were recorded for women. The rollout of supervisor self-service in ESR is a new development, expected to begin in the latter half of 2025. This is anticipated to improve the recording of flexible working arrangements in ESR, enabling a complete and more accurate picture of uptake across the workforce in future reporting periods.

Analysis of NHS Staff Survey responses shows that non-binary and transgender staff report the lowest satisfaction with flexible working compared to all other groups.

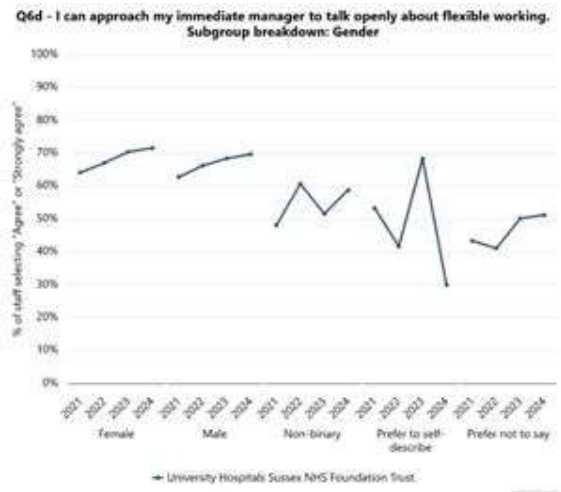
Reviewing the data by gender identity in more detail, it can be seen that:

- ▶ In 2024, as in 2023, non-binary staff reported the least satisfaction with flexible working opportunities.
- ▶ Male staff (58.6% of 1,846 respondents) and female staff (58.6% of 5,835 respondents) reported the highest satisfaction in 2024.
- ▶ Satisfaction increased since 2023 for male, female and non-binary staff (34 respondents) but declined for those who prefer to self-describe (19 respondents) or not disclose their gender (275 respondents).



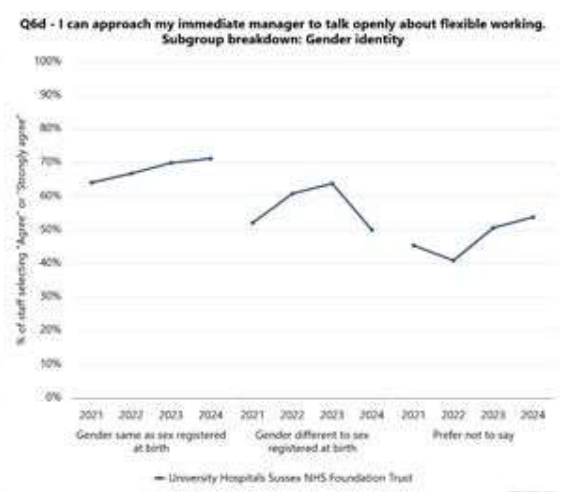
Staff who prefer to self-describe also reported the lowest confidence in approaching their manager about flexible working. Reviewing the data further, it can be seen that:

- ▶ In 2024, female staff reported the highest agreement (71.6% of 5,839 respondents).
- ▶ Agreement improved for all groups except staff who self-describe, where it fell sharply from 68.4% (of 20 respondents) in 2023 to 30.0% (of 19 respondents) in 2024.
- ▶ Across most groups, confidence in approaching managers was higher than satisfaction with flexible working opportunities overall.



Staff whose gender differs from their sex registered at birth remain less satisfied with flexible working than those whose gender aligns with their sex registered at birth.

- ▶ Satisfaction in this group fell significantly, with agreement on flexible working opportunities dropping from 50.9% (of 57 respondents) in 2023 to 39.1% (of 64 respondents) in 2024, and confidence in approaching managers declining from 63.8% (of 58 respondents) to 50.0% (of 64 respondents) in 2024.



HIA 4: Workforce Health Inequalities (Gender)

Burnout (NSS – Q12b)

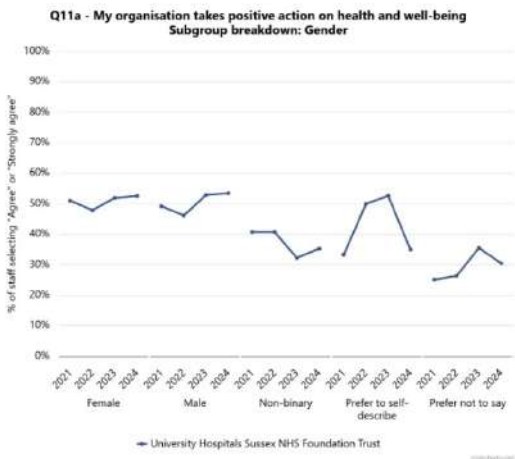
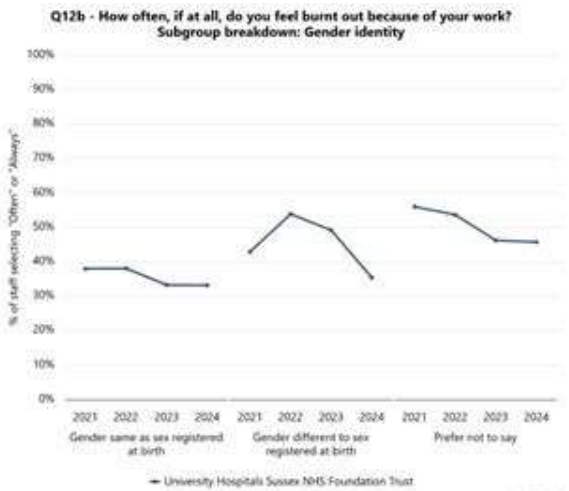
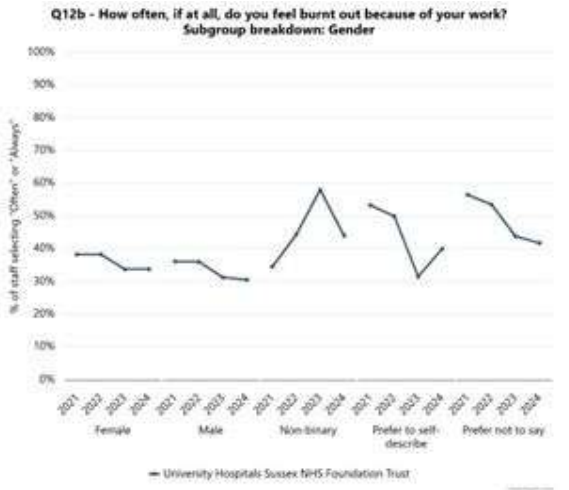
Analysis of NHS Staff Survey responses shows that male staff continue to report the lowest levels of burnout, while non-binary staff report the highest.

- ▶ In 2024, as in 2023, non-binary staff reported the highest levels of burnout (44.12% of 34 respondents).
- ▶ Since 2023, burnout levels have improved for male staff, non-binary staff and those who preferred not to disclose their gender.
- ▶ In contrast, staff who prefer to self-describe reported an increase in burnout.

By gender identity, staff whose gender differs from their sex registered at birth continue to report higher burnout than those whose gender aligns with their sex registered at birth. However, this group saw a notable improvement, with 35.4% (of 65 respondents) in 2024 reporting they “often” or “always” feel burnt out, down from 49.1% (of 57 respondents) in 2023.

Positive action on health and wellbeing (NSS – Q11a)

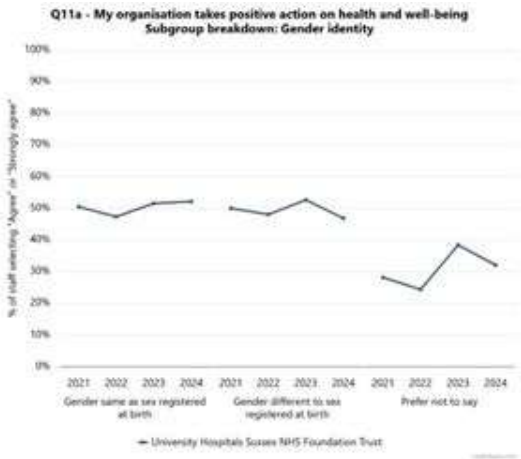
Analysis of NHS Staff Survey responses by gender shows that in 2024 more male staff (53.5% of 1,851 respondents) and female staff (52.6% of 5,786 respondents) agreed with the statement “My organisation takes positive action on health and well-being.” Agreement among non-binary staff rose slightly to 35.3% of 34 respondents (up from 32.3% of 31 respondents in 2023), while fewer staff who prefer to self-describe or not say their gender agreed than in 2023.



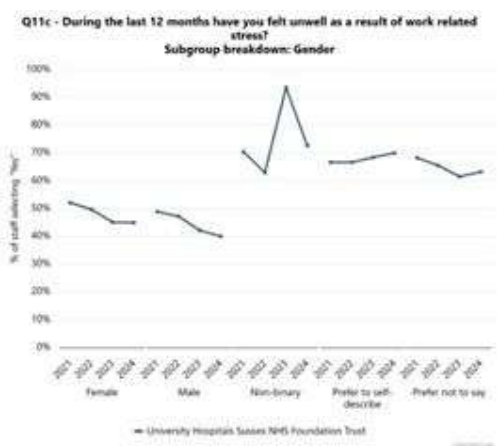
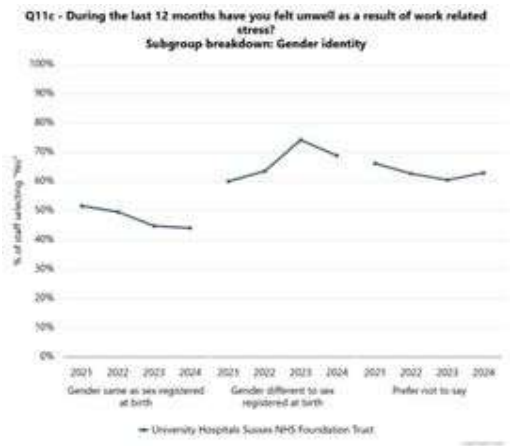
By gender identity, staff whose gender aligns with their sex registered at birth reported higher agreement (52.1% of 7,010 respondents, up from 51.5% of 7,354 respondents in 2023) than those whose gender differs (46.9% of 64 respondents) and those who preferred not to say (32.1% of 265 respondents), both of whom saw declines since 2023.

Work related stress (NSS – Q11c)

Analysis of NHS Staff Survey responses by gender shows that in 2024 more non-binary staff (72.7% of 33 respondents), staff who prefer to self-describe (70.0% of 20 respondents) and those who preferred not to say their gender (63.2% of 269 respondents) reported feeling unwell due to work-related stress.



There was a reduction in reports of work-related stress among non-binary, male and female staff compared to 2023.



By gender identity, staff whose gender differs from their sex registered at birth (68.8% of 64 respondents) and those who preferred not to say (62.9% of 264 respondents) reported higher levels of work-related stress than staff whose gender aligns with their sex registered at birth (44.0% of 7,027 respondents).

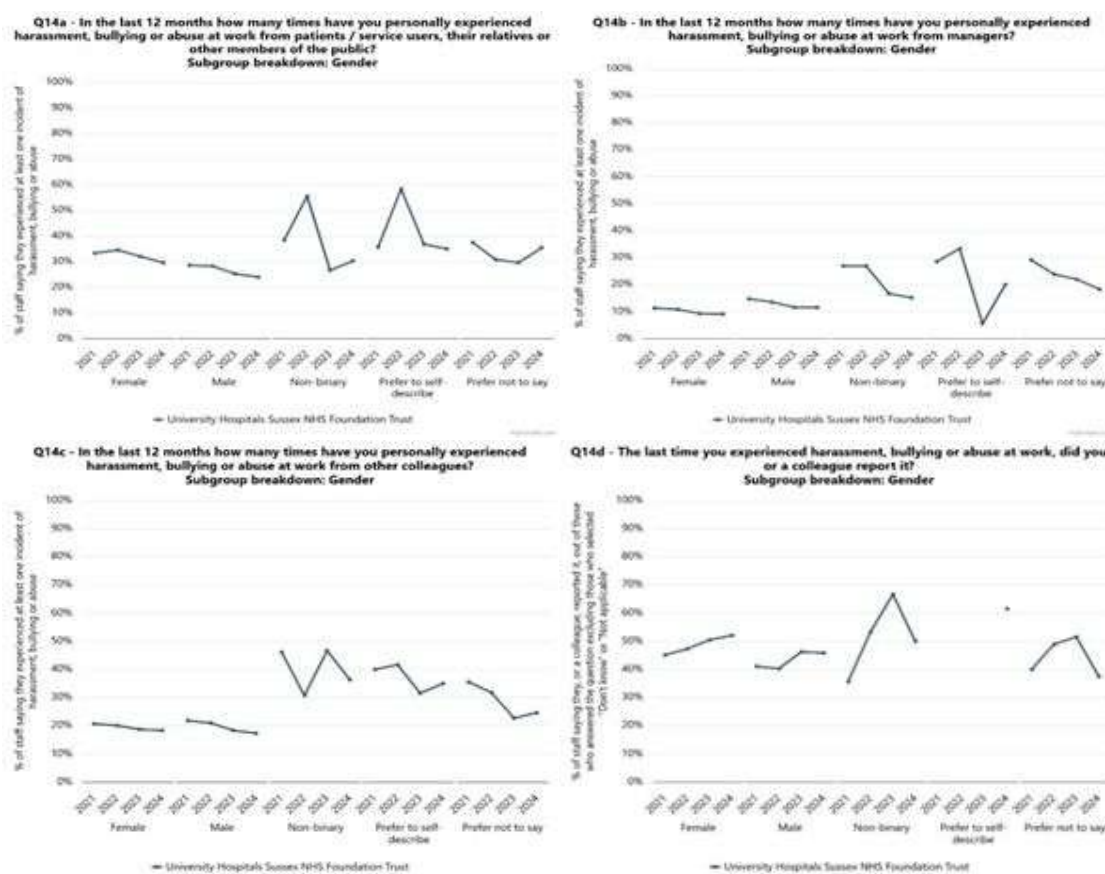
HIA 6: Eliminate Discrimination (Gender)

Harassment, bullying or abuse by gender (NSS – Q14a-d)

Analysis of NHS Staff Survey responses highlights that non-binary staff and those who prefer to self-describe or not disclose their gender and transgender staff report higher levels of harassment, bullying and abuse.

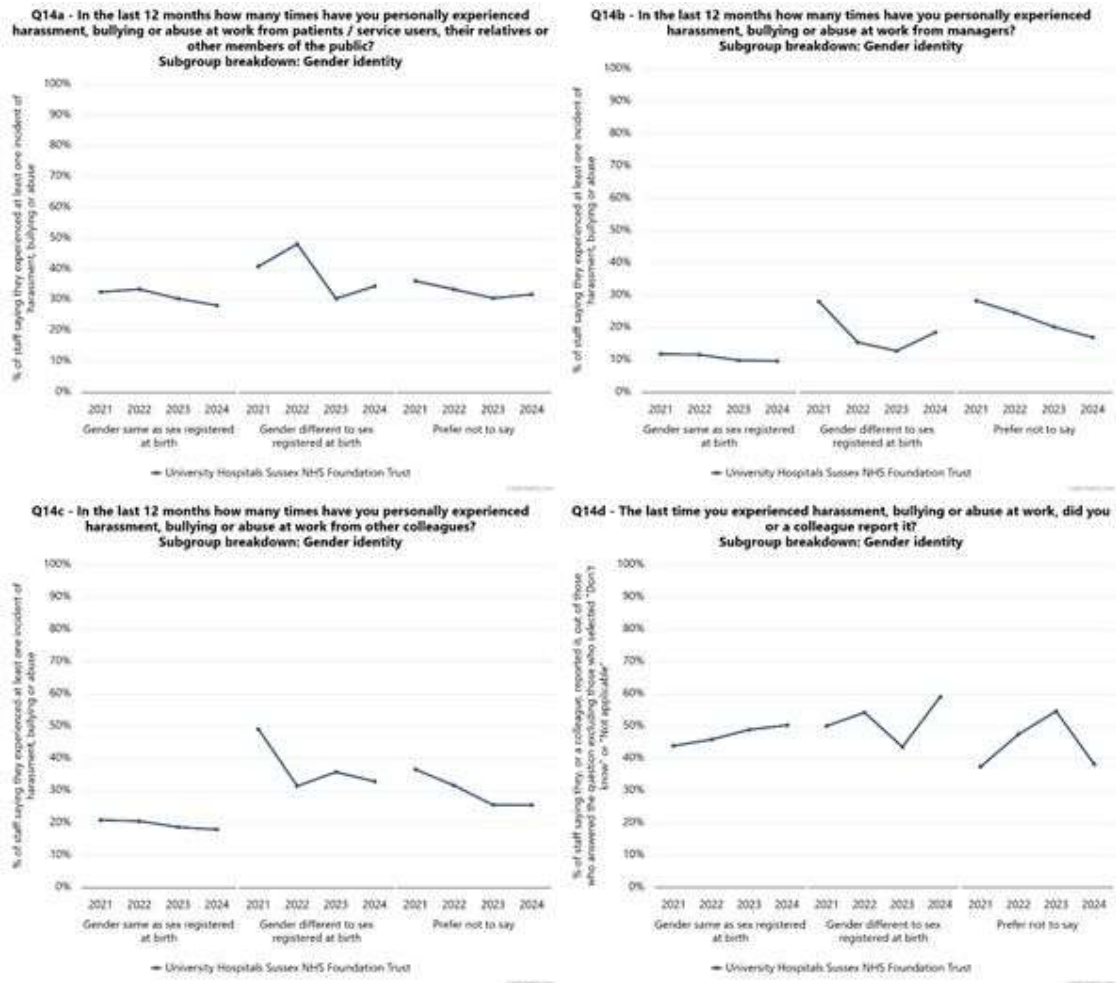
Reviewing the data by gender in more detail it can be shown that:

- ▶ Staff who prefer to self-describe or not disclose their gender reported more harassment, bullying and abuse from patients or the public (35.00% of 20 respondents, and 35.42% of 271 respondents) and managers (20.00% of 20 respondents, and 18.22% of 269 respondents) than staff of other genders.
- ▶ Non-binary staff reported the highest levels of harassment, bullying and abuse from colleagues (36.36% of 33 respondents).
- ▶ Since 2023, there has been a marked increase in reports of harassment, bullying and abuse from patients or the public among non-binary staff and those who preferred not to disclose their gender. Reports of such behaviour from managers also rose notably among staff who self-describe their gender.
- ▶ In contrast, staff of other genders saw little change or a decrease in these experiences since 2023.
- ▶ Women reported a higher rate of harassment, bullying and abuse (29.57% of 5,833 respondents) than men (23.98% of 1,856 respondents) from patients or the public, and colleagues (18.34% of 5,803 respondents, vs. 17.36% of 1,832 respondents).and were more likely to report these experiences (52.10% of 2,142 respondents).
- ▶ Staff who preferred not to disclose their gender were also less likely to report these experiences (37.59% of 133 respondents) compared to staff of other genders, with reporting rates for this group showing a significant decline since 2023.



Reviewing the data by gender identity in more detail it can be shown that:

- ▶ Staff who identify with a gender different to their sex registered at birth reported more harassment, bullying and abuse from patients or the public (34.38% of 64 respondents, compared to 28.15% of 7,045 respondents for staff whose gender aligns with their sex registered at birth), managers (18.46% of 65 respondents, vs. 9.59% of 7,009 respondents) and colleagues (32.81% of 64 respondents, vs. 17.91% of 7,006 respondents).
- ▶ Since 2023, there has been a marked increase in reports of harassment, bullying and abuse from patients or the public and managers among this staff group.
- ▶ Staff who preferred not to disclose their gender identity were substantially less likely to report these experiences (38.21% of 123 respondents), despite a sharp rise in reported incidents for staff identifying with a gender different to their sex registered at birth (58.97% of 39 respondents).



Discrimination by Sex and Gender: Raising Concerns About Inequality
Out of 22 discrimination cases raised through the [Freedom to Speak Up Guardian Service](#) (FTSUG) during the 2024/25 financial year, 2 (9.1%) included sex as either

a primary or contributing theme, with 1 (4.5%) identifying sex as the primary theme. 1 (4.5%) additional case identified gender as a primary theme. Two cases (9.1%) did not specify a primary or other theme, suggesting some gaps in reporting detail.

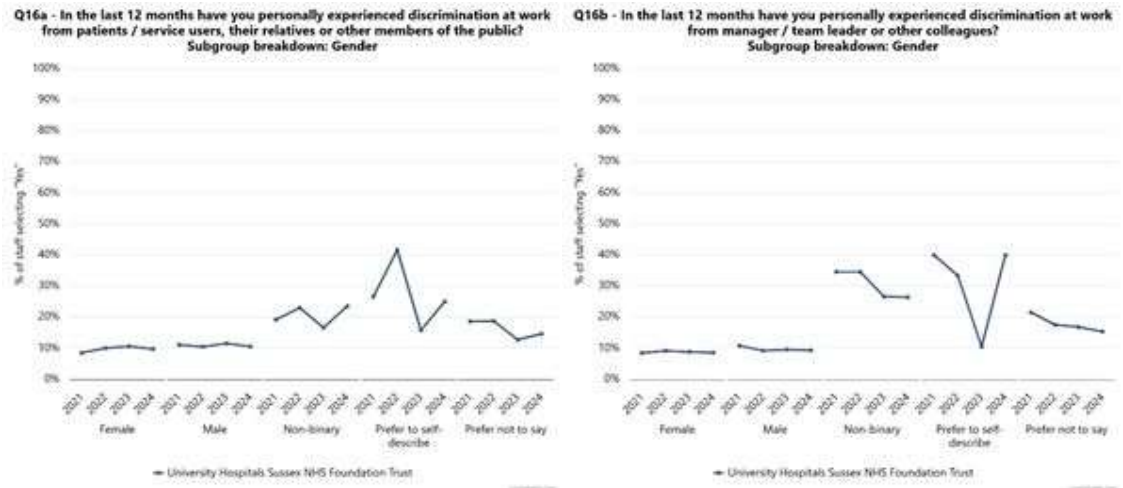
In comparison, during the 2023/24 financial year, 1 out of 14 (7.1%) cases raised through FTSUG mentioned sex, none mentioned gender. However, 9 (64.3%) did not specify any primary or other theme, limiting the ability to fully understand the nature of concerns raised. It is furthermore important to note that only eight months of data were available for the 2023/24 reporting period.

Discrimination from managers or colleagues by gender (NSS – Q16a-b)

Analysis of NHS Staff Survey responses shows that non-binary staff, those who prefer to self-describe their gender and transgender staff report the highest levels of discrimination.

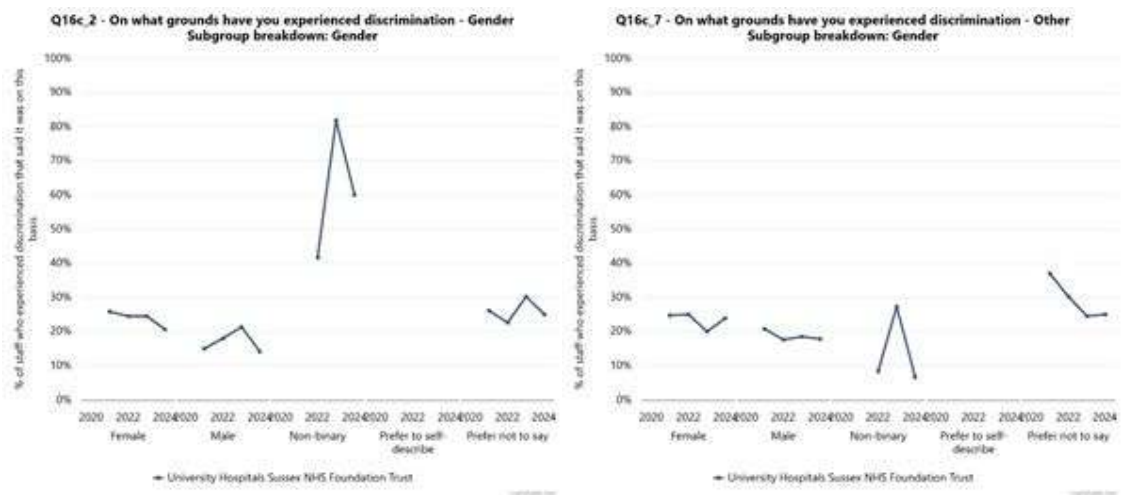
Reviewing the data by gender in more detail it can be shown that:

- ▶ In 2024, 23.5% of non-binary staff (34 respondents) and 25.0% of staff who prefer to self-describe (20 respondents) reported experiencing discrimination from patients or the public, and 26.5% (of 34 respondents) and 40.0% (of 20 respondents) respectively reported experiencing discrimination from managers or colleagues. Reports of discrimination among these groups have worsened since 2023.
- ▶ Female staff reported the least experiences of discrimination from patients or the public (9.78% of 5,826 respondents) and managers or colleagues (8.59%), while male staff reported 10.58% (of 1,843 respondents) and 9.35% (of 1,829 respondents) respectively. Rates of discrimination among these groups saw minor changes or improved over the last years.



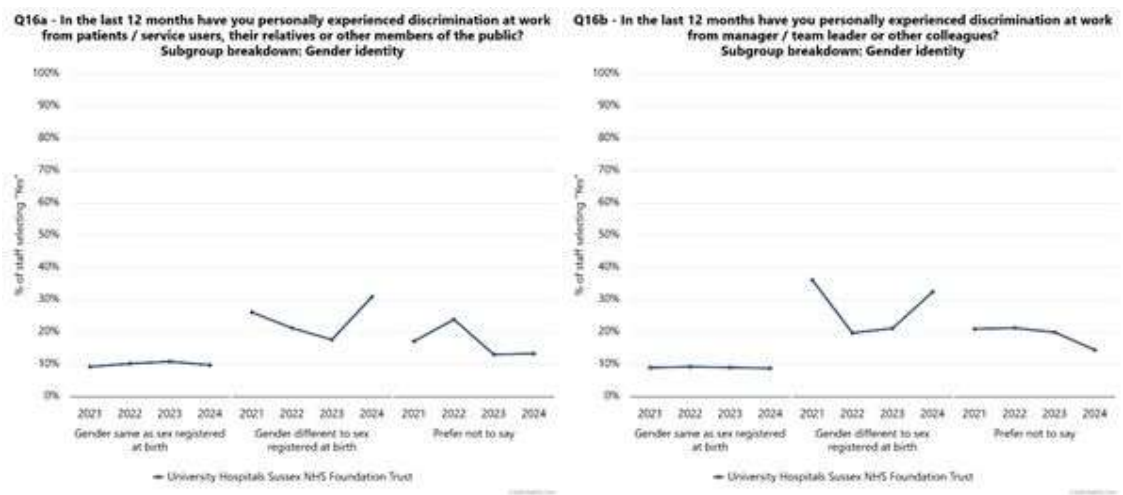
A higher proportion of women who had experienced discrimination felt this was on the grounds of gender (20.62% of 878 respondents). This view was also held by 60% of non-binary staff (15 respondents), 25% of those who preferred not to

disclose their gender (60 respondents), and 14.14% of male staff (297 respondents) also felt this was also on the grounds of gender. Notably, women were also more likely to attribute discrimination to ‘other’ reasons (23.92% of 878 respondents).



Reviewing the data by gender identity in more detail it can be shown that:

- ▶ Staff who identify with a gender different to their sex registered at birth reported more reported experiencing discrimination patients or the public (30.77% of 65 respondents, compared to 9.67% of 7,029 respondents whose gender aligns with their sex registered at birth) managers and colleagues (32.31% of 65 respondents, vs. 8.69% of 6,977 respondents).
- ▶ Since 2023, there has been a marked increase in reports of harassment, bullying and abuse from patients or the public and managers among this staff group.
- ▶ Staff who identify with a gender different to their sex registered at birth reported felt this was on the grounds of gender 42.42% (of 33 respondents), compared to 19.51% of staff whose gender aligns with their sex registered at birth (1,061 respondents).

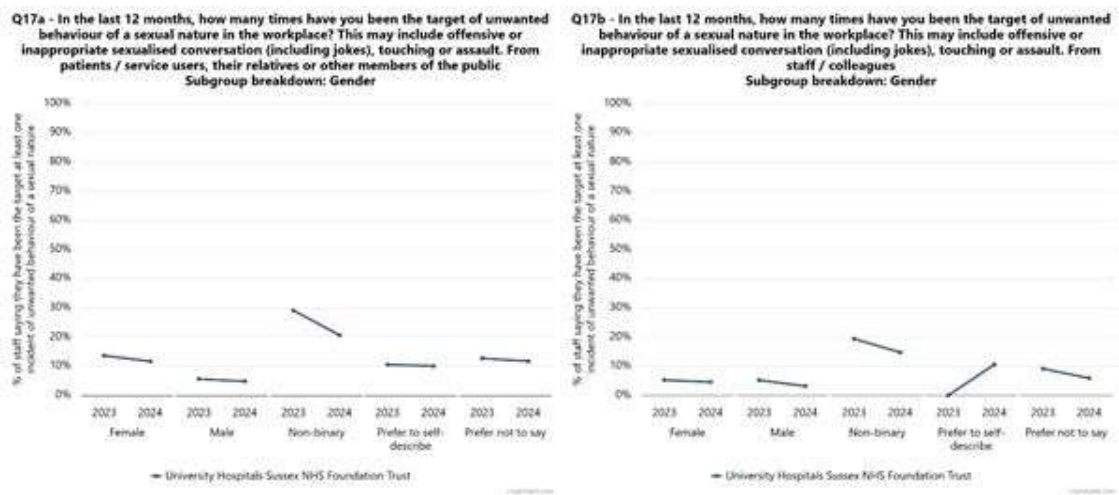


Sexual harassment by gender (NSS – Q17a-b)

Analysis of NHS Staff Survey responses shows that non-binary and transgender staff report the highest levels of sexual harassment.

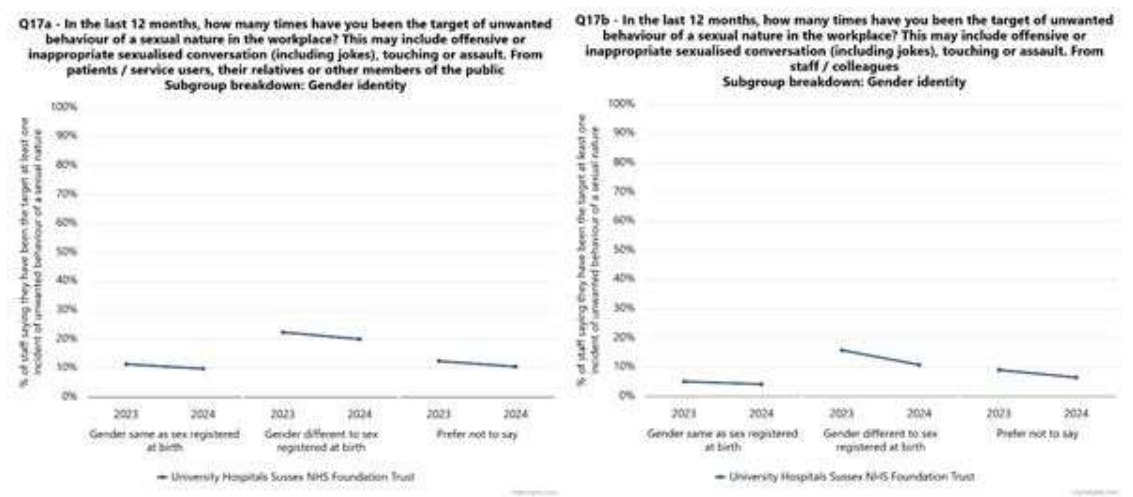
Reviewing the data by gender shows notable disparities in experiences of sexual harassment:

- ▶ In 2024, 20.6% (of 34 respondents) non-binary staff reported experiencing sexual harassment from patients or the public, and 14.7% (of 34 respondents) from managers or colleagues.
- ▶ While rates of sexual harassment have improved or saw minor changes across most groups since 2023, there has been a sharp increase among staff who prefer to self-describe, with reports of sexual harassment from managers or colleagues rising from 0% (of 18 respondents) in 2023 to 10.5% (of 19 respondents) in 2024.



Reviewing the data by gender identity shows notable disparities in experiences of sexual harassment:

- ▶ Staff whose gender differs from their sex registered at birth reported higher levels of sexual harassment from patients or the public (20.0% of 65 respondents, compared to 9.8% (of 7,057 respondents) for staff whose gender aligns with their sex registered at birth) and from managers and colleagues (10.8% of 65 respondents, vs 4.2% of 7,034 respondents).
- ▶ However, reports of harassment, bullying and abuse from managers and colleagues among this group have decreased since 2023.



4. Sexual Orientation

Sexual Orientation Equality Summary

The proportion of staff at UHSussex identifying as lesbian, gay, bisexual, undecided or other sexual orientations (LGBUO) is higher than in the wider Sussex and England populations. A higher proportion of LGBUO staff responded to the NHS Staff Survey compared to their overall presence in the workforce.

In clinical roles, heterosexual and LGBUO staff were equally likely to be in senior positions. However, in medical roles, heterosexual staff were significantly more likely to be consultants and in non-consultant career grades than LGBUO staff, and these gaps have grown in some areas compared to last year. In non-clinical management, LGBUO staff were proportionally more likely to hold senior roles.

Recruitment outcomes were broadly fair, but some groups within LGBUO reported lower confidence in career progression, particularly staff who selected “another sexual orientation” or preferred not to disclose their orientation. Burnout and stress levels were highest among bisexual staff and those selecting “another sexual orientation,” while heterosexual staff reported the lowest levels of burnout, stress, and harassment.

Reports of bullying, harassment, and discrimination were highest for bisexual staff and those identifying with “another sexual orientation,” with some indicators worsening compared to last year. These groups also reported increased experiences of sexual harassment from patients, managers, and colleagues, while other groups saw little change or improvements.

HIA 1: Leadership and Accountability (Sexual Orientation)

Staff voice

The Trust has a [Lesbian, Gay, Bisexual, Trans, Queer, Intersex, \(LGBTQI+\) Network](#) sponsored by the Chief Operating Officer.

The LGBTQI+ Staff Network has recently nominated a new lead who will be taking them through the next chapter. Their 20-month charity programme plan will informal coffee mornings, sports events, monthly network meetings, and monthly socials outside of work, with an aim to improve staff wellbeing, increase attendance and help staff to feel they belong.

The monthly network meetings will aim to involve speakers from all walks of the LGBTQIA+ community to increase learning and obtain an understanding of who we



8 – LGBTQI+ Network:
Pride 2024

are and how we can support one another. The network collaborates with other trusts within Sussex, and other networks within UHSussex, with the goal of connecting staff with one another based on their similarities, and to learn how we can all work together.

This Pride Month (June 2025) the LGBTQI+ Staff Network held two coffee mornings – one at the Royal Sussex County Hospital and one at Worthing Hospital, one staff network meeting with local Drag King; Prince of Persia invited, and one evening out at The Actors pub in Brighton. The network also went to Preston Park with the LGBTQI+ network from Sussex Community NHS Foundation Trust to play Rounders together. The network lead ensures future events occur throughout Sussex so that all staff across the Trust can be involved.

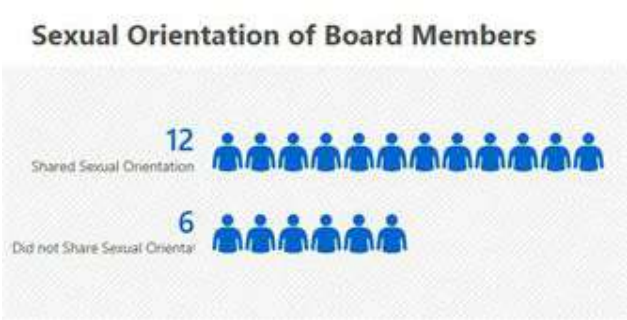


9 – (both) UHSussex LGBTQI+ Network: Preston Park Rounders Social with Sussex Community NHS Foundation Trust

With additional support from My University Hospitals and legacy charities, the network is running a successful Pride programme across Summer 2025, participating in Worthing Pride and Brighton & Hove Pride with opportunities to promote the Trust.

Board sexual orientation composition

Twelve members of the Trust Board shared a sexual orientation (66.7%), and six did not state their sexual orientation (33.3%). This has improved from last year (50% did not state).



HIA 2: Inclusive Talent (Sexual Orientation)

Sexual orientation workforce representation

Out of a permanent workforce of 17,972 in March 2025, 6.96% (1,250) were recorded as LGBUO² on ESR. This represents an increase of nearly 0.8 percentage points compared to the previous year (2024 = 6.2%). Out of this, 3.86% identified as gay or lesbian, 2.31% as bisexual, 0.58% as another sexual orientation not listed and 0.19% as undecided.

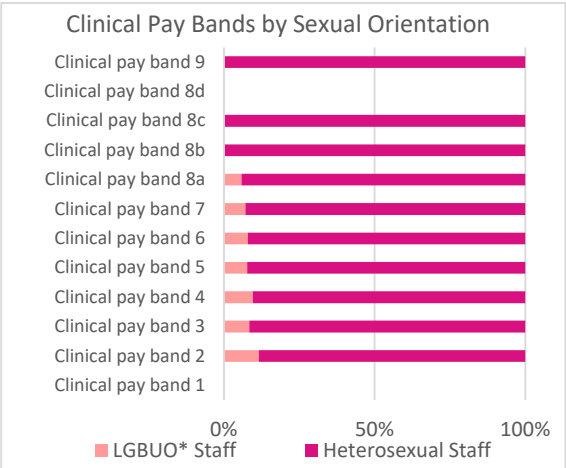
This compares to 3.17% of the population in England (1.54% gay or lesbian, 1.29% bisexual, 0.23% pansexual, 0.06% asexual, 0.03% queer, 0.02% other sexual orientations) and 4.4% (2.33% gay or lesbian, 1.60% bisexual, 0.27% pansexual, 0.07% asexual, 0.07% queer, 0.02% other sexual orientations) across East Sussex, West Sussex and Brighton and Hove combined (Census 2021, ONS).

In the 2024 NHS Staff Survey, responses were received from 6,769 (83.61%) heterosexual or straight staff, 372 (4.59%) gay or lesbian staff, 234 (2.89%) bisexual staff, 72 (0.89%) staff who reported their sexual orientation to be another not listed, and 563 (6.95%) staff who preferred not to disclose their sexual orientation at UHSussex.

Clinical Agenda for Change Staff Disparity Ratios

Out of 9,635 clinical staff on Agenda for Change (AfC) terms and conditions:

- ▶ 5,682 staff were in lower bands (AfC 1-5) out of which 7.4% were LGBUO.
- ▶ 3,569 staff were in middle bands (AfC 6-7) out of which 6.8% were LGBUO.
- ▶ 384 staff were in upper bands (AfC 8a+) out of which 6.3% were LGBUO.



Heterosexual staff were **as likely (1.1 times)** to be in senior clinical roles (AfC bands 8-VSM) than LGBUO staff, compared to their representation in support or newly qualified roles (AfC bands 1-5). This falls within the equality target range (target between 0.8-1.25) and has improved (down) from 1.4 times in 2024.

² LGBUO = Lesbian, Gay, Bisexual, Undecided, Other

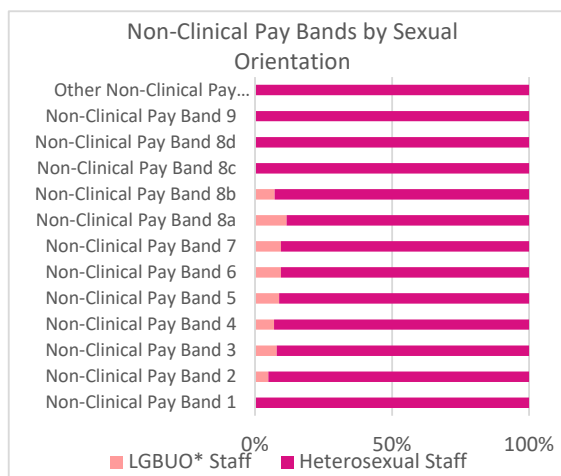
Overall, heterosexual clinicians were **just as likely** to be in bands 6-7 as LGBUO clinicians, compared to their representation in bands 1-5. This is unchanged from 2024.

Representation Disparity Ratio	2024	2025
Disparity ratio – lower (Bands 1-5) to middle (Bands 6-7)	1.02	1.10
Disparity ratio – middle (Bands 6-7) to upper (Bands 8a-VSM)	1.38	1.11
Disparity ratio – lower (Bands 1-5) to upper (Bands 8a-VSM)	1.41	1.21

Non-Clinical Agenda for Change Staff Disparity Ratios

Out of 5,637 non-clinical staff on Agenda for Change (AfC) terms and conditions:

- ▶ 4,107 staff were in lower bands (AfC 1-5) out of which 5.7% were LGBUO.
- ▶ 942 staff were in middle bands (AfC 6-7) out of which 8.3% were LGBUO.
- ▶ 588 staff were in upper bands (AfC 8a+) out of which 9% were LGBUO.



Heterosexual staff were just over **half as likely** (0.6 times) to be non-clinical senior managers (AfC bands 8-VSM) as LGBUO staff, compared to support and entry level roles (AfC bands 1-5), falling outside the equality target range (target between 0.8-1.25). This is unchanged from 2024.

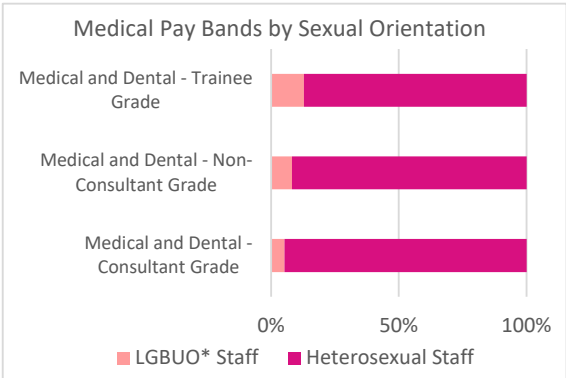
Heterosexual staff were similarly likely (0.9 times) to be non-clinical senior managers (AfC bands 8-VSM) than LGBUO staff, compared to junior managers roles (AfC bands 6-7), falling within the equality target range (target between 0.8-1.25).

Representation Disparity Ratio	2024	2025
Disparity ratio – lower (Bands 1-5) to middle (Bands 6-7)	0.76	0.65
Disparity ratio – middle (Bands 6-7) to upper (Bands 8a-VSM)	0.76	0.93
Disparity ratio – lower (Bands 1-5) to upper (Bands 8a-VSM)	0.58	0.60

Medical & Dental Staff Disparity Ratios

Out of 2,627 staff on medical and dental contracts:

- ▶ 1,092 were trainees, out of which 10.5% were LGBUO.
- ▶ 573 were on non-consultant career grades (NCCGs) out of which 6.5% were LGBUO.
- ▶ 962 were consultants, out of which 4% were LGBUO.



Heterosexual staff were 2.7 times more likely to be consultants than LGBUO staff compared to their proportions in trainee grades, this is above the equality target range (target between 0.8-1.25). This is **worsened** (up), from 2.1 times in 2024.

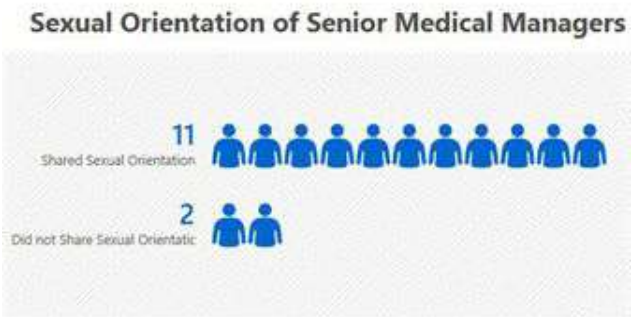
Heterosexual staff were over **1.7 times more likely** to be in non-consultant career grades than LGBUO staff compared to their representation in trainee grades, this is above the equality target range (target between 0.8-1.25). This is **improved** (down), from 2.2 times in 2024.

Heterosexual staff were **1.6 times more likely** to be consultants as LGBUO staff compared to their proportions in non-consultant career grades, this is above the equality target range (target between 0.8-1.25). This ratio has **worsened** (up), from 0.9 times in 2024, when it fell within the equality target range.

Representation Disparity Ratio	2024	2025
Disparity ratio – Trainee to NCCG	2.20	1.70
Disparity ratio – NCCG to Consultant	0.94	1.61
Disparity ratio – Trainee to Consultant	2.08	2.74

Senior Medical Managers

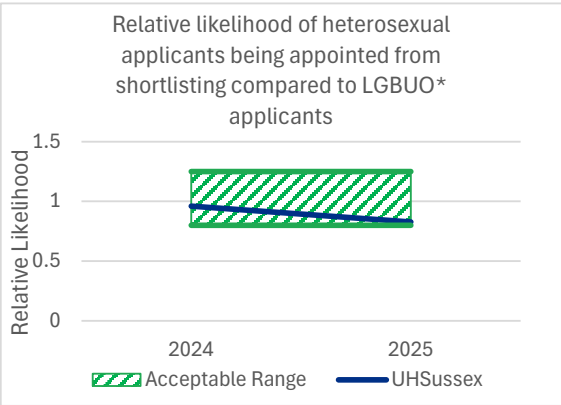
Out of all consultants, 13 were identified as senior medical managers (a medical consultant who is either a Medical Director, a Deputy Medical Director or who reports directly to a Medical Director or Deputy Medical Director). Eleven of these shared their sexual orientation (84.6%) and two (15.4%) did not share their orientation on their staff record.



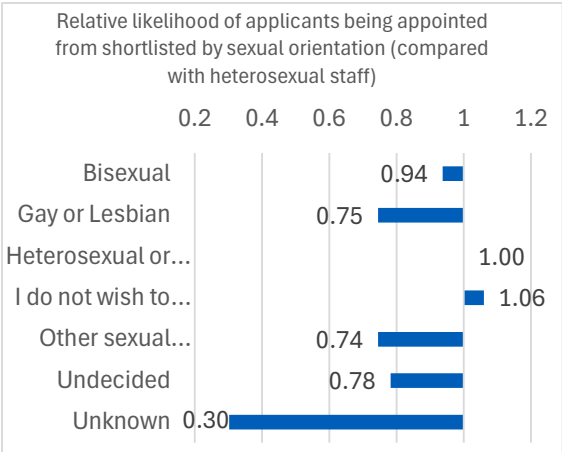
Sexual orientation shortlisting-to-appointment relative likelihood

In the 2024/25 financial year UHSussex appointed 302 LGBUO* people and 2,494 heterosexual people.

The Trust was as likely (0.83 times) to appoint heterosexual staff from shortlisting as LGBUO* staff. This has decreased since last year but still falls within the equality target range (0.8-1.25).



Heterosexual applicants were less likely than applicants who chose another sexual orientation not listed (0.74 times), gay or lesbian applicants (0.75 times less likely), and applicants who were undecided about their sexual orientation (0.78) to be appointed from shortlisting, falling just below the equality target range (target between 0.8-1.25).

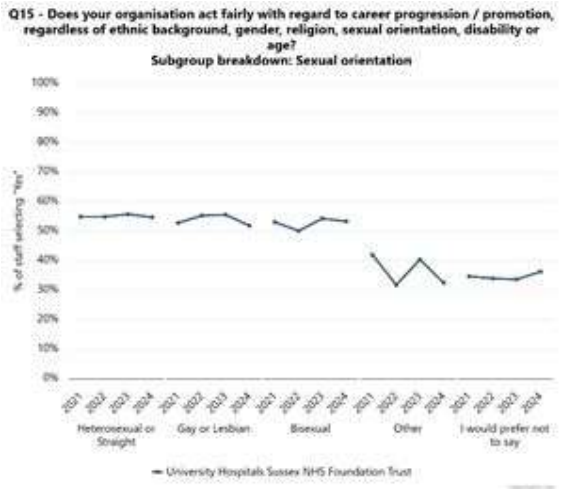


Heterosexual applicants were 0.3 (a third) times less likely to be appointed from shortlisting than staff who did not disclose their sexual orientation.

Equality of opportunity for career progression / promotion (NSS – Q15)

Reviewing the NHS Staff Survey question on fair opportunities for career progression and promotion shows notable disparities by sexual orientation:

- ▶ Staff who selected “another sexual orientation” (32.4% of 71 respondents) or preferred not to say (36.2% of 567 respondents) reported the lowest agreement with the statement compared to all other groups.
- ▶ Since 2023, agreement has fallen among gay or lesbian staff and sharply for those who preferred not to disclose their sexual orientation.

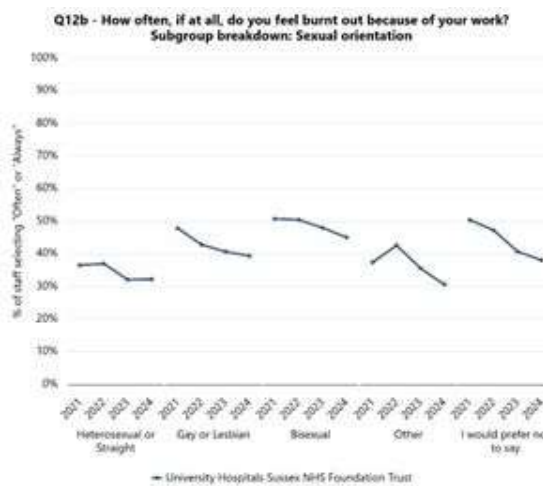


HIA 4: Workforce Health Inequalities (Sexual Orientation)

Burnout (NSS – Q12b)

Reviewing the NHS Staff Survey question on burnout shows notable differences by sexual orientation:

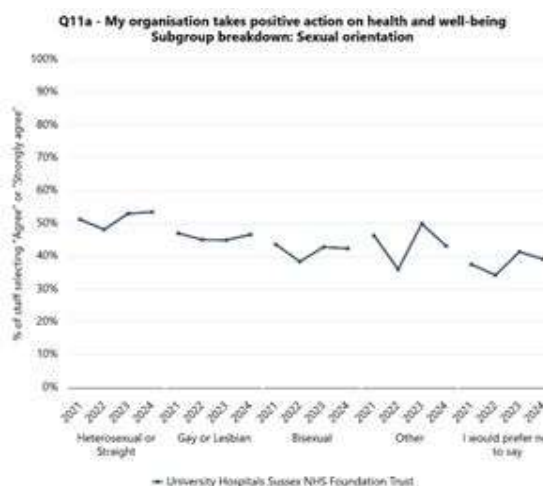
- ▶ Bisexual staff reported the highest levels of burnout (45.1% of 235 respondents), followed by gay or lesbian staff (39.4% of 373 respondents), compared to all other groups.
- ▶ Reports of burnout decreased across all groups except heterosexual staff, where levels remained stable between 2023 and 2024.



Positive action on health and wellbeing (NSS – Q11a)

Reviewing the NHS Staff Survey question “My organisation takes positive action on health and well-being” shows:

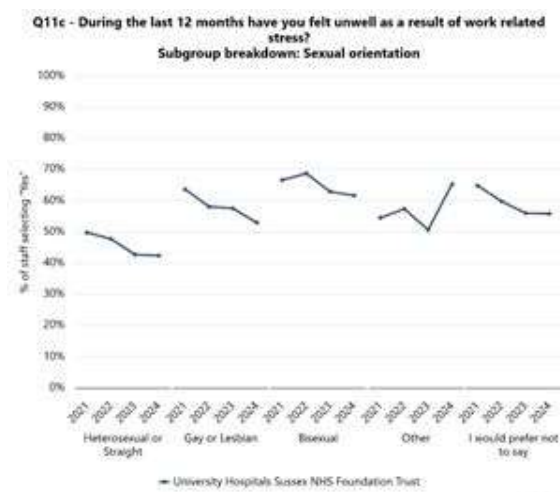
- ▶ Heterosexual staff reported the highest agreement (53.5% of 6,745 respondents), though levels across all groups were broadly similar.
- ▶ Most scores remained stable; however, there was a sharp decline among staff who selected “another sexual orientation,” with agreement falling from 50.0% (of 74 respondents) in 2023 to 43.2% (of 74 respondents) in 2024.



Work related stress (NSS – Q11c)

Reviewing the NHS Staff Survey question on feeling unwell due to work-related stress in the last 12 months shows:

- ▶ Staff who selected “another sexual orientation” reported the highest levels (65.3% of 72 respondents), while heterosexual staff reported the lowest (42.4% of 6,762 respondents).
- ▶ Most scores remained stable; however, there was a decrease of just under 5 percentage points among gay or lesbian staff and a sharp rise among those selecting “another sexual orientation,” increasing from 50.7% (of 71 respondents) in 2023 to 65.3% (of 72 respondents) in 2024.

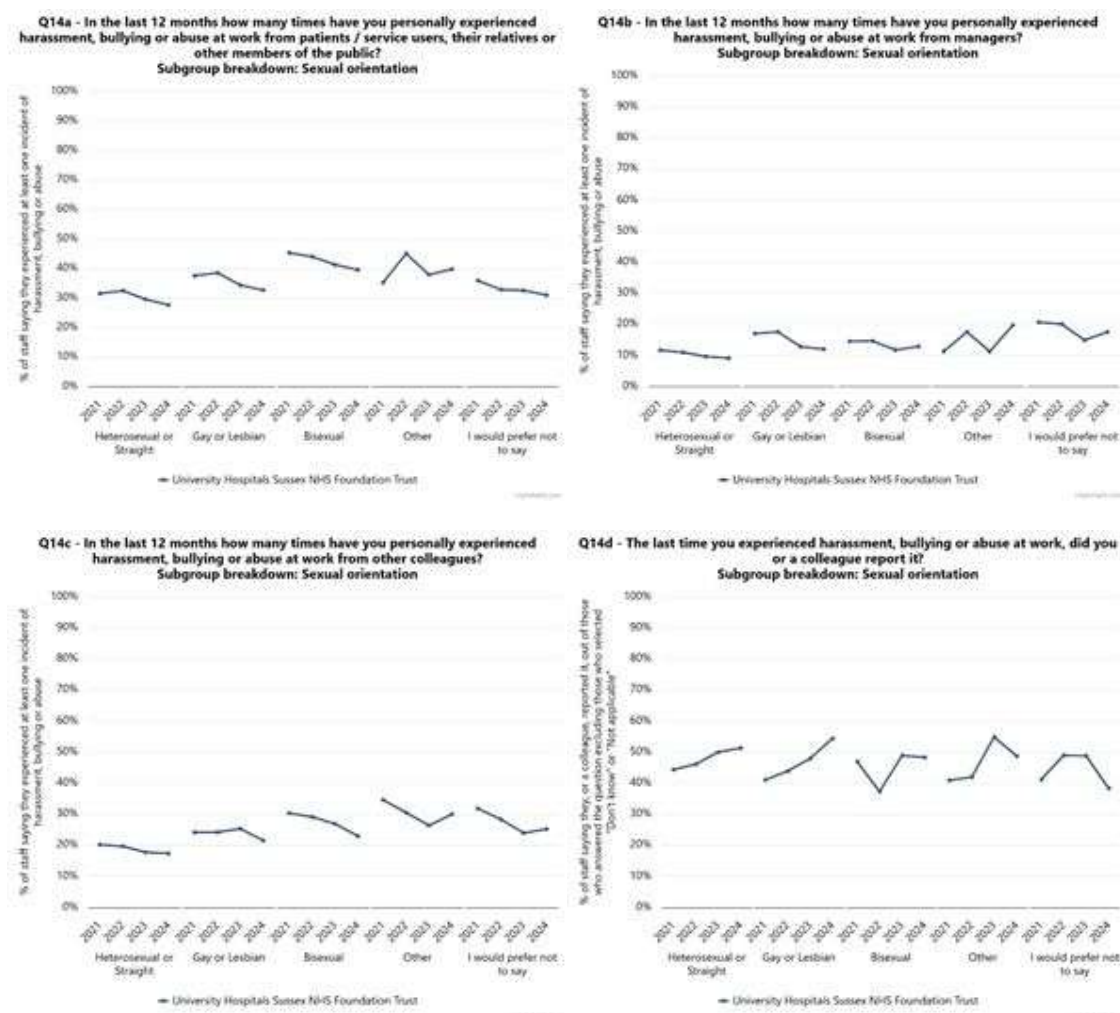


HIA 6: Eliminate Discrimination (Sexual Orientation)

Harassment, bullying or abuse by sexual orientation (NSS – Q14a-d)

Analysis of NHS Staff Survey responses highlights that heterosexual staff report lower levels of harassment, bullying and abuse compared to staff of other sexual orientations. Reviewing the data by in more detail, it can be seen that:

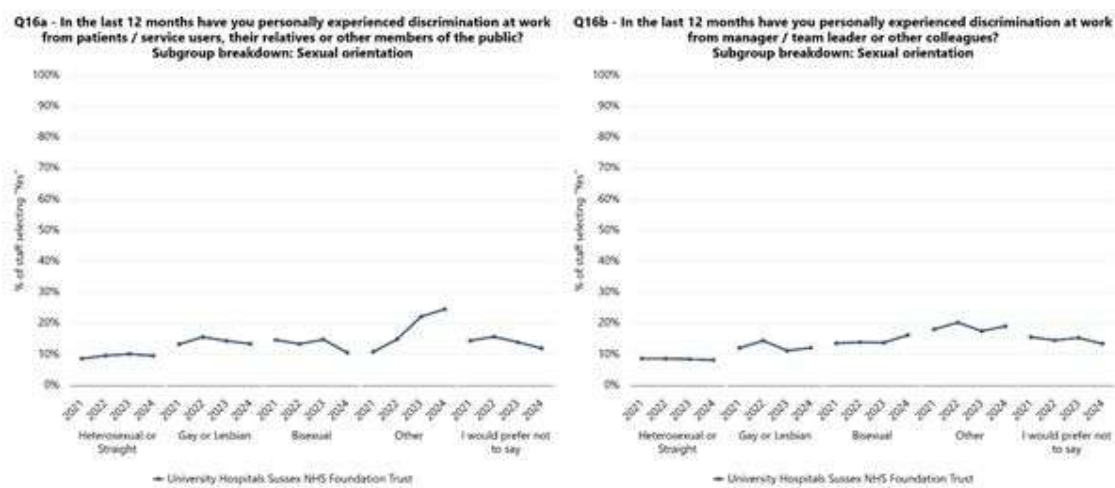
- ▶ Heterosexual staff reported the least harassment, bullying and abuse from patients or the public (27.6% of 6,785 respondents), managers (9.1% of 6,743 respondents) and colleagues (17.4% of 6,747 respondents).
- ▶ Staff who selected “another sexual orientation” and bisexual staff reported the highest levels of harassment, bullying and abuse from patients or the public (39.7% of 73 respondents and 39.5% of 233 respondents).
- ▶ Staff who selected “another sexual orientation” also reported the highest levels of harassment, bullying and abuse from managers (19.7% of 71 respondents) and colleagues (30.0% of 70 respondents).
- ▶ Since 2023, there has been a marked increase in reports of harassment, bullying and abuse from patients, managers and colleagues among staff who selected “another sexual orientation,” with some increase among staff who preferred not to disclose their sexual orientation (managers and colleagues).
- ▶ In contrast, other groups saw little change or a decrease in these experiences since 2023.
- ▶ Staff who selected “another sexual orientation” or preferred not to disclose their sexual orientation were also less likely to report these experiences in 2024, with reporting rates showing a significant decline since 2023.



Discrimination from managers or colleagues by sexual orientation (NSS – Q16a-b)

Analysis of NHS Staff Survey responses shows that staff who selected “another sexual orientation” report the highest levels of discrimination, while heterosexual staff report the lowest. Reviewing the data in more detail, it can be seen that:

- ▶ In 2024, 24.7% (of 73 respondents) staff who selected “another sexual orientation” reported experiencing discrimination from patients or the public, compared to 9.7% (of 6,767 respondents) heterosexual staff. Similarly, 19.2% (of 73 respondents) staff who selected “another sexual orientation” reported discrimination from managers or colleagues, compared to 8.3% (of 6,707 respondents) heterosexual staff.
- ▶ Reports of discrimination have continued to rise for staff who selected “another sexual orientation” since 2021, while rates for other groups saw minor changes or declined.



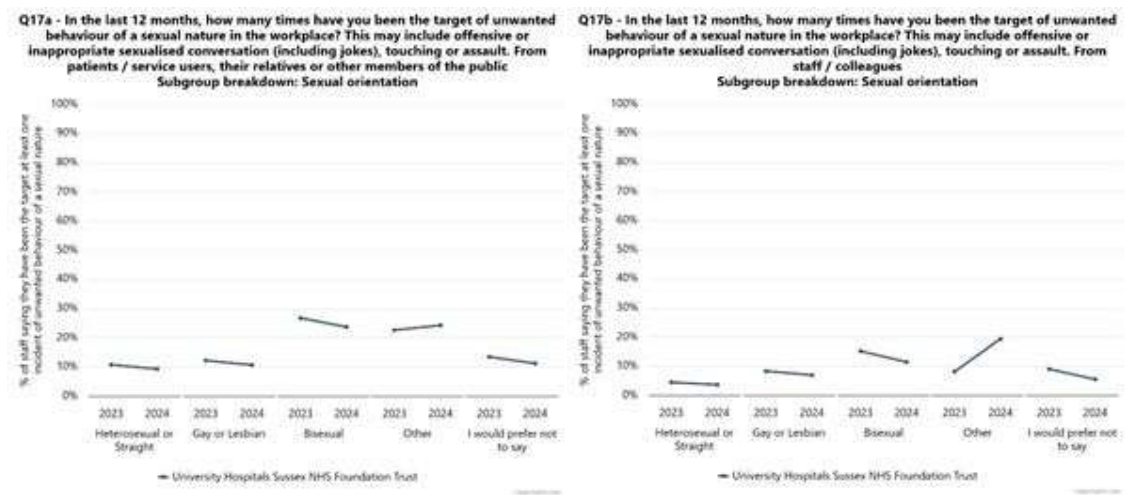
A higher proportion of gay or lesbian staff who had experienced discrimination felt this was on the grounds of sexual orientation (53.16% of 79 respondents). This view was also held by 27.27% of bisexual staff (55 respondents), and 20.83% staff who selected “another sexual orientation” (24 respondents). Notably, gay or lesbian staff were also more likely to attribute discrimination to ‘ethnic background’ (41.77 % of 79 respondents), while bisexual and staff who selected “another sexual orientation” were also more likely to attribute discrimination to ‘gender’ (45.45% of 55 respondents, and 41.67% of 24 respondents).

Sexual harassment by sexual orientation (NSS – Q17a-b)

Analysis of NHS Staff Survey responses shows that bisexual staff and those who selected “another sexual orientation” report the highest levels of sexual harassment compared to all other groups.

Reviewing the data in more detail, it can be seen that:

- ▶ Bisexual staff (23.7% of 236 respondents) and those who selected “another sexual orientation” (24.3% of 74 respondents) reported the highest levels of sexual harassment from patients or the public.
- ▶ Staff who selected “another sexual orientation” also reported the highest levels of sexual harassment from managers, team leaders or colleagues (19.4% of 72 respondents).
- ▶ Since 2023, reports of sexual harassment have increased among staff who selected “another sexual orientation,” while rates for other groups have declined.



5. Religion and Belief

Religion & Belief Equality Summary

At UHSussex, around two-thirds of the permanent workforce are recorded as holding a religious belief. This is similar to the proportion in Sussex and slightly lower than in England overall. Religious staff made up half of respondents to the NHS Staff Survey in 2024.

Disparities in senior roles are evident between atheist staff and those holding a religious belief. Atheist staff were more likely to be in senior roles across clinical, non-clinical, and medical groups. They were significantly over-represented in senior non-clinical management and consultant positions, with some of these gaps exceeding equality targets. In recruitment, atheist applicants were more likely to be appointed from shortlisting than applicants from most religious groups, and this gap has widened since last year.

Workplace experiences also varied. Jewish staff and those who did not disclose their religion reported the lowest confidence in fair career progression and health and well-being support. They also had some of the highest levels of burnout and work-related stress. In contrast, Sikh, Hindu, and Muslim staff reported higher satisfaction with health and well-being and some of the lowest levels of burnout and stress.

Bullying, harassment, and discrimination were reported more often by staff of “any other religion,” Jewish staff, and those who did not disclose their religion. Muslim, Sikh, and Hindu staff reported fewer incidents of these behaviours. Reports of unwanted sexual behaviour were highest among staff of “any other religion” and Jewish staff, while Hindu and Muslim staff reported the lowest levels.

HIA 1: Leadership and Accountability (Religion & Belief)

Staff voice

The Trust's [Religion and Belief \(R&B\) Network](#) was relaunched in July 2024 and is sponsored by the Chief Governance Officer.

One of the R&B Network's main priorities has been building up the membership and making staff aware of the existence of the network. This will continue to be a priority for the coming year. So far in network meetings they have had a talk from Imam Idris Nawab about Islam and the impact of the summer riots on Muslims and a session led by a network member on the Roman Catholic Feast of Divine Mercy. The network meetings have enabled staff members to share how their faith and beliefs shape their lives and they have been able to speak of their deeply held beliefs in a forum where they know it is safe from prejudice and ridicule.

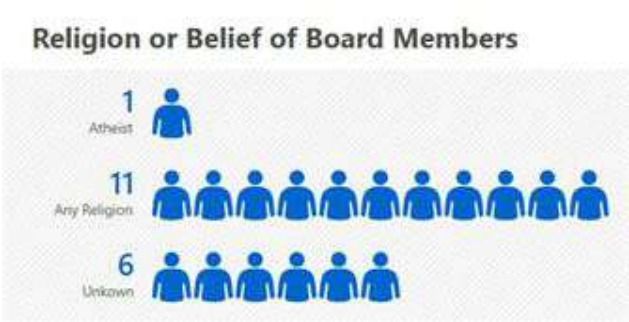
The R&B Network are currently forming a list of significant dates for different faiths and beliefs and discussing how we shall acknowledge and mark them during the year. The staff survey data indicated that our Muslim colleagues feel unsupported, so the network used some of their money from the 20-month charity programme to provide water, dates and fruit so that staff observing Ramadan could break safely their fast without having to wait until the end of the shift. It was very well received, with staff sharing feedback like:

- ▶ *"Amazing gesture. Thankful for this and means a lot as a Muslim doctor for me to work in a hospital that is supportive."*
- ▶ *"Really appreciate kind and generous gesture. Means a lot."*
- ▶ *"Thank you very much for giving us such opportunity to share these. It is great."*

The Religion and Belief Network 20-month charity programme plan includes a session on fasting and feasting in different faiths. They plan on supporting other significant days for faith and belief and supporting the chaplaincy department in reviewing which acts of worship would be possible. Overall, they plan to share the awareness of the vital role that faith and belief plays in the lives of our staff.

Board religion and belief composition

Eleven members of the Trust Board indicated they had a religion (61.1%), one indicated to be atheist (5.6%) and six either indicated they did not wish to disclose their religion or belief or did not have any data available (33.3%).



HIA 2: Inclusive Talent (Religion & Belief)

Workforce religion and belief representation

Out of a permanent workforce of 17,972 in March 2025, 63.73% (11,462) were recorded as religious on ESR. This represents an increase of over three percentage points compared to the previous year (2024 = 60%). Out of these, 1.17% indicated their religion to be Buddhism, 43.58% Christianity, 2.73% Hinduism, 3.15% Islam, 0.04% Jainism, 0.20% Judaism, 0.15% Sikhism, and 12.74% indicated to be of another religion or belief not listed.

In the 2024 NHS Staff Survey, responses were received from 3,490 (43.11%) staff who indicated to not hold a religion (atheist), 3,394 (41.92%) Christian staff, 89 (1.10%) Buddhist staff, 165 (2.04%) Hindu staff, 14 (0.17%) Jewish staff, 149 (1.84%) Muslim staff, 11 (0.14%) Sikh staff, 137 (1.69%) staff who reported their

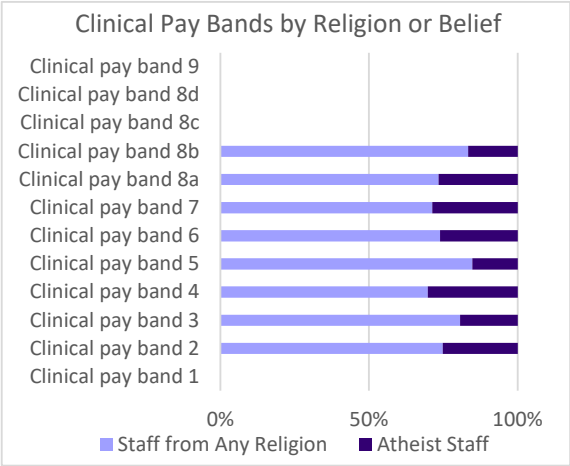
religion to be another not listed, and 530 (6.55%) staff who preferred not to disclose their sexual orientation at UHSussex.

This compares to 67% of the population in England (57% Christian, 1% Buddhist, 2% Hindu, 1% Jewish, 6% Muslim, 1% Sikh, 1% Other) and 60 % across East Sussex, West Sussex and Brighton and Hove combined (55% Christian, 1% Buddhist, 0.4% Hindu, 0.2% Jewish, 2% Muslim, 0.1% Sikh, 2% Other) (Census 2021, ONS).

Clinical Agenda for Change Staff
Disparity Ratios

Out of 9,635 clinical staff on Agenda for Change (AfC) terms and conditions:

- ▶ 5,682 staff were in lower bands (AfC 1-5) out of which 71.6% held a religious belief.
- ▶ 3,569 staff were in middle bands (AfC 6-7) out of which 61.9% held a religious belief.
- ▶ 384 staff were in upper bands (AfC 8a+) out of which 64.3% held a religious belief.



Atheist staff were **1.6 times more likely** to be in specialist or advanced clinical roles (bands 6-7) than staff holding any religious belief, compared to their representation in support or newly qualified roles (bands 1-5). This is above the equality target range (target between 0.8-1.25). This is **worsened** (up) marginally, from 1.5 times in 2024.

Atheist staff were also **1.3 times more likely** to be in senior clinical roles (bands 8-VSM) than staff holding any religion, compared to their representation in support or newly qualified roles (bands 1-5). This is above the equality target range (target between 0.8-1.25). This is **improved** (down) marginally from 1.5 times in 2024.

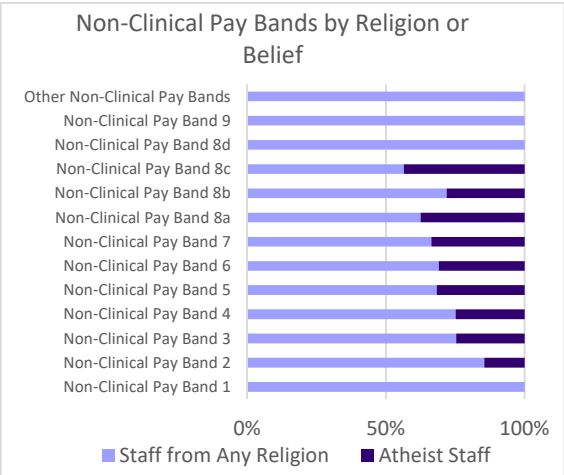
Atheist clinical staff were **just as likely** (0.8 times) to be in senior management roles (bands 8a-VSM) as clinical staff with any religious belief, compared to their representation in specialist or advanced clinical roles (bands 6-7). This is largely unchanged from 2024.

Representation Disparity Ratio	2024	2025
Disparity ratio – lower (Bands 1-5) to middle (Bands 6-7)	1.53	1.60
Disparity ratio – middle (Bands 6-7) to upper (Bands 8a-VSM)	0.95	0.83
Disparity ratio – lower (Bands 1-5) to upper (Bands 8a-VSM)	1.46	1.33

Non-Clinical Agenda for Change Staff Disparity Ratios

Out of 5,637 non-clinical staff on Agenda for Change (AfC) terms and conditions:

- ▶ 4,107 staff were in lower bands (AfC 1-5) out of which 64.6% held any religious belief.
- ▶ 942 staff were in middle bands (AfC 6-7) out of which 55% held any religious belief.
- ▶ 588 staff were in upper bands (AfC 8a+) out of which 51.9% held any religious belief.



Atheist staff were also **1.9 times more likely** to be in non-clinical junior management roles (bands 6-7) than staff holding any religious belief, compared to support and entry level roles (bands 1-5). This is above the equality target range (target between 0.8-1.25). This is **worsened** (up) marginally, from 1.7 times in 2024.

Atheist non-clinical staff were **just as likely** to be in senior management roles (bands 8a-VSM) compared to junior management roles (bands 6-7). This headline finding is masking disparities by division. This is largely unchanged from 2024.

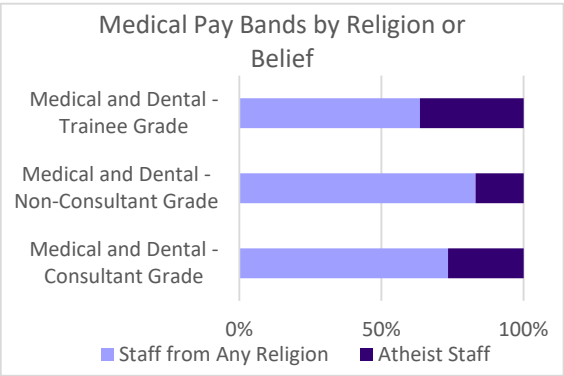
Atheist staff were **1.8 times more likely** to be non-clinical senior managers (bands 8-VSM) compared to staff holding any religious belief, compared to support and entry level roles (bands 1-5). This is above the equality target range (target between 0.8-1.25). This is largely unchanged from 2024.

Representation Disparity Ratio	2024	2025
Disparity ratio – lower (Bands 1-5) to middle (Bands 6-7)	1.68	1.76
Disparity ratio – middle (Bands 6-7) to upper (Bands 8a-VSM)	1.02	1.06
Disparity ratio – lower (Bands 1-5) to upper (Bands 8a-VSM)	1.71	1.87

Medical & Dental Staff Disparity Ratios

Out of 2,627 staff on medical and dental contracts:

- ▶ 1,092 were trainees, out of which 51.5% held any religious belief.
- ▶ 573 were non-consultant career grades (NCCGs) out of which 64.3% held any religious belief.
- ▶ 962 were consultants, out of which 50.9% held any religious belief.



Atheist staff were 1.7 times more likely to be consultants than staff holding any religious beliefs, compared to their proportions in NCCGs. This is above the equality target range (target between 0.8-1.25). This is **improved** (down) marginally, from 1.9 times in 2024.

Atheist staff were just under a third less likely (0.37 times) to be consultants than staff holding any religious beliefs, compared to their proportions in trainee grades. This is less than the lower limit of the equality target range (target between 0.8-1.25) and unchanged from 2024.

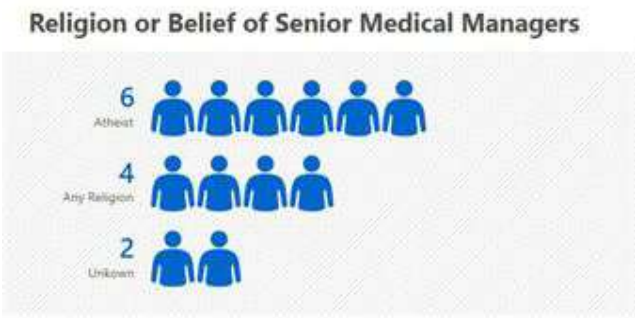
Atheist staff were just under half less likely (0.6 times) to be in NCCGs than in trainee grades compared to staff holding any religious beliefs. This is less than the lower limit of the equality target range (target between 0.8-1.25) and largely unchanged from 2024.

Representation Disparity Ratio	2024	2025
Disparity ratio – Trainee to NCCG	0.33	0.37
Disparity ratio – NCCG to Consultant	1.91	1.68
Disparity ratio – Trainee to Consultant	0.62	0.61

Senior Medical Managers

Out of all consultants, 13 were identified as senior medical managers (a medical consultant who is either a Medical Director, a Deputy Medical Director or who reports directly to a Medical Director or Deputy Medical Director).

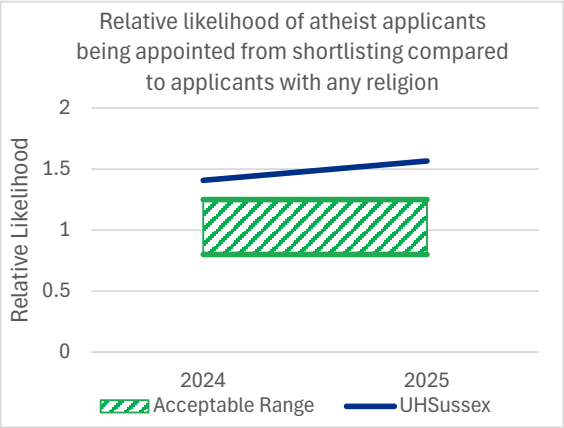
Four senior medical managers held a religious belief (30.8%). Six (46.2%) were atheist, and another two decided to not share their religion or belief.

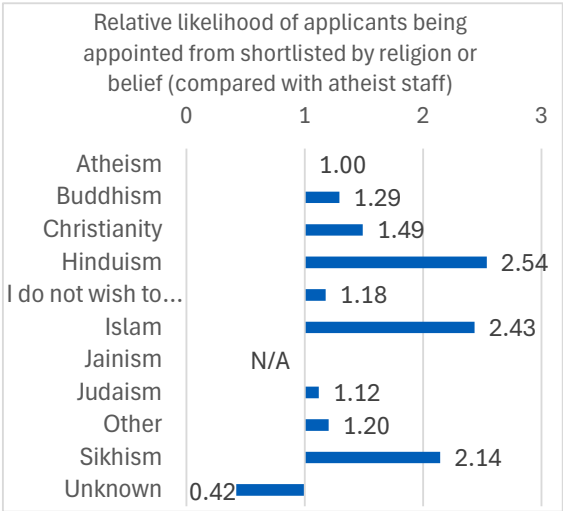


Religion and belief shortlisting-to-appointment relative likelihood

In the 2024/25 financial year UHSussex appointed 1,803 religious applicants and 772 atheist applicants.

The Trust was **1.6 times more likely** to appoint atheist people from short-listing compared to applicants from any religion. This has increased from 1.4 times last year and continues to fall outside of the equality target range (0.8-1.25).





When investigating the relative likelihood of staff by religious group, it can be shown that atheist applicants are as likely as applicants who did not wish to share their religion or belief, Jewish applicants and applicants with another not listed belief to be appointed from shortlisting, falling within the equality target range (target between 0.8-1.25).

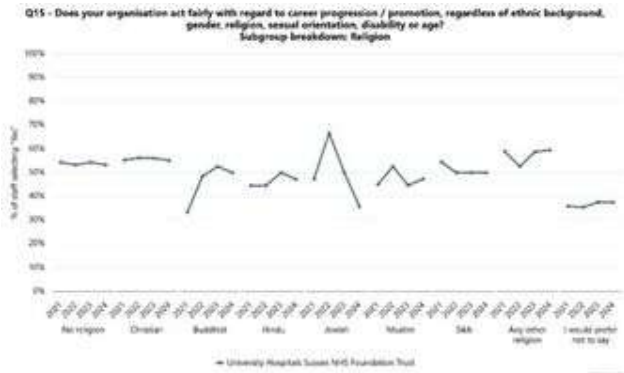
Atheist staff were more likely to be to be appointed from shortlisting compared to staff indicating their religion to be

Buddhism, Christianity, Hinduism, Islam, or Sikhism, with all relative likelihoods falling above the equality target range (target between 0.8-1.25).

Equality of opportunity for career progression / promotion (NSS – Q15)

Analysis of NHS Staff Survey responses shows that staff who did not disclose their religion and Jewish staff report the lowest agreement that their organisation acts fairly on career progression and promotion. Reviewing the data by religion in more detail, it can be seen that:

- ▶ Staff of “any other religion” reported the highest agreement (59.6% of 136 respondents), followed by Sikh staff (50.0% of 12 respondents) and Christian staff (55.1% of 3,355 respondents).
- ▶ Staff who did not disclose their religion (37.5% of 525 respondents) and Jewish staff (35.7% of 14 respondents) reported the lowest agreement compared to all other groups.
- ▶ Since 2023, agreement decreased most sharply among Jewish staff (falling from 50.0% of 14 respondents to 35.7% of 14 respondents), while most other groups saw minor changes or saw minor changes.

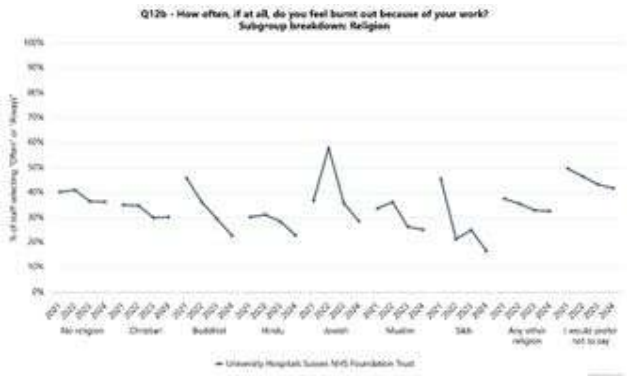


HIA 4: Workforce Health Inequalities (Religion & Belief)

Burnout (NSS – Q12b)

Analysis of NHS Staff Survey responses shows that staff who did not disclose their religion report the highest levels of burnout, while Sikh and Hindu staff report the lowest. Reviewing the data by religion in more detail, it can be seen that:

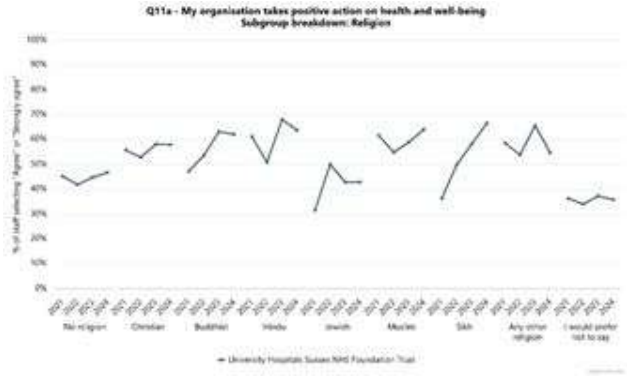
- ▶ 41.8% (of 533 respondents) staff who did not disclose their religion reported feeling “often” or “always” burnt out, the highest of all groups.
- ▶ Sikh (16.7% of 12 respondents), Hindu (22.9% of 166 respondents) and Buddhist (22.73% of 88 respondents) staff reported the lowest levels of burnout in 2024.
- ▶ Since 2023, burnout levels decreased across all groups, with notable reductions among Buddhist staff (down from 29.5% of 78 respondents to 22.7% of 88 respondents) and Sikh staff (from 25.0% of 12 respondents to 16.7% of 12 respondents).



Positive action on health and wellbeing (NSS – Q11a)

Analysis of NHS Staff Survey responses shows that staff who did not disclose their religion, Jewish staff and staff who indicate to not hold a religion report the lowest levels of agreement that their organisation takes positive action on health and well-being. Reviewing the data by religion in more detail, it can be seen that:

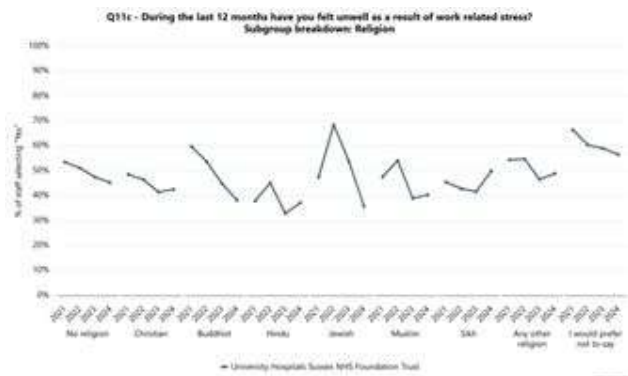
- ▶ Sikh staff (66.7% of 12 respondents) and Muslim staff (64.1% of 153 respondents) reported the highest levels of agreement, followed closely by Hindu staff (63.7% of 168 respondents).
- ▶ Staff who did not disclose their religion (35.8% of 528 respondents) and Jewish staff (42.9% of 14 respondents) reported the lowest agreement compared to all other groups.
- ▶ Since 2023, agreement increased for Muslim staff (from 59.0% of 156 respondents to 64.1% of 153 respondents), while staff of “any other religion” saw the sharpest decline (from 65.6% of 160 respondents to 54.6% of 141 respondents).
- ▶ Between 2021 and 2024, Sikh staff showed the largest overall improvement, rising from 36.4% (of 12 respondents) to 66.7% (of 12 respondents). In contrast, staff who did not disclose their religion have remained consistently lower over time, with little change.



Work related stress (NSS – Q11c)

Analysis of NHS Staff Survey responses shows that staff who did not disclose their religion report the highest levels of work-related stress, while Hindu and Jewish staff report the lowest. Reviewing the data by religion in more detail, it can be seen that:

- ▶ In 2024, 56.6% (of 527 respondents) staff who did not disclose their religion reported feeling unwell due to work-related stress, the highest of all groups.
- ▶ Hindu staff (37.2% of 164 respondents) and Jewish staff (35.7% of 14 respondents) reported the lowest levels compared to other groups.
- ▶ Since 2023, levels of work-related stress have decreased for most groups, including Buddhist staff (down from 44.9% of 78 respondents to 38.2% of 89 respondents) and staff with no religion (from 47.5% of 3,507 respondents to 45.3% of 3,471 respondents).
- ▶ Jewish staff saw the largest year-on-year reduction, with levels dropping sharply from 53.9% (of 13 respondents) in 2023 to 35.7% (of 14 respondents) in 2024.



HIA 6: Eliminate Discrimination (Religion & Belief)

Harassment, bullying or abuse by religion and belief (NSS – Q14a-d)

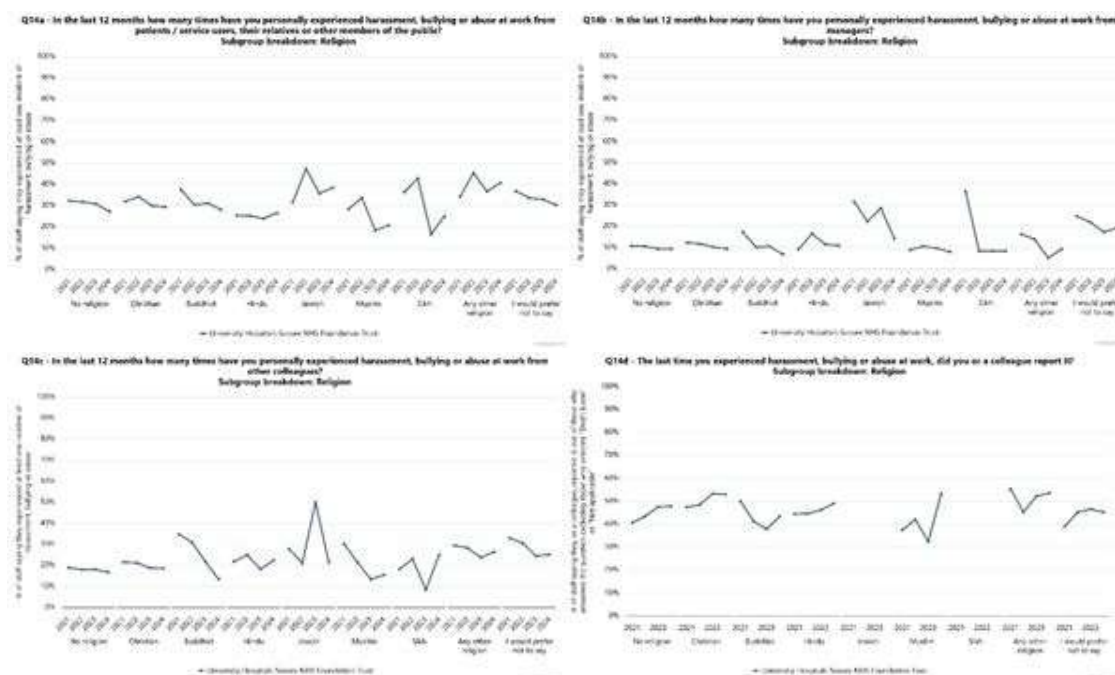
Analysis of NHS Staff Survey responses highlights that Muslim and Sikh staff report the lowest levels of harassment, bullying and abuse, while staff of “any other religion” and those who did not disclose their religion report the highest levels across all sources.

Reviewing the data by religion in more detail, it can be seen that:

- ▶ Muslim staff (20.8% of 154 respondents) and Sikh staff (25.0% of 12 respondents) reported the fewest incidents of harassment, bullying and abuse from patients or the public in 2024, while staff of “any other religion” (40.7% of 140 respondents) and Jewish staff (38.5% of 13 respondents) reported the most.
- ▶ Buddhist staff (6.8% of 88 respondents) reported the lowest levels of harassment, bullying and abuse from managers, whereas Jewish staff (14.3% of 14 respondents) and staff who did not disclose their religion (19.2% of 525 respondents) reported the highest.
- ▶ Buddhist staff (13.5% of 89 respondents) also reported the lowest levels of harassment, bullying and abuse from colleagues, while staff of “any other

religion" (26.4% of 140 respondents) and those who did not disclose their religion (25.2% of 524 respondents) reported the highest.

- ▶ Since 2023, reports of harassment, bullying and abuse increased among Sikh staff (from patients and colleagues) and staff of "any other religion" (from all sources) while Jewish staff saw significant decreases in experiences of harassment, bullying and abuse from managers and other colleagues.
- ▶ In 2024, staff of "any other religion" (53.6% of 69 respondents) and Muslim staff (53.3% of 45 respondents) were the most likely to report incidents of harassment, bullying and abuse, a positive trend. For Muslim staff, this represents a sharp increase from 32.4% (of 37 respondents) in 2023, reflecting a positive trend in reporting.



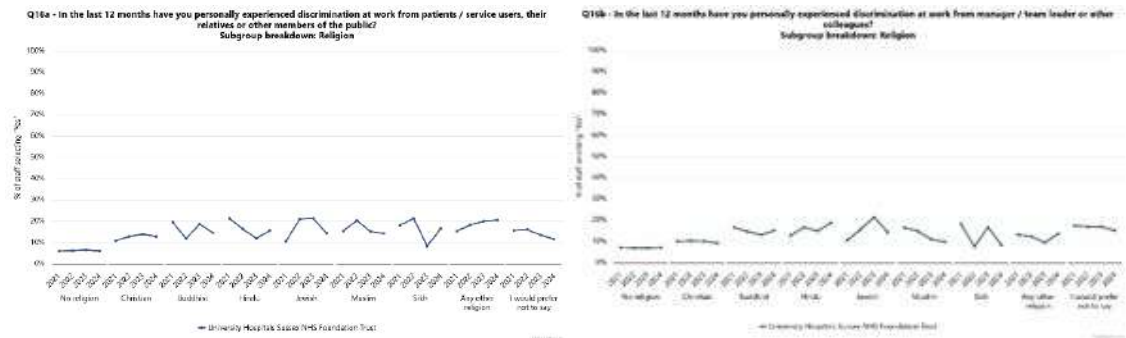
Discrimination from managers or colleagues by religion and belief (NSS – Q16a-b)

Analysis of NHS Staff Survey responses shows that staff with no religion were least likely to report discrimination, while levels were higher among most other groups.

Reviewing the data by religion in more detail, it can be seen that:

- ▶ 20.6% (of 141 respondents) staff of "any other religion" reported discrimination from patients or the public, compared to 6.0% (of 3,474 respondents) staff with no religion. Similarly, 18.8% (of 165 respondents) Hindu staff and 13.7% (of 139 respondents) staff of "any other religion" reported discrimination from managers or colleagues, compared to 7.2% (of 3,450 respondents) staff with no religion.
- ▶ Reports of discrimination from patients or the public increased for staff of "any other religion" Hindu and Sikh staff, while rates fell for all other groups.

- ▶ Reports of discrimination from managers or colleagues rose for Hindu staff and staff of “any other religion”, while most other groups remained stable or declined.

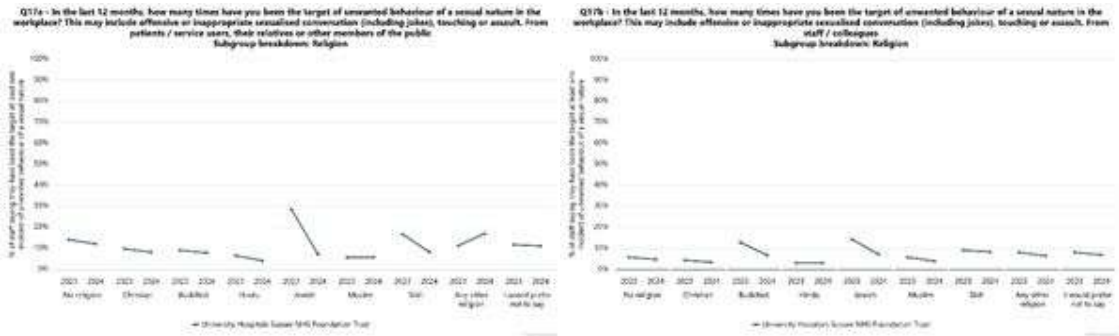


A higher proportion of Muslim staff who had experienced discrimination felt this was on the grounds of religion (22.58% of 31 respondents), compared to 3.10% (of 612 respondents) Christian staff, 4.35% (of 23 respondents) Buddhist staff, and 4.65% (of 43 respondents) Hindu staff. Notably, Muslim, Hindu and Christian staff were also more likely to attribute discrimination to ‘ethnic background’ (77.42% of 31 respondents, and 76.74% of 43 respondents, and 69.28% of 612 respondents).

Sexual harassment by religion and belief (NSS – Q17a-b)

Analysis of NHS Staff Survey responses shows that Hindu and Muslim staff were least likely to report experiencing unwanted sexual behaviour, while staff of “any other religion” and Jewish staff reported the highest levels. Reviewing the data by religion in more detail, it can be seen that:

- ▶ 17.0% (of 141 respondents) staff of “any other religion” reported experiencing unwanted sexual behaviour from patients or the public, compared to 4.1% (of 169 respondents) Hindu staff and 5.8% (of 156 respondents) Muslim staff.
- ▶ Similarly, 7.1% (of 14 respondents) Jewish staff and 8.3% (of 12 respondents) Sikh staff reported experiencing unwanted sexual behaviour from colleagues, compared to 3.0% (of 165 respondents) Hindu staff and 4.0% (of 151 respondents) Muslim staff.
- ▶ Reports decreased for most groups since 2023, including sharp reductions among Jewish staff (patients/public: 28.6% of 14 respondents to 7.1% of 14 respondents; colleagues: 14.3% of 14 respondents to 7.1% of 14 respondents). However, staff of “any other religion” saw an increase in incidents from patients or the public (from 11.3% of 159 respondents to 17.0% of 141 respondents).



6. Age

Age Equality Summary

At UHSussex, the majority of the workforce are aged between 26 and 55, with over half falling between 26 and 45. However, senior leadership roles are largely held by older staff, with most Board members and senior medical managers aged 51 or above.

Recruitment outcomes were broadly fair across all age groups, with applicants equally likely to be appointed from shortlisting. The only exception was applicants under 20, who were more likely to be appointed than other groups.

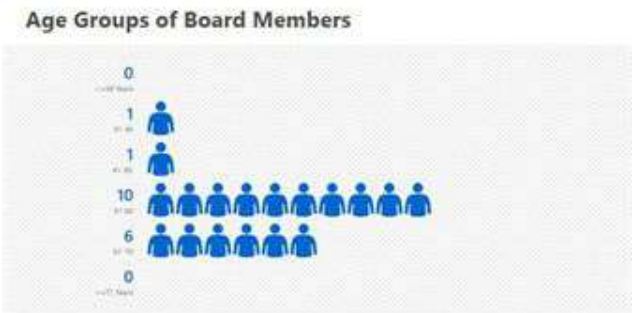
Younger staff were more positive about fair career progression and promotion, while older staff were least likely to agree. However, younger staff also reported the highest levels of burnout, stress, and harassment. In contrast, staff aged 66 and over reported the lowest levels of burnout, stress, and discrimination, and were more positive about health and well-being support from the Trust.

Musculoskeletal (MSK) problems were most commonly reported by staff aged 31–65, while younger and older staff reported these issues less often. Younger staff were also more likely to experience unwanted sexual behaviour, particularly from patients or the public, whereas older staff reported the lowest levels of these incidents.

HIA 1: Leadership and Accountability (Age)

Board age composition

Ten board members were between the ages of 51 and 60 (55.6%). Six (46.2%) were between the ages of 61 and 70. One board member was represented each in the age groups 31-40 and 41-50 respectively.

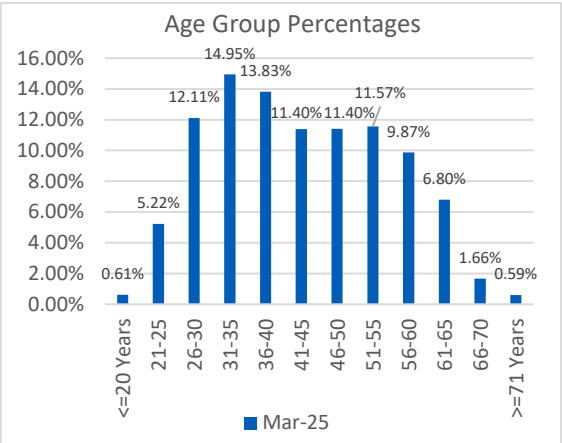


HIA 2: Inclusive Talent (Age)

Workforce age representation

Three-quarter (75.26%) of the permanent workforce (17,972) were between the ages of 26 and 55 on ESR in March 2025, with a majority of 52,14% falling between the ages of 26 and 45. The highest represented age group was 31-25 with just under 15% of staff falling in this age bracket.

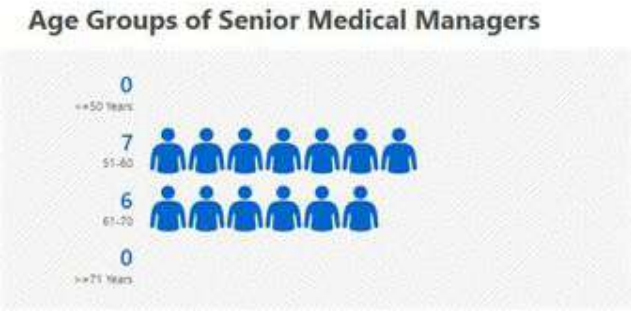
In the 2024 NHS Staff Survey, responses were received from 48 (0.59%) staff in the 16-20 age group, 1,017 (12.56%) staff in the 21-30 age group, 2,025 (25.01%) staff in the 31-40 age group, 2,000 (24.70%) staff in the 41-50 age group, 2,657 (32.82%) staff in the 51-65 age group, 185 (2.29%) staff in the 66+ age group at UHSussex.



Senior Medical Managers

Out of all consultants, 13 were identified as senior medical managers (a medical consultant who is either a Medical Director, a Deputy Medical Director or who reports directly to a Medical Director or Deputy Medical Director).

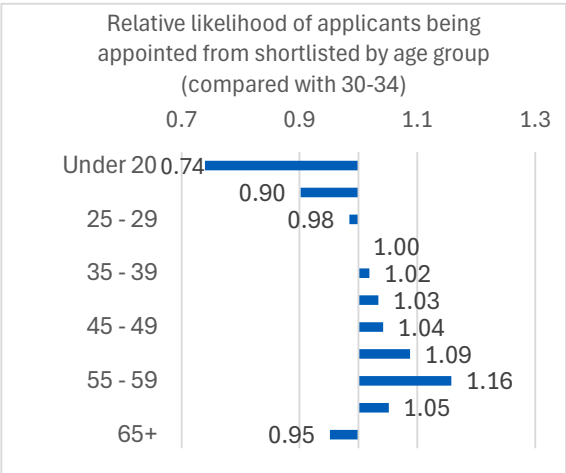
Seven senior medical managers were between the ages of 51 and 60 (53.8%). Six (46.2%) were between the ages of 61 and 70.



Age shortlisting-to-appointment relative likelihood

Applicants in the Trust's largest age band (30-34 years old) were as likely as applicants from all other age bands to be appointed from shortlisting with relative likelihoods for all age bands, falling within the equality target range (0.8-1.25).

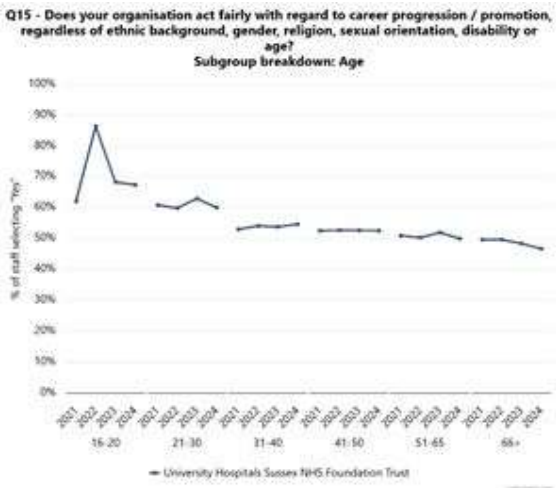
The only exception is applicants under 20. With applicants from the 30-34 age band being 0.74 times less likely to be appointed from shortlisting compared to applicants who were younger than 20.



Equality of opportunity for career progression / promotion (NSS – Q15)

Analysis of NHS Staff Survey responses shows that younger staff were more likely to agree their organisation acts fairly on career progression and promotion, while older staff were least likely to agree. Reviewing the data by age in more detail, it can be seen that:

- ▶ 67.4% (of 46 respondents) staff aged 16–20 agreed with the statement, compared to 46.7% (of 182 respondents) staff aged 66 and over.
- ▶ Agreement declined slightly for staff aged 51–65 (from 51.9% of 2,577 respondents to 50.0% of 2,624 respondents) and 66+ (from 48.4% of 155 respondents to 46.7% of 182 respondents) since 2023, while younger age groups remained broadly stable.
- ▶ Since 2021, staff aged 66 and over have consistently reported the lowest agreement.



HIA 4: Workforce Health Inequalities (Age)

Burnout (NSS – Q12b)

Analysis of NHS Staff Survey responses shows that younger staff were most likely to report feeling burnt out, while older staff were least likely to report these experiences. Reviewing the data by age in more detail, it can be seen that:

- ▶ 44.7% (of 47 respondents) staff aged 16–20 and 44.0% (of 1,024 respondents) staff aged 21–30 reported feeling “often” or “always” burnt out, compared to just 13.2% (of 182 respondents) staff aged 66 and over.
- ▶ Burnout levels decreased slightly since 2023 for most age groups, except staff aged 16–20, where levels remained high and increased marginally (from 43.9% of 41 respondents to 44.7% of 47 respondents).
- ▶ Since 2021, staff aged 66 and over have consistently reported the lowest levels of burnout.



Positive action on health and wellbeing (NSS – Q11a)

Analysis of NHS Staff Survey responses shows that older staff were more likely to agree their organisation takes positive action on health and well-being, while younger staff were least likely to agree. Reviewing the data by age in more detail, it can be seen that:

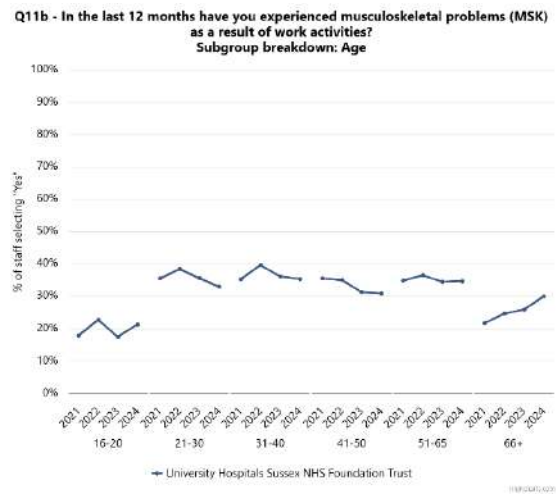
- ▶ In 2024, 62.3% (of 183 respondents) staff aged 66 and over agreed with the statement, compared to 46.9% (of 1,013 respondents) staff aged 21–30 and 62.5% (of 48 respondents) staff aged 16–20.
- ▶ Agreement increased for staff aged 66 and over (from 55.2% of 165 respondents in 2023, to 62.3% of 183 respondents), while levels fell sharply among staff aged 16–20 (from 76.2% of 42 respondents, to 62.5% of 48 respondents).
- ▶ Since 2021, staff aged 66 and over have consistently reported higher agreement than most other groups.



Musculoskeletal (MSK) problems (NSS – Q11b)

Analysis of NHS Staff Survey responses shows that staff aged 31–65 were most likely to report musculoskeletal (MSK) problems caused by work, while younger and older staff were least likely to report these issues. Reviewing the data by age in more detail, it can be seen that:

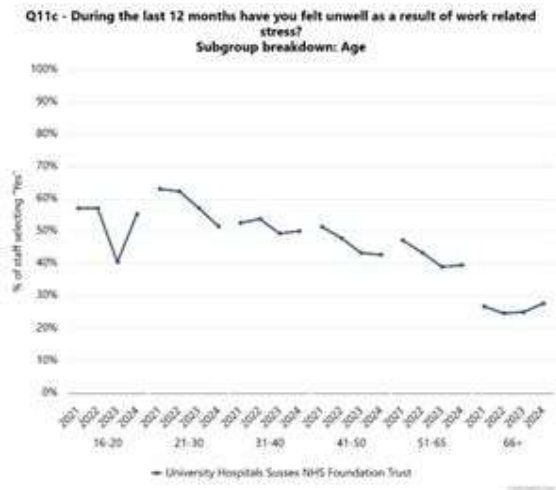
- ▶ In 2024, 35.4% (of 2,023 respondents) staff aged 31-40 and 34.7% (of 2,664 respondents) staff aged 51–65 reported MSK problems, compared to 21.3% (of 47 respondents) staff aged 16–20 and 30.0% (of 180 respondents) staff aged 66 and over.
- ▶ Reports of MSK problems decreased slightly for most age groups since 2023, except staff aged 16–20 (which increased from 17.5% of 40 respondents, to 21.3% of 47 respondents) and 66+ (from 25.9% of 166 respondents, to 30.0% of 180 respondents).
- ▶ Since 2021, staff aged 16–20 and 66+ have consistently reported much lower levels of MSK problems than other groups.



Work related stress (NSS – Q11c)

Analysis of NHS Staff Survey responses shows that younger staff were most likely to report feeling unwell due to work-related stress, while older staff were least likely to report these experiences. Reviewing the data by age in more detail, it can be seen that:

- ▶ In 2024, 55.3% (of 47 respondents) staff aged 16–20 and 51.5% (of 1,021 respondents) staff aged 21–30 reported feeling unwell due to work-related stress, compared to 27.6% (of 181 respondents) staff aged 66 and over.
- ▶ Since 2023, stress levels decreased slightly for most age groups except staff aged 16–20, where levels increased sharply (from 40.5% of 42 respondents, to 55.3% of 47 respondents).
- ▶ Since 2021, staff aged 66 and over have consistently reported the lowest levels of work-related stress.



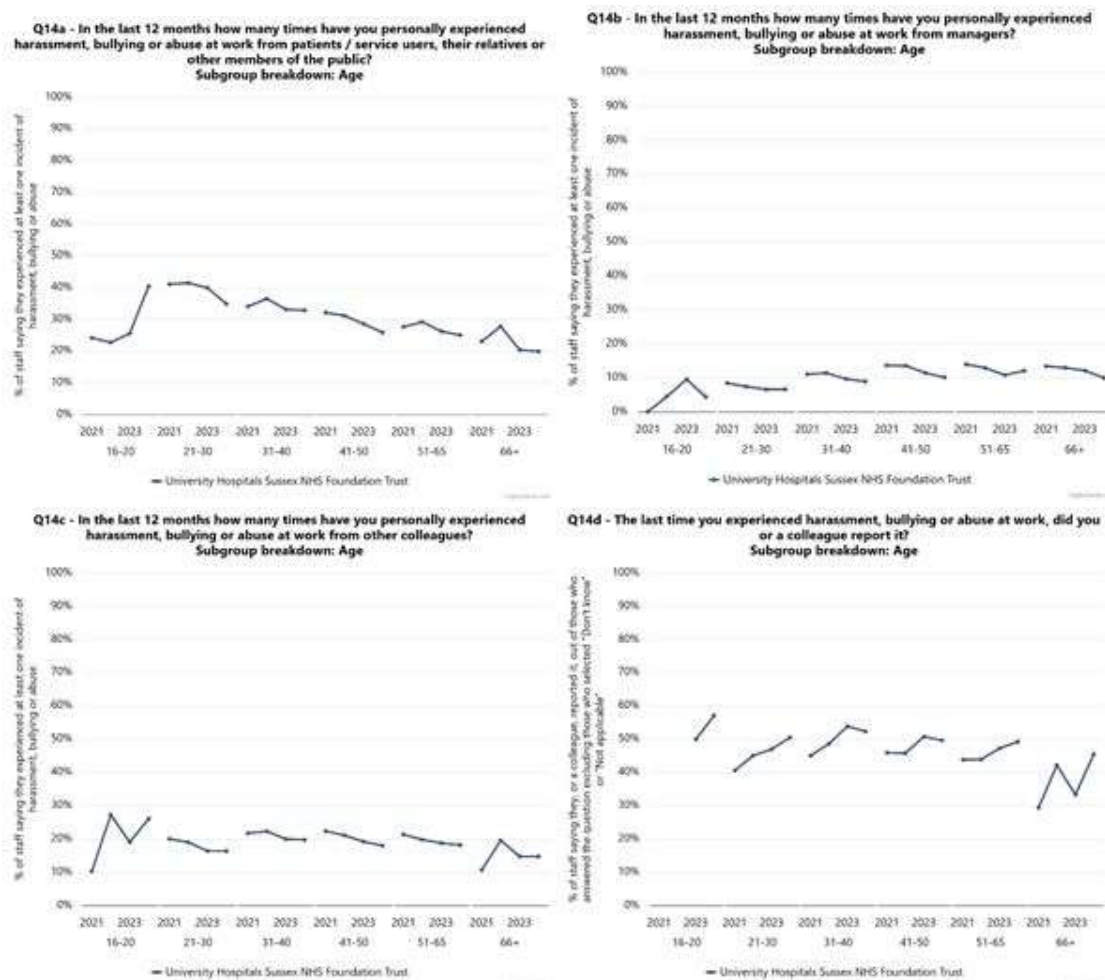
HIA 6: Eliminate Discrimination (Age)

Harassment, bullying or abuse by age band (NSS – Q14a-d)

Analysis of NHS Staff Survey responses shows that staff aged 16–20 were most likely to report experiencing harassment, bullying or abuse, while staff aged 66 and over were least likely to report these experiences. Younger staff were also the most likely to report such incidents when they occurred.

Reviewing the data by age in more detail, it can be seen that:

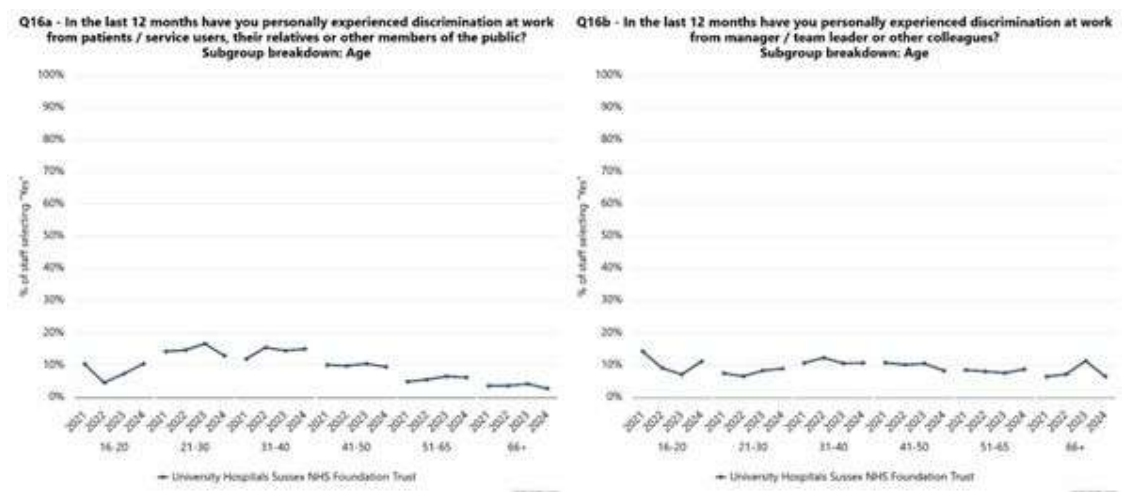
- ▶ 40.4% (of 47 respondents) staff aged 16–20 reported harassment, bullying or abuse from patients or the public, compared to 19.9% (of 181 respondents) staff aged 66 and over.
- ▶ Staff aged 16–20 also reported the highest levels of harassment, bullying and abuse from colleagues (26.1% of 46 respondents), while staff aged 66 and over reported the lowest levels across all sources.
- ▶ Harassment, bullying and abuse from managers was reported least often by staff aged 16–20 (4.4% of 46 respondents) and most often by staff aged 51–65 (12.1% of 2,647 respondents).
- ▶ Since 2023, harassment, bullying and abuse increased sharply for staff aged 16–20 (patients: 25.6% of 43 respondents to 40.4% of 47 respondents; colleagues: 19.1% of 42 respondents to 26.1% of 46 respondents), while most other groups saw decreases or remained stable.
- ▶ In 2024, staff aged 16–20 (57.1% of 21 respondents) and 31–40 (52.3% of 801 respondents) were the most likely to report incidents of harassment, bullying or abuse. Staff aged 66 and over were least likely to report such incidents (45.5% of 55 respondents) but saw a marked improvement from 2023, when only 33.3% (of 45 respondents) reported doing so.



Discrimination from managers or colleagues by age band (NSS – Q16a-b)

Analysis of NHS Staff Survey responses shows relatively small differences in reported discrimination between age groups, though younger staff were slightly more likely to report these experiences than older staff. Reviewing the data by age in more detail, it can be seen that:

- ▶ 15.1% (of 2,025 respondents) staff aged 31-40 and 13.0% (of 1,019 respondents) staff aged 21-30 reported discrimination from patients or the public, compared to just 2.8% (of 182 respondents) staff aged 66 and over.
- ▶ Discrimination from managers or colleagues varied little across age groups, with rates ranging from 6.5% (of 185 respondents) for staff aged 66 and over to 11.1% (of 45 respondents) for staff aged 16-20.
- ▶ Since 2023, discrimination from patients or the public increased slightly for staff aged 16-20 but fell or remained stable for most other age groups.

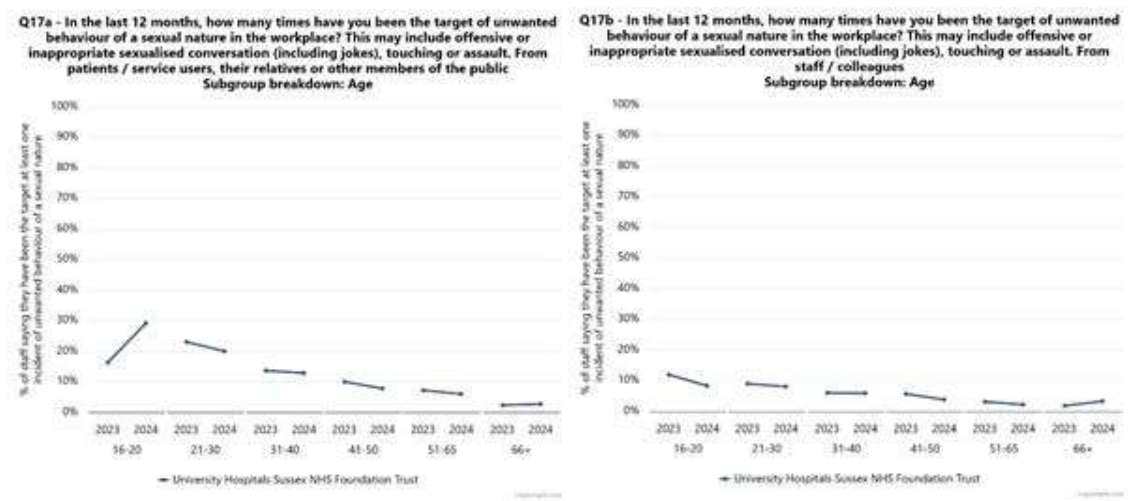


A higher proportion of staff aged 66 who had experienced discrimination felt this was on the grounds of age (53.85% of 13 respondents), compared to 24.46% (of 184 respondents) staff aged 21–30, 22.26% (of 328 respondents) staff aged 51–65, and 7.51% (of 293 respondents) staff aged 41–50.

Sexual harassment by age band (NSS – Q17a-b)

Analysis of NHS Staff Survey responses shows that younger staff were more likely to report experiencing unwanted sexual behaviour, while older staff were least likely to report these experiences. Reviewing the data by age in more detail, it can be seen that:

- ▶ 29.2% (of 48 respondents) staff aged 16–20 and 20.0% (of 1,024 respondents) staff aged 21–30 reported unwanted sexual behaviour from patients or the public, compared to just 2.8% (of 182 respondents) staff aged 66 and over.
- ▶ Reports of unwanted sexual behaviour from colleagues were highest among staff aged 16–20 (8.3% of 48 respondents) and 21–30 (8.0% of 1,020 respondents), while staff aged 66 and over reported the lowest levels (3.3% of 184 respondents).
- ▶ Since 2023, incidents from patients or the public increased sharply for staff aged 16–20 (from 16.3% of 42 respondents, to 29.2% of 48 respondents) but fell for most other age groups. Reports of unwanted sexual behaviour from colleagues decreased slightly across all age groups, except for staff aged 66 and over where levels increased slightly.



7. Caring Responsibilities

Carers Equality Summary

At UHSussex, less than 1% of staff are recorded as carers on ESR, though almost 29% of NHS Staff Survey respondents said they look after someone with a long-term health condition or illness. This gap is likely because staff have only recently been encouraged to update their caring status on ESR, and planned awareness campaigns are expected to give a clearer picture in future. This reported figure is also much higher than the proportion of people providing unpaid care in England overall.

Carers and non-carers reported broadly similar experiences in many areas. Both groups were equally likely to feel the Trust acts fairly in career progression and promotion, and they reported similar levels of satisfaction with flexible working opportunities. Carers were slightly more confident than non-carers about approaching their manager for flexible working, with both groups seeing small improvements since last year.

Carers reported slightly higher levels of burnout, stress, and musculoskeletal (MSK) problems compared to non-carers. They also experienced marginally higher rates of harassment, bullying, and discrimination, particularly from managers and colleagues.

HIA 1: Leadership and Accountability (Carers)

Staff Voice

The Trust has a [Carers Network](#) running since March 2024, sponsored by the Chief Nurse. The Annual Staff Survey has found that 29% of our UHSussex colleagues provide unpaid caring support for friends, families and loved ones. Approximately one third of NHS staff nationally identify as carers: research by Carers UK suggests that the actual number may be somewhat higher, as often people don't self-identify as carers. We are exploring ways to support colleagues who may not have access to the intranet as part of their work role and remain unaware of the Staff Networks.

In November 2025 the Carers Network held a conference to mark National Carers Rights Day, hosting a selection of guest speakers covering subjects including recognising your rights as a carer, financial wellbeing, and a Q&A session with a lived experience panel. The event had 60 attendees, and the feedback was overwhelmingly positive. The Carers Network are currently planning a full-day event in November 2025.

In June 2025 the Carers Network hosted information stalls across our five main hospital sites during National Carers Week: we had conversations with over 80 people who visited the stalls. The events gave the network the opportunity to meet current members and engage with colleagues who didn't previously know about the

network, signpost colleagues to internal and external support, to help them with their own physical, emotional and financial wellbeing. Several new members signed up and the network is continuing to see an increased level of contact.

The Carers Network continue to hold monthly hybrid meetings where members can discuss the issues they experience in their caring roles and see presentations from guest speakers. In addition to these meetings, the network is planning a series of seminars to focus more fully on specific topics.

In April UHSussex registered as a member of [Employers for Carers](#), a national organisation which provides support for employers seeking to develop carer-friendly policy and practice. The Carers Network played a vital role in this and is collaborating with Employers for Carers to explore ways to help carers at UHSussex balancing their caring commitments and their work.

The Carers Network Lead has furthermore been a key stakeholder in the [UHSussex HR Carers Policy](#) which was adopted by the Trust in June 2025, thanks to the hard work of Nick Groves, Associate Director of Leadership, OD & Engagement.

The Carers Network 20-month charity programme plan priorities for the next year are:

- ▶ Continue to build relationships with other staff networks to support carers from minoritised demographics.
- ▶ Continue our work with Employers for Carers so UHSussex can move towards becoming a Carer Confident accredited organisation.
- ▶ Build on the success of the 2024 Carers Rights Day conference in the planning of the 2025 event.
- ▶ Continue to support our carer colleagues by providing a forum for their experiences as well as regularly providing seminars to offer information and support.
- ▶ Engage with managers and the Executive to promote a carer-friendly workplace.



10 – Carers Network: Dom Duke (Network Lead) and Maggie Davis (Chief Nurse) opening the Carers Rights Day 2024 Hybrid Conference



11 – Carers Network: Carers Rights Day 2024 Hybrid Conference Market Place and Break Room



12 – (left) Carers Network: Dom Duke and Tracy Cox-Horton at stalls for Carers Week 2024 at Royal Sussex County Hospital

13 – (right) Carers Network: Dom Duke and Rachel Potts (Carers Health Team, SCFT) at stalls for Carers Week 2024 at Princess Royal Hospital

HIA 2: Inclusive Talent (Carers)

Carer workforce representation

130 staff members were recorded as working carers in their ESR record as of 31 March 2025, representing 0.72% of the workforce. However, this figure likely under-represents the true number of carers, as only recently has the Trust started encouraging staff to record their caring status on ESR. Planned awareness campaigns from the Carers Network and data quality exercises aim to improve this information, which should give a clearer picture in future.

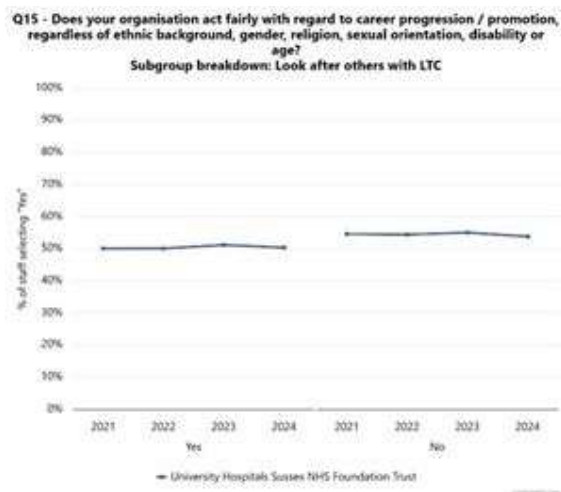
By comparison, in the 2024 NHS Staff Survey, responses were received from 2,328 (28.75%) staff who indicated looking after others with long-lasting health condition or illnesses (disabled), while 5,577 (68.89%) indicated they didn't.

This compares to 4.7 million people in England (8.15% of the population) who provide unpaid care (Census 2021, ONS).

Equality of opportunity for career progression / promotion (NSS – Q15)

Analysis of NHS Staff Survey responses shows little difference in perceptions of fairness in career progression between staff with and without caring responsibilities.

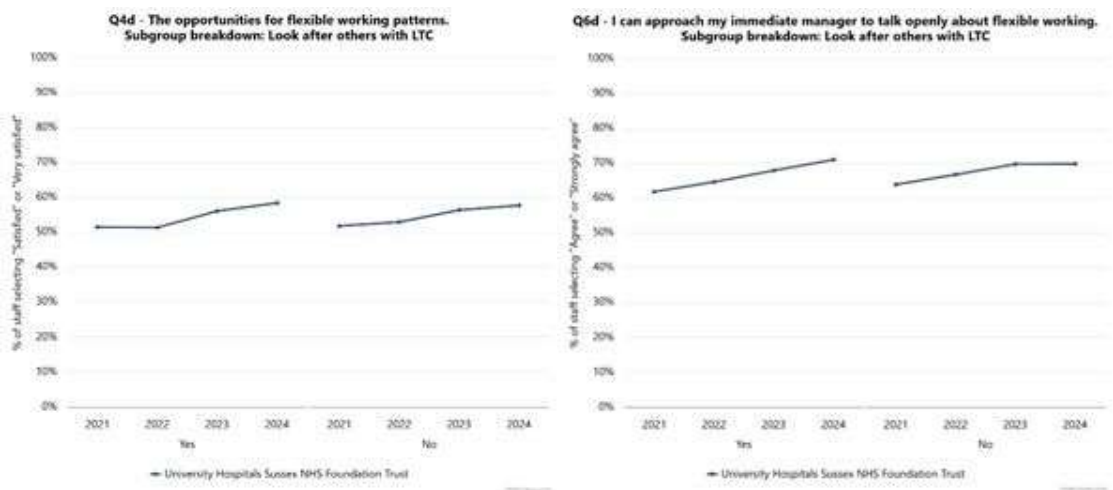
- ▶ 50.4% (of 2,312 respondents) staff with caring responsibilities agreed their organisation acts fairly on career progression, compared to 53.8% (of 5,524 respondents) staff without caring responsibilities.
- ▶ Agreement declined slightly for both groups since 2023.



Flexible working opportunities (NSS – Q4d; Q6d)

Analysis of NHS Staff Survey responses shows little difference in perceptions of flexible working between staff with and without caring responsibilities.

- ▶ 58.5% (of 2,344 respondents) carers and 57.8% (of 5,569 respondents) non-carers were satisfied with flexible working opportunities.
- ▶ 71.0% (of 2,341 respondents) carers felt able to approach their manager about flexible working, compared to 69.9% (of 5,573 respondents) non-carers.
- ▶ Both groups saw slight improvements since 2023.

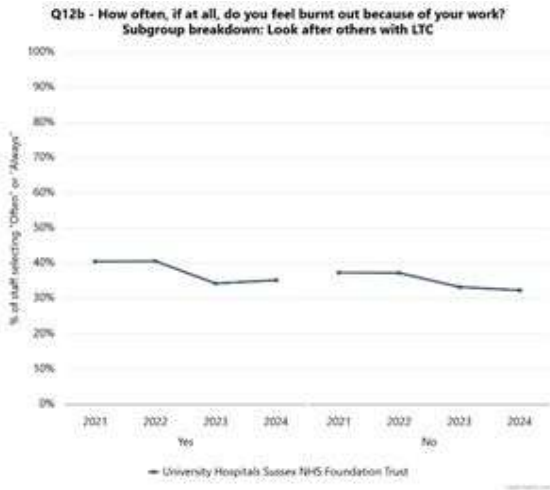


HIA 4: Workforce Health Inequalities (Carers)

Burnout (NSS – Q12b)

Analysis of NHS Staff Survey responses shows that staff with caring responsibilities reported slightly higher levels of burnout than those without.

- ▶ 35.3% (of 2,349 respondents) carers said they “often” or “always” feel burnt out, compared to 32.4% (of 5,597 respondents) non-carers.
- ▶ Burnout levels remained stable for both groups since 2023.



Positive action on health and wellbeing (NSS – Q11a)

Analysis of NHS Staff Survey responses shows little difference between carers and non-carers in perceptions of positive action on health and well-being.

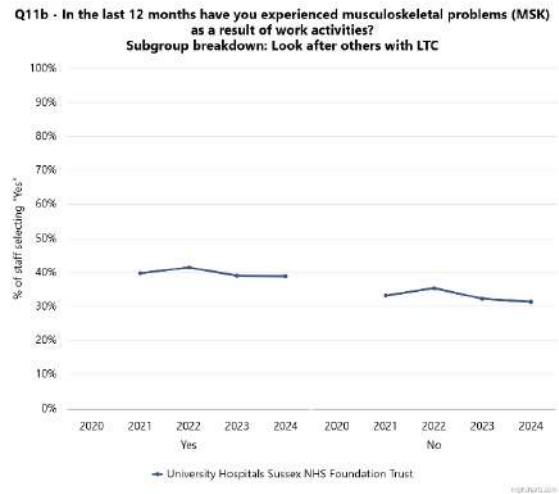
- ▶ 53.2% (of 2,328 respondents) carers agreed with the statement, compared to 51.3% (of 5,543 respondents) non-carers.
- ▶ Agreement increased slightly for carers since 2023, while levels remained stable for non-carers.



Musculoskeletal (MSK) problems (NSS – Q11b)

Analysis of NHS Staff Survey responses shows that staff with caring responsibilities reported higher levels of musculoskeletal (MSK) problems than those without caring responsibilities.

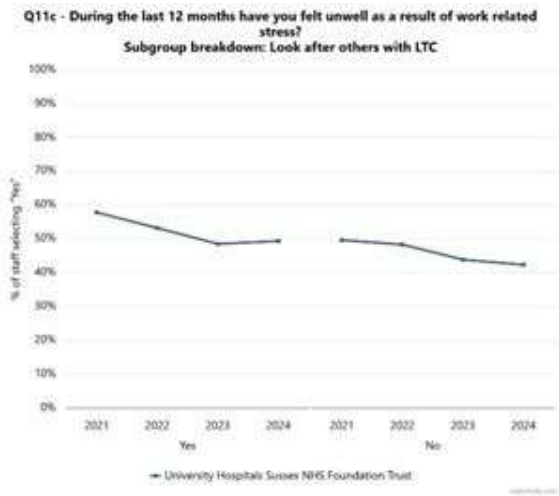
- ▶ 38.9% (of 2,338 respondents) carers reported MSK problems caused by work, compared to 31.4% (of 5,570 respondents) non-carers.
- ▶ These levels remained broadly stable for both groups since 2023.



Work related stress (NSS – Q11c)

Analysis of NHS Staff Survey responses shows that staff with caring responsibilities reported higher levels of feeling unwell due to work-related stress than those without caring responsibilities.

- ▶ 49.4% (of 2,340 respondents) carers reported feeling unwell, compared to 42.4% (of 5,560 respondents) non-carers.
- ▶ Stress levels remained stable for carers since 2023 but declined slightly for non-carers.



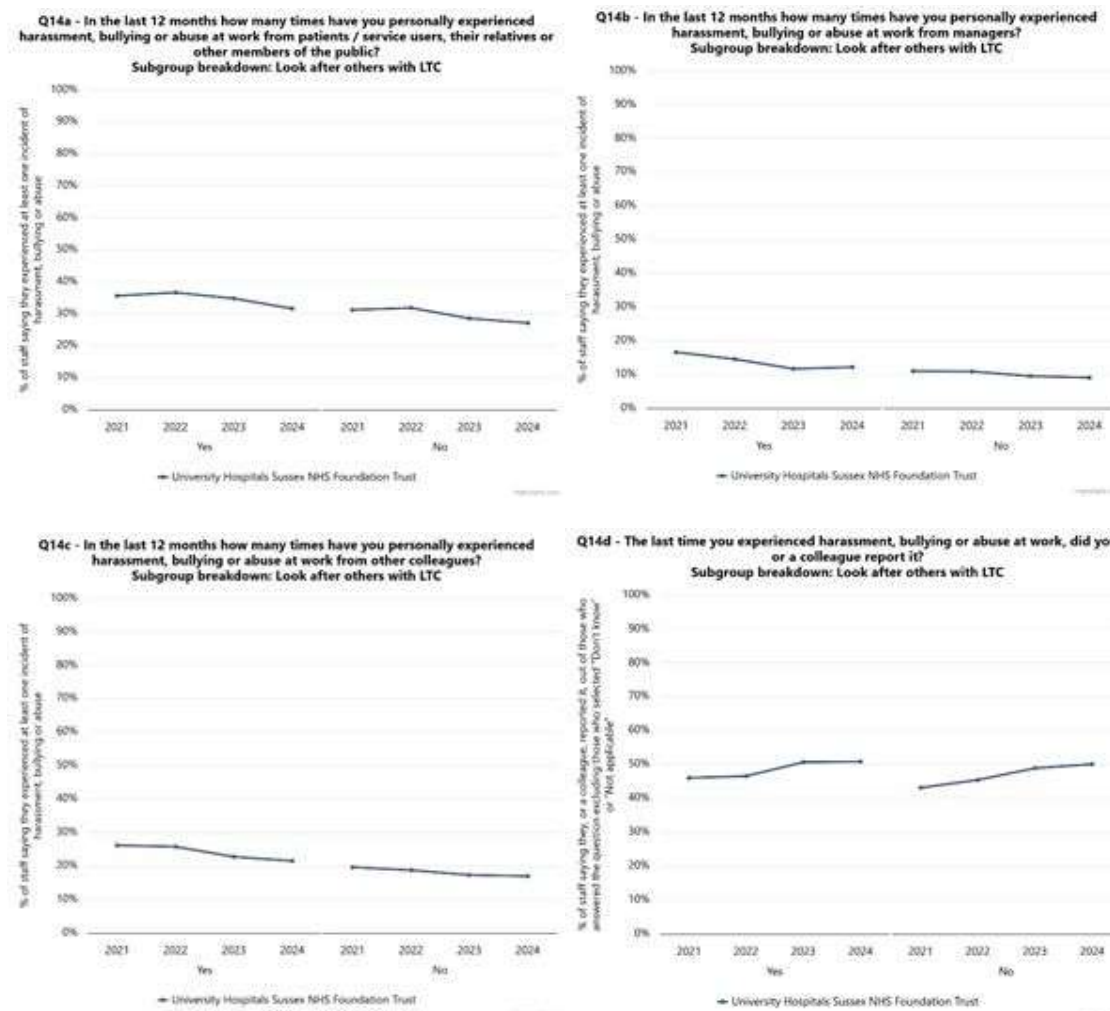
HIA 6: Eliminate Discrimination (Carers)

Harassment, bullying or abuse by gender (NSS – Q14a-d)

Analysis of NHS Staff Survey responses shows that staff with caring responsibilities reported slightly higher levels of harassment, bullying and abuse than those without caring responsibilities. However, both groups reported incidents at similar rates when they occurred.

- ▶ 31.6% (of 2,340 respondents) carers reported harassment, bullying or abuse from patients or the public, compared to 27.1% (of 5,586 respondents) non-carers.
- ▶ Carers also reported higher levels of harassment, bullying and abuse from managers (12.2% of 2,329 respondents, vs. 9.1% of 5,547 respondents) and colleagues (21.5% of 2,319 respondents, vs. 17.0% of 5,549 respondents).

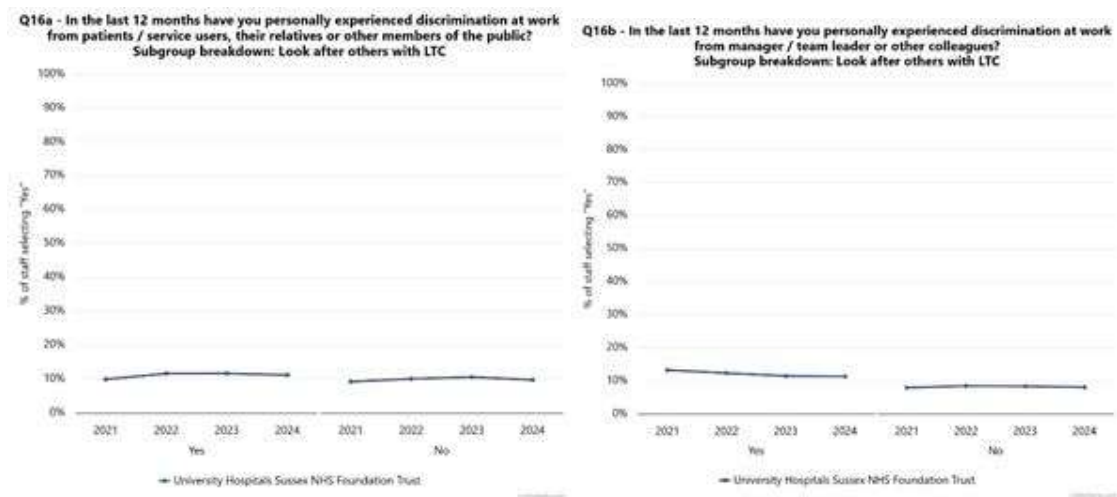
- ▶ Since 2023, levels declined slightly for both groups across all sources, except harassment from managers for carers, which rose marginally.
- ▶ In 2024, 50.9% (of 946 respondents) carers and 50.1% (of 1,940 respondents) non-carers said they or a colleague reported the last incident, with both groups showing small improvements since 2023.



Discrimination from managers or colleagues by gender (NSS – Q16a-b)

Analysis of NHS Staff Survey responses shows that staff with caring responsibilities reported slightly higher levels of discrimination than those without caring responsibilities.

- ▶ 11.2% (of 2,338 respondents) carers reported discrimination from patients or the public, compared to 9.8% (of 5,568 respondents) non-carers.
- ▶ Discrimination from managers or colleagues was also reported more often by carers (11.4% of 2,321 respondents) than non-carers (8.1% of 5,520 respondents).
- ▶ Levels have remained broadly stable for both groups since 2023.

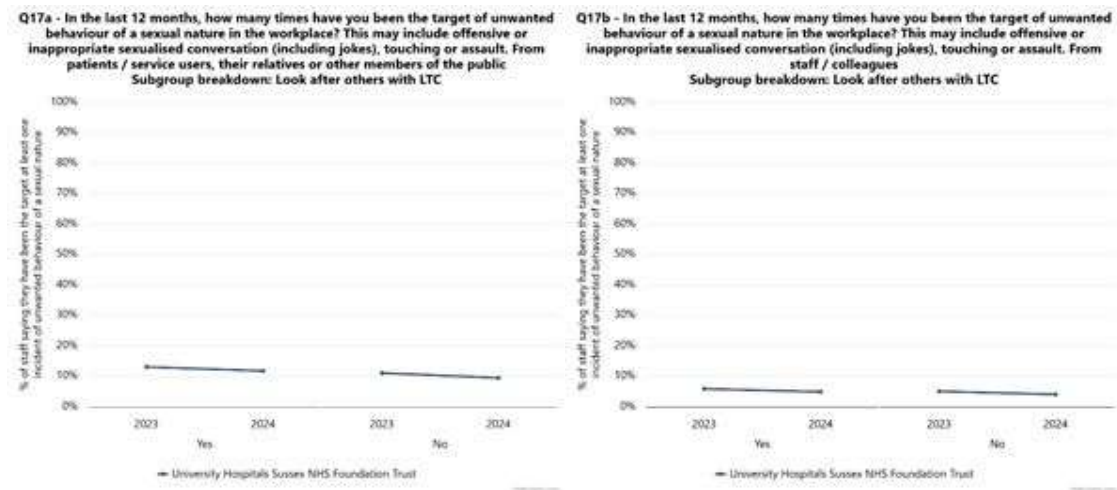


13.32% of staff with caring responsibilities who had experienced discrimination felt this was on the grounds of disability (428 respondents), compared to 7.84% of non-carers (816 respondents).

Sexual harassment by gender (NSS – Q17a-b)

Analysis of NHS Staff Survey responses shows little difference in reported levels of unwanted sexual behaviour between staff with and without caring responsibilities.

- ▶ 11.8% (of 2,349 respondents) carers reported unwanted sexual behaviour from patients or the public, compared to 9.5% (of 5,596 respondents) non-carers.
- ▶ Levels of unwanted sexual behaviour from colleagues were very similar for both groups (carers: 4.9% of 2,339 respondents; non-carers: 4.0% of 5,565 respondents).
- ▶ Both groups saw slight decreases since 2023.



8. Armed Forces

Staff Voice

The Trust has an [Armed Forces Community \(AFC\) Staff Network](#) sponsored by the Chief People Officer.

The priorities of the Armed Forces Community 20-month charity programme plan for 2025/26 include:

- ▶ Serving those who have Served: To create an NHS environment where military service is understood, valued and supported across all levels of healthcare delivery
- ▶ Re-engaging and expanding network membership
- ▶ Deliver clear network governance and consistent communications to network members
- ▶ Deliver an education programme to promote learning, member well-being and development needs
- ▶ Deliver a cultural Armed Forces engagement programme to celebrate Armed Forces diversity and foster cultural awareness



14 – (left) David Grantham and Vital Azambourg with wreaths laid in commemoration of Armistice Day at Southlands Hospital, Commemorative Gardens on the 11th November 2024.

15 – (right) Seaside Hospital Radio, League of Friends, UHSussex Armed Forces Community, Executive Sponsor, and Rev. Allison Becker in commemoration of Armistice Day at Southlands Hospital, Commemorative Gardens on the 11th November 2024.

Armed forces workforce representation

Forty staff members were recorded as Armed Forces Reservist, Veterans or Cadet Volunteers in their ESR record as of 31 March 2025, representing 0.22% of the

workforce. 33 staff members (0.18%) were recorded as family members of Armed Forces. However, this figure likely under-represents the true number of Armed Forces members, as only recently has the Trust started encouraging staff to record this on ESR. Planned awareness campaigns and data quality exercises aim to improve this information, which should give a clearer picture in future.

In comparison, 3.8% of the population in England and 4.2% in the South East who reported that they had previously served in the UK armed forces (Census 2021, ONS). Furthermore, on 1 January 2025, there were approximately 361,558 serving personnel across all branches, representing about 0.52% of the UK's population of roughly 69.86 million at that time.³

³ <https://www.gov.uk/government/statistics/quarterly-service-personnel-statistics-2025/quarterly-service-personnel-statistics-1-january-2025>

Appendices

Appendix 1: Technical Definitions

Compliance

This report complies with our regulatory duty to publish information about the performance of our statutory duty to advance equality (Equality Act 2010), including our duty to publish gender pay gap information. It also meets our contractual obligations relating to publishing information, including about the workforce race equality standard (WRES) and the workforce disability equality standard (WDES).

Privacy

The report does not publish counts of fewer than ten staff where someone might be identifiable, to preserve privacy, except where publication is a specific regulatory or contractual requirement (e.g. Board composition). Equality in employment is based on data from electronic staff records (ESR), employee relations case-trackers, the NHS Staff Survey (NSS) and the Trust's recruitment management system, TRAC.

Scope

Workers with a substantive assignment are counted in this report, and workers with bank-only assignments are excluded, except where indicated. Contractors, or staff on honorary contracts, or secondees, or shared appointees, or volunteers are also excluded. Non-executive directors (appointees) are counted, except associate non-executive directors (NEDs) who are included in Board counts, but not workforce counts.

Please note that very senior managers (VSM) counts do not follow the VSM pay framework and instead follow definitions laid down in technical reporting guidance published by NHS England.

Data quality

In 2024/25, the Trust undertook a range of activities to improve the quality and completeness of diversity data across the organisation:

- ▶ Board Engagement: Board members were encouraged to complete or update their personal characteristics (PC) data by March 2025.
- ▶ Staff Self-Service Campaign: All UHSussex staff were encouraged to review and update their equality and diversity information via ESR self-service. A targeted communication was sent to 2,780 substantive staff (15.55% of the substantive workforce) who were identified as having missing data for one or more protected characteristics.
- ▶ EDI Dashboard Development: The Trust continued to develop and roll out its Equality, Diversity and Inclusion (EDI) dashboards, releasing versions 3 to 5 during the year to improve access to diversity insights and support informed decision-making.

Disparity ratio

The disparity ratio is a summary measure of the representation of staff in a focal group (e.g. White) across different pay levels, compared with staff in a reference group (e.g. Black, Asian, and Minoritised Ethnic).

The Agenda for Change (AfC) workforce is considered at three levels: lower; middle; and upper. Three ratios of progression are measured between these levels. This is except for the AfC disabled workforce where there were instead four levels and correspondingly four progression ratios.

The Medical and Dental (M&D) workforce is considered at three levels: trainee; non-consultant career grade (NCCG); and consultant, with three progression ratios measured.

Shortlisting-to-appointment ratio

This is a measure of the representation of shortlistees from a focal group (e.g. White) being appointed in recruitment, compared with staff in a reference group (e.g. Black, Asian, and Minoritised Ethnic).

Only the shortlisting and appointment stages are considered, with one progression ratio measured between them.

Application stage data is presented alongside this ratio in this report only to help understand the context and is not considered in the way the metric is formulated.

Target range

A ratio of one indicates parity of progression – whether within recruitment or within career progression – although due to results being down to chance or another factor, a practical significance test, the "80% Rule", is applied so that a value falling anywhere between 0.8-1.25, is within the acceptable target range. This is referred to as the equality target range.

Any value greater than 1.25 shows a potential for disadvantage affecting staff in the reference group. Any value lower than 0.8 shows potential for disadvantage affecting staff in the focal group. That is not to say that figures falling outside of the target range prove discrimination or suggest disadvantage. They are a practical guide to what should be analysed further, such as statistical significance testing or Statistical Process Control Charts.

Ratings

Where there was year-on-year improvement in this report against relevant measures of workforce diversity, and current performance is outside of the target range, this is rated 'amber'. Where a relevant metric has declined year-on-year and is presently outside of the target range, this is rated 'red'. Where current performance is within the target range, or at the target value, this is rated 'green'.

Appendix 2: Gender Pay Gap Data

Gender Pay Gap proportion of males and females divided into four quartiles ordered from lowest to highest paid

Quartile	Gender	Number of employees	% of Employees
1 (lowest paid)	Female	3,180	69.80%
	Male	1,376	30.20%
2	Female	3,383	74.07%
	Male	1,184	25.93%
3	Female	3,642	79.73%
	Male	926	20.27%
4 (highest paid)	Female	2,818	61.70%
	Male	1,749	38.30%
Totals	Total female staff	13,023	71.33%
	Total male staff	5,235	28.67%

Gender Pay Gap mean and median Ordinary Pay Gap

Gender Hourly Pay Gap	Mean Hourly Pay			Median Hourly Pay		
	2023	2024	2025	2023	2024	2025
Male	22.26	24.01	25.85	16.84	18.10	19.25
Female	18.73	19.97	21.60	16.84	17.69	18.98
Difference	3.53	4.04	4.25	0.00	0.41	0.27
Pay Gap %	15.86%	16.83%	16.43%	0.00%	2.29%	1.40%

Gender Pay Gap mean and median Bonus Pay Gap

Gender Bonus Pay Gap	Average (Mean) Hourly Pay			Median Hourly Pay		
	2023	2024	2025	2023	2024	2025
Male	9,658.62	9,600.89	12,013.92	4,396.06	4,795.08	8,143.20
Female	6,157.81	6,591.38	8,078.33	4,396.06	4,795.08	3,015.97
Difference	3,500.80	3,009.51	3,935.59	0.00	0.00	5,127.23
Pay Gap %	36.25%	31.35%	32.76%	0.00%	0.00%	62.96%

Appendix 3: Ethnicity Pay Gap Data

Ethnicity Pay Gap proportion of white and minoritised ethnic groups divided into four quartiles ordered from lowest to highest paid

Quartile	Ethnic Group	Number of employees	% of Employees
1 (lowest paid)	Any white	3,571	78.38%
	Minoritised ethnicity	865	18.99%
2	Any white	2,878	63.02%
	Minoritised ethnicity	1,561	34.18%
3	Any white	2,970	65.03%
	Minoritised ethnicity	1,451	31.77%
4 (highest paid)	Any white	3,122	68.36%
	Minoritised ethnicity	1,172	25.66%
Totals	Total white staff	12,541	68.69%
	Total minoritised ethnicity staff	5,049	27.66%

Ethnicity Pay Gap mean and median Ordinary Pay Gap

Ethnicity Ordinary Pay Gap	Average (Mean) Hourly Pay		Median Hourly Pay	
	2024	2025	2024	2025
Asian	£21.67	£23.25	£18.10	£19.42
Black	£20.11	£21.14	£17.62	£17.81
Mixed	£21.91	£23.74	£18.10	£18.95
NULL	£23.19	£32.39	£20.62	£27.49
Not Stated	£24.18	£27.55	£19.73	£22.86
Other	£22.43	£24.65	£19.18	£20.83
White British	£20.77	£22.36	£17.68	£18.75
White Other	£20.92	£22.87	£17.42	£18.66

Ethnicity Pay Gap mean and median Bonus Pay Gap

Ethnicity Bonus Pay Gap	Average (Mean) Hourly Pay		Median Hourly Pay	
	2024	2025	2024	2025
Asian	£7,079.49	£10,194.50	£4,795.08	£5,000.00
Black	£6,809.96	£11,248.80	£4,795.08	£5,730.44
Mixed	£5,302.87	£3,015.96	£4,795.08	£3,015.96
NULL	N/A	£234.58	N/A	£234.58
Not Stated	£6,846.37	£10,479.99	£4,795.08	£6,596.59
Other	£7,209.58	£15,381.62	£4,795.08	£18,096.00
White British	£9,218.43	£10,615.88	£4,795.08	£6,032.04
White Other	£7,434.59	£10,625.02	£4,795.08	£6,226.30

Appendix 4: Equality Delivery System (EDS) Grades 2025

Domain 2: Workforce health and well-being

Outcome	Evidence	Rating	Owner (Dept/Lead)
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• Burnout (NSS – Q12b) • Positive action on health and wellbeing (NSS – Q11a) • Musculoskeletal (MSK) problems (NSS – Q11b) • Work related stress (NSS – Q11c) • Pressure to work from manager when unwell (NSS – Q11e; WDES 6) • Adequate adjustments for disabled people (NSS – Q31b; WDES 8)	2	CPO
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• Harassment, bullying or abuse (NSS) • Discrimination from managers (NSS) • Sexual harassment (NSS) • Disciplinary and capability (Employee Relations) • Raising Concerns	2	CPO
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• Staff networks • Freedom to Speak Up / Raising Concerns data • NHS Staff Survey • Due Regard Assessments (DRA)	2	CPO
2D: Staff recommend the organisation as a place to work and receive treatment	NHS Staff Survey: • I would recommend my organisation as a place to work • If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	1	CPO
Domain 2: Workforce health and well-being overall rating		7	

Domain 3: Inclusive leadership

Outcome	Evidence	Rating	Owner (Dept/Lead)
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Staff voice • Network sponsorships • Executive Briefing • Due Regard Assessments	2	Board
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• Due Regard Assessments • Public Board papers	1	Board
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• Workforce Inclusion Plan • Inclusion Dashboard • Workforce Equality Standards Report • Annual Equality Report	2	Board
Domain 3: Inclusive leadership overall rating		4	

Please note domain 1: Commissioned or provided services is unscored.

EDS Organisation Rating (overall rating):	12	Developing

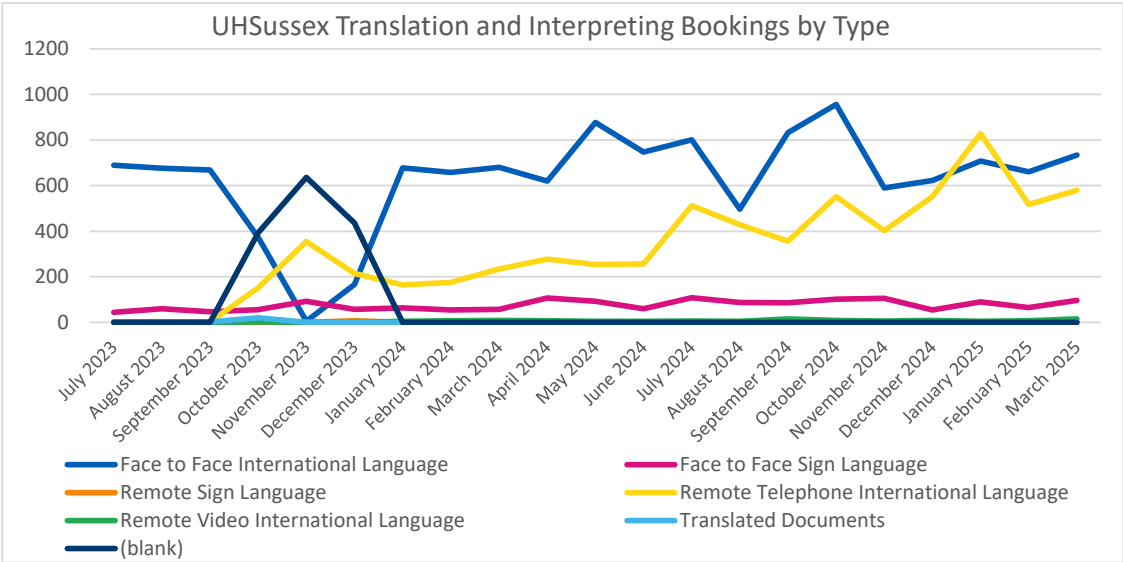
Key: A score under 8, is rated *Undeveloped*. Between 8 and 21, is rated *Developing*. Between 22 and 32, is rated *Achieving*. A score of 33, is rated *Excelling*.

Appendix 5: Interpreting and Translation

The following data covers the financial year 2024–2025 (April 2024 to March 2025). As no data was available for the first quarter of the previous financial year (April to June 2023), direct year-on-year comparisons are not possible. However, where available, data from June 2023 onwards has been included to support a more comprehensive review.

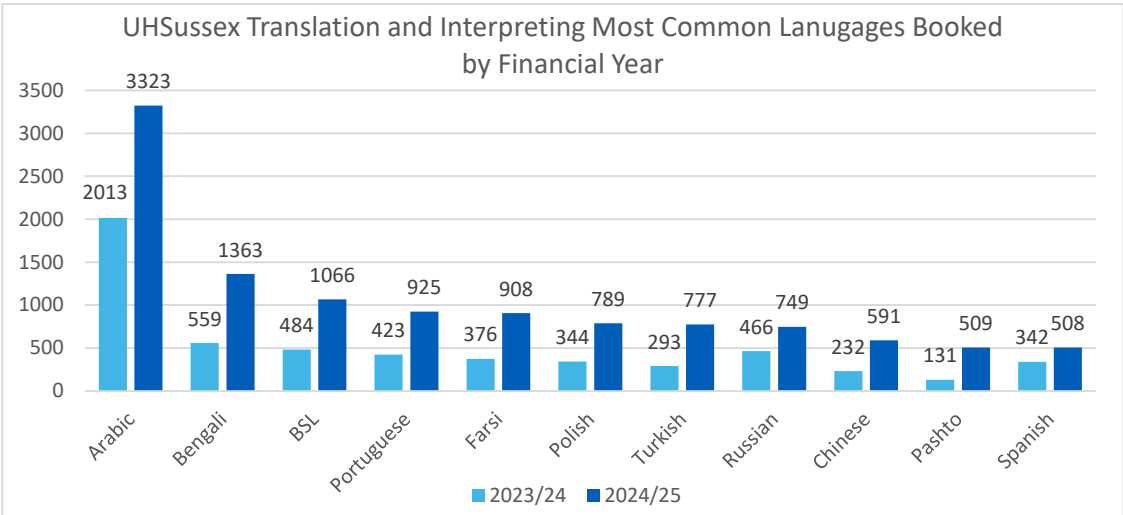
Service type

Face-to-face international language interpreting remains the most used service. However, there has been a significant increase in remote telephone bookings for international languages.



Languages

The most booked languages are shown in the graph below. In 2024/25, the highest number of translation and interpreting bookings were for Arabic, Bengali, and British Sign Language (BSL) – consistent with the top languages recorded in 2023/24.



Appendix 6: Alignment Key

The equality indicators referenced in this report are aligned with the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES), the National Staff Survey (NSS), and the High Impact Actions (HIAs) outlined in the national NHS Equality, Diversity and Inclusion Improvement Plan. For ease of reference, these indicators are summarised below.

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To: Board via the Audit Committee

Date: September 2025

From: Chair of the Audit Committee

Agenda Item: 18

FOR ENDORSEMENT

ANNUAL REPORT FROM THE AUDIT COMMITTEE TO THE BOARD 2024-25

1.0 INTRODUCTION

- 1.01 The purpose of this report is to formally report to the Board on the work of the Audit Committee during the period 1 April 2024 to 31 March 2025 and to set out how the Committee has met its terms of reference and key priorities.
- 1.02 The Audit Committee's Terms of Reference require it to report annually to the Board outlining the work it has undertaken during the year and where necessary, highlighting any areas of concern.

2.00 EXECUTIVE SUMMARY

- 2.01 The Audit Committee has the delegated authority to act on behalf of the Board in accordance with the Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation. It follows best practice guidance as set out in the NHS Audit Committee Handbook providing a form of independent check upon the management of the Trust.
- 2.02 The Committee is responsible for providing assurance to the Board that appropriate systems of internal control and risk management are in place covering all corporate and clinical areas of the Trust. In carrying out this work the Audit Committee obtains assurance from the work of the Internal Audit, External Audit and Counter Fraud Services.
- 2.03 The Committee independently reviews, monitors, and reports to the Board on the attainment of effective control systems and financial reporting processes supported by assurance from Internal Audit, External Audit, the Local Counter Fraud Service and Management through the BAF.
- 2.04 The Committee reviews the financial year-end Annual Report, Annual Accounts and Annual Governance Statement with the External Auditor prior to Board approval and sign off.
- 2.05 The Committee continues to drive forward developments to the structure of the Trust's Board Assurance Framework to better support the work of each Board Committee with their assurance reporting to the Board.
- 2.06 The Audit Committee through the membership of the respective Committee Chairs has been able to note the continuation of a regular risk review of the risks pertinent to each individual Board Committee, during their Board Committee meetings.
- 2.07 The Audit Committee was presented with a clear Internal Audit plan that was aligned to the Trust's Board Assurance Framework.
- 2.08 The Audit Committee over 2024/25 has engaged with the Company Secretary to continue to enhance the format of the Board Assurance Framework to be clear on the impact of actions of the current risk scores and the development of an in-year target risk score to allow for better focusing of attention on those risk outside the yearly target score.

3.00 COMMITTEE MEMBERSHIP AND MEETINGS

- 3.01 The Audit Committee comprises solely of independent Non-Executive Directors in line with the Code of Governance for Foundation Trusts. There are five Non-Executive Directors who are allocated to the Committee although all Non-Executive Directors, except for the Chair who attends by invitation only, can attend the meetings.
- 3.02 The Audit Committee, who play a pivotal role in providing assurance over the risk management processes of the Trust, has a membership of only Non-Executive Directors. Through the Non-Executive Chairs and the Audit Committee membership the Committee works with the other Board Committees to allow them to challenge robustly the Trust's management of risk and through the BAF that the Committees each seek reasonable assurance over the adequacy of the respective controls.
- 3.03 In order to share learning and to ensure linkages are made across Trust Committees the membership of the Audit Committee includes the Chair of the Patient & Quality Assurance Committee (Lucy Bloem), the Chair of the People & Culture Assurance Committee (Paul Layzell), the Chair of the Research, Innovation & Digital Strategy Assurance Committee (Jackie Cassell), the Chair of the Finance & Performance Assurance Committee (Philip Hogan).
- 3.04 The Chief Financial Officer, Chief Governance Officer (up to 31 January 2025), Director of Finance, Company Secretary, Local Counter Fraud Services, Internal and External Auditors are regular attendees at meetings of the Committee. Other Executives and Senior Managers also attend Committee meetings for specific items at the Committee's request usually linked to Internal Audit activity.
- 3.05 The table below details the membership and attendance of Committee members in respect of the period 1 April 2024 to 31 March 2025.

Audit Committee	
Total number of meetings in the year	5
Alan McCarthy MBE DL (until 30.06.24) Trust Chairman	n/a
Phillipa Slinger (from 01.07.24) Trust Chair	n/a
Paul Layzell Deputy Chair, Non-Executive Director	5 of 5 100%
Lucy Bloem Non-Executive Director	3 of 5 60%
Professor Jackie Cassell Non-Executive Director	5 of 5 100%
David Curley Non-Executive Director	5 of 5 100%
Professor Gordon Ferns (from 01.08.24) Non-Executive Director	n/a
Philip Hogan Non-Executive Director	3 of 4 75%
Wayne Orr Non-Executive Director	n/a
Lizzie Peers (until 10.05.24) Non-Executive Director	1 of 1 100%
Malcom Reed (until 31.07.24) Non-Executive Director	n/a
Bindesh Shah Non-Executive Director	n/a
Executives	

Audit Committee	
Dr George Findlay Chief Executive	n/a
Dr Andy Heeps Deputy Chief Executive & Chief Operating Officer	Attends
Dr Maggie Davies Chief Nurse	n/a
Sandi Drewett Chief Culture & Organisational Development Officer	n/a
Karen Geoghegan Chief Financial Officer (until 19.05.24)	Attends
David Grantham Chief People Officer	n/a
Darren Grayson Chief Governance Officer (until 31.01.25)	Attends
Nigel Kee Chief Operating Officer (from 10.03.25)	n/a
Jonathan Reid Chief Financial Officer (from 01.11.24)	Attends
Roxanne Smith Chief Strategy Officer	n/a
Clare Stafford Interim Chief Financial Officer (from 20.05.24 until 31.10.24)	Attends
Professor Catherine "Katie" Urch Chief Medical Officer	n/a

4.00 CYCLE OF BUSINESS

- 4.01 The Audit Committee agenda is based upon an agreed forward work plan which is reviewed and approved at the start of the financial year.
- 4.02 Internal Audit activity is agreed jointly by both the Executive and the Non-Executive Committee members at the start of the year and are focused on areas of perceived highest risk alongside those required by the Head of Internal Audit to formulate his opinion. The Audit Committee receives the reports of these Internal Audits and tracks the implementation of recommendations at each of its meetings.
- 4.03 In order to maintain independent channels of communication, the Chair of the Audit Committee holds a private meeting collectively with External Audit, Internal Audit and Counter Fraud throughout the year. This provides all parties the opportunity to raise any issues without the presence of management.
- 4.04 The Committee followed its agreed annual work plan throughout the year and received a series of executive presentations around Internal Audit, External Audit and Local Counter Fraud Services and dedicated additional time at each meeting to scrutinise in detail the Board Assurance Framework, Corporate Risk Register and Risk Management Compliance.

5.00 INTERNAL AUDIT

- 5.01 Internal audit provide an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives.
- 5.02 The Trust's Internal Auditor for the year was BDO. In January 2024 the Committee discussed the outline the approach for the appointment of the Internal Auditor for the 3-year period commencing 01

July 2024. The recommended approach was to use an existing framework agreement to make the appointment, with the planned timing of the invitation to tender procurement process due to commence in January 2024, with the responses expected by February 2024, with the evaluation process being concluded by March 2024, with a view to making an appointment recommendation to the April 2024 Audit Committee meeting. The Committee endorsed the recommended approach for the appointment of the Internal Auditor for 3 years from 01 July 2024.

- 5.03 The Internal Audit plan for 2024/25 was approved by the Audit Committee in July 2024. Performance against the approved plan is attached as Appendix A. The plan was based upon discussions held with management and the Audit Committee and was constructed in such a way as to gain a level of assurance on the main financial and management systems reviewed.
- 5.04 The Head of Internal Audit presents a progress report to each of the Committee's meetings. The report sets out progress against the agreed audit plan, and the principal outcomes from audits completed in the period since the previous meeting. The Committee also receives a summary of all reports together with the full report of any audit with a below Moderate Assurance rating.
- 5.05 During the year the Audit Committee received 8* (3 in draft to July 25) finalised Internal Audit reports, with those in draft and in progress being carried forward to 2025/26. Internal Audit Reports comprise two Assurance ratings; one relates to the Design of the system being reviewed whilst the other relates to the Effectiveness of the system being reviewed. Internal Audit can provide Assurance Levels of: 'substantial', 'moderate', 'limited' or 'no' assurance. Of the audits relevant to this period four* received an assurance level of either substantial or moderate, whilst two* received an assurance level of limited. One [or two, see below?] of the Audit Reports was advisory in their nature and did not have an assurance rating. However, the Head of Internal Audit reflected in his opinion that UHSussex has, "a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently."
- 5.06 Based on work undertaken during the period of this report the Head of Internal Audit has stated in his Head of Internal Audit Opinion that "Overall, we provide Moderate Assurance that there is a sound system of internal controls, designed to meet the Trust's objectives, that controls are being applied consistently across various services".
- 5.07 Internal Audit completed a total of seven reviews (six assurance audits and two advisory reviews [is this eight?]). The advisory reviews related to Maternity Incentive Scheme Year 6 and the Data Security Protection Toolkit and did not carry an opinion. For the six assurance audits, none were rated substantial, 67% moderate and 33% limited in the design of the controls. This is similar to the prior year when 22% were rated substantial, 67% moderate and 11% limited in the design of the controls. For the six assurance audits, none were rated substantial, 67% moderate and 33% limited in their operational effectiveness. This is similar to the prior year when 11% were rated substantial, 56% moderate and 33% limited in operational effectiveness. The seven reports for the year to date resulted in a total of 25 recommendations (High: 16%, Medium: 52% and Low: 32%), compared to the year before (High: 15%, Medium: 63% and Low: 22%). The Trust performed satisfactorily in implementing audit recommendations within the specified timeframes. As at the end of May 2025, there were 3 recommendations in progress (Medium: [3]) and 5 recommendations overdue (High: 2, Medium: 3). As is the case across the NHS, the Trust has faced significant financial and operational challenges during the year. As is the case across the NHS, the Trust has faced significant financial and operational challenges during the year. It has reported a deficit of £30m for the year, compared to its £15m deficit in 2023/24.

6.00 LOCAL COUNTER FRAUD SERVICE (LCFS)

- 6.01 The Counter Fraud service is provided by an external provider RSM, who report quarterly to the Committee. The team is responsible for day-to-day awareness and activities. The quarterly reports describe proactive work to prevent or deter fraud and also set out the results of reactive work undertaken in response to referrals about suspected fraud.

- 6.02 A work plan for 2024/25 was agreed with the Finance Director and approved at the Audit Committee in April 2024. The work plan outlined the core Local Counter Fraud Specialist (LCFS) activities to be undertaken during the financial year within the agreed resources. Key activities undertaken include areas of strategic governance, inform, and involve, prevent and deter and hold to account.
- 6.03 During the year the LCFS participated in a number of proactive projects to prevent or detect fraud. The LCFS also advised on improvements to policies and procedures, to reduce the risk of fraud.
- 6.04 The Local Counter Fraud Specialist reports annually on behalf of the Trust and has not identified any significant control weaknesses during their work. Where improvements have been identified then, similar to Internal Audit they make recommendations and the delivery of these is tracked and reported to the Audit Committee.

7.00 BOARD ASSURANCE FRAMEWORK

- 7.01 The Committee continues to drive forward developments to the structure of the Trust's Board Assurance Framework to better support the work of each Board Committee with their assurance reporting to the Board.
- 7.02 During the course of the year the Committee continued to dedicate a substantial amount of focus on ensuring that the BAF was used to structure the assurances that the Committee sought through its meetings. In conjunction with the BAF the Committee received the Risk Management Compliance report, supported by the newly formed Risk Oversight Group which further corroborated the reporting and assurances received through the BAF.
- 7.03 The Audit Committee over 2024/25 has engaged with the Company Secretary to enhance the format of the Board Assurance Framework to make clearer the impact of actions of the current risk scores and the development of an in-year target risk score to allow for better focusing of attention on those risk outside the yearly target score.

8.00 YEAR END REPORTING

- 8.01 The Committee reviewed and approved the Annual Report and Accounts and the Annual Governance Statement allowing the Audit Committee members to be appropriately engaged in the preparation of the Annual Report and Accounts.
- 8.02 The Committee also received information from the Chief Financial Officer that enabled the Committee to be assured that there were no matters that had not been disclosed to the Auditors.
- 8.03 The Committee received a report on the Trust's processes for registering declarations of interest, the receipt of gifts, hospitality, and sponsorship along with the compliance with the fit and proper persons' regime. The Committee was informed that no Board Member had declared any significant commitments that require disclosure or any management actions. In line with the standard contract for NHS Services each Trust is required to report on the level of staff required to make an annual declaration that have made such a declaration. For 2024/25 1281 of 1344 (95%) of the required staff made their declaration recognising that the majority of staff made a nil return. Of those who did not provide a return none have any budgetary responsibilities.
- 8.04 The submission of the 2024/25 Accounts and Annual Report took place on the 27 June 2025. This was in line with the national timetable.

9.00 EXTERNAL AUDIT

- 9.01 External Audit report to the Trust on the findings from their audit work, in particular their review of the financial statements and the Trust's economy, efficiency, and effectiveness in its use of resources.

- 9.02 Grant Thornton reported quarterly to the Committee. These reports included approval of the approach to the audit of the financial statements. The table below summarises the key elements of external audit work undertaken during the year:

Area of Work	Conclusion
Opinion on the Trust's:	
Financial statements	Unqualified opinion – Grant Thornton completed their audit of the financial statements and issued an unqualified audit opinion on 25 June 2025, following the Audit Committee meeting on 18 June 2025.
Parts of the remuneration and staff report to be audited	Grant Thornton were required to give an opinion on whether the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the requirements of the Act, directed by the Secretary of State with the consent of the Treasury. Elements of the Remuneration Report and Staff Report, including the Fair Pay Multiple Disclosures, as required by the Code, and there were no matters to report.
Consistency of the annual report and other information published with the financial statements	Grant Thornton were required to give an opinion on whether the other information published together with the audited financial statements (including the Annual Report), was materially inconsistent with the financial statements or their knowledge obtained in the audit or otherwise appears to be materially misstated. Minor inconsistencies were identified between a few figures in the Annual Report and the financial statements, but these have been corrected by management. They issued an unmodified opinion in this respect.
Reports by exception:	
Value for money arrangements	For 2024/25 within the Value for Money Conclusion Grant Thornton provided a conclusion within three areas these being financial sustainability, governance and improving economy, efficiency, and effectiveness.
Consistency of Annual Governance Statement	Grant Thornton had nothing further to report in this regard.
Referrals to the NHS Regulator	Grant Thornton have not referred any issues to the NHS Regulator for UHSussex.
Public interest report and other auditor's powers	Grant Thornton have not issued a Public Interest Report
Reporting to the Trust on their consolidation schedules	Grant Thornton concluded that the Trust's consolidation schedules agreed to the Trust's audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	Grant Thornton had nothing to report in this regard.

- 9.03 It is normal practice for there to be a full debrief to the Audit Committee following the submission of the year-end accounts. The Audit Committee noted the positive engagement and the pragmatic approach to completing the audit.

10.00 Reporting to the Trust Board

Audit Committee Annual Report
September 2025

10.01 The Committee reported to the Trust Board after each meeting. A summary of the key points of discussion at each meeting, for example highlights of the internal audit reports or any formal recommendations were provided to the Board.

11.00 Engagement with the Council of Governors

11.01 The Chair of the Audit Committee is scheduled to report to the Council of Governors on the work of this Committee and the engagement made by External Audit. This reporting supported the Governors discharge their responsibility for the appointment of the Trust's External Auditors.

12.00 Conclusion

12.01 The Audit Committee of University Hospitals Sussex NHS Foundation Trust is of the view that it has taken appropriate steps to perform its duties as delegated by the Board and it has no cause to raise any issues of significant concern with the Board arising from its work during 2024/25.

12.02 In making this statement, the Committee members acknowledge the support given to it by management, in particular the Chief Financial Officer, Chief Governance Officer (to January 2025), the Director of Finance, and the Company Secretary, and that given by the internal and external auditors along with the local counter fraud specialist.

12.03 During 2025/26, the Committee will continue to drive forward the risk management and board assurance agenda continuing the extended time being devoted within the Committee to the review of the impact of the actions to the Trust's strategic risks. Through the Audit Committee membership, the Committee will continue to use the inter committee referral processes to drive the respective Board Committee's ability to provide strengthened assurance to the Board on the Trust's risk profile. This will be supported through the introduction of a call in / deep dive in respect of strategic risks not progressing to the 31 March target scores, allowing the Board to better understand where risk outside the Board appetite is identified.

12.04 In their annual report for 2024/25, Grant Thornton made recommendations in respect of addressing both the significant weaknesses and it had been noted by the Audit Committee regarding the management actions agreed to. The Audit Committee whilst it would be receiving an update on the progress being made with the specific recommendations, the Board should also be seeking views from the respective Committee Chairs as to the assurance they are receiving in their committees showing the outcome of the management actions agreed are reducing the identified risks.

13.00 Recommendation

13.01 The Committee is asked to:

- **Endorse** that this Annual Report be provided to the Board

David Curley
Chair of the Audit Committee
July 2025

APPENDIX A: INTERNAL AUDIT OPERATIONAL PLAN 2024/25 (extract of Internal Audit activity from the IA operational report)

AREA	DAYS	BAF	TIMING	DESCRIPTION OF REVIEW	REASON FOR INCLUSION	RESPONSIBLE DIRECTORS
Core assurance						
Business Continuity Planning (EPRR)	20	4.1	Q2	The purpose of the audit is to provide assurance on the Trust's emergency planning resilience; specifically the audit will focus on the adequacy of business continuity planning on a Trust-wide basis	Under the Civil Contingencies Act 2004 and the Health and Care Act 2022, all NHS organisations have a duty to put in place continuity arrangements. It is understood that the ICB may request an accredited audit as opposed to peer review as occurred previously.	Chief Operating Officer - Andy Heeps Managing Director Unscheduled Care - Siobhan Murray Managing Director Scheduled Care - Huw Edwards
Divisional Finance Controls	20	2.1	Q2	To review the adequacy of financial controls at Divisional level and how this is managed and reported on. As part of the review we will review the identification, delivery and reporting of CIP to assess the adequacy of the Divisional processes in place.	This is a key area that impacts the Trust's overall financial performance. Required for Head of Internal Audit Opinion	Interim Chief Financial Officer - Clare Stafford Interim Director of Finance - Alison Ingoe
Data Quality	30	5.2	Q2	To review the timeliness and accuracy of performance data at an operational level and compliance with the Trust's Policy. We will cover the Trust's Emergency Department Access Standards in Year 1.	The performance information is used by Executives to make decisions therefore data must be accurate and up to date to ensure the most appropriate decisions are made.	Chief Operating Officer - Andy Heeps Managing Director Unscheduled Care - Siobhan Murray

AREA	DAYS	BAF	TIMING	DESCRIPTION OF REVIEW	REASON FOR INCLUSION	RESPONSIBLE DIRECTORS
						Director of Performance and Information - James Eaton
Fit & Proper Person Regulation (FPPR) Checks	20	3.1	Q3	Review the Trust's processes and procedures for fit and proper person regulation checks.	CQC may hold NHS Trusts to account for any breaches of the FPPR requirements.	Chief People Officer - David Grantham Director of Workforce Planning and Deployment -David Vincent
Key Financial Systems	25	2.1	Q3	Cyclical review of key systems and controls to provide assurance on the core financial controls in place. Coverage to be agreed annually with the Director of Finance.	Required for Head of Internal Audit Opinion.	Interim Chief Financial Officer - Clare Stafford Interim Director of Finance - Alison Ingoe
Maternity Incentive Scheme Year 6	20	1.1	Q3	We will work with the Trust to ensure systems and processes are in place for the Year 6 submission to capture the required evidence, prior to the 2025 submission date.	Key area of reputational risk to the Trust. Failure to achieve all 10 Safety Actions can result in the lack of access to significant MIS funding.	Chief Nurse - Maggie Davies Director of Midwifery - Emma Chambers
Data Security and Protection Toolkit	20	6.2	Q4	The purpose of this audit is to provide an independent high-level review of the assertions and evidence items in the DSP Toolkit self-assessment return and to identify how compliance could be improved for the year-end returns.	Mandated by NHS Digital and required for Head of Internal Audit Opinion.	Chief Strategy Officer - Roxanne Smith Chief Information Officer - Cara Wiliams
TOTAL	155					

AREA	DAYS	BAF	TIMING	DESCRIPTION OF REVIEW	REASON FOR INCLUSION	RESPONSIBLE CORPORATE AND MANAGING DIRECTOR
Soft controls						
RMN Specialling	20	2.1	Q2	To ensure the adequacy of identification, booking and reporting processes in and out of hours for patients requiring 1:1 observation (specialling) from a Registered Mental Health Nurse (RMN) following risk assessment.	Area of significant financial cost pressure.	Chief Nurse - Maggie Davies Directors of Nursing
Risk Management	25	3.2	Q3	The purpose of the BDO Risk Maturity Assessment is to help ensure an effective risk management culture becomes embedded across the Trust, by highlighting areas where processes could be improved.	The Trust are currently finalising their updated BAF, with significant engagement with divisions to strength risk management processes.	Chief Governance Officer - Darren Grayson Company Secretary - Glen Palethorpe
Mental Health Act Compliance	20	4.2	Q4	The purpose of the audit is to review the Trust's compliance with the Mental Health Act and provide assurance over the administrative and governance practices that are adhered to across the Trust.	Risk highlighted by CQC and is a key area being considered across our client base.	Chief Nurse - Maggie Davies Deputy Chief Nurse of Quality - Jane Wollard
Cultural Maturity	25	3.2	Q3	The purpose of this review is to give an assessment of whether the organisational values are fully in evidence in business decisions and operations and incorporated in key processes including governance, communication, recruitment, induction, training, performance management and reward structures. We will also consider how processes of an	Requested by the Executive Directors. This innovative tool allows the Trust to gain a further level of insight into how the organisation is perceived both internally and externally. It is	Chief People Officer - David Grantham Director of Workforce Planning

AREA	DAYS	BAF	TIMING	DESCRIPTION OF REVIEW	REASON FOR INCLUSION	RESPONSIBLE CORPORATE AND MANAGING DIRECTOR
				appropriately governed culture support the performance of employees and the overall organisation.	an important metric to ensuring the right tone is set within the organisation which is a vital component in ensuring the effectiveness of internal controls. We will utilise 'The Culture of Care Barometer' which is designed to help organisations measure the culture of care they provide and explore certain areas of culture in greater depth.	and Deployment - David Vincent
TOTAL	90					

AREA	DAYS	BAF	TIMING	DESCRIPTION OF REVIEW	REASON FOR INCLUSION	RESPONSIBLE CORPORATE AND MANAGING DIRECTOR
Future focussed assurance						
Trust Quality Scorecards and Quality & Safety Governance	30	4.1	Q3	This review will provide assurance that quality scorecards are derived from consistent and accurate feeder score cards to ensure the Trust receives appropriate assurance over quality and safety delivery. In addition a review of the adequacy and completeness of quality and safety governance reporting arrangements to provide assurance that they are in place and operating in line with Trust expectations from directorates up to QGSG.	Ensure that the Trust are focusing on the key metrics and that targeted escalation reporting is in place for assurance and decision-making. The feeder score cards are important as they are meant to escalate key metrics that are not compliant and moving in wrong direction Provide assurance over completeness and adequacy of quality governance reporting arrangements.	Chief Nurse - Maggie Davies Chief Medical Officer - Katie Urch Deputy Chief Nurse of Quality - Jane Wollard Or Director of Performance and Information - James Eaton
TOTAL	30					

AREA	DAYS	TIMING	DESCRIPTION OF REVIEW	REASON FOR INCLUSION	RESPONSIBLE DIRECTOR
Flexible audit resource - To be allocated during the year as required but could include the examples shown below					
Time to be allocated during the year	40	Q1 - Q4	Will be discussed and agreed throughout the year. Examples could include: • Strategic risk and work programmes • Preparation for or response to CQC inspections • Response to recent Synnovis Cyber Attack • Advice on system implementation • Benefits Realisation	Gives the Executive Team and the Audit Committee the flexibility to respond to emerging risks or issues that may require urgent attention.	Interim Chief Financial Officer - Clare Stafford Interim Director of Finance - Alison Ingoe
TOTAL	40				

AREA	DAYS	TIMING	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION
Contract management				
Planning / liaison / management / contingency	20	Q1 - Q4	Creation of audit plan, meeting with Corporate, Managing and Executive Directors. Contingency to assist with any emerging risks	Effective contract management
Recommendations follow up	20	Q1 - Q4	Assessment and reporting of status of implementation of recommendations raised	Assurance for Executive Directors and Audit Committee
Audit Committees	15	Q1 - Q4	Attendance at Audit Committee meetings, pre-meets and Audit Committee Chair liaison	Effective contract management
TOTAL	55			
PLAN TOTAL	370			