University Hospitals Sussex NHS Foundation Trust

Meeting of the Board of Directors

10:00 to 13:30 on Thursday 05 February 2026

Washington Suite Boardroom, 2nd Floor, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH

AGENDA – MEETING IN PUBLIC

Item:1	10:00	**Welcome and Apologies for Absence** *Apologies: Nigel Kee*	*To note*	Verbal	Presenter: Philippa Slinger
		Confirmation of Quoracy *A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present this being eight Board members. With a minimum of two Executives and two Non-Executive Directors.*	*To agree*	Verbal	Presenter: Philippa Slinger
Item:2	10:00	**Declarations of Interests**	*To determine if any action is required*	Verbal	Presenter: All
Item:3	10:00	**Minutes of UHSussex Board Meeting held on 5 December 2025**	*To approve*	Enclosure	Presenter: Philippa Slinger
Item:4	10:05	**Matters Arising from the Minutes**	*None*	n/a	Presenter: Philippa Slinger
Item:5	10:05	**Questions from the public** To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	*To respond*	Verbal	Presenter: Philippa Slinger
Item:6	10:30	**Service Presentation – Paediatric Services**	*To note*	Presentation on the day	Chief of Service Women & Children Division
Item:7	11:00	**Report from Chief Executive**	*To receive and note overview of the Trust's activities*	Enclosure	Presenter: Dr. Andy Heeps
Item:8	11:35	**One UHSussex**	*To note*	Enclosure	Presenter: Dr. Andy Heeps

		PERFORMANCE AND RISK			
Item:9	11:50	**Integrated Performance Report**	*To discuss and agree actions*	Enclosure	Presenter: Dr. Andy Heeps
Item:10	12:10	*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.*			
	12:15	***5 Minute Break***			
Item:11	12:20	**Board Assurance Framework**	*To approve*	Enclosure	Presenter: Glen Palethorpe
Item:12	12:30	**Maternity Update**	*To receive papers*	Enclosure	Presenter: Emma Chambers
		ASSURANCE REPORTS FROM COMMITTEES			
		Escalated Items Only:			
Item:13	12:40	**Report from the Research Innovation & Digital Strategy Assurance Committee from the meeting held on the 28 January 2025**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Prof. Jackie Cassell
Item:14	12:45	**Report from Patient & Quality Assurance Committee from the meetings held on the 16 December 2025, 27 January 2026**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Lucy Bloem
Item:15	12:55	**Report from People & Culture Assurance Committee from the meetings held on the 27 January 2026**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Prof. Paul Layzell
Item:16	13:00	**Report from Finance & Performance Assurance Committee from the meetings held on the 27 November 2025, 29 January 2026**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Prof. Paul Layzell as meeting Chair
Item:17	13:05	**Report from Strategy & Major Projects Assurance Committee from the meetings held on the 29 January 2026**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Prof. Paul Layzell

Item:18	13:10	**Report from Audit Committee from the meeting held on the 3 February 2026**	*To note assurance from Committee and action recommendations from the Committee*	Verbal	Presenter: Mike Driver
		WELL LED & COMPLIANCE			
Item:19	13:15	**Company Secretary Report** For information only	*For information only*	Enclosure	Presenter: Glen Palethorpe
Item:20	13:20	**OTHER**			
		Any Other Business To receive any notified urgent business and action	*To receive any notified urgent business and action*	Verbal	Presenter: Philippa Slinger
Item:21	13:30	**Date and time of next meeting:** The next meeting in public of the Board of Directors is scheduled to take place at **10:00 on Tuesday 31 March 2025.**		Verbal	Presenter: Philippa Slinger

Supporting Appendices:

Item 12	Maternity	a) Perinatal Quality Oversight Model Report & Dashboards b) ATAIN Quarterly report 25/26 c) Transitional Care Quarterly report 25/26 d) CNST MIS Year 7 Declaration	*To receive and note*
Item 13	Research Innovation & Digital Strategy	a) Terms of Reference	*To receive and approve the TOR*
Item:14	Patient & Quality	a) Terms of Reference	*To receive and approve the TOR*
Item:15	People & Culture	a) Terms of Reference	*To receive and approve the TOR*
Item:16	Finance & Performance	a) Terms of Reference b) Emergency Preparedness Resilience and Response Annual Report 202	*To receive and approve the EPRR publication to the Trust website, and approve the TOR*
Item:17	Strategy & Major Projects	a) Terms of Reference	*To receive and approve the TOR*

Minutes

University Hospitals Sussex
NHS Foundation Trust

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

Present:

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

In Attendance:

Mark Edwards	Chief of Service, Medicine and Emergency Care RSCH and PRH; HALO Programme SRO
Mae Sullivan	HALO Programme Lead
Glen Palethorpe	Company Secretary
Tamsin James	Board and Committees Manager (Minutes)
Catherine Bridger	Board and Committees Manager (meeting support)

TB/12/25/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chair welcomed all those present to the meeting, including Mark Edwards & Mae Sullivan who were in attendance at the meeting today for their service presentation.

1.2 The Chair noted apologies for absence was received from Bindesh Shah.

1.3 The Chair shared that Michelle Arrowsmith would be leaving their role of Chief Corporate Affairs Officer in mid-January to take up a new role as Executive Managing Director of the Queen Elizabeth Hospital King's Lynn.

1.4 The Board acknowledged Sandi Drewett's contributions as former Chief Culture and Organisational Development Officer, and noted her departure from the Trust following a period of extended work for the Trust in the area of Organisational Development support.

TB/12/25/2 DECLARATIONS OF INTERESTS

2.1 There were no interests declared.

TB/12/25/3 MINUTES OF THE MEETING HELD ON 13 NOVEMBER 2025

3.1 The Board received the minutes of the meeting held on 13 November 2025.

3.2 David Grantham raised a query regarding item 9.7 and asked that further information was added in relation to the previous conversation held regarding the Trust's capacity review.

3.3 It was suggested to amend the previous minutes at item 9.7 to reflect: *As a driver to change, David Grantham outlined the challenge of middle management requiring additional support, training and guidance, and pointed to the importance of tracking organisational development through a capacity review which should be positioned as a driver for meaningful change.*

3.4 With that amendment agreed, the minutes of the meeting held on 13 November 2025 were **APPROVED** as a correct record.

TB/12/25/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

4.1 There were three matters raised at the previous Board of Directors meeting in Public, the first was in respect of improvements to patient flow and length of stay, where there remained a variation in discharge levels across sites especially at weekends, and it was asked that a review of these levels was overseen by the Finance & Performance Assurance Committee. The second matter was in relation to the NHS England 10-Point Plan to improve resident doctors' working lives, whereby the Chair asked that this plan and subsequent actions were overseen at the People & Culture Assurance Committee. The third matter was in respect of the review being undertaken by the Managing Director of Planned Care which focused on long-waiting patients, incorporate improvements to patient booking processes, and the outcome of this be overseen by the Finance and Performance Assurance Committee.

4.2 The Board heard that the respective Committees had received the referrals, and the respective updates had been agreed to be provided to their January 2026 meetings; assured by the updates the Board agreed for these matters to be closed.

TB/12/25/5 QUESTIONS FROM THE PUBLIC

5.1 There were two questions received from the Public for answering at the Board today. The Chair stated that questions were always encouraged as it provided the Board with valuable opportunities to be engage with the public.

5.2 The first question was from Mr Tucknott, who asked the Board: What specific data, unmet need or performance indicators would the Board need to see for IBD to be recognised as a formal priority within the Trust's improvement and recovery work? Given that the Trust's current digital and reporting systems do not routinely capture the information needed for effective oversight, what support can the Trust provide to:

- enable the gastroenterology team to collect, access and report the relevant data;
- use that data to identify gaps, risks and operational challenges within the IBD pathway; and
- ensure IBD is appropriately considered and prioritised for future improvement and change?

Who within the Trust holds responsibility for supporting this data infrastructure and pathway oversight, and how will the Board ensure this becomes operational?

5.3 The Chair thanked Mr Tucknott for his question, and Professor Katie Urch provided a detailed response and provided strategic oversight for service improvement and was leading a series of multidisciplinary workshops which aimed to address service variation and enhance integration, including digital programmes linked to the EPR system and collaboration with the Information Governance team on patient databases. Katie further drew out the key initiatives which included:

- Expanding pharmacy services for specialised biologic therapies, supported by investment in senior pharmacists, dedicated training schemes, and consistent clinics across all sites.
- Strengthening dietetic support and CNS structures to ensure comprehensive care for patients throughout their lifelong journey.
- Reviewing surgical provision for IBD patients, addressing the current lack of specialist surgeons, and improving pathways for complex MDT cases and biologic treatments.
- Working with gastroenterology colleagues to identify and develop specialist IBD interests, create template structures, and optimise general clinic management.

Katie further explained that this is an exciting period of transformation, with significant opportunities to standardise care and improve patient outcomes across the Trust.

5.4 The Chair asked whether the Board should treat this as a priority, and if so, how should it be approached, and what data should be reviewed? Katie Urch explained that the Trust's focus was on providing assurance, oversight, and confidence that key areas within the pathway had been identified and improved. At this stage, updates would continue to be raised through the Patient & Quality Assurance Committee. It was shared that reliance on surveys and Datix IQ highlighted high levels of unmet need a few years ago. Since then, significant work had been undertaken to reduce these issues, and through Katie's personal involvement there was confidence that a robust plan and strong governance were in place, supported by clear evidence of progress.

5.5 The second question was from Mr Strand regarding the West Sussex Fire Service issued safety enforcement notice at St Richards Hospital and asked whether each of the Trust's hospital sites have a fire safety officer, and who is responsible for fire safety across each of the hospital sites.

5.6 Jonathan Reid as Chief Financial Officer, thanked Mr Strand for his question, and explained that each of the Trust's sites has an allocated fire safety officer who work with a series of fire wardens and site teams forming part of the Trust overall fire safety team. This team provides a programme of training and guidance for all staff, which is overseen by the Trust Health and Safety Committee. Each of the fire officers report to a Trust fire lead who is responsible for more strategic element of fire safety including policy development, learning from fire audits and engaging with others in the Trust such as the capital and estates team to ensure that fire risks assessments for areas of significant change are undertaken. The Board had previously agreed at its September 2025 meeting that there would be review of the level of these resources and the People and Culture Assurance Committee agreed to consider this at their January 2026 meeting, taking into account any relevant lessons from recent fire service inspections and reviews.

5.7 Jonathan added that in respect of the fire safety notice the Trust had developed a detailed action plan in response to the fire safety enforcement notice which was shared with West Sussex Fire Service, and colleagues from that service recently met with the relevant leaders within the Trust, and reviewed progress on the action plan, the Fire Service has returned to the Trust and confirmed

that good progress has been made and expect the notice to be lifted fully by February 2026.

5.8 The Board questions received and their subsequent responses can be found here on the UHSussex Trust website: https://www.uhsussex.nhs.uk/about/board/board-meetings/

TB/12/25/6 CHIEF EXECUTIVES REPORT

6.1 Dr Andy Heeps introduced the report and provided wider context to the Board's discussions by highlighting recent national and regional developments that are relevant to the Trust's plans and performance.

6.2 Andy Heeps shared that the Government had opened a consultation on changes to local government structures across East Sussex, Brighton & Hove and West Sussex, with proposals aiming to replace the current two-tier system with new single tier "unitary" authorities. Several options were being considered, ranging from single or dual unitary authorities in both East and West Sussex to a five-unitary model put forward by Brighton & Hove, and the intention was to simplify governance, strengthen financial sustainability and support future devolution arrangements.

6.3 Andy Heeps added that NHS England had published the Medium-Term Planning Framework and 2026/27–2027/28 allocation tables, which set a tight financial context for Surrey and Sussex and for UHSussex. Surrey and Sussex ICB remain materially above its fair-share target at around 4% in 2025/26, reducing only slightly over the period, and as a result receives some of the lowest recurrent growth nationally, meaning that improvement and transformation of services would need to come primarily from productivity improvements rather than income growth. For UHSussex, it would therefore assume very limited growth, a firm expectation of a requirement for annual breakeven, and increased scrutiny of our productivity and performance in urgent care, theatres, discharge, coding and outpatients.

6.4 Andy Heeps went on to outline that nationally flu cases were already three times higher than at this time last year, and there was an active increase in admissions and workforce sickness absence across our hospitals as a result. It was added that vaccination rates among healthcare workers were in decline. However, despite a 35% uptake rate across UHSussex in 2024, Andy reported that just over halfway through this year's programme of staff vaccination clinics, the Trust had already reached 34% uptake.

6.5 Andy Heeps acknowledged that on 26 November 2025, Brighton Magistrates Court fined UHSussex £200,000 plus costs, following the prosecution brought by the Care Quality Commission (CQC) regarding the tragic case of 16-year-old Ellame Ford-Dunn.

6.6 In addition, Andy Heeps shared that the CQC were due to publish inspection reports covering maternity and urgent and emergency care services at the Royal Sussex County Hospital (RSCH), following inspections carried out in February 2025. Andy added that colleagues had worked with the CQC to develop and implement an action plan to improve safety and address concerns inspectors had previously raised, and it was shared that the CQC confirmed in July 2025 that it was satisfied with progress made. Andy also shared that the CQC's maternity report would reflect the improvements colleagues in the service had made in safety, staffing and experience since the Trust's last inspection in 2021.

6.7 Andy further outlined the developments to staff wellbeing following the launch of the Five a Day Greengrocers scheme involving the selling of fruit and vegetables to colleagues, patients and visitors within the foyers of our hospitals.

6.8 Andy explained that a high priority for December was the requirement of financial sustainability given the sustained pressure within the Trust. , From a regulatory perspective, there remained a clear need for a visible and reliable compliance function, which Michelle Arrowsmith was currently addressing.

6.9 In respect of the recent industrial action in November 2025, Nigel Kee expressed thanks to the Trust's workforce for their quick response to the industrial action planning, noting that planning meetings were quickly organised despite challenges such as staff leave and sickness. He emphasised the well-coordinated approach to managing elective work, particularly adapting to the new AMU pathway at RSCH, which would offer a better environment for both staff and patients. The Chair acknowledged the huge effort from the team, whilst recognising the ongoing challenges posed by the long waiting lists nationally and stressed the importance of looking out for and supporting colleagues during this time. Andy Heeps also praised the resilience of the Trust's workforce who had stepped up to cover shifts during this period of industrial action.

6.10 Maggie Davies highlighted the collective effort in managing flu prevention measures that included increased vaccination points, and collaboration with community services to avoid unnecessary hospital admissions. She also urged visitors to stay home if they were unwell to help protect both patients and staff.

6.11 Gordon Ferns queried that in relation to the CQC prosecution case what actions had the Trust already taken to prevent similar incidents, and what measures were now in place to avoid any future occurrences. Maggie Davies reported that immediate organisational recommendations had been implemented, with oversight being provided through the Quality Governance Steering Group and the Patient & Quality Assurance Committee. It was added that policies had been reviewed and continued to be updated, with shared learning disseminated to reduce risk.

6.12 In addition, Andy Heeps emphasised the Trust's ongoing exposure to risk, particularly in caring for vulnerable patients, and the importance of working with system partners to ensure more appropriate placements for those people in the ED and Trust that did not have a primary physical health problem. Lucy Bloem noted that this issue had been tracked through subsequent reports through the Board Committees and highlighted that the highest risks remained in acute mental health areas. She acknowledged that despite ongoing work, pressure continued around securing safe and appropriate spaces for varying ages of patients, and that the escalation of this risk remained appropriate.

6.13 The Board noted Paul Layzell's comments recognising the developing system of care across Sussex and the importance of responding well to the local government reform consultation. He highlighted the paper's focus on accountability and high-quality services, stressing that the Board should not miss the opportunity to reflect these priorities, which were critical to future success. Andy added that NHS Sussex faced a number of challenges with the proposed reform, having built neighbourhood team models that cross boundaries, with supporting infrastructure being established.

6.14 The Board **NOTED** the Chief Executive update.

TB/12/25/7 SERVICE PRESENTATION

7.1 The Board welcomed Mark Edwards, Chief of Service for Medicine and Emergency Care for RSCH/PRH and HALO SRO, and Mae Sullivan, HALO Programme Lead, who were presenting on the Hospital Alternative Oversight Programme piloted for RSCH/PRH.

7.2 Mark Edwards drew the Board's attention to slide 3 – The Case for Change – and explained that a 2024 GIRFT (Getting It Right First Time) review identified opportunities to reduce avoidable admissions through earlier intervention and stronger community partnerships. With sustained acute pressure and increasingly complex patient needs, extending care coordination beyond hospital walls remained essential and in October 2024, the Medicine Division launched HALO to, a) Intervene earlier, b) Strengthen system flow, and c) Embed person-centred care; thus supporting the NHS 10 year plan ambition to shift care closer to home, and the Trust's strategy by improving outcomes for patients, enabling our people to thrive, and supporting healthier communities.

7.3 The Board welcomed Mae Sullivan who shared an overview of the challenges to fragmented working and limited care pathways this pilot was established to address. Mae added that the HALO programme aimed to extend care by supporting a shared goal of better patient outcomes by addressing and creating a level playing field for care, the developing of delirium pathways, and improving care for vulnerable patients. Work would be aligned regionally with neighbouring Trusts and underpinned by three foundation pillars thus creating strong opportunities for the Trust workforce, its partners and the wider system.

7.4 Mae further outlined the Brighton Unscheduled Care Navigation Hub initiative and explained that acute consultants work alongside SECAmb (South-East Coast Ambulance) in the East Sussex centre., Mae added that the model improved ambulance efficiency through to the Trust's AMU/AAU rather than the ED therefore reducing time and enabling faster redeployment.

7.5 Mae then outlined the intervention and impact for the Care Home / Hospital Link and The Red Bag initiative whereby the GIRFT care home programme was developed to strengthen collaboration between care homes, and hospital acute teams, and frailty services. A multi-agency workshop clarified what support care homes required which led to improved relationships, targeted outreach, direct ward manager contact, and closer working with the frailty teams. Mae also added that with charity funding, a Red Bag transfer scheme was introduced, ensuring residents' belongings, medications and key information accompanied them into hospital, triggering early team intervention.

7.6 In respect of virtual wards Mae added that this represented a shift in care delivery across Sussex, creating a higher level of engagement and enabling support for higher-acuity patients. In support of this, cross-provider workshops were held to develop pathways, particularly for frail and respiratory patients, in preparation for winter pressures. Specialty oversight was also in place, with step-by-step guidance to optimise capacity, reduce demand, and integrate virtual wards within other programmes.

7.7 Mae framed the value and sustainability of this pilot, through both a system lens, and through productivity and efficiency outcomes, and explained that collectively, the programmes had delivered tangible capacity benefits, which was being aligned with the Trust's wider efficiency programme, ensuring the projects directly supported organisational priorities. Mae added that all modelling had been developed within the national guidance framework, and the team were working closely with the system to clearly articulate and evidence the value these programmes deliver.

7.8 The Board thanked both Mark Edwards and Mae Sullivan for their presentation.

7.9 The Board praised the presentation and the improvements made, highlighting the virtual ward service as being among the best nationally. Andy Heeps emphasised the importance of creating opportunities and driving success. Mae thanked colleagues for the feedback and reflected on the programme's unique delivery methodology. She highlighted the importance of appropriate SRO oversight, taking time to understand the service, and that the programme's success would come from the credibility of aligned ambitions, better collaboration with partners and provider organisations, and building trust through visibility and responsiveness.

7.10 The Board further discussed collaborative working with the Trust's Palliative and End of Life Care (EOLC) teams and the additional support being provided which included work within the frailty pathways incorporating the virtual ward, and care home initiatives. Katie Urch confirmed that the EOLC palliative care team were keen to continue and strengthen close working with this team.

7.11 Paul Layzell questioned the tangible benefits of the programme for partners and whether the model provided a sustainable footing as he referenced SECAmb's perspective on benefits, particularly for care homes and GPs, and whether these stakeholders were seeing substantial, realised benefits. Mark Edwards advised that SECAmb were seeing benefits and credited the transformation efforts to the hub model which had been previously trialled with local hospital partners.

7.12 The Board focused on the funding benefits along with the opportunities that could be pursued, particularly around extended weekend or evening working; it was confirmed by Mark Edwards that this would have an impact worth the investment noting that this could be delivered within a fixed cash envelope, whereby two existing functions could be combined into one, effectively doubling productivity within a clinical session and freeing some weekend capacity.

7.13 The Board reflected on the need to apply these improvements across the Trust, not just for financial gain, but by optimising non-elective pathways, and avoiding increased costs, and by collaborating with system partners to ensure healthcare budgets were used effectively in the right care environments. It was recommended that clear system-wide and trust-level plans are developed to support next year's financial and delivery plan. The Chair also expressed the Board's commitment to this whilst acknowledging the importance of addressing sustainability, productivity challenges within the 2026/27 annual plan.

7.14 The Board thanked both Mark Edwards and Mae Sullivan and asked that their additional thanks be passed on to divisional colleagues for their ongoing support.

7.15 The Board **NOTED** the update.

TB/12/25/8 OTHER BUSINESS

8.1 There were no further items discussed.

TB/12/25/9 DATE OF NEXT MEETING

9.1 It was noted that the next meeting of the Board of Directors in Public was scheduled to take place at **10.00** on **Thursday 05 February 2026 in Worthing**

Tamsin James
Board & Committees Manager
December 2025

Signed as a correct record of the meeting.

…….. Chair

..…… Date

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	7.	**Meeting:**	Trust Board in Public	**Meeting Date:**	5 February 2026
Report Title:	Chief Executive's Report				
Sponsoring Executive Director:	Dr Andy Heeps, Chief Executive				
Author(s):	Dr Andy Heeps, Chief Executive				

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 **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)*	This report provides the Board with an overview of key national, regional and local developments affecting UHSussex. It highlights the impact of resident doctors' industrial action, the CQC inspection reports, the National Maternity and Neonatal investigation, organisational change in the Sussex ICB, an important milestones in operational performance.
Recommendation *(linked to What Next section)*	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 (*please explain where matter previously considered, and assurance provided)*	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 (note which theme)	**Care**	**People**	**Future**	**Communities**	**One UHSussex**	**Culture**
	Yes	Yes	Yes	Yes	Yes	Yes

Link to annual delivery plan	Achieving the objectives of the Annual Delivery Plan depends on the organisational culture, leadership and governance foundations described in this report.

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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**	**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*	

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Chief Executive's Report – February 2026

I'm delighted to be with you today as Chief Executive of University Hospitals Sussex, following my substantive appointment in December. I'm grateful to the Trust Board for the confidence they have placed in me, and to everyone who took the time to contribute to the appointment process.

What came through strongly is that colleagues across our hospitals know we need to change and want us to get on with it. My overall priority is to deliver our new strategy, **Excellent Care Everywhere**, starting with a clear focus on supporting our staff, performance and delivery, leadership and culture, partnership working, and our financial position. The updates that follow link directly to those priorities and should help set the context for our discussion today.

National Policy and Regulation

CQC reports: Maternity and UEC

Since our last Board meeting, the Care Quality Commission (CQC) has published reports of inspections of our maternity and urgent and emergency care (UEC) services at the Royal Sussex County Hospital (RSCH), Brighton, carried out in February 2025.

I am pleased to report that the maternity unit saw its CQC rating upgraded to Requires Improvement. Across the individual inspection domains, the service earned upgrades to Requires Improvement for Safe and Well-led but was downgraded from Outstanding to Good on the Effective measure. UEC services at RSCH remain rated as Requires Improvement overall but were downgraded from Good to Requires Improvement in the Effective, Caring, and Well-led domains, and from Requires Improvement to Inadequate in the Safe domain. Following the visit, Emergency Department colleagues worked with the CQC to develop and implement an action plan to improve safety and address immediate concerns the inspectors raised.

CQC maternity survey results

The kindness, compassion and strong teamwork the CQC inspectors recognised in our maternity teams were reflected in the results of the regulator's national maternity survey too. Feedback from families published in December rated maternity care at UHSussex as either similar to or better than the national average on all measures. For example, 98% of respondents said they were treated with dignity and respect, 97% had confidence and trust in staff, and 95% felt they were sufficiently involved in decisions about their care. Overall, this meant our ranking rose to 10th out of the 55 trusts included, up from 22nd in 2023 and 18th in 2024.

National maternity and neonatal investigation

In January, our maternity teams at RSCH and the Princess Royal Hospital (PRH), Haywards Heath, hosted Baroness Amos and her team as part of the national investigation into maternity and neonatal services commissioned by the Government last year. The investigators held focus groups for staff and will be talking to service users through our Maternity and Neonatal Voices Partnership. They also plan to visit Worthing and St Richard's in the next weeks.

During the visit, Baroness Amos stressed that the trusts taking part in the investigation were selected for a variety of reasons, including demography, geography, size and outcomes. The coastal population we serve is one area of interest, for example. Although each participating Trust will receive its own report, the investigation aims to produce a single set of recommendations for maternity and neonatal care across England. Interim findings are expected to be shared in February with final publication scheduled for Spring.

Local government reorganisation

In January, we submitted our response to the government's statutory consultation on proposals to change the structure of local government across Sussex. Our view as a pan-Sussex organisation is that efficient partnership working between NHS providers and a small number of authorities holding full responsibility for adult social care, children's and community services will be most effective in supporting the system transformation required in health and social care. We would therefore prefer a reorganisation that creates the smallest possible number of unitary authorities across Sussex.

Resident doctors' industrial action

Resident doctors continue to take industrial action in their dispute over pay and conditions, with another round taking place in December. NHS England again instructed acute trusts to aim to deliver 95% of planned elective activity during the five days of the strike, a target we exceeded at UHSussex thanks to consultants and other colleagues stepping in to sustain services and maintain safe access to emergency care. No patient safety incidents relating to the industrial action were reported.

Elleme Ford-Dunn inquest

An inquest into the death of 16-year-old Elleme Ford-Dunn, who took her own life after absconding from Worthing Hospital in 2022, opened on January 25th. UHSussex was fined £200,000 by Brighton Magistrates last November after accepting a charge of failing to provide safe care and treatment resulting in avoidable harm to Elleme. I will report the findings of the inquest when it concludes.

<u>Regional and ICB update</u>

Surrey and Sussex planning event

NHS providers from across Surrey and Sussex came together for the first time last month at an Integrated Care Board (ICB)-hosted workshop held to recognise collective challenges, share individual plans and consider common priorities across the enlarged ICB patch.

Discussion focused on strategy alignment, agreement of priority population health outcomes and how we can best continue working together in developing plans to build resilient health services that maximise value for money.

Surrey and Sussex Integrated Care Board transition

A substantive executive team has now been appointed to lead the new single ICB for Surrey and Sussex. Chief Executive Karen McDowell is joined by the following:

- Deputy Chief Executive: Mark Smith
- Chief Medical Officers: Dr Charlotte Canniff and Professor Andrew Rhodes
- Chief Nursing Officer: Allison Cannon
- Chief Financial Officer: Clare Stafford
- Chief Commissioning Officer, Strategy, Planning and Evaluation: Claudia Griffith
- Chief Commissioning Officer, Neighbourhood Health and Partnerships: Amy Galea
- Joint Chief People and Culture Officer (in partnership with NHS Kent and Medway): Indiana Pearce

The transition to a single ICB is being guided by the recently published Strategic Commissioning Framework, which clarifies expectations of ICBs as commissioners, their place in the emerging NHS operating model and role in achieving the ambitions of the Government's 10-year Health Plan. The new framework updates the traditional commissioning cycle with an emphasis on outcomes, system leadership and population health intelligence, adapted to the current integrated care context.

Pressure on services across Surrey and Sussex

Hospitals and primary care services experienced significant operational pressures during the first weeks of the year, with three Surrey trusts declaring critical incidents for a short period of time. We also had to call business continuity incidents across our Trust, which reflects the intensity of pressure across the whole system. Contributing factors will be familiar: increased ED attendances (particularly frail and older patients with complex needs), very cold weather, a high incidence of flu and other respiratory illness, workforce pressures, and ongoing discharge constraints driven by limited capacity in social and community care.

Ambulance fleet upgrades

The South East Coast Ambulance Service (SECAmb) has received 17 new ambulances as part of a £75 million national fleet upgrade. The trust is replacing almost 100 ambulances this year.

University Hospitals Sussex

Performance

UHSussex moved up from 117th to 113th out of 134 acute trusts in the latest NHS England league table published in December. We remain among the 28 trusts in Tier 4 of the NHS Oversight Framework segmentation.

The challenges we face in urgent and emergency care were also highlighted last month by local media coverage of the experience of patients being cared for in escalation areas on a particularly pressured day in the Emergency Department (ED) at RSCH.

We never want to have to manage patients in ED corridors or other non-clinical areas and I would like to apologise again to anyone who experiences this at any of our hospitals. We know it happens far too often still, and whilst we have made progress on the issue, and our use of ED escalation areas has reduced in recent months, eliminating it entirely remains a huge challenge. We are working with our partners to reduce unnecessary hospital admissions and enable patients to leave our care as soon as they are medically ready to do so, and internally to relieve pressure points that are within our control: for example, by moving patients onto wards sooner, enabling operations to take place earlier in the day and strengthening seven-day UEC services.

Acute Medical Unit opening

Urgent and emergency care at RSCH has benefited since our last meeting from the opening of our new Acute Medical Unit (AMU), which provides a single point of assessment for patients referred to medical specialties, whether by their GP or colleagues in the ED. Alongside the Surgical Assessment Unit we opened in 2024, the AMU replaces the hospital's Acute Admission Unit to provide a better and faster service and vastly improved experiences for patients and staff. Being able to move more patients away from the pressured ED environment sooner is good for everyone, although we know there is much more work needed to improve flow through the hospital and beyond.

Electronic Patient Record supplier appointment

We began the year by reaching an important milestone in our journey towards an electronic patient record (EPR) when we announced Alcidion as our preferred supplier. More than 1,500 colleagues were involved in the selection process, helping define our requirements and then reviewing supplier bids.

Introducing an EPR is one of the biggest analogue-to-digital changes we will make as part of our new strategy's approach to providing Excellent Care for our Future. But it will also have a positive impact on the strategy's other ambitions. For *patients*, the EPR will mean they only have to tell us their story once. For *our people*, it will mean less re-entering information, less time spent on admin and more time spent on care. Our *communities* will benefit from improved information flows between hospitals and partner services, enabling better continuity of care. And for *One UHSussex*, a shared system will enable consistent ways of working and help us unlock the benefits of scale available to us.

The first phase of the EPR – trust-wide e-noting, a unified EPMA and observations system, and a single, reliable source of all clinical documentation – will go live in 2027. Before then, we will be upgrading our infrastructure, preparing data, working with staff to standardise ways of working, and testing the new system with the teams that will be using it.

St Richard's cardiac catheterisation laboratory

Following a recommendation from NHS England, we appointed Dr Yaver Bashir to lead the independent review we have commissioned into the future of the cardiac catheterisation laboratory service at St Richard's Hospital, Chichester. Dr Bashir is a distinguished and highly experienced consultant cardiologist based at the Oxford Heart Centre and Clinical Director of NHS England's Internal Medicine Clinical Network (South East).

We had to close the cath lab in January 2025 after finding a significant issue with the air exchange ventilation system required for safe use of its theatre. The lab provides pacing procedures for around 300 patients a year, a service we have continued to offer at St Richard's in the Interventional Radiology Suite. Fixing the ventilation issue would take 18-24 months and cost around £2 million, so assessing all our options to ensure we have the right service in place for our patients over the next 20 years is the correct thing to do.

Dr Bashir is meeting with colleagues from our cardiology service across the Trust and considering the findings of a wide-ranging strategic review carried out by our clinicians last year. His expertise will ensure our proposals for cardiac catheterisation services are benchmarked against the highest national clinical standards. We expect to receive his findings before the next Board meeting in March.

New cancer treatment

UHSussex patients now have access to a new prostate cancer treatment through our participation in the national STAMPEDE 2 trial. Lutetium PSMA uses advanced PET-CT PSMA scanning to pinpoint cancer cells so clinicians can target them with internal radiation treatment while protecting surrounding healthy tissue.

Access to the trial has been made possible by outstanding collaboration between our cancer, nuclear medicine, medical physics and research and innovation teams, while a new Sussex Cancer Fund-supported research radiographer post is opening more national radiotherapy trials in Sussex, giving local patients access to cutting-edge treatments without having to travel.

Long service recognition

I was very pleased to be able to join our Chair, Philippa Slinger, in hosting two special events to salute the incredible commitment of many of our longest-serving members of staff in December. There was a total of 2,500 years of dedication to our hospitals in the room, along with countless acts of kindness and support for patients and colleagues. During 2025, we sent out 800 invitations to long-service events and expanded our recognition scheme so we start saying thank you to everyone who has worked here for 10 years or more.

Best of UHSussex

We ended 2025 by publishing the latest edition of our Best of UHSussex magazine, highlighting and celebrating colleagues' achievements over the year. The publication features awards, accolades, innovations and improvements from across our hospitals as well as the stories of the patients benefiting from them. It's a really uplifting read and, as the title suggests, showcases UHSussex at its best.

New People Pulse survey

As part of our continuing efforts to give colleagues more opportunities to speak up about working life at UHSussex and tell us how the Trust can better support them, we have been promoting participation in the new quarterly national NHS People Pulse survey. This asks participants about their experiences at work, how motivated they feel and the support that would make the biggest difference to them. We will include the results with other feedback and use it to inform our planning and decision making.

Operation Bramber

Sussex Police continue to review historic cases of surgery and neurosurgery patients at the Royal Sussex County Hospital, assisted by independent medical experts. We are expecting the police to provide their next update to families in the coming weeks, and I will update the Board on this once it has been shared with us. In the meantime, we remain committed to cooperating fully with the inquiry, responding as quickly as possible to any requests for information, and taking any immediate action required by either Sussex Police or their medical experts.

New interim Chief Corporate Affairs Officer

And finally, I'm very pleased to welcome Helen Brown to the UHSussex executive team as our new interim Chief Corporate Affairs Officer and successor to Michelle Arrowsmith in the role. Michelle has left us slightly earlier than planned, having been appointed Managing Director of the Queen Elizabeth Hospital in Kings Lynn, part of the Norfolk and Waveney University Hospitals Group.

Dr Andy Heeps
Chief Executive
February 2026

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	8.	**Meeting:**	Trust Board in Public	**Meeting Date:**	5 February 2026
Report Title:	One UHSussex - Developmental Well-Led Review – Next Steps				
Sponsoring Executive Director:	Dr Andy Heeps, Chief Executive				
Author(s):	Dr Andy Heeps, Chief Executive				
Purpose of the report: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For discussion**	**For Information only**	
	N/A	*N/A*	*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*	*Yes*	
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)*

What

This paper summarises progress since November 2025 in delivering the Trust's response to the developmental well-led review. It focuses on what has materially moved forward over the last three months and where the next phase of work will need to concentrate.

The most significant development is that work on culture, leadership, organisational structure and people systems is now being brought together as a single, coherent programme of change, rather than a set of parallel initiatives.

So What

This work is beginning to rebuild confidence in the organisation's leadership, culture and structure and create our new One UHSussex culture. The key areas of progress, covering the development of a practical Values and Behaviours Framework; the closure of the consultation on the Trust Operating Model (TOM); the appointment of a TOM Implementation Director; the delivery of significant progress in the external review of the HR function; and the tighter alignment between organisational structure, culture and people systems has seen the Trust move from design to early implementation.

What Next

Since November 2025, the Trust has entered a more decisive phase of change. This next phase will focus on developing clear delivery plans and strengthening programme management to ensure momentum is built and maintained and that the work translates into tangible impact, consistently seen across the whole organisation

The coming months will be critical in setting clear accountabilities, supporting leaders and ensuring that the Trust Operating Model, leadership expectations and people systems are aligned and experienced consistently across UHSussex.

Recommendation
(linked to What Next section)

Note progress and the movement from designing frameworks to turning these agreed plans into everyday practice.

Note launch of the Values and Behaviours Framework.

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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	N/A					
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 findings of the Developmental Well-Led Review have implications for all current Board Assurance Framework (BAF) risks, particularly those relating to leadership capacity and capability, culture and behaviours, staff experience, governance effectiveness, and delivery of strategic objectives. The recommendations and associated cultural narrative may affect both the current risk scores and the assurance profiles. As part of the response programme, all BAF risks will be reviewed to ensure they reflect the issues identified, with adjustments made to scoring, controls, and assurance sources as appropriate. This will ensure the BAF remains an accurate tool for Board oversight during the implementation of the developmental well-led programme.					
Link to CQC domain	**Safe**	**Caring**	**Effective**	**Responsive**	**Well-led**	**Use of Resources**
	N/A	*N/A*	*N/A*	*N/A*	*Yes*	*N/A*

Other impacts	**Equality and Diversity (*if yes has HEIA completed)***	**Environmental**	**Legal**	**External Registrations *(if yes please indicate which)***
	N/A	*N/A*	*N/A*	*Yes – CQC, NHS England*

University Hospitals Sussex
NHS Foundation Trust

Building One UHSussex – our response to the 2025 developmental well-led review

Progress Update – February 2026

1. Purpose of this update

This paper summarises progress since November 2025 in delivering the Trust's response to the developmental well-led review. It focuses on what has materially moved forward over the last three months and where the next phase of work will need to concentrate.

The most significant development is that work on culture, leadership, organisational structure and people systems is now being brought together as a single, coherent programme of change, rather than a set of parallel initiatives.

Key areas of progress include:

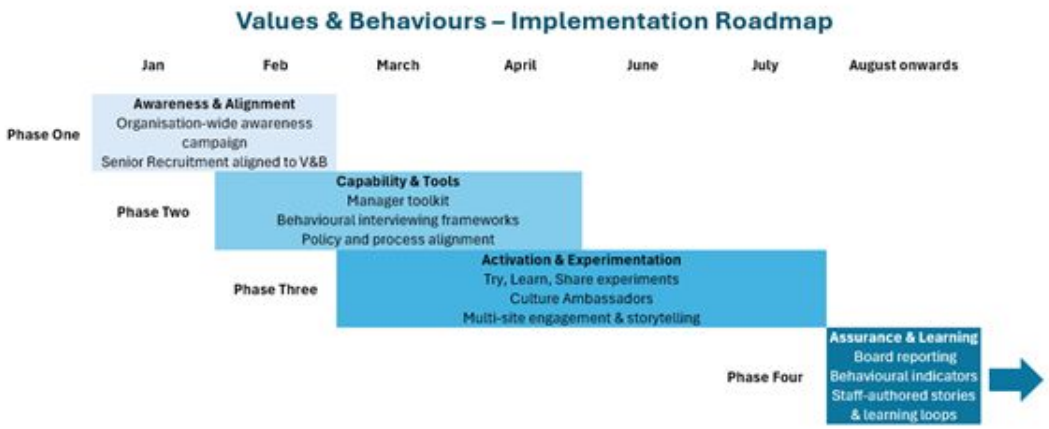
- the development of a practical Values and Behaviours Framework;
- closure of the consultation on the Trust Operating Model (TOM);
- appointment of a TOM Implementation Director;
- significant progress in the external review of the HR function;
- tighter alignment between organisational structure, culture and people systems.

Overall, the Trust has moved from design to early implementation. The next phase will focus on developing clear delivery plans and strengthening programme management to ensure momentum is built and maintained and that the work translates into tangible impact, consistently seen across the whole organisation.

2. Values and behaviours

Since November, the Values and Behaviours Framework has been developed into a more practical and explicit set of expectations for how people work and lead at UHSussex. This is helping move the framework from a statement of intent to a shared organisational standard.

An update was presented to this month's People and Culture Sub-Committee, including the proposed approach to rolling out the framework and supporting tools over the next six months, as summarised in the graphic below. This is an exciting and pivotal programme of work, with absolute commitment from the Executive team and very strong organisational engagement in the work to date.



In parallel, the Trust is strengthening how it understands and measures culture. The culture heat map will be refreshed following publication of the nationally benchmarked NHS Staff Survey results. Work is also underway to develop a small number of composite culture indicators for Board reporting, so that cultural signals can be considered alongside quality and performance metrics.

3. Trust Operating Model (TOM)

The consultation on the Trust Operating Model has now closed.

At the time of writing, the Trust is reviewing feedback from staff, clinical leaders, corporate teams and staff-side representatives. This feedback is being considered alongside operational, financial and governance requirements. The executive team expects to finalise the model and publish the Trust's response to the consultation in the coming days.

Several consistent themes have emerged:

- a strong desire for clearer accountability at divisional and site level;
- the importance of credible and supported clinical leadership;
- the need for corporate functions to be more consistent and responsive;
- concerns about complexity and duplication of roles.

To support implementation, the Trust has appointed a TOM Implementation Director. This role will provide dedicated leadership and coordination of the transition to the new operating model, including organisational design, workforce implications, governance changes and communication.

Implementation planning is progressing in parallel with the consultation analysis. Work is underway to:

- refine divisional structures;
- clarify site leadership roles;
- align governance and assurance processes with the new model;
- prepare divisions and corporate functions for transition.

The next phase will focus on communicating the final model clearly, supporting leaders through transition and ensuring that the TOM leads to greater clarity of accountability in practice.

4. Leadership development

Good progress has been made in clarifying and enhancing our leadership development offer over the past three months. A number of new, targeted programmes have commenced including multi-professional leadership cohorts, operational management development and the SAS doctor leadership programme.

These programmes are increasingly designed to bring together leaders from different sites and professions, reinforcing the One UHSussex ambition and supporting more consistent leadership practice across the Trust.

The range of leadership modules on offer through the Trust's e-learning platform has been reviewed and updated, with new modules on psychological safety the has been reviewed and updated, with several new modules developed.

- setting clear expectations;

- holding difficult conversations;
- managing performance consistently;
- leading across organisational boundaries;
- strengthening accountability and psychological safety.

Leadership development is also being aligned more explicitly with the Trust Operating Model, so that leadership expectations match the accountabilities in the emerging organisational structure.

The key challenge remains translating frameworks and development activity into consistent leadership behaviour across the organisation. The next phase will focus on embedding leadership expectations more firmly into performance management, senior appointments and governance processes.

5. People systems – external review

The external review of the Trust's HR function is now well advanced.

The reviewer has engaged with most HR staff through individual and group discussions and has met with key stakeholders, including chiefs of staff, directors of operations, executive directors and staff-side representatives. More than fifty documents relating to the People function have been reviewed, alongside benchmarking against Model Hospital data and standards from the Chartered Institute of Personnel and Development.

Qualitative feedback is being combined with quantitative data to assess capability, capacity, structure and impact. The review remains on track to conclude by the end of March 2026, with a final report and recommendations to be agreed by the Trust.

The findings will inform decisions about the future shape of the People function and its alignment with the Trust Operating Model and the One UHSussex ambition.

In parallel, work is underway to simplify HR policies and processes, with a focus on:

- clarity and consistency;
- earlier resolution of issues;
- improved support for managers and leaders.

The next phase will involve implementing the review's recommendations at pace while maintaining organisational stability.

6. Strategy, Governance and Risk.

Strategy Delivery planning: following approval of the Trust's 'Excellent Care Everywhere' strategy, work over the past three months has focused on ensuring the ambitions set out in the strategy are underpinned by clear delivery plans, with effective progress monitoring and reporting. The strategy and Major Projects sub-committee approved the delivery plan in November 2025 and received the first progress update at its January meeting. This reporting will continue to develop and iterate over the coming months.

Governance: Committee Terms of Reference (TOR) have been reviewed and updated to ensure alignment with 'Excellent Care Everywhere' and committee effectiveness reviews have been undertaken, to support their discussion and approval through this month's committee cycle. Work is underway to review the Board Assurance Framework to ensure alignment with the strategy and provide a refreshed view of the key strategic risks to delivery. This will be

presented to the March Board for consideration, together with a revised risk appetite statements.

Risk Management: An external review of our risk management process has been undertaken and provided detailed advice on how our approach can be strengthened.

Over the next three months the focus will be on improving reporting (with the potential to introduce a 'triple A' (Alert, Advice, Assure) approach and reviewing Executive and Divisional level governance to ensure that the new operating model (TOM) is as effective as possible, with Divisions supported, enabled and held to account for delivery of safe, effective and responsive care.

7. Bringing the strands together

A significant development since November is the way in which the Trust Operating Model, Values and Behaviours Framework and People function review are now being shaped in relation to each other.

Rather than operating as separate programmes, they are increasingly being aligned so that:

- organisational design supports clear accountability;
- leadership expectations reflect structural responsibilities;
- people systems reinforce behavioural and leadership standards.

This integrated approach is intended to address the root causes identified in the developmental well-led review, rather than treating culture, leadership and structure as disconnected issues.

7. Next steps

Over the next two months, priorities are to:

- finalise and communicate the Trust Operating Model;
- mobilise TOM implementation;
- begin leadership development at scale;
- complete the external HR review and agree a future People operating model;
- embed Values and Behaviours more firmly into performance management and governance;
- prepare divisions and corporate functions for transition to the new structure from April 2026.
- Continue to progress work on governance and risk management.

8. Key risks

Three principal risks remain:

- pressure on leaders and teams during a period of high operational demand and organisational change;
- uneven adoption of behavioural expectations across the organisation;
- the need to act on the external review findings at pace while maintaining stability.

These risks are being managed through programme governance, executive oversight and phased implementation.

9. Conclusion

Since November 2025, the Trust has entered a more decisive phase of change. The focus is now less on designing frameworks and more on turning agreed plans into everyday practice.

The coming months will be critical in setting clear accountabilities, supporting leaders and ensuring that the Trust Operating Model, leadership expectations and people systems are aligned and experienced consistently across UHSussex.

Dr Andy Heeps
Chief Executive
February 2026

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	9.	**Meeting:**	Trust Board in Public	**Meeting Date:**	5 February 2026
Report Title:	Integrated Performance Report				
Sponsoring Executive Director:	Andy Heeps, Chief Executive				
Author(s):	Various Executives				

Purpose of the report: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For discussion**	**For Information only**
	N/A	*N/A*	*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	The Board is expected to receive routine reporting on the Trust's performance.

Summary	Please see enclosed the integrated performance report for University Hospitals Sussex. It shows our performance to December 2025 and sets out the progress we are making to deliver the Trust's priorities, the NHS National Oversight Framework (and associated league tables launched from July-25) and the NHS Operating Plan, framed against the new Trust Strategy which will develop further over the next few months with its associated delivery plan. Where possible and meaningful we will use Statistical Process Control to illustrate special cause variation beyond normal variation to help focus on key changes to performance. We have also included some of the key corporate projects underway to support our future success. This report provides the Board with an overview and headlines of the Trust's performance, and is aligned to the new trust strategy five key ambitions: our patients, our people, our communities, our future, and One UHSussex. The metrics shown fit under these ambitions, and follow that structure. This supports our ten year goal and overall aim of excellent care, everywhere, which aligns with NHS national objectives and our local aims.
Recommendation *(linked to What Next section)*	The Board is asked to **NOTE** and **DISCUSS** this report.
Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*	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 (note which theme)	**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 (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc	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 (*if yes has HEIA completed)***	**Environmental**	**Legal**	**External Registrations *(if yes please indicate which)***
	N/A	*N/A*	*N/A*	*N/A*

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Integrated Performance Report

December 2025 *(reporting period)*

Excellent
Care
Everywhere

We are compassionate
We are inclusive
We are respectful

Chief Executive summary

Excellent
Care
Everywhere

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

Chief Executive Summary

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Please see enclosed the integrated performance report for University Hospitals Sussex. It shows our performance to December 2025 and sets out the progress we are making to deliver the Trust's priorities, the NHS National Oversight Framework (and associated league tables updated to Q2 in Dec-25) and the NHS Operating Plan, framed against the new Trust Strategy which will develop further over the next few months with its associated delivery plan. Where possible and meaningful we will use Statistical Process Control to illustrate special cause variation beyond normal variation to help focus on key changes to performance. We have also included some of the key corporate projects underway to support our future success.

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

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

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

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

Chief Executive Summary page 2

Overall Trust performance during December was challenging, with industrial action and Christmas/New Year pressure across urgent and emergency care pathways, but continued incremental improvement in planned care recovery longest waits and cancer performance. Workforce, finance, and quality indicators remain broadly in line with trajectory, although several areas require ongoing focus to ensure delivery of year-end targets. The Trust continues to progress its range of ongoing major projects which will enhance patient care across various services as part of our strategic plans.

Our Patients

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

Incident rates per 1000 bed days are tracked each month and by their severity. The Trust strives for improved levels of incident reporting to encourage continuous learning as part of an open and transparent culture. Latest incidents are within expected range for acute trusts. Key themes from incidents, include falls and pressure ulcers as key contributors. The Falls Rate per 1,000 bed days December 2025, was 4.27, with an average rolling year 4.34 against a target of 4.2. Overall, Trust data is tracking along the mean average and within the upper control limit, for both the number of falls and the number of falls per 1,000 bed days. Work continues with harm free care alongside divisions to undertake risk assessments relating to bed rails, and blood pressure levels, to reduce risk. The pressure ulcer damage rate, was been below the mean average Dec-25 and has reduced since March 2025 from 185 to 137 in month. The mattress audit and replacement programme are actions to reduce pressure ulcers further. Pressure ulcers and falls both impact patient experience, outcomes and length of stay and recovery in hospital.

Trust constitutional access standard performance saw deterioration in diagnostics as a result of challenges for endoscopic modalities, and the combination of industrial action and Christmas period impacting on patient availability and capacity. Whilst elective waits remain a material issue for the Trust, reflected in the Trust being in Tier 1 for elective support from NHSE, the Trust 65 week position was the lowest it has been since the pandemic, and 52 week performance was below planned trajectory. The waiting list is higher than planned due to increases in demand, and some constraints in certain specialties. The Trust has secured additional investment from NHSE to support recovery of 18 week performance and reduction of waiting list which are behind plan at the end December. Long waits impact patient experience, and has a strong relationship with financial performance , including the ambition to improve productivity for outpatient and theatre utilisation within budget where possible. This remains a key focus area for the operational teams.

Cancer performance for 62 day performance was below Trust planned recovery target in November but did improve by 5% relative to October. Faster diagnosis performance was 78.3% which whilst below plan was above the national average for November (76.5%). In both cases the largest challenge has been for skin patients which has improved significantly in November for FDS performance, and colorectal and urology patients. Renewed focus is being dedicated to these anatomical sites.

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Chief Exec Summary page 3

ED performance at the Trust has remained challenging in quarter 3. In December, the Trust saw 67.6% of patients within four hours. 12 hour performance and corridor care saw a worsened position in Q3 but remained materially better than Q3 2024/5 levels. Work to improve UTC and emergency care environment forms a key part of the Trust strategy. The Trust also has renewed its UEC improvement programme with the intention to help facilitate flow of patients from A&E, to inpatient wards and early supported discharge with help from our community, social care and mental health partners. The trust is targeting improved streaming of patients to urgent treatment centres, same day emergency care (SDEC), to decongest the front door, with quick and enhanced therapy support, improve performance against the safer care bundle and target shorter length of stay, pre and post the point at which a patient no longer requires acute care. This all impacts positively on flow and performance indicators, and influences financial costs, staff morale and nursing cover requirements, patient experience indicators, and health outcomes.

Our People

Sickness levels at the trust have risen marginally in quarters 2 & 3, as can be expected with seasonal flu etc, but remained below the mean average at the Trust over the past 14 months and track peers (broadly in line with Regional averages and better than other Sussex providers). Work to target areas with most sickness continues including F&E and nursing hotspots. High levels of sickness can impact staff morale, patient care, and cost to fill in clinical areas.

As part of Trust and NHS resilience plans the Trust's flu vaccination has achieved 50.3% coverage, an improvement on the previous year (and exceeding our original target of 50%).

Vacancy rates have reduced to 8.1%. A range of recruitment initiatives are being undertaken to further reduce substantive vacancies, although some are held as part of cost control. It is critical that the Trust has a sufficient core workforce to deliver patient care and minimise the use of agency or bank deployment unless necessary.

Statutory and Mandatory Training and Appraisal rates performed well over the past quarters, with step change to target compliance (above 90%) in both of these areas.

Our Communities

Patient experience improved to 92.5% in December, above the 90% target. A&E FFT remains most challenged for the Trust (and nationally) with 85.6% Dec-25, compared to 77.1% Nationally (November) with links to A&E waiting times and 4hr performance. Work to improve this environment through UTC and other emergency department strategic developments should therefore aid further improvement to patient experience scores.

Chief Exec Summary page 4

Our Future

Performance against statutory financial requirements to break even were c£1M behind plan end of Dec-25. It is important to note that there is continued risk into the remainder of the year, as the continued positive variance relies on delivery of the cost improvement programme and in the context of continued RTT performance requirements, and delivery of challenging efficiency targets.

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

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

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

One UHSussex

Staff engagement scores are tracking below national average staff survey results. However other indicators, such as declining turnover, sickness absence and vacancies suggest a stable or improving position, reflected too in early staff survey results. These will be available in full in March.

National performance assessment framework

The Trust remains within Segment 4 of the National Performance Assessment Framework (NPAF), noting the national judgement on segmentation is based on Quarter 2 information. The framework contains five segments from best performing segment 1 to those requiring mandated support segment 5. The Trust has submitted its provider capability assessment which as with all providers will be used by NHS England to determine if any new Trusts need to move into segment 5 and into the national Trusts provider improvement programme.
The Trust continues to engage with NHS England and the ICB through their formal oversight processes in respect of all aspects of our performance, which through these quarterly meetings provide assurance on the delivery of Trust's annual plan. The segmentation for quarter 3 will be undertaken in due course

Summaries

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Metric Summary

Performance Measure	Latest	Month	Previous	Direction	24/25 Month	Target	Plan	National
A&E and Emergency flow - % treated and admitted/discharged within 4 hours	Dec-25	67.6%	70.4%	Decrease	68.10%	78%	71.90%	73.8%
A&E and Emergency flow - Ambulance Handovers > 60 minutes	Dec-25	2.80%	2.1%	Increase	6.5%	< 2024/5	470	7.70%
A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	Dec-25	7.58%	7.12%	Increase	8.73%	< 2024/5	7.48%	10.20%
Cancer - 28 day faster diagnosis standard	Nov-25	78.3%	75.5%	Increase	71.0%	80.0%	78.3%	76.5%
Cancer - To achieve the 62 day standard	Nov-25	66.8%	61.8%	Increase	63.8%	75.0%	69.7%	70.16%
Diagnostics - % Breaching 6 week target (DM01 modalities)	Dec-25	15.3%	12.6%	Increase	22.10%	<5%	8%	21.7%
RTT 52 Weeks	Dec-25	4730 (4.07%)	4855 (4.19%)	Decrease	8278 (6.83%)	3301 Mar-26	4900	2.25%
RTT Elective care - >=65 Weeks	Dec-25	187 (0.16%)	314 (0.27%)	Decrease	2278	0	173 (0.15%)	0.13%
RTT Elective care - 18 Week Performance	Dec-25	51.1%	51.80%	Decrease	48.2%	55%	53.0%	61.8%
Safer Staffing - Average fill rate - registered nurses/ midwives (day shifts)	Dec-25	92.2%	93.5%	Decrease	88.5%	95%		
Safer Staffing - Average fill rate - registered nurses/ midwives (night shifts)	Dec-25	94.5%	95.0%	Decrease	90.6%	95%		
Safer Staffing - Average fill rate - care staff (day shifts)	Dec-25	83.3%	83.1%	Increase	83.1%	95%		
Safer Staffing - Average fill rate - care staff (night shifts)	Dec-25	91.4%	92.1%	Decrease	91.2%	95%		
Care Hours Per Patient Day	Dec-25	8.0	7.8	Increase	7.6			
Incidents/1000 beddays	Nov-25	60.53	60.11	Increase	53.86			
Falls/1000 beddays	Dec-25	4.27	4.55	Decrease	4.35			
Pressure Ulcers	Dec-25	2.34	2.82	Decrease	2.78			
Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	Sep-25	101.7	102.6	Decrease	103.8	100 (as expected range)		100
Training & development - Appraisals completed	Dec-25	90.8%	89.2%	Increase	84.90%	>90%		
Training & development - STAM Weighted Average	Dec-25	93.3%	92.7%	Increase	91.30%	>90%		
Workforce capacity - Vacancy Factor (Substantive contracted FTE) - monthly	Dec-25	8.1%	8.5%	Decrease	8.30%	10%		
Workforce efficiency - Absence Sickness in month	Dec-25	4.8%	4.9%	Decrease	5.60%	<4%		
Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good	Dec-25	92.5%	90.70%	Increase	89.30%	>=90%		91.10%
Financial Stability - Variance from breakeven plan YTD	Dec-25	£-0.97M	-£0.97M	Same		£0	£0	
Bank and Agency Spend against planned trajectory	Dec-25	£-22.95M	£-20.71M	Increase		£0	£0	
Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies (rank)	Dec-25	28	28	Same		<27th		
Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	Dec-25	6.2	6.6	Decrease	6.3	>6.9		6.85

Statistical Process Control

Statistical process control

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

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

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

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

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

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

All these rules are aids to interpretation but still require intelligent examination of the data.
This tool highlights when a rule has been broken and highlights whether this is improvement or deterioration

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

Icon key

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IPR SPC Summaries

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT < 18 Week Performance	Dec 25	51.1%	55.0%			49.2%	47.2%	51.2%
A&E < 4 hr Performance	Dec 25	67.6%	78.0%			70.7%	67.7%	73.6%
A&E 12 hr breaches	Dec 25	2793	2498			2708	1935	3481
Ambulance Handovers > 60 mins	Dec 25	2.8%	0.0%			3.7%	1.2%	6.2%
Cancer - 28 day faster diagnosis standard	Nov 25	78.3%	77.0%			73.6%	65.9%	81.4%
Cancer <62 Day performance	Nov 25	66.8%	75.0%			61.5%	52.2%	70.7%
RTT >52 Weeks	Dec 25	4730	3301			7382	5794	8969
Diagnostics - % <6 weeks	Dec 25	15.3%	5.0%			17.4%	12.4%	22.3%
RTT >65 weeks patients	Dec 25	187	0			1330	346	2314
L&D - Appraisals completed	Dec 25	90.8%	90.0%			85.5%	83.3%	87.7%
L&D - STAM Weighted Average	Dec 25	93.3%	90.0%			91.7%	90.7%	92.8%
Workforce - Vacancy Factor	Dec 25	8.1%	10.0%			8.9%	7.5%	10.2%
Workforce - In Month Sickness	Dec 25	4.8%	4.0%			4.8%	4.2%	5.5%
National staff engagement score	Dec 25	6.24	6.90			6.35	6.06	6.65
Summary Hospital-level Mortality Indicator (12M)	Sep 25	101.70	100.00			103.56	102.32	104.80
Patient experience - FFT	Dec 25	92.5%	90.0%			90.6%	88.7%	92.5%
Incident Rate /1000 Beddays	Nov 25	60.53	-			56.64	49.84	63.44
Patient Experience FFT A&E	Dec 25	85.6%	90.0%			82.4%	77.3%	87.5%
Safer Staffing: CHPPD	Dec 25	8.00	-			8.02	7.33	8.71
Falls	Dec 25	250	-			261	216	306
Pressure Ulcers	Dec 25	137	-			156	104	207
Falls per 1000 beddays	Dec 25	4.27	4.20			4.43	3.69	5.18
Pressure Ulcers per 1000 beddays	Dec 25	2.34	2.00			2.64	1.88	3.40

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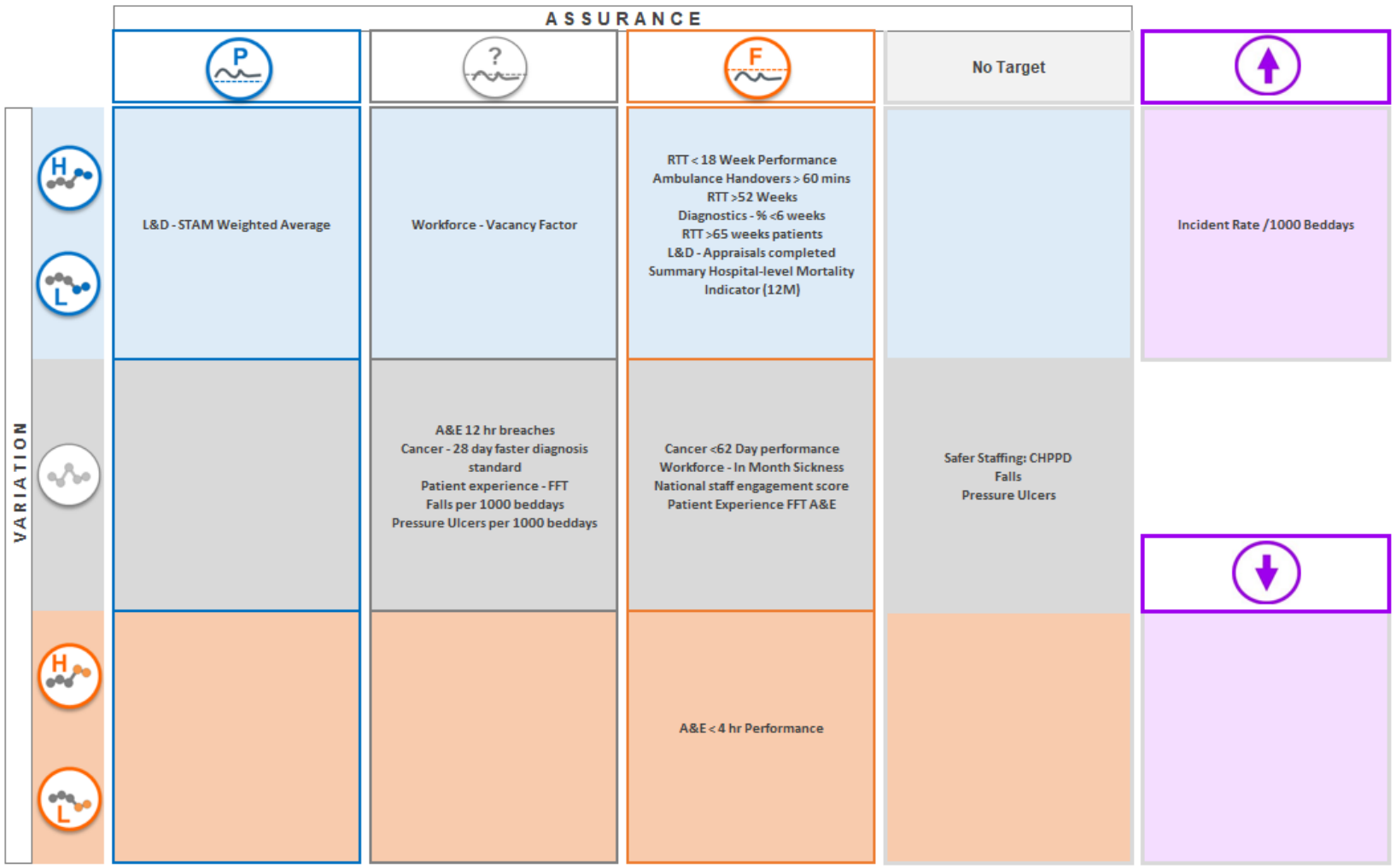
IPR SPC Summaries



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Patients

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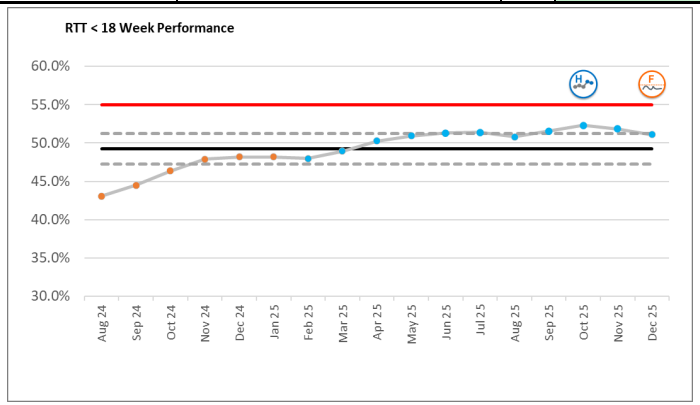
Our Ambition: Patients: Faster Access to Planned Treatment and Cancer Care					
Elective Care: RTT <18 Week Performance	**Target**	55% by March-26			
Latest Month Plan	53.00%	**National Rank**	145/149		
Latest Month Actual	51.10%	**National Performance**	61.8% November		
Latest Month Trend	Decreased (worsened)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- RTT <18 Week performance was 51.1% for UHSX in Dec-25, a deterioration of 0.7% from Nov-25 but a +2.9% improvement since Dec-24. It is behind the Trust's improvement trajectory of 53.0% for Dec-25. National performance for Nov-25 was 61.8%.
- The waiting list size increased marginally to 116,319 in Dec-25 compared to 115,993 in Nov-25 and 121,127 in Dec-24. This is 7860 higher than the operational plan for Dec-25. The Trust aimed to reduce the waiting list size to just below 102,000 by the end of Mar-26, by increasing productivity and activity by ~5% compared to 2024/5.
- The adverse variance to plan for performance and waiting list size is driven by demand growth being above 1% planning assumption. The Trust has agreed actions with NHS England to recover incomplete performance to plan by 31/03 as part of the national Q4 elective sprint.

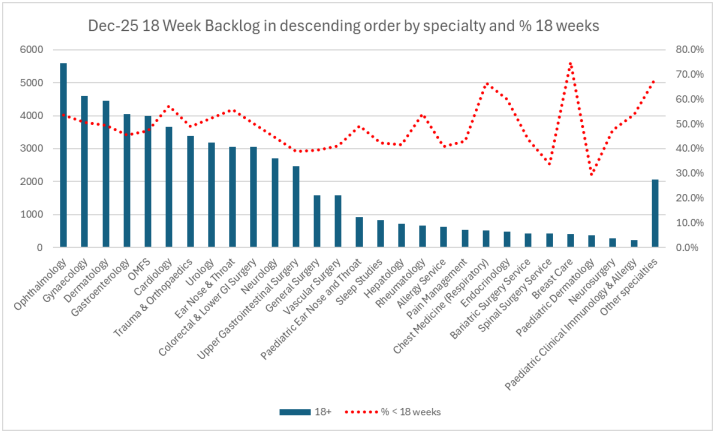


Key Actions

- Delivery of activity and productivity plans, to ensure enough patients are treated to reduce waiting list size and backlog over 18 weeks. Within this, the trust is focused on reducing waits for first appointment both to support this reduction but also to increases downstream time available for subsequent stages of the pathway.
- Reducing backlog of routine referrals waiting longer than 7 days for triage and processing from ~3.3k to <=1k by Mar-26.
- Expanding use of Netcall to increase clock stops: 12-weekly validation of inpatient WL (complete - Oct-25); creation of central list of standby patients to fill short-notice cancellations (complete - Oct-25); use of automatic text reminders for admitted appointments (including endoscopy) (from Dec-25)
- Improving oversight of non-surgical specialties who can go further to help drive 18 week backlog clearance, through improved regular RTT oversight and governance.
- Elective Co-ordination Centre to support transfers of patients for earlier treatment both between UHSX sites (to rebalance waits), and to external providers where agreed if deemed affordable
- Through Q4 elective sprint, increase outpatient capacity to drive down the length of wait to be seen and the total number waiting for first appointment (which comprise two thirds of the total waiting list at present).

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	50.2%	49.8%	50.7%	51.2%	51.1%	51.5%	52.3%	53.1%	53.0%	53.8%	54.4%	55.0%
Actual	50.3%	50.9%	51.3%	51.4%	50.8%	51.6%	52.3%	51.8%	51.1%			
Variance	0.1%	1.1%	0.6%	0.2%	-0.3%	0.1%	0.0%	-1.3%	-1.9%			

Breakdown Latest Month



Interdependencies with other performance indicators

- RTT performance impacts patient experience indicators, and quality. Underperformance impacts on Trust ERF income, and can be influenced by improved productivity metrics

Exec Owner Nigel Kee **SRO** Huw Edwards

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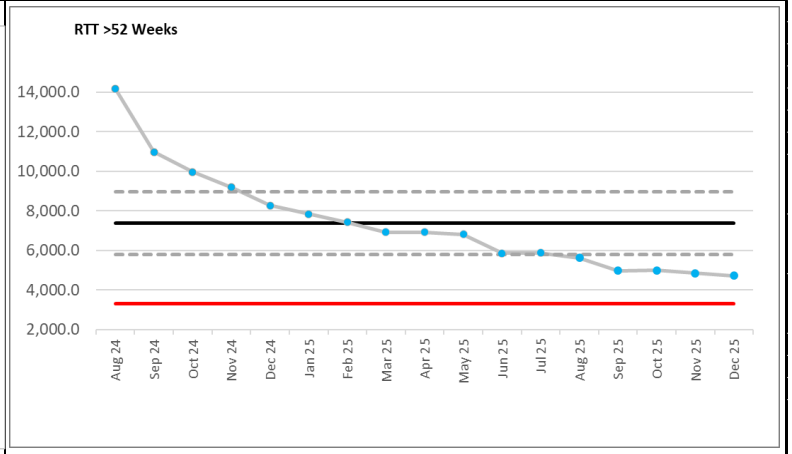
Our Ambition: Patients: Faster Access to Planned Treatment and Cancer Care					
Elective Care: RTT > 52 Week Waits	**Target**	<=3300 March-26			
Latest Month Plan	4900	**National Rank**	Nov-25 139/149		
Latest Month Actual	4730 (4.07%)	**National Performance**	2.25% November		
Latest Month Trend	Reduced (improved)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- 52 Week breaches reduced by 125 patients at December month end – to 4,730 patients. This is 3,548 fewer than Dec-24, and 265 fewer than the planned recovery trajectory.
- 52ww breaches comprised 4.07% of the total waiting list, an improvement of 0.12 percentage points compared to Nov-25 and 4.6pp better than Sep-24. This is 0.2pp better than planned recovery trajectory. National performance was 2.25% of WL in Nov-25
- Specialties with most 52 week waits Nov-25 are dermatology (642 patients), Oral Surgery/Max Facial (521 patients), Gastroenterology (514) and Gynaecology (475 patients)
- There were 187 65-week waits in Dec-25, a decrease of 127 compared to Nov-25. UHSx agreed a monthly trajectory and cohort trajectory to reach virtually zero 65-week waits by Mar-26. In Dec-25, the Trust was 194 patients ahead of the revised monthly trajectory. This is the lowest 65-week position since the pandemic.
- NHS England has subsequently asked organisations to reach zero 65-week waits by Dec-25. UHSX is not able to commit to zero but took actions to improve Dec-25 from the trajectory 381 to 173 which the Trust marginally missed by 14 patients

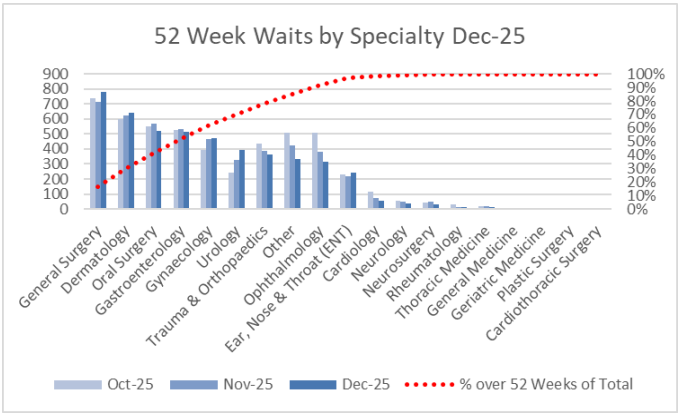


Key Actions

- Divisions have created recovery plans to mitigate Dec-25 55-week risks with detailed weekly and daily monitoring to track progress. This follows successful reductions of 61ww by June and 58ww by Septemeber, and the Trust shifts focus from 65-week waits to 52-week waits over the course of the year.
- Targeted plans have been agreed for the 8 specialties with greatest number of 52-week breaches (as detailed above), to virtually eradicate 65-week breaches by Mar-26. Weekly MD to DDO oversight is in place to oversee these plans.
- Throughout Sep-25 and Oct-25, twice weekly line-by-line reviews of 65ww cohort undertaken by MD with these targeted specialties.
- UHSX has participated in GIRFT 'focused support' programme, with external benchmarking of pathways and processes and access to national experts helping to drive up productivity.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	7230	7198	6900	6428	6050	5781	5432	5120	4900	4995	4213	3301
Actual	6925	6826	5860	5884	5629	4977	5007	4855	4730			
Variance	-305	-372	-1040	-544	-421	-804	-425	-265	-170			

Breakdown Latest Months



Interdependencies with other performance indicators

- RTT 52 Week performance impacts patient experience indicators, and quality. Underperformance impacts on Trust ERF income, and can be influenced by improved productivity metrics

Exec Owner Nigel Kee **SRO** Huw Edwards

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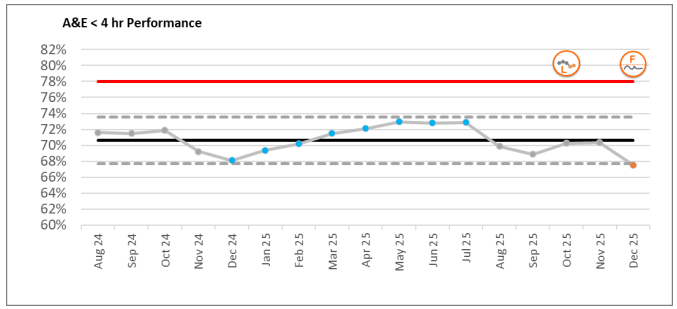
A&E <4Hour % Performance	**Target**	78% by March-26			
Latest Month Plan	71.90%	**National Rank**	100th of 121 Trusts (Dec-25)		
Latest Month Actual	67.60%	**National Performance**	73.8% Dec-25		
Latest Month Trend	Reduced (worsened)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- A&E <4-hour performance was 67.6% in Dec-25. This is 2.8% lower than Nov-25, and 0.5% lower than Dec-24. National performance was 73.8% in November. It is below the Trust planned improvement trajectory of 71.9% for Dec-25.
- RSCH saw a drop in performance from 59.9% Nov-25 to 56.1% Dec-25, 0.9% better than Dec-24. PRH fell to 60.9% from 67.0% Nov-25 and 60.7% Dec-24. Worthing fell to 54.6% from 60.2% Nov-25 and 59.5% Dec-24. SRH saw an improvement to 67.1% from 64.9% Nov-25 and 61.4% Dec-24 and RACH fell to 83.6% from 86.8% Nov-25 and 91.0% Dec-24
- A&E attendances were 1.7% higher in Dec-25 compared to Dec-24 and -4% lower than Nov-25 (allowing for calendar days), with ambulance handovers being 4.3% higher between years, and walk ins being 1.0% higher.
- There were 33 fewer 21-day patients on average in Dec-25 compared to Nov-25, and 48 fewer than 449 in Dec-24. DRD patients on average per day reduced by 48 patients from last month to 306, and was 13 more than Dec-24
- All sites except SRH continue with declining 4hr performance, with a number of causative factors – capacity in all sites is highly restricted by increasing delayed discharge which reduces the ability to expedite simple discharges, as there is physically less space to treat patients in each hospital, causing the overcrowding delays in each ED. The Trust continues to work with the ICB, Primary Care, each Social Care and Community organisation to identify opportunities to improve flow and discharge.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	71.2%	70.6%	73.2%	74.2%	74.8%	74.6%	76.1%	73.2%	71.9%	71.0%	74.0%	78.0%
Actual	72.1%	72.9%	72.8%	72.9%	69.9%	68.9%	70.3%	70.4%	67.6%			
Variance	0.9%	2.3%	-0.4%	-1.3%	-4.9%	-5.8%	-5.8%	-2.8%	-4.3%			

Key Actions

- The UEC Improvement Programme continues to focus on the need to improve UTC performance and productivity. Work continues to achieve the 32 national UTC standards on each site, to improve the cost of each service, including a forthcoming workshop on Streaming Guidelines to reduce variation, improve GP work-rates and comply with NHSE guidelines.
- The three UEC programme buckets continue to provide focus on the key areas of Front Door, Wards & Departments and Discharge. Traction and progress remains slow and a focus on clinical engagement and inclusion is being promoted via the SRO (COO), CMO, the DCMOs and the Medicine Division Chiefs in order to improve outputs and include the clinical voice.
- Work continues to identify capacity for the surgical division that allows SAU to flow more consistently although financial restrictions and increased planned cardiac surgery activity have delayed allocation of beds to surgery.
- RSCH ED Front-door improvement programme to combine the Social Care and UHSx admission-avoidance teams to improve efficiency and outcomes
- Pathway 1 improvement work in partnership with Brighton and Hove Council, the Better Care Fund (LGA) and the ICB to improve pre-Discharge-Ready process, and complex discharge downstream processes in collab with SCFT.
- UTC Streaming Workshop being planned for mid-February (postponed X3 already)
- NCTR reporting method-change implemented, with subsequent NCTR and DRD definition awareness work required to improve clinical staff awareness and understanding.
- Conveyance avoidance work continuing with SECAMB to develop the Hub model (in the SECAMb Ops Centre) with key Acute Medical consultants.
- Liaison commenced with the Sussex Primary Care Provider Collaborative to identify opportunities for ED & Acute Medicine to provide enhanced advice and guidance to GP and HCP colleagues.

A&E4hr	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
UHS<4hr %	72.9%	69.9%	68.9%	70.3%	70.4%	67.6%
RSCH	59.2%	58.0%	57.4%	63.2%	59.9%	56.1%
PRH	69.2%	68.4%	64.6%	65.6%	67.0%	60.9%
RACH	95.1%	94.8%	91.9%	90.4%	86.8%	83.6%
Worthing	66.3%	57.9%	57.4%	59.1%	60.2%	54.6%
SRH	67.2%	67.0%	64.0%	62.1%	64.9%	67.1%
National	*76.4%*	*75.9%*	*75.0%*	*74.1%*	*74.2%*	*73.8%*
A&E 12 hours in department	1,765	2,443	2,823	3,007	2,641	2,793
A&E Attendances	38,746	37,446	36,455	38,471	37,096	36,827
Time to Triage	18	16	17	19	18	19
Time to Treatment	126	137	137	141	133	140
Mean Waiting Time	272	306	345	327	316	329
Ambulance Handovers	7,540	7,556	7,256	7,576	7,350	7,583
Ambulance Handover <15 minutes	64.0%	58.0%	55.8%	52.5%	55.6%	53.3%
Ambulance Handover >45 minutes	2.6%	8.8%	7.3%	9.0%	7.4%	8.9%
Ambulance Handovers > 60 minutes	0.6%	1.4%	2.6%	3.5%	2.1%	2.8%
Emergency Admissions > 1 LOS	6147	5655	5703	5941	5565	6055
Bed Occupancy	92.6%	94.2%	94.4%	94.5%	94.5%	94.7%
Average LOS (Excl LOS 0)	9.10	9.10	10.10	9.70	9.90	9.60
>= 7 day LOS Patients	926	990	990	959	995	951
>=21 day LOS Patients	397	447	433	459	434	401
Ave. DRD per day	335	360	352	353	354	306

Interdependencies with other performance indicators

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

Exec Owner Nigel Kee **SRO** David Coyle

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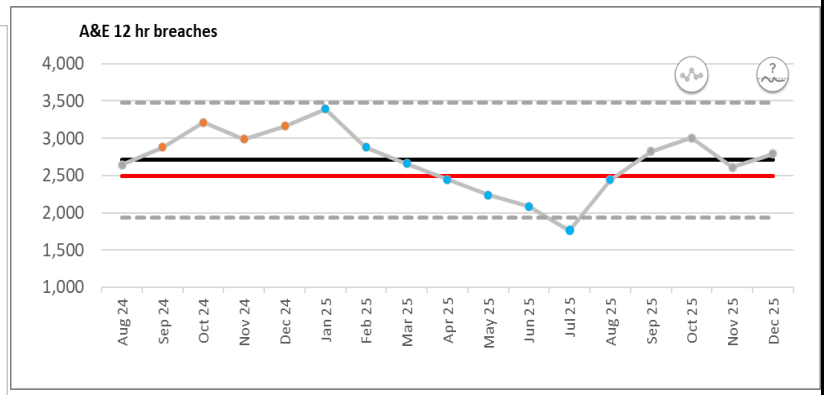
Our Ambition: Patients: Better urgent and emergency care					
A&E > 12 Hour waits	**Target**	A reduction in 2025/6 compared to 2024/5			
Latest Month Plan	2495	**National Rank**	52/86 week of 16th Jan-26		
Latest Month Actual	2793 (7.58%)	**National Performance**	10.2% Nov-25		
Latest Month Trend	Increased (worsened)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- The Trust has improved materially in 2025/6 to date, relative to 2024/5 in terms of numbers of patients waiting in A&E for 12 hours or more.
- However, there was a deterioration in performance and delays in Dec-25 which was higher than the planned level of reduction for December.
- Of 2793 patients who waited over 12 hrs in A&E, prior to leaving the department, 1011 were at the Royal Sussex County due to extended flow constraints in month. This was 3.4% higher than in Nov-25 but 11.7% lower than Dec-24.
- Worthing site also had a challenging month with 878 over 12 hr waits, 7.9% more than Nov-25. This was 45.1% higher than in December 24.
- In percentage terms as % of all attendances, the Trust had 7.97% >12 hr attendances in Dec-25 compared to 7.12% Nov-25 and 8.73% Dec-24



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	2849	2716	2556	2701	2179	2495	2732	2560	2753	2946	2574	2498
25/26	2448	2240	2088	1765	2443	2823	3007	2641	2793			
Variance	-401	-476	-468	-936	264	328	275	81	40			

Key Actions

- The increasing seasonal system bed capacity constraints had a material impact on our 12hr performances in ED for December. Worthing's deteriorated performance was particularly stark in comparison to Dec 2024, which the trust is focussing on.
- Whilst we improved overall on the same month in 2024 we continue to focus on reducing the reasons for 12hr ED delays via the UEC Improvement Programme. This includes:
- Reducing NCTR numbers: Trust-wide work is being delivered to focus on internal discharge-planning improvements via increased training packages, focussed work to prepare patients for NCTR and improved referrals.
- SDEC productivity: EDs have introduced Streaming processes that rapidly identify patients suitable for our SDECs - this is a nationally recognised model - the limiting factor is downstream exit-block which reduces flow out of SDEC and reduces their capacity to see, treat and discharge. The national SDEC process is being adhered to on all sites with new SDECs in RSCH and SRH functioning, the WH SDEC (EF) continues with focus on space, staff & process to increase capacity asap.

A&E >12 hours in Department	2024/25			2025/26			Last Year		Last Month		
Site:	Oct-24	Nov-24	Dec-24	Oct-25	Nov-25	Dec-25	Var.	% Var.	Var.	% Var.	
RSCH	1,337	1,218	1,151	1,050	978	1,011	-140	-12.2%	33	3.4%	
PRH	445	471	512	333	363	395	-117	-22.9%	32	8.8%	
RACH	5	9	0	0	4	7	7		3	75.0%	
SRH	740	610	894	964	482	502	-392	-43.8%	20	4.1%	
WSH	688	678	605	660	814	878	273	45.1%	64	7.9%	
UH Sussex ALL	3,215	2,986	3,162	3,007	2,641	2,793	-369	-11.7%	152	5.8%	

As % of all Attendances	2024/25			2025/26			Last Year		Last Month		
Site:	Oct-24	Nov-24	Dec-24	Oct-25	Nov-25	Dec-25	Var.	% Var.	Var.	% Var.	
RSCH	17.78%	16.81%	16.50%	12.62%	12.68%	13.41%		-3.1%		0.7%	
PRH	10.27%	10.87%	11.47%	7.15%	8.06%	8.80%		-2.7%		0.7%	
RACH	0.20%	0.29%	0.00%	0.00%	0.13%	0.24%		0.2%		0.1%	
SRH	10.13%	8.65%	12.20%	13.04%	6.81%	7.29%		-4.9%		0.5%	
WSH	7.90%	7.78%	6.94%	7.52%	9.45%	9.87%		2.9%		0.4%	
UH Sussex ALL	8.71%	8.15%	8.73%	7.82%	7.12%	7.97%		-0.8%		0.9%	

Interdependencies with other performance indicators

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

Exec Owner Nigel Kee **SRO** David Coyle

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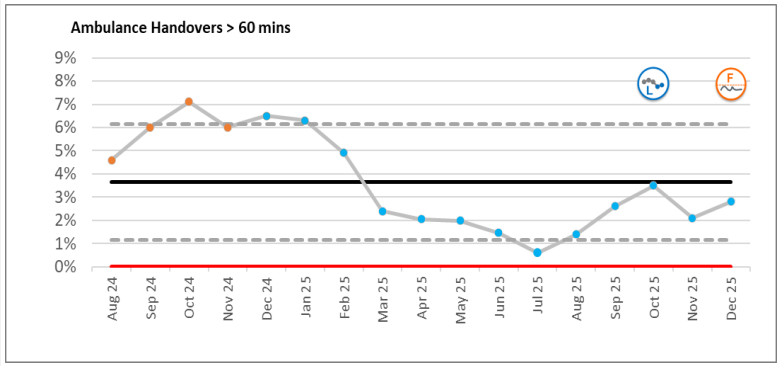
Our Ambition: Patients: Better urgent and emergency care				
Ambulance Handovers > 60 mins	**Target**	A reduction in 2025/6 compared to 2024/5		
24/25 Actual	6.50%	**National Rank**	Second Best Performing Region	
Latest Month Actual	2.80%	**National Performance**	7.7% National -1.4% South East Coast	
Latest Month Trend	Increased (worsened)	**NPAF Area: Access to Services**	**DQ**	Amber

- The Trust has seen significant improvement in extended ambulance handover delays in 2025/6 to date, with 10 consecutive months below mean (since Aug-24)
- There was an increase to 211 >60 min handovers in Dec-2025 compared to 157 in Nov-25 but this remains favourable to Dec-24 which saw 470 over 60 min handover delays.
- Of the 211 delays in August, 88 of these were at the Royal Sussex County, whilst 61 were at Worthing Hospital and 48 at Princess Royal Hospital.
- As a % of all handovers, Dec-25 saw 2.8% of 7583 handovers over 60 mins, compared to 2.1% Nov-25, and 6.5% in Dec-24.



Key Actions

- Increased ambulance conveyances, particularly following the christmas period has caused an increase (worsening) in our 60min handover performance.
- As part of the UEC Improvement Programme we have a workstream which focusses on reducing both the numbers of patients and the length of time these pts spend in the ED corridor which should in turn reduce handover delays.
- This workstream employs methods such as continuous flow and rapid-referral as required to move pts through the ED to the appropriate care area.
- The Trust-wide Internal Professional standards are used to achieve this movement although this continues to be a challenging area in terms of speciality compliance and overall clinical engagement.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	590	478	333	408	321	422	515	434	470	460	315	169
25/26	144	145	104	45	105	189	263	157	211			
Variance	-446	-333	-229	-363	-216	-233	-252	-277	-259			

Handovers:	2024/25			2025/26			Last Year	
Site	Oct-24	Nov-24	Dec-24	Oct-25	Nov-25	Dec-25	Var.	% Var.
RSCH	2,442	2,336	2,215	2,542	2,517	2,560	345	15.6%
PRH	776	811	847	836	859	858	11	1.3%
SRH	1,858	1,877	2,003	1,975	1,824	1,876	-127	-6.3%
WSH	2,171	2,188	2,206	2,223	2,150	2,289	83	3.8%
UH Sussex ALL	**7,247**	**7,212**	**7,271**	**7,576**	**7,350**	**7,583**	**312**	**4.3%**

>60 Minute Handovers:	2024/25			2025/26			Last Year	
Site	Oct-24	Nov-24	Dec-24	Oct-25	Nov-25	Dec-25	Var.	% Var.
RSCH	302	309	272	83	75	88	-184	-67.6%
PRH	36	33	64	27	26	48	-16	-25.0%
SRH	68	18	75	104	18	14	-61	-81.3%
WSH	109	74	59	49	38	61	2	3.4%
UH Sussex ALL	**515**	**434**	**470**	**263**	**157**	**211**	**-259**	**-55.1%**

% >60 Mins Handover:	2024/25			2025/26			Last Year	
Site	Oct-24	Nov-24	Dec-24	Oct-25	Nov-25	Dec-25	Var.	% Var.
RSCH	12.4%	13.2%	12.3%	3.3%	3.0%	3.4%		-8.8%
PRH	4.6%	4.1%	7.6%	3.2%	3.0%	5.6%		-2.0%
SRH	3.7%	1.0%	3.7%	5.3%	1.0%	0.7%		-3.0%
WSH	5.0%	3.4%	2.7%	2.2%	1.8%	2.7%		0.0%
UH Sussex ALL	**7.1%**	**6.0%**	**6.5%**	**3.5%**	**2.1%**	**2.8%**		**-3.7%**

Interdependencies with other performance indicators

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

Exec Owner Nigel Kee **SRO** David Coyle

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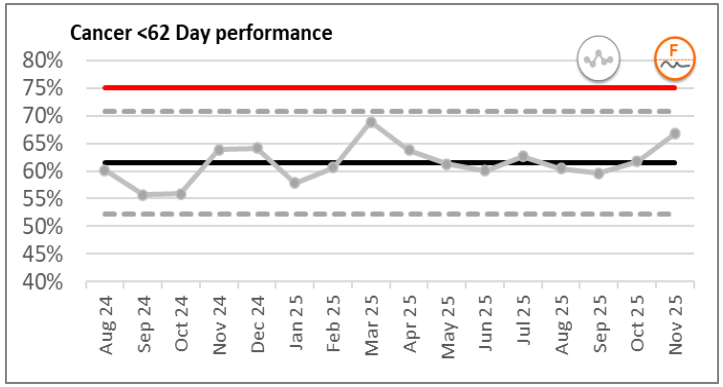
Our Ambition: Patients: Faster Access to planned treatment and cancer care					
Cancer Care : 62 Day Performance	**Target**	75% by March-26			
Latest Month Plan	69.70%	**National Rank**	101 of 146 - November-25		
Latest Month Actual	66.80%	**National Performance**	70.16%		
Latest Month Trend	Increased (Better)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- Cancer 62-day cancer treatment targets were not met in Nov-25 with 66.8% starting treatment under 62 days. This was a 5% improvement from Oct-25, and a 2.9% improvement from Nov-24. It was lower than the National average of 70.2% for Nov-25 and behind the Trust recovery trajectory plan for October (69.7%). The national position increased to 70.2% Nov-25 from 68.8% in October. **UHSx ranks 79/118 for 62D in Nov**
- There has been an increase in over 62-day patient backlog at the end December with 444 from 390 in November and an increase in 104-day prospective waits in December to 113 patients from 100 November. Skin is 25.7% of this backlog and worsened from 94 patients Nov-25 to 114 patients Dec-25. To reduce the backlog requires a reduction in retrospective performance (ie more treatment of backlog patients). The backlog is reducing in Jan 26
- The anatomical sites with most over 62 day patients at the end of Nov-25 were skin (114 patients , 20 more than Nov-25) , colorectal (92 patients, 14 fewer than Nov-25), and urology (89 patients, 32 more than Nov-25). The total backlog is 54 more than Dec-24.
- December will remain challenged for 62D as the trust continues to reduce the prospective backlog for skin patients with breast also facing significant demand/capacity mis-match constraints. The UHSx expected position is to then improve February and March 26 to achieve the commitments in our plan i.e. hitting the 62-day and FDS 28-day standards.

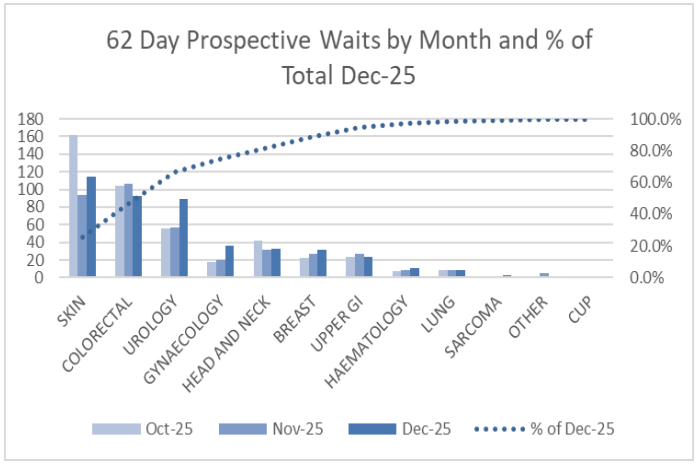


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	61.4%	61.5%	61.5%	61.2%	60.4%	65.7%	68.9%	69.7%	71.0%	67.8%	72.8%	75.2%
Actual	63.8%	61.2%	60.1%	62.7%	60.4%	59.6%	61.8%	66.8%				
Variance	2.4%	-0.3%	-1.4%	1.5%	0.0%	-6.1%	-7.1%	-2.9%				

Key Actions

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

62 Day prospective waits by Month



Interdependencies with other performance indicators

- Delays to cancer treatment can impact patient experience and outcomes

Exec Owner Nigel Kee **SRO** Huw Edwards

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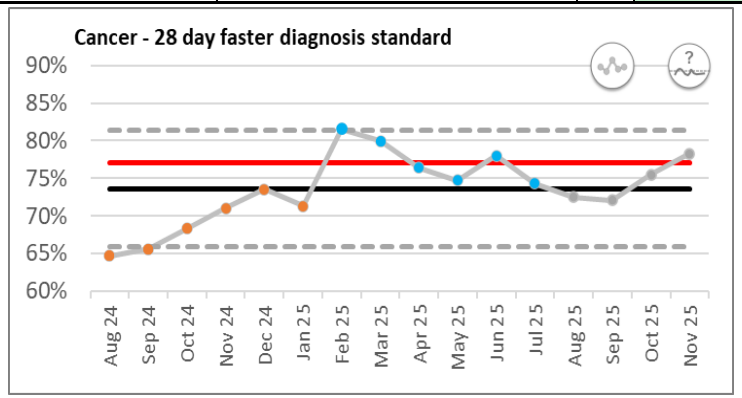
Our Ambition: Patients: Faster Access to planned treatment and cancer care					
Cancer Care :<28 Day Faster Diagnosis Standard	**Target**	75% by March-26			
Latest Month Plan	79.60%	**National Rank**	72 of 142 -Nov-25		
Latest Month Actual	78.30%	**National Performance**	76.52%		
Latest Month Trend	Increased (improved)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- FDS improved to 78.3% Nov-25 from 75.5% in October and was 71.0% in Nov-24. Trust performance was better than the national average of 76.5%. **UHSx ranks 57/118 in Nov for FDS**
- The Trust has committed to hitting the 80% Faster diagnosis standard - ie 80% of patients diagnosed with or without cancer within 28 days, by March-26.



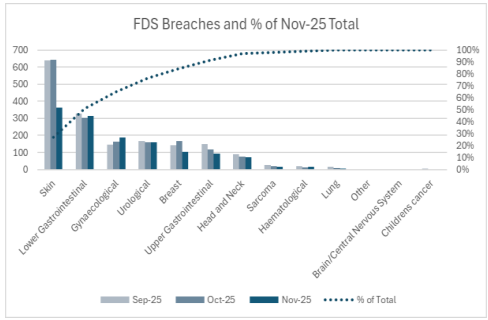
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	77.9%	78.0%	77.9%	76.3%	76.7%	78.7%	78.7%	79.6%	80.4%	78.6%	80.0%	80.0%
Actual	76.4%	74.7%	78.0%	74.3%	72.5%	72.1%	75.5%	78.3%				
Variance	-1.5%	-3.2%	0.1%	-2.0%	-4.2%	-6.6%	-3.3%	-1.3%				

Key Actions

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

Faster Diagnosis Standard by Anatomical Site

Anatomical Site	Sep-25	Oct-25	Nov-25
Brain/CNS	97.0%	94.3%	96.2%
Breast	87.8%	87.8%	92.2%
Gynaecological	71.8%	71.9%	64.8%
Haematological	41.9%	50.0%	33.3%
Head and Neck	85.5%	88.6%	87.3%
LGI	67.1%	71.3%	68.7%
Lung	70.6%	82.8%	89.2%
Other	71.4%	71.4%	66.7%
Sarcoma	64.9%	71.6%	72.1%
Skin	63.5%	66.8%	78.2%
UGI	67.5%	76.9%	76.4%
Urological	65.0%	68.3%	66.5%
Childrens cancer	71.4%	92.3%	100.0%



Interdependencies with other performance indicators

- Delays to cancer treatment can impact patient experience and outcomes

Exec Owner Nigel Kee **SRO** Huw Edwards

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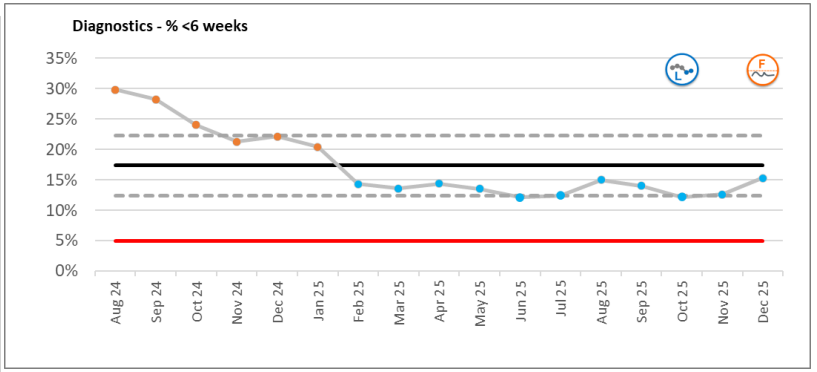
Our Ambition: Patients: Faster Access to Planned Treatment and Cancer Care					
Elective Care :Diagnostic <6 Week Waits	**Target**	<=5% by March-26			
Latest Month Plan	8.00%	**National Rank**	37th of 112 (NHS providers >5000 WL size) Nov-25		
Latest Month Actual	15.30%	**National Performance**		21.7% (Nov-25)	
Latest Month Trend	Increased (worsened)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

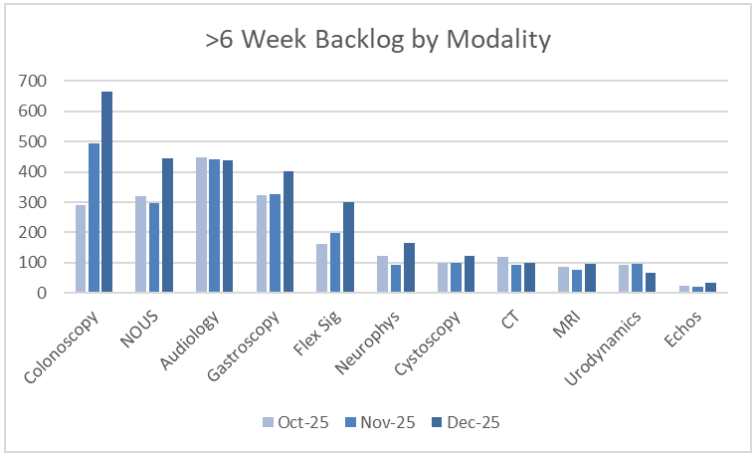
- Diagnostic Performance increased by 2.7% to 15.3% in Dec-25 from 12.6% in Nov-25, but 6.0% better than Dec-24. This is 6.4% lower than National average November (21.7%). This is however 7.3% adverse against the planned trajectory for the month of 8%.
- The waiting list size increased by 871 patients in December. The 6 week backlog increased by 606 patients.
- Highest backlog numbers in Dec-25 are colonoscopy, non-obstetric ultrasound and audiology.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	14.0%	14.0%	12.0%	11.0%	12.0%	10.0%	8.0%	6.0%	8.0%	8.0%	6.5%	5.0%
Actual	14.4%	13.5%	12.1%	12.4%	15.0%	14.0%	12.2%	12.6%	15.3%			
Variance	0.4%	-0.5%	0.1%	1.4%	3.0%	4.0%	4.2%	6.6%	7.3%			

Key Actions

- The Trust is refreshing recovery plans to target improvement to the 5% Operational Standard March-26 with continued scrutiny at modality level, particularly on improving endoscopic modalities.



Interdependencies with other performance indicators

- Delays to diagnostics can delay onward care, patient experience and outcomes

Exec Owner Nigel Kee **SRO** Huw Edwards

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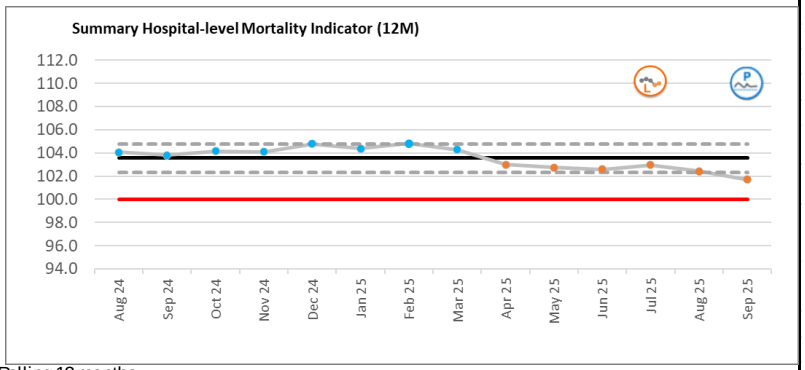
Our Ambition: Patients: Fairness in access, experiences and outcomes					
Standardised Hospital Mortality Indicator	**Target**	In Expected Range			
24/25 Actual	103.80	**National Rank**	In expected range		
25/26 Actual	101.70	**National Performance**	100		
Latest Month Trend	Reduced (improved)	**NPAF Area : Patient Experience**		**DQ**	Green

Key Messages

- The SHMI (Summary Hospital-level Mortality Indicator) gives an indication of whether the number of deaths in a hospital is higher or lower than expected, based on the types of patients they treat. It does this by comparing the actual number of patients who die following hospital treatment (either during their stay or within 30 days of discharge) with the number expected to die. The expected number of deaths is calculated using a statistical model that predicts the number of deaths we would expect for a given group of patients, the case mix model used to calculate the expected number of deaths is based on the patients age, gender, primary diagnosis, comorbidities, admission method and socioeconomic factors (like deprivation index).
- The SHMI for UHSx is 101.7 (Oct 24-Sept 25), which has reduced over the passed year and is now not considereed an outlier. The In-hospital SHMI is 103.12. The Out-of-Hospital SHMI is 98.62, and SHMI adjusted for pallitave care is 96.94. RSCH has the highest SHMI of all sites (In-hospital SHMI: 118.2 (above 90% control limit)) with Weekend and weekday SHMI both statistically high. PRH shows a below expected SHMI (In-hospital SHMI: 90.54).
- Quality Coding Issues: Recent months show: a Drop in coding depth, comorbidity scores an Increase in R-coded primary diagnoses and a Drop in supportive care coding - These patterns are not consistent with previous years and may artificially inflate mortality ratios



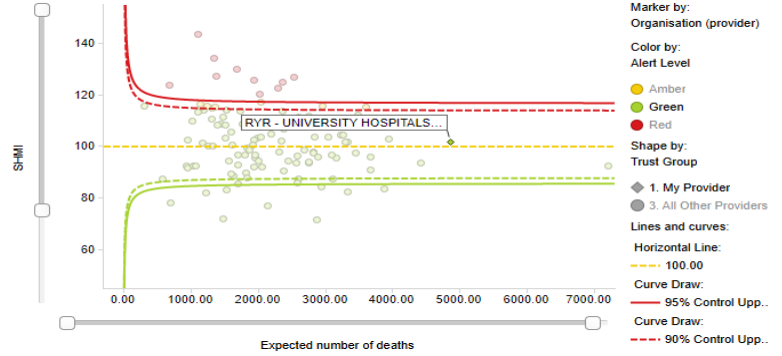
Rolling 12 months

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25 Actual	104.2	103.1	103.6	104.3	104.1	103.8	104.2	104.1	104.8	104.4	104.8	104.3
25/6 Actual	103.0	102.7	102.6	103.0	102.6	101.7						
Variance	-1.2	-0.4	-1.0	-1.3	-1.5	-2.1						

Key Actions:

- Investigation work has been undertaken for SHMI outlier alerts to understand any route causes.
- **Coding audit** of: R-coded primary diagnoses, Comorbidity capture (Charlson components) & Palliative vs supportive care coding.
- **Reinforce coder–clinician collaboration**, especially in: Respiratory, Elderly care & Rheumatology
- **Provide coding refresher training**
- **Review palliative care referral pathways** across sites.
- **Ensure consistent documentation** of End-of-life decisions, DNACPR & Anticipatory care planning
- **Standardise supportive care coding** to avoid under-coding complexity

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



Interdependencies with other performance indicators

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

Exec Owner Prof Katie Urch **SRO** Dan Rennie-Hale

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	Our Ambition: Patients: Fairness in access, experiences and outcomes				
	Safer Staffing % Staffing against planned rota	**Target**	>95%		
	Latest Month Plan		**National Rank**		
	Latest Month Actual	Table below	**National Performance**		
	Latest Month Trend	Variable per staff group/shift as below	**NPAF Area: Patient Safety**	**DQ**	Amber

Key Messages

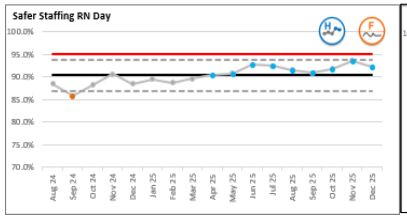
- Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN, 2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board).

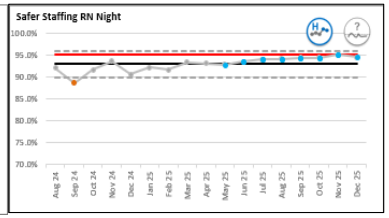
- Care Hours Per Patient Per Day (CHPPD) trust wide has seen a gradual increase from 7.1 in April 24 to 8.0 in December 25 .Please note there is a drop in CHPPD from 9.2 to 8.2 in August 25 this is a result of removing paediatrics and neonates from the CHPPD reporting to align with the national reporting. In addition, after benchmarking with other trusts ITU has been removed due to over inflating the CHPPD and masking lower levels of staffing in other areas.

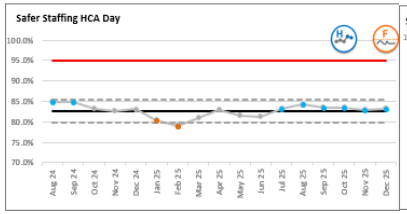
- In the model hospital data published in September 25 the trust has moved to the top of quartile 2 for registered nurses which is a decrease from the last quarter. This decrease corralates with aligning the reporting and the previouse reduction in CHPPD to align with national reporting. The trust has moved quartile 3 for care staff reflecting the slow improvement in fill rate.

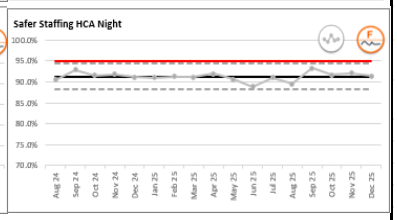
- The charts shows the fill rate % for Day and Night shifts for Registered Nurses/midwives and Health Care Assistants. The RN day fill rates have remained consistenty over 90% since April 25 and HCA night fill rate has been above 90% since September 25

- Day HCA fill rates are lowest with 83.3% cover , compensated in part by the RN cover, but the area of most focus in terms of actions to increase.









		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Registered Day	**24/25**	84.0%	82.2%	84.4%	83.7%	88.5%	85.8%	88.2%	90.6%	88.5%	89.5%	88.7%	89.6%
	25/26	90.4%	90.7%	92.7%	92.5%	91.6%	90.9%	91.8%	93.5%	92.2%			
Registered Night	**24/25**	87.5%	85.9%	85.8%	85.2%	92.0%	88.7%	91.7%	93.6%	90.6%	92.2%	91.7%	93.4%
	25/26	93.1%	92.8%	93.5%	94.0%	94.1%	94.4%	94.4%	95.0%	94.5%			
HCA Day	**24/25**	81.9%	81.1%	82.4%	83.0%	85.0%	84.8%	83.3%	82.7%	83.1%	80.5%	79.1%	81.0%
	25/26	83.0%	81.6%	81.2%	83.2%	84.3%	83.6%	83.7%	83.1%	83.3%			
HCA Night	**24/25**	89.5%	89.1%	89.5%	90.6%	90.4%	93.0%	91.6%	91.8%	91.2%	91.0%	91.3%	91.1%
	25/26	91.9%	90.6%	88.9%	91.0%	89.6%	93.3%	91.7%	92.1%	91.4%			
Care Hours/Patient Day	**24/25**	7.1	7.3	7.4	7.4	7.7	7.3	7.5	7.6	7.6	7.7	7.6	7.8
	25/26	8.0	9.0	8.9	9.2	8.20	8.23	8.20	7.80	8.00			

Key Actions

- The Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce with the skill and experience to deliver quality care.
- The subgroups focusing on agency reduction, recruitment, retention, safe care, roster optimising and sickness management. The Deputy Chief Nurse (DCN) for Workforce along with the clinical workforce team undertook establishment reviews using the safer nursing care tool (SNCT) in November / December. The audit will be repeated in Feburary, at which time the wards will have completed much of the onboarding following the establshment changes in nursing and HCA's in the last year.
- Recent changes to the Health and Care Visa which is a subtype of the skilled worker visa has increased the salary to 25k. The increased salary threshold for visa sponsorship has created challenge recruiting directly to band 3 posts with approx. 45% of applications requiring sponsorship. As a result, there has been extensive recruitment to band 2 HCA's who transition to band 3 at 6 months. This has resulted in challenge in the ward due to the higher leave skill restrictions in place for band 2 staff.
- As part of the establishment restacking there is a commitment to exit agency in non-specialist areas and in this financial year. There has been excellerated focus since the 12 of Janurary with a programme of agenct switch off ward by ward reviewed weekly. Enhanced controls have been increased with Divisional Director of Nursing and DCN approval for break glass agency in any area identified to exit. 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.

Interdependencies with other performance indicators

- Safer staffing has links to safe care for patients, staff experience, moral and fatigue, and financial cover

Exec Owner	**Dr. Maggie Davies**	**SRO**	**Annette Gericke**

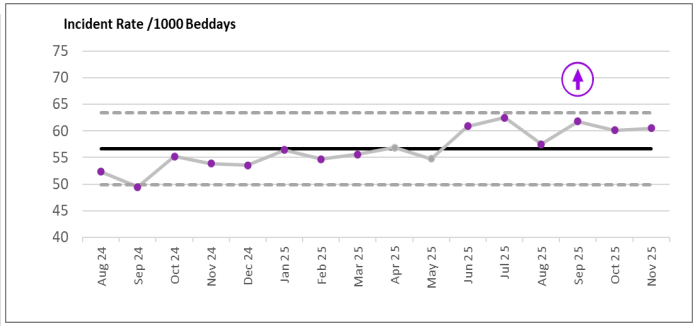
Excellent Care Everywhere

University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Fairness in access, experiences and outcomes					
Incidents per 1000 beddays	**Target**				
2024/25	53.86	**National Rank**			
25/26 Latest Month Actual	60.53	**National Performance**			
Latest Month Trend	Reduced	**NPAF Area: Patient Safety**		**DQ**	Green

Key Messages

- National Benchmarking : The NHS England Learning from Patient Safety Incidents (LfPSE) has released the second report (Q2) 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 trusts. There was variation in recording rates across different types of NHS trusts. Recording rates (per 1,000 bed days) ranged from 18 to 143 incidents in acute trusts. UHSussex has consistently increased the reporting rate per thousand bed days since merger and as a reporting acute Trust (>60), the score was within the main average reporting cohort and not identified as an outlier as low reporting. LfPSE are not currently providing a national benchmark for what organisations will be measured against, although an increase in reporting is indicative of an improving safety culture. The UHSUSSEX rate is reported a month in arrears to allow for data validation.
- Q3 report- For **actual** harms (approved) graded as low, moderate, severe and death, the highest percentage of reported patient safety incidents are graded as no/low harm (97%). Pressure damage, falls and medication incidents are the most common themes within the **low harm** categories. Security incidents also feature in Decembers report.
- However delays to appointments, diagnosis and lost to follow-up are now the highest recorded categories for both **severe and moderate** harms.



Incident Rate	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/25	49.22	52.74	50.58	50.88	52.32	49.49	55.24	53.86	53.55	56.43	54.69	55.58
2025/26	56.88	54.79	60.90	62.52	57.50	61.82	60.11	60.53				
Variance	7.7	2.1	10.3	11.6	5.2	12.3	4.9	6.7				

Key Actions

- Collaboration with clinical simulation and learning and development with regard to human factors training in patient safety incidents.
- An improvement programme on surgical safety commences in Q4 to prevent the risk of Never Event.
- Collaboration with ICB/System partners regarding the commissioning and quality assurance of the contracts with independent providers e.g. MIP.
- 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.
- A new RLDatix (DCIQ) training video is now available on Iris to support the understanding of the incident reporting and handling processes.
- 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.
- Patient Stories are presented at the Patient Safety Group.
- The UHSussex Patient Safety Partners open each PSG with a presentation on shared learning from incident themes. Shared learning from inquest and Prevention of Future Death reports (Regulation 28)

Interdependencies with other performance indicators

- Relationship with the top themes from complaints, the fundamentals standards of care (improvement on falls and pressure damage reduction) and waiting times for appointment.
- Through themes and learning the reporting influences UEC/RTT/Medicines safety and mental heath care action and improvement plans

In December 2025, Table 1 shows the Top 10 incidents reported in DCIQ by subcategory for the month, these subcategories are not dissimilar to ones reported in November (Table 2). Inappropriate Medication Error, Falls/Slips, and PU Category 2 remain the top three reported trends, lowering slightly from last month.

Table 1	December
Pressure Ulcer Category 2. Present On Admission	209
Medication Error	208
Fall / Slip on same level / Lost Balance	199
Pressure Ulcer Category 2. Developed or worsened during care	111
Physical Restraint by SO on a Pt (clinical reasons)	91
Requested to Search due to suspicion of weapons or Drugs	64
Incontinence associated dermatitis (caused by urine/faeces) developed or worsened during care	59
Stock level discrepancy	48
Verbal Abuse / Harassment	48
Physical Assault against staff	46
Grand Total	**1083**

Table 2	November
Medication Error	226
Fall / Slip on same level / Lost Balance	201
Pressure Ulcer Category 2. Present On Admission	163
Pressure Ulcer Category 2. Developed or worsened during care	126
Physical Restraint by SO on a Pt (clinical reasons)	85
Requested to Search due to suspicion of weapons or Drugs	68
Radiation Inappropriate	68
Incontinence associated dermatitis (caused by urine/faeces) developed or worsened during care	54
Patient injury - skin tear	53
Abscond from Emergency Department	52
Grand Total	**1096**

Exec Owner Dr. Maggie Davies **SRO** Jo Habben

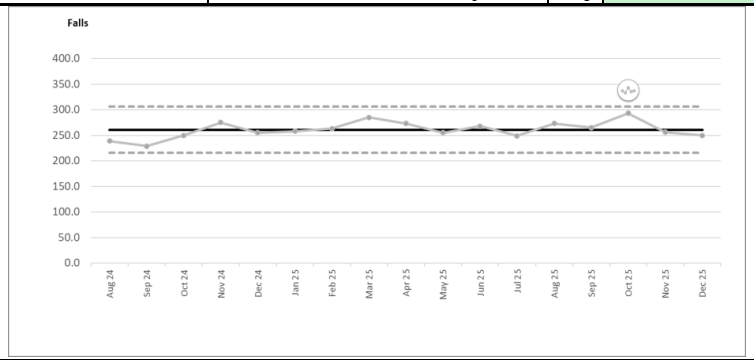
Excellent Care Everywhere

University Hospitals Sussex NHS Foundation Trust

Our Ambition: Patients: Fairness in access, experiences and outcomes					
Falls	**Target**	To reduce falls by 30%; 4.2, per 1,000 bed days			
2024/25	275	**National Rank**	n/a		
2025/6 latest month	250 (4.27 per 1000 beddays)	**National Performance**	n/a		
Latest Month Trend	Reduced	**NPAF Area: Patient Safety**		**DQ**	Green

Key Messages

- Falls are a top contributor in terms of harms across UHSussex, and therefore key focussed work area to minimise them.
- There has been a decrease in falls since March 2025, 285 to 250 Dec-25.
- 73.2% of falls (183 patients) in December 2025 reporting no harm.
- Falls Rate per 1,000 bed days December 2025, 4.27. Average rolling year 4.34. Target 4.2. Overall, Trust data is tracking along the mean average and within the upper control limit, for both the number of falls and the number of falls per 1,000 bed days.
- Moderate harm and above falls since April 2024 have not identified pattern or trend currently.

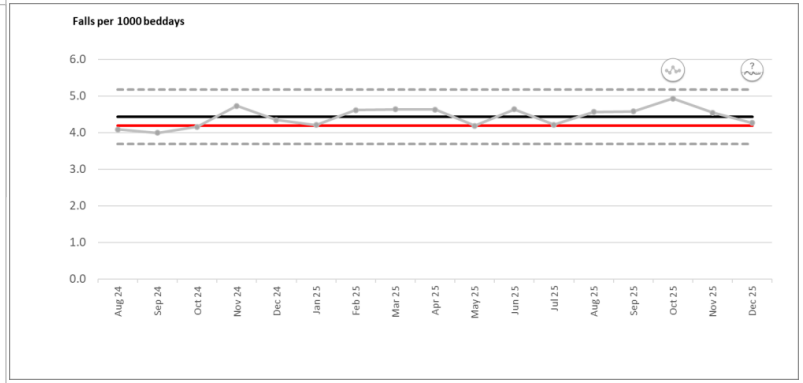


- **Key Actions**
- KPIs have been set for falls per 1000 beddays across UHSussex at 4.2 or less.
- The harm free care and education team continue to work with sites and divisions to support quality improvement workstreams.
- Rate of falls will continue to be monitored via the weekly Harm Free Care Group, monthly QGSG and two monthly FSoC patient safety group.
- The three month Decaf by Default pilot continues this month - while some wards report a perceived improvement in delirium, and the lowest number of falls in 12 months, other wards have seen minimal change. HFC is monitoring the number of falls reported during this period and engaging with teams to identify any additional patient safety benefits emerging from the trial.

Numbers	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	256	310	238	227	239	229	250	275	255	258	263	285
25/26	273	255	268	249	273	265	293	256	250			
Variance	17.00	-55.00	30.00	22.00	34.00	36.00	43.00	-19.00	-5			
/1000 beddays	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	4.35	5.15	4.15	3.86	4.09	4.00	4.16	4.73	4.35	4.21	4.62	4.64
25/26	4.63	4.19	4.64	4.22	4.57	4.58	4.93	4.55	4.27			
Variance	0.28	-0.96	0.49	0.36	0.48	0.58	0.77	-0.18	-0.15			

Interdependencies with other performance indicators

- Falls are closely interdependent with other key performance indicators, including emergency department (ED) length of stay, inpatient flow, patient experience, staffing capacity and overall harm metrics.
- Prolonged ED stays and delayed transfers increase patient deconditioning, fatigue and disorientation, which are associated with a higher risk of inpatient falls.
- Patients who experience a fall are also more likely to have extended lengths of stay, reduced mobility and poorer reported experience.
- There is a strong interdependency with pressure ulcer prevention, as both risks affect similar frail and immobile cohorts and require coordinated multidisciplinary management. Consequently, falls performance acts as a key proxy indicator of wider system flow, inpatient safety and quality of care.



Exec Owner Dr. Maggie Davies **SRO** Jane Woollard

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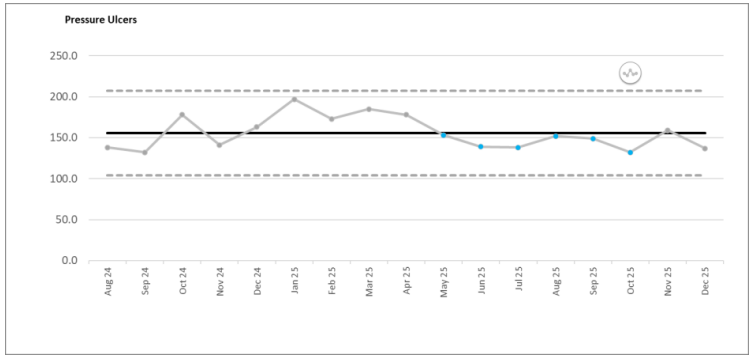
University Hospitals Sussex NHS Foundation Trust

Our Ambition: Patients: Fairness in access, experiences and outcomes					
Grade 2+ Pressure Ulcers	**Target**	2.0 per 1,000 bed days			
24/25 Actual	163	**National Rank**	n/a		
25/26 Latest Month Actual	137 (2.34 per 1000 beddays)	**National Performance**	n/a		
Latest Month Trend	Reduced	**NPAF Area: Patient Safety**		**DQ**	Green

Key Messages

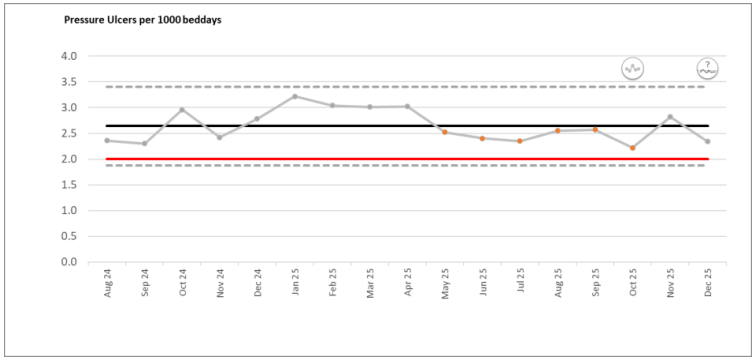
- Pressure ulcer prevention remains a priority patient safety focus for the Trust.
- The most recent data reports 137 category 2 and above pressure ulcers, reduced from 185 in March 2025 (and 163 Dec-24)
- The rolling 12-month rate is 2.58 per 1,000 bed days, above the Trust ambition of 2.0.
- Risk assessment compliance has improved to 91.6%, demonstrating strong frontline engagement and early identification of risk.
- SPC analysis confirms stable performance with no evidence of deterioration, supported by effective governance and clinical leadership.



Key Actions

- Focus improvement activity on reducing the current rate of 2.58 per 1,000 bed days toward the 2.0 ambition.
- Strengthen reliability of preventative interventions for patients identified through the 91.6% risk assessment compliance.
- Target wards contributing disproportionately to the 137 reported category 2+ pressure ulcers.
- Maintain the rolling mattress inspection and replacement programme to support ongoing prevention.
- Sustain Tissue Viability Nurse-led education and coaching to deliver continued reduction from the March peak of 185 cases.

Numbers	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	157	147	149	140	138	132	178	141	163	197	173	185
25/26	178	153	139	138	152	149	132	159	137			
Variance	21.00	6.00	-10.00	-2.00	14.00	17.00	-46.00	18.00	-14%			
/1000 beddays	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	2.67	2.44	2.60	2.38	2.36	2.30	2.96	2.42	2.78	3.22	3.04	3.01
25/26	3.02	2.52	2.40	2.35	2.55	2.57	2.22	2.82	2.34			
Variance	0.35	0.08	-0.20	-0.03	0.19	0.27	-0.74	0.40	0.4			



- **Key interdependencies with other performance metrics**
- Pressure ulcers are closely interdependent with other key performance indicators, including length of stay, patient experience, mobility, nutrition and workforce capacity. Patients who develop pressure ulcers are more likely to experience prolonged hospital stays, reduced mobility and poorer reported experience, while workforce pressures can impact the reliability of preventative care.
- There is also a clear interdependency with falls prevention, as both risks affect similar high-risk patient groups and require coordinated multidisciplinary management. As a result, pressure ulcer performance acts as a key proxy indicator of overall inpatient care quality and safety.

Exec owner Dr. Maggie Davies **SRO** Jane Woollard

Excellent Care Everywhere

Our People

Excellent
Care
Everywhere

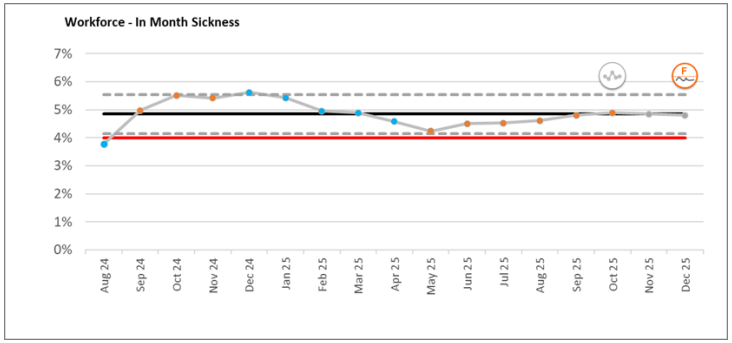
We are compassionate. We are inclusive. We are respectful.

University Hospitals Sussex NHS Foundation Trust

Our Ambition: Our People			
Sickness Absence Rates	**Target**	<4% sickness	
24/25 Month Actual	5.60%	**Regional Rank**	
25/26 Month Actual	4.80%	**National Performance**	5.0% S.E. Region (Oct-25)
Latest Month Trend	Reduced (improved)	**NPAF Area: People and Workforce**	**DQ** Green

Key Messages

- Sickness rates measure the percentage of staff absence due to illness and reflect staff health and wellbing and workforce capacity.
- In-month rates throughout 2025-26 have shown a reduction on the previous year, except for August ,with the M9 (December) figure at 4.8%. The 12 month rolling sickness absence fell to 4.9% in December 25, its lowest figure since the end of 2023. For comparison on the most recently available figures (Oct 25) UHSx is below both the ICB position at 5.3% and the south-east region-wide position at 5.0%.
- To date in 2025-26 most Divisions have achieved reductions with the best sustained performance in Specialist Division but there are other notable improvements in historically higher areas e.g. 3.9% in November in Medicine RSCH/PRH. This reflects the strong divisional focus on sickness.
- In terms of staffing groups HCAs have seen a reduction in absence through 25/26 but ancillary staff absence has slightly increased in the same period.

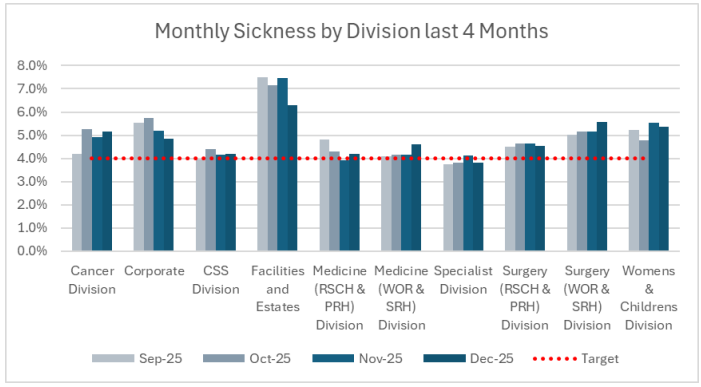


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	4.9%	4.9%	4.9%	5.4%	3.8%	5.0%	5.5%	5.4%	5.6%	5.4%	5.0%	4.9%
25/26	4.6%	4.2%	4.5%	4.5%	4.6%	4.8%	4.9%	4.9%	4.8%			
Variance	-0.4%	-0.6%	-0.4%	-0.8%	0.8%	-0.2%	-0.6%	-0.5%	-0.8%			

Key Actions

- **Nursing and Midwifery** - workstream with a focus on 72 hotspot areas for sickness, DDoNs are currently reviewing the areas of focus given improvements that have been achieved.
- **Systems** - Managers continue to be encouraged to use the facility in Healthroster to record completed return to work (RTW) interviews. A change will shortly be made to remove the 'Other' category for sickness which has seen an increase in use and this will align to a national steer to remove it.
- **Mental Health Action Plan**–MH Action plan has been produced and is currently in phase one of implementation. A change from 1 April 2026 will see a secondary reason for MH absence available on healthroster which in the future will give an improved granular breakdown of types of MH absence.
- **Medical Workforce** - a workstream to improve the recording and management of doctors' absence is underway. A medics sickness toolkit is now available to support managers.
- **Staff Group -** tailored action plans in place for HCAs and Ancillary staff.

Breakdown of Latest Month



Interdependencies with other performance indicators

- Excessive sickness can impact operational performance and bank and agency spend, and staff morale and motivation. The high level staff survey results would indicate an overall improvement in staff wellbeing.

Exec Owner David Grantham **SRO** Helen Weatherill

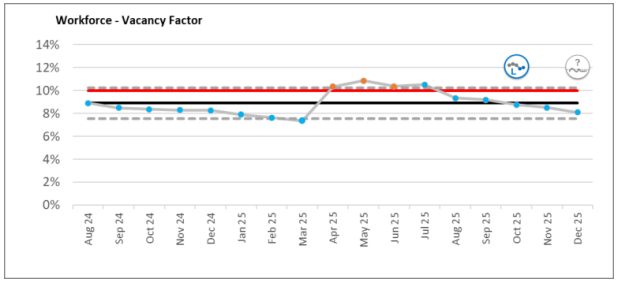
Excellent Care Everywhere

University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Our People			
Vacancy Factor	**Target**	**<10%**	
24/25 Month Actual	8.30%	**National Rank**	**Not available**
25/26 Month Actual	8.10%	**National Performance**	Not available
Latest Month Trend	Reduced (improved)	**NPAF Area: People and Workforce**	**DQ** Green

Key Messages

- The vacancy rate expresses, as a percentage of the Trust's overall budgeted establishment in month, the proportion of posts that are vacant. Vacant posts can impact service delivery, safety and temporary staffing costs.
- The Trust's budgeted establishment is 18,151 (increase of 890 from prior year). There are 16,676 wte staff in post (increase of 841 wte from prior year and an increase of 253 between Q2-Q3). The Trust currently has 1,475 wte vacancies, resulting in a vacancy rate of 8.1% for M9.
- There has been significant investment in substantive budgeted establishment (including the N&M workforce to reflect safer staffing tool outputs) and there are ongoing plans to fill these newly created posts and to keep vacancy levels within target.
- There are an additional 321 wte registered nurses and 125 wte Healthcare Assistants in the organisation since April 2026, this has impacted positively on RN agency deployment.

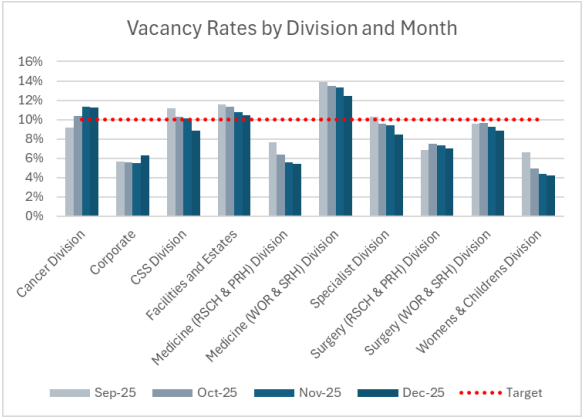


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	8.3%	8.7%	8.7%	9.0%	8.9%	8.5%	8.4%	8.3%	8.3%	7.9%	7.6%	7.4%
25/26	10.3%	10.9%	10.4%	10.5%	9.3%	9.2%	8.8%	8.5%	8.1%			
Variance	2.0%	2.2%	1.7%	1.5%	0.4%	0.7%	0.4%	0.2%	-0.2%			

Key Actions

- Filming of staff for social media and online recruitment content concluded in October 2025 and will be used in conjunction with the new "Excellent Care Starts with You" branding to launch a fresh social media campaign in April 2026 (budget dependency)
- Linked In Recruiter licence is being utilised to directly source hard-to-fill, niche roles including the following: clinical vascular scientist, biomedical scientist and a training post in biomedical science.
- Resourcing team attended the Ability Fair in Brighton on 4 November, strengthening our profile as a Disability Confident Level 3 employer and promoting inclusive employment opportunities.
- Recruitment newspaper which had a strong focus on values, inclusion and local recruitment, has now been added as a slip-book on the UHSussex careers site.
- Once budget is available in April 2026, 3 Trust vehicles will be wrapped with 'Excellent care starts with you' employer brand and recruitment advertising.
- Rolling programme of HCA and RN recruitment events.
- Retention activities such as career conversations, health and well being and staff recognition under various People programmes.

Breakdown of Latest Month



Interdependencies with other performance indicators

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

Exec Owner	**David Grantham**	**SRO**	**David Vincent**

Excellent Care Everywhere

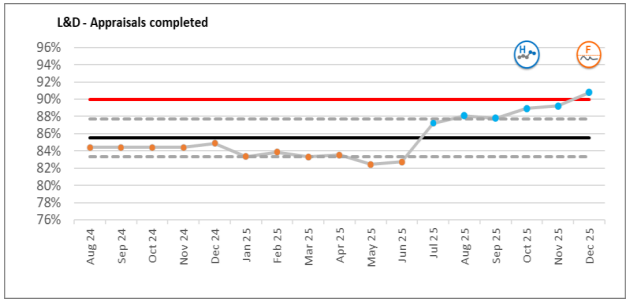
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Our People

Annual Appraisal %Compliance	Target	>90%		
24/25 Month Actual	84.90%	National Rank	Not available	
25/26 Month Actual	90.80%	National Performance	Not available	
Latest Month Trend	Increased(improved)	NPAF Area: People and Workforce	DQ	Green

Key Messages

- The metric reports the proportion of eligible non-medical staff who have an Appraisal recorded as complete within the previous 12 months.
- In Dec. 2025, **Non-Medical Appraisal Rate was 90.3%**. This is **above the 90% target**, is a further **improvement on Nov. 2025** (88.6%), and is **the highest compliance since reporting began** in Oct. 2021.
- By Staff Group, 5/8 groups are now >90%. Below target: Healthcare Scientists (84.7%), Additional Prof. Scientific & Technical (87.2%), and A&C (87.4%) – although these groups have gradually improved during 2024/25.
- 9/17 Divisions are now >90%. Lowest reported compliance are Deputy CEO (68.9%) and COO (84.0%), although both Divisions are relatively smaller (headcount).
- All but two Divisions improved position against Nov. 2025. Greatest month-to-month improvements were Deputy CEO (+3.4% points) and CSS Division (+3.8% points).

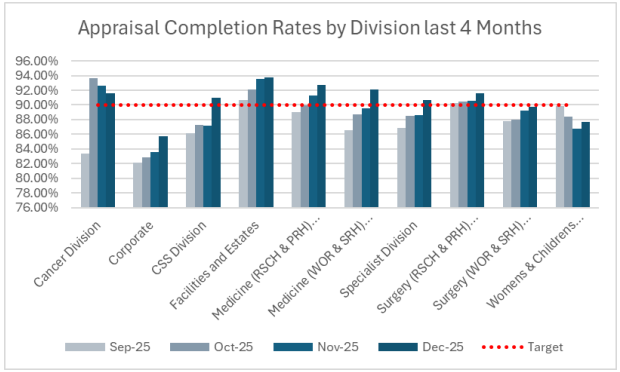


Incl Medics	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	80.6%	81.8%	82.2%	82.4%	82.4%	84.3%	83.3%	83.9%	84.9%	83.4%	83.8%	83.3%
25/26	83.5%	82.4%	82.7%	87.2%	88.1%	87.8%	88.9%	89.2%	90.8%			
Variance	2.9%	0.7%	0.6%	4.8%	5.7%	3.5%	5.6%	5.3%	5.9%			
Non-medics	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25						84.5%	83.3%	83.9%	84.8%	83.1%	83.7%	83.0%
25/26	82.3%	81.1%	81.4%	86.2%	87.3%	87.1%	88.3%	88.6%	90.3%			
Variance						2.6%	5.0%	4.7%	5.5%			

Key Actions

- Appraisal compliance continues to be a **strong focus of COO performance meetings** with Divisions, and **support from HRBPs to Divisional Management Teams**.
- Refreshed Non-Medical Appraisal documentation and guidance will be introduced in Q4 2025/26. Appraisee **qualitative feedback remains very positive**, eg. 92% report appraisal was positive experience overall, 92% felt safe to talk about personal issues.
- The refreshed Non-Medical Appraisal Policy is due to be approved in Feb. 2026.

Breakdown of Latest Month



Interdependencies with other performance indicators

- Effective appraisal is strongly linked with staff engagement and patient outcomes, and is a critical enabler of *Excellent Care Everywhere*.
- The overall improvement in compliance during 2024/25 has been achieved in spite of significant operational pressures – this remains a challenge for line managers.

Exec Owner David Grantham **SRO** Nick Groves

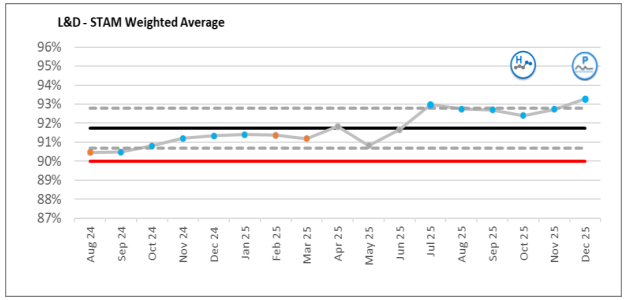
Excellent Care Everywhere

University Hospitals Sussex NHS Foundation Trust

Our Ambition: Our People			
Statutory and Mandatory Training Compliance %	**Target**	**>90%**	
24/25 Month Actual	91.30%	**National Rank**	**Not available**
25/26 Month Actual	93.30%	**National Performance**	Not available
Latest Month Trend	Increased (improved)	**NPAF Area: People and Workforce**	**DQ** Green

Key Messages

- 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.
- The UHSussex STAM compliance rate continues to be strong, with a rate of 93.3% in M9 (December), 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 85.9% (the ninth month in a row within the 80% range), all other groups are compliant above 90%
- Divisionally, all divisions are above the 90% compliance rate

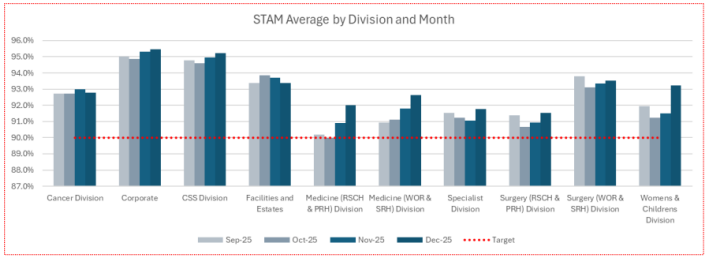


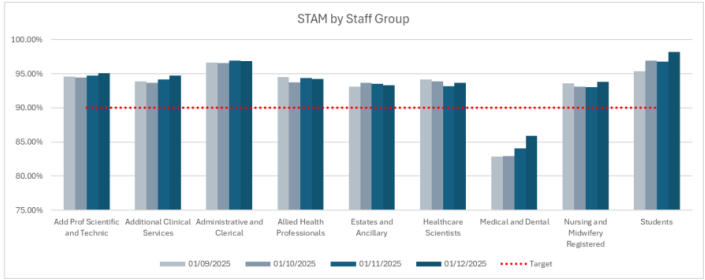
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	90.5%	90.7%	90.6%	90.7%	90.5%	90.5%	90.8%	91.2%	91.3%	91.4%	91.4%	91.2%
25/26	91.8%	90.8%	91.7%	93.0%	92.7%	92.7%	92.4%	92.7%	93.3%			
Variance	1.3%	0.1%	1.1%	2.3%	2.3%	2.2%	1.6%	1.5%	2.0%			

Key Actions

- 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 (87% although up from 84% last month) 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.

Breakdown of Latest Month





Interdependencies with other performance indicators

- STAM compliance features in the expectations of a number of regulators and ensures staff have basic competancies and awareness impacting health and safety and patient and staff experience.

Exec Owner David Grantham **SRO** Martyn Clark

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Communities

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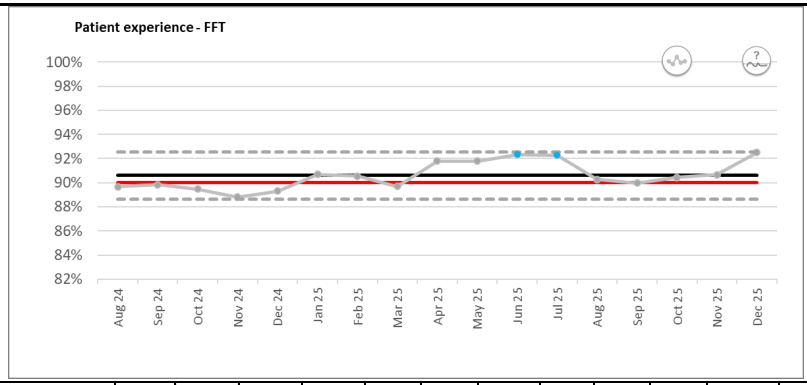
Our Ambition: Communities					
Patient Experience: FFT	**Target**	>90%			
24/25 actual	89.3%	**National Rank**	48th of 121 A&E, 103 of 131 Inpatients, 16th of 130 outpatients		
Latest Month Actual	92.5%	**National Performance**	91.12% (Nov-25)		
Latest Month Trend	Increased (improved)	**NPAF Area: Patient Experience**		**DQ**	Green
Key Messages					

- The Friends and Family Test (FFT) is a survey being distributed to ask patients to rate their care on a scale of very good (1) to very poor (5) and to give a reason for their score. The survey is grouped into four touchpoints – ED, maternity, inpatients and outpatients.
- Based on available FFT data, the significant majority of patients (over 92% at the end of Q3 2025/26) are satisfied that they have a good or very good experience of care, based on more than 30,000 responses.
- Patient reported experience of ED closely aligns to 4-hour performance
- The positive experience of care episodes identified through FFT is in contrast to trajectories for volumes of complaints and concerns, which are steeply upward. Triangulated data across complaints, PALS and other patient feedback identifies that the most prevalent causes of poor patient experience are delays to treatment, follow up, referral onward, results and tests, clinical care, the communication with the patient (including responsiveness by phone and email) and the behaviour of doctors.



Key Actions

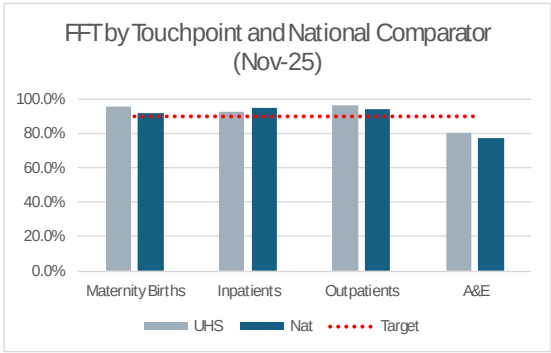
- Emergency department improvements and waits are integrated within the new strategy, and drivers such as 4-hour performance and RTT targets are integrated within the IPR. Patient reported experience via FFT will improve with reducing 4 hour and 12 hour waits, and ambulance handover times.
- A new FFT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

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	88.9%	89.4%	88.8%	89.0%	89.7%	89.8%	89.5%	88.8%	89.3%	90.7%	90.5%	89.7%
25/26	91.8%	91.8%	92.3%	92.3%	91.7%	90.0%	90.4%	90.7%	92.5%			
Variance	2.9%	2.4%	3.6%	3.3%	2.0%	0.1%	1.0%	1.9%	3.2%			

Breakdown Latest Month

Nov-25

FFT Scores	UHS	Nat
Maternity Births	95.2%	92.0%
Inpatients	92.1%	94.6%
Outpatients	96.5%	94.0%
A&E	79.9%	77.1%



Interdependencies with other performance indicators

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

Exec Owner Dr. Maggie Davies **SRO** Nicole Chavaudra

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Future

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Our Ambition: Excellent Care for the Future					
Financial Stablility/variance from Breakeven Plan	**Target**	£0			
25/26 Plan YTD (£m)	£15.54m deficit	**National Rank**	n/a		
25/26 Actual YTD (£m)	£16.51m deficit	**National Performance**	n/a		
Latest Month Trend	Increased (worsened)	**NPAF: Finance and Productivity**		**DQ**	Green
Key Messages					

- The Trust submitted a revised breakeven financial plan for 2025/26; the YTD plan at M9 is for a £15.54 deficit. The actual deficit is £16.51m, which is £0.97m adverse to plan.
- The plan to achieve the breakeven position includes the delivery of a £112.96m efficiency programme. This programme is phased; efficiences increase as additional schemes are due to commence through the year. The YTD plan at M9 is for efficiency delivery of £62.13m. Actual delivery is £55.07m, £7.06m adverse to plan. The position includes £11.48m benefit of non-recurrent schemes.
- The cash position is £3.31m which is £0.89m favourable to plan.
- The capital expenditure plan is adjusted through the year to recognise additional capital funding that has been granted to the Trust. As at M9 the full-year plan totals £139.58m of which £94.13m is YTD. Actual capital expenditure YTD is £84.34m, £9.79m behind plan. This in-part reflects in-year timing differences but brokerage of funding between financial years is being explored where some schemes are now expected to slip into 2026/27.

2025/26 M09 £m	Annual Plan	YTD		
		Plan	Actual	Variance Fav/(Adv)
I&E (Surplus) / Deficit	0.00	15.54	16.51	(0.97)
Efficiency	112.96	62.13	55.07	(7.06)
Cash	2.42	2.42	3.31	0.89
Capital	139.58	94.13	84.34	9.79

YTD as at	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	4.94	9.78	13.10	14.28	14.98	15.18	14.19	14.33	15.54			
Actual	4.67	9.29	12.62	13.79	14.96	15.16	15.16	15.30	16.51			
Variance	0.27	0.49	0.48	0.49	0.02	0.02	-0.97	-0.97	-0.97			

Key Actions

- The financial plan requires a transisition from monthly deficits to surpluses as the year progresses in order to deliver the final breakeven position. This is planned to be achieved through increased delivery of cost improvement plans. Delivery of schemes is montiored on an on-going basis with mitigations sought to offset any underdelivery.
- There is an over-arching risk that the Trust will not deliver the financial plan as a result of a number of key contributors: delivery of the full efficiency target, cost of elective recovery within tariff and funded envelopes, 2024/25 exit run-rate above 2025/26 planning assumption, the clawback of ERF funding should insufficent activity be delivered and non-elective activity volumes driving costs. The previously noted risk arising from industrial action has been mitigated through receipt of addditional funding although this is subject to clawback should the Trust not deliver its financial plan. Following the H2 delivery "sprint" work, members of the Executive Team now meet on a weekly basis with operational division leadership teams to review progress on development of plans to meet activity and financial targets and monitor delivery of these.
- Internal Audit have completed their assessment of the Trust against the Healthcare Financial Management Association publication 'Improving NHS financial sustainability: are you getting the basics right?'. As measured on a maturity scale, of the eight domains reviewed six were rated as mature (4/5) and two as proactive (3/5). Where not already in place, plans will be developed to address areas where practice needs to be improved.

Interdependencies with other performance indicators

- RTT performance: securing the variable ERF income that is assumed in the financial position requires relevant clinical activity to be undertaken and fully and appropriately recorded.

Exec Owner Jonathan Reid **SRO** Naeem Uddin

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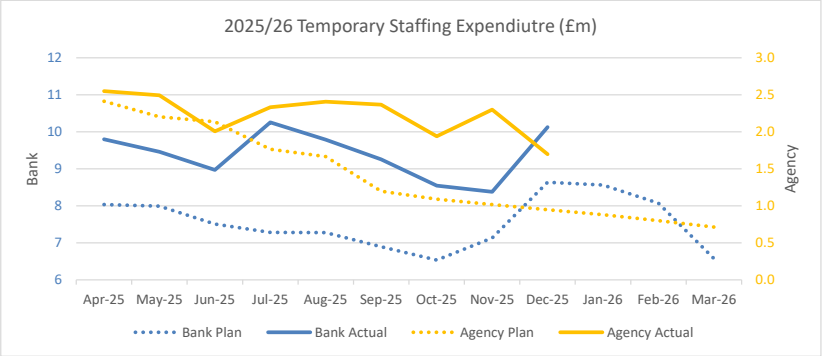
Our Ambition: Excellent Care for the Future					
Temporary Staffing Expenditure against Plan	**Target**	<£90.51M 25/6 Bank; £16.84M Agency			
25/26 Plan YTD (£m)	81.74	**National Rank**			
25/26 Actual YTD (£m)	104.68	**National Performance**			
Latest Month Trend	Increased (worsened)	**NPAF: Finance and Productivity**	**DQ**	Green	
Key Messages					

- The 2025/26 national planning guidance included a requirement for systems to reduce their temporary staffing expenditure; agency by a minimum of 30% and bank by a minimum of 10%. This system requirement flows into provider organisations planning for reductions in temporary staffing expenditure.
- The UHSussex 2025/26 plan is for 13.5% year-on-year reduction in bank staff expenditure from £104.6m in 2024/25 to £90.5m and a 49.1% reduction in agency staff expenditure from £33.1m to £16.8m. This means a total planned reduction in temporary staffing costs of 22.0%. NB The financial values given are for revenue expenditure only; temporary staff are also used in delivering some capital projects.
- The reductions in temporary staffing expenditure, particularly the premium agency costs, contribute to delivery of the Trust's efficiency programme and support delivery of high quality care.
- Planned monthly bank expenditure, while variable through the year, reflects a monthly reduction from £8.0m in M1 to £6.6m in M12.
- Actual bank expenditure to M9 is in excess of plan each month and by a cumulative total of £17.3m. This includes the impact of industrial action.
- Agency expenditure is planned to reduce on a monthly basis from £2.4m in M1 to £0.7m in M12.
- Actual agency expenditure to M9 is in excess of plan in all months apart from M3 giving a cumulative total overspend of £5.7m.



£m	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	YTD	Annual Plan
Bank Plan	8.04	7.99	7.51	7.28	7.28	6.90	6.53	7.13	8.64	8.57	8.07	6.58	67.30	90.51
Bank Actual	9.80	9.46	8.97	10.25	9.79	9.26	8.55	8.38	10.13				84.59	
Variance	(1.76)	(1.47)	(1.46)	(2.97)	(2.51)	(2.36)	(2.01)	(1.25)	(1.49)				(17.29)	
Agency Plan	2.41	2.20	2.14	1.77	1.67	1.20	1.09	1.02	0.95	0.88	0.80	0.71	14.44	16.84
Agency Actual	2.55	2.49	2.01	2.33	2.41	2.37	1.94	2.30	1.70				20.10	
Variance	(0.14)	(0.29)	0.13	(0.57)	(0.74)	(1.17)	(0.85)	(1.28)	(0.75)				(5.66)	
Combined Plan	10.45	10.19	9.65	9.05	8.94	8.10	7.62	8.15	9.59	9.45	8.88	7.29	81.74	107.35
Combined Actual	12.35	11.96	10.98	12.59	12.20	11.62	10.49	10.68	11.83				104.68	
Variance	(1.90)	(1.76)	(1.33)	(3.54)	(3.25)	(3.53)	(2.86)	(2.53)	(2.24)				(22.95)	

Key Actions

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

Interdependencies with other performance indicators

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

Exec Owner Jonathan Reid **SRO** Naeem Uddin

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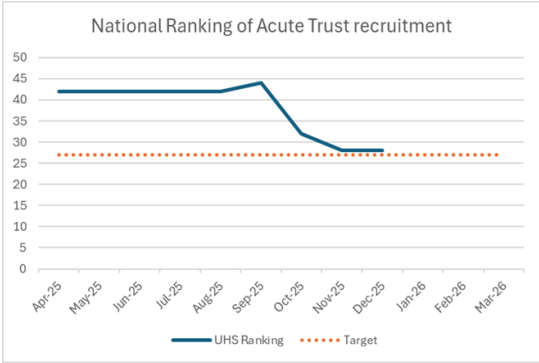
Our Ambition: One UHSx					
Recruitment to studies national ranking	**Target**	27th or less			
24/25 Actual	55th	**National Rank**			
25/26 Actual	28th	**National Performance**			
Latest Month Trend	Reduced (improved)	**NPAF Area: Access to Services**		**DQ**	Green
Key Messages					

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



Key Actions

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

Exec Owner	**Prof Katie Urch**	**SRO**	**Martin Llewellyn**

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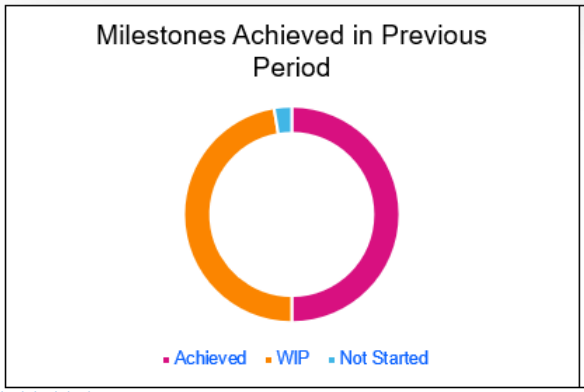
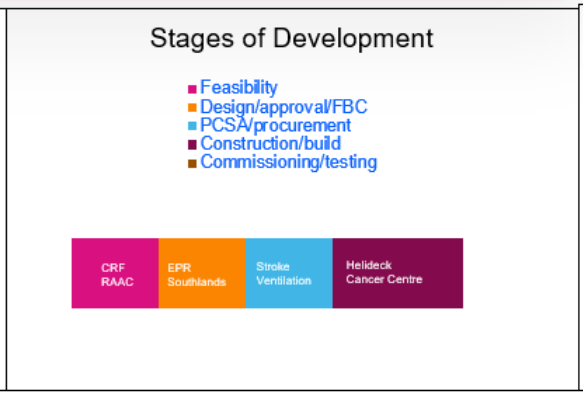
Major Projects Portfolio Overview

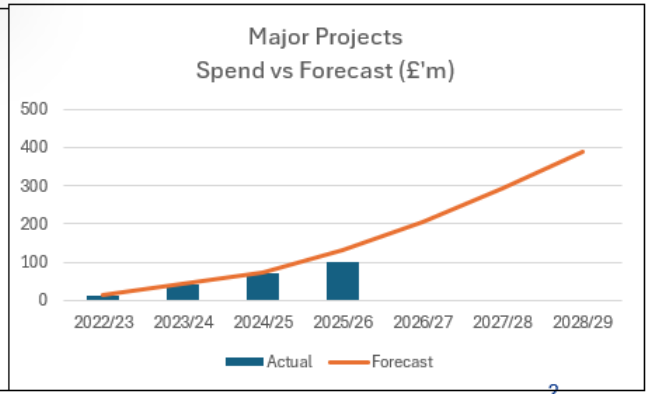
The portfolio has achieved many key milestones during the period, and we continue to make strong progress across the large, complex portfolio the Trust is holding. The **financial profile remains slightly off forecast** reflecting the timeline challenges that some projects have experienced. **Procurement legislation changes during 2025 have heavily impacted early stage major projects** and the teams are now working together to better understand how processes can be completed in parallel and timelines minimised. Following work on lessons learnt, **changes in communication on cost management and timelines will be implemented** to improve both cost to budget management and expectation setting. The portfolio holds the reins on a number of highly complex projects including the **SRH RAAC remediation and Service Hub projects that are interdependent** and complex to resolve across all aspects of cost, programme timings and clinically preferred solutions. The governance through SMPB provides a strong forum for decision making and **conflicting priority resolution** where the interdependencies are all major projects but there are still challenges (which need resolving) on visibility of these interdependencies with smaller or Divisional projects. In the next period key focus areas will be agreement of the **do minimum option for SRH RAAC Remediation, tender for Southlands theatres, tender award for RSCH AFR & reconfirmation of cost and design changes, decant plan for RSCH theatres to support Ventilation programme, opening of Helideck and agreement of preferred solution for Clinical Research Facility –** These focus areas will impact positively on the overall portfolio health ratings which remain unchanged from the previous reporting period.

Portfolio Health

Project/Programme		Cost		
	Time	£R	£C	Qlty
Stages 2&3	🟢	🟢	🟢	🟢
Helideck	🟡	🟢	🟢	🟢
EPR	🟢	🟢	🟢	🟢
Stroke Reconfiguration	🟢	🟢	🟡	🟢
RSCH AFR	🟡	🟢	🔴	🟢
Clinical Research Facility	🟢	🟢	🟡	🟡
Southlands Theatres	🟡	🟢	🟡	🟢
SRH RAAC Remediation	🟡	TBC	TBC	🟡
Theatre Ventilation	🟢	🟢	🟢	🟢
Property Rationalisation	🟢	🟢	🟢	🟢







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Anticipated Challenges and focus in the next period

Major project	Challenges and Actions in Next Period
Helideck	• Implementation of a decant space for level 1 neonates to enable window work to take place in the nurseries (should be complete by SMPB) • Completion of capital works to TKT windows to planned timeline due to need to decant neonates • Occurrence of high winds have impacted the ability to complete works more frequently than planned and this remains a risk outwith our control .
Stroke	• Financial revenue model to be finalised and mitigation to overcommitment identified – ICB commitment to £3.7m and additional £365k related to pay awards and NI contributions to be secured • RIBA Stage 4 report to be released and final capital costs to be agreed
RSCH AFR	• External consultants reconfirming designs and costings inc. Redesign of IT hub to support cost management and delay to enabling works (no impact on overall programme delivery) • Workforce modelling and costing for phases 2 & 3 and development of benefits plans • Finalisation of designs for Phase 2 & 3 ahead of tendering for works
Clinical Research Facility	• Refreshed options to SMPB with re-costings following feasibility study outcomes • Agreement on most appropriate option to pursue needs to be taken in January
Southlands Theatres	• The requirement to switch procurement strategy, to use SBS framework, has driven significant change to programme timeline • Focus on design to keep within financial budget will be required
SRH RAAC Remediation	• Focus on agreeing options for SOC, due February
Ventilation	• Programme is running to an aggressive timeline so there is risk as no built-in contingency. Contract placement for mobile theatres is critical path • Options paper for decant theatre at RSCH has been development to facilitate decision making – provision of decant space is essential to progress • WGH and non-theatre ventilation will progress post procurement of decant theatres and initial survey works

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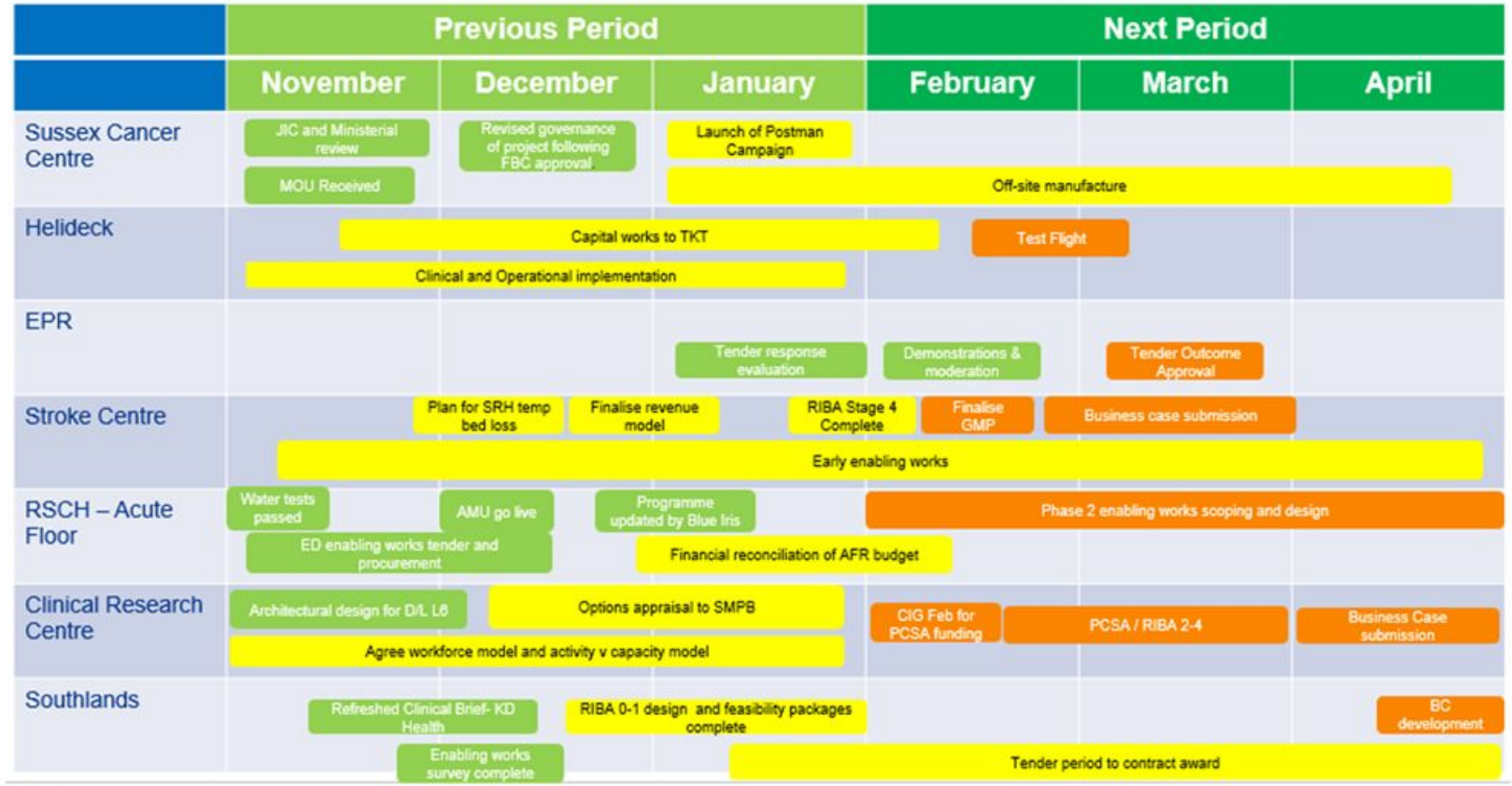
Key Milestones in previous and next period



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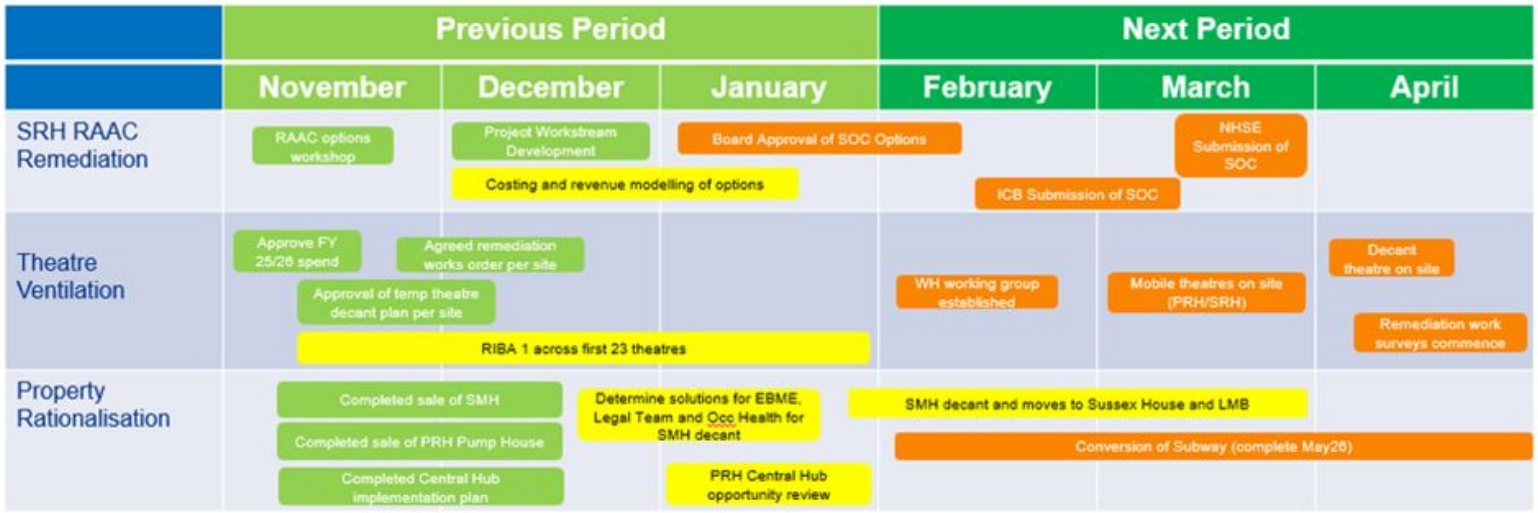
Key Milestones in previous and next period cont.



Completed

WIP

Not started

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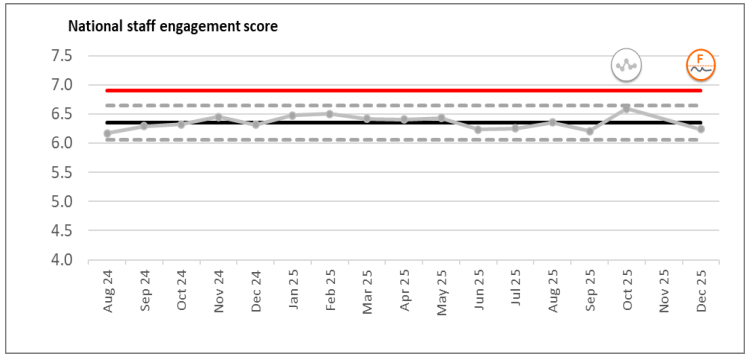
Our Ambition: One UHSx					
Staff Engagement Scores	**Target**	>6.9			
24/25 Actual	6.29	**National Rank**			
25/26 Actual	6.21	**National Performance**	6.85 - 2024 National NHS Staff Survey		
Latest Month Trend	Reduced (worsened)	**NPAF Area: People and Workforce**		**DQ**	Green

Key Messages

- Staff engagement is measured nationally through the NHS annual Staff Survey and quarterly People Pulse survey, and locally through the monthly UHSussex Pulse Survey.
- The third quarter of the 2025-26 year has remained below the national average staff engagement score in the UHSussex monthly Pulse Survey, ending with a score of 6.24 (out of 10) in December 2025 (Q3 score range: 6.24 to 6.59). This is compared to our 6.32 score in December 2024. The Trust achieved the staff engagement target in the first quarter of 2024 but it has been consistently below 7.0 from July 2024 onwards.
- Our staff engagement score was 6.59 (out of 10) in the 2024 national NHS Staff Survey, compared to the national acute Trust average score of 6.84. Although our score has declined slightly since 2021, the gap to the national average has stayed consistent. 2025 NHS Staff Survey results will be available in March.
- UHSussex scored 5.49 (out of 10) in the most recent July 2025 national NHS People Pulse quarterly survey, compared to the 6.29 national average score.

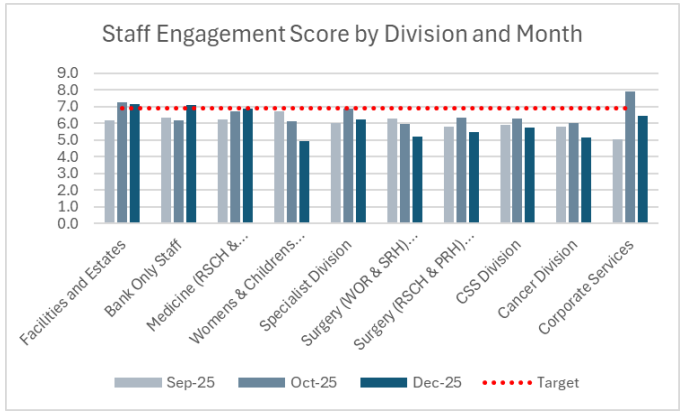


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	7.3	7.1	7.3	7.1	6.9	6.3	6.3	6.5	6.3	6.5	6.5	6.4
25/26	6.4	6.4	6.2	6.3	6.4	6.2	6.6		6.2			
Variance	-0.9	-0.7	-1.0	-0.8	-0.6	-0.1	0.3		-0.1			

Key Actions

- The People and Culture Strategy Delivery Plan has been agreed and sets out the programmes being delivered by the People Directorate that support achievement of the Trust's strategic ambitions. Delivery of these priorities is expected to improve UHSussex as an employer, with a corresponding improvement anticipated in staff engagement scores.
- Following recent changes in leadership of the Culture Programme, strategic refinement of the Culture work is underway to ensure it remains responsive to organisational needs.
- A paper presented to the People and Culture Assurance Committee in January summarised the findings of a review and external benchmarking of the Trust's staff experience insight mechanisms and their governance. It found that the current mix of national and local measures, supported by workforce intelligence, aligns with best practice. The priority now is to strengthen participation, triangulation and reporting discipline, rather than introduce new tools. Work is underway to improve response rates, consolidate insight and establish a more consistent reporting cycle, providing a stronger evidence base for Well-led oversight and delivery of the Trust Strategy.

Breakdown Latest Month



Interdependencies with other performance indicators

- When triangulating a low staff engagement score with other workforce metrics, it is common to see a correlation with high sickness absence and turnover rates. However, these rates are comparatively positive (4.8% and 6.2% respectively) and our stability rate is 91.8%.

Exec Owner David Grantham **SRO** Helen Weatherill

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National Performance Assessment Framework and League Tables

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National Performance Assessment Framework and League Tables

University Hospitals Sussex NHS Foundation Trust

Current segmentation

- The Trust remains within Segment 4 of the National Performance Assessment Framework (NPAF), noting the national judgement on segmentation is based on Quarter 2 information. The framework contains five segments from best performing segment 1 to those requiring mandated support segment 5. The Trust has submitted its provider capability assessment which as with all providers will be used by NHS England to determine if any new Trusts need to move into segment 5 and into the national Trusts provider improvement programme.
- The Trust continues to engage with NHS England and the ICB through their formal oversight processes in respect of all aspects of our performance, which through these quarterly meetings provide assurance on the delivery of Trust's annual plan.
- The segmentation for quarter 3 will be undertaken in due course.

Drivers of the segmentation

- During Q2 the Trust continued to focus on Emergency Care, Cancer and Planned Care delivery. The Trust remains within Tier 1 oversight for Planned Care performance having exited Tier 1 for cancer performance and remains in Tier 2 oversight for Emergency Care performance, where we are seeing enhanced performance oversight continue with NHS England. The Trust whilst continuing to make significant progress in reducing its overall RTT waiting list numbers and meeting its planned care performance plan did not achieve zero patients waiting over 65 weeks and in respect of emergency care performance the Trust has not made the performance gains it expected to within the quarter. The Trust, also within quarter 2 saw a decrease within its cancer performance.
- The Trust has met its financial plan for the first half of the year, and continued to meet its plan in quarter 3, however, the Trust has a deficit meaning that the Trust cannot be placed into a segment above 3. The Trust in developing is 2025/26 plan has recognised that there remains a degree of risk in achieving its breakeven position by the year end and this is reflected within the BAF financial strategic risk. 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 and is recognised that the Trust's productivity performance domain's relative performance against other Trusts being slightly above average.
- The Board Assurance Framework, as reported to the Board shows a predicted continued level of elevated strategic risks especially in the areas of Quality and Finance strategic risks.

Implications of this segmentation

- As the Trust is not in segment 5 of the framework it is not in receipt of mandated support, however the Trust has utilised its position within segment 4 to secure access to external advice and support specifically within the areas of UEC improvement and patient flow and with an extended review of the drivers of the Trust's financial deficit.

Actions being taken to move from segment 4

- The Trust's developed Strategy sets out the Trust's ambitions over the next 5 years to 2030. As these ambitions are translated into the respective annual delivery plans these seek to move the Trust forward to provide excellent care everywhere and lift the Trust from segment 4. However, the Trust recognises it has much to do, namely in the area of culture and to improve its access performance. The Trust has undertaken a review against its undertakings and submitted this to NHS England but given the Trust's operational performance and finance risks the Trust does not expect to exit segment 4 in the first part of 2026/27.
- The Board either directly or through its Patient and Quality, People and Culture and Finance and Performance Assurance Committees continues to exert oversight of the delivery of the respective improvement plans. This is complemented through the receipt of and actioning of feedback from the routine NHS England Provider Oversight meetings to determine areas of improvement that can be progressed more effectively to aid the movement from segment 4.
- The Trust does recognise given the degree of operational and financial risks that the Trust may be considered for support via the Provider Recovery Support Programme and has already proactively commenced work to understand actions that can be taken to improve flow and to address the drivers of the deficit to enable the Trust to be in a stronger position for 2026/27 – 2027/28.

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National Performance Assessment Framework and League Tables

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Select a trust

University Hospitals Sussex NHS Foundation Trust (RYR)

View the glossary page

Average score

2.84

Higher by 0.02 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).

Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

Yes

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

4 - Low performing

Previous quarter's segment: 4

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

Some of the more challenged trusts may be referred to the Recovery Support Programme and therefore allocated to a fifth segment.
How has segment been calculated?

Trust rank

113 out of 134

Previous quarter's rank: 117 out of 134

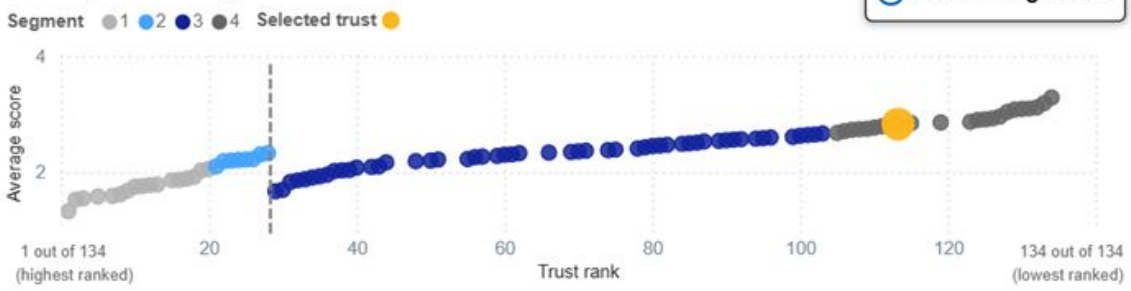
Each trust receives a rank based first on their segment and then their average score within that segment. Ranks range from 1 (the segment one trust with the lowest average score) to 134 (the segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Access to services	4 - Low performing
Finance and productivity	2 - Above average
Effectiveness and experience	4 - Low performing
Patient safety	4 - Low performing
People and workforce	3 - Below average

Average score by trust rank placement

View full league table



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National Performance Assessment Framework and League Tables

University Hospitals Sussex NHS Foundation Trust

ACCESS

University Hospitals Sussex NHS Foundation Trust (RYR) | All

Quarter	Segment	Access to services domain segment
Q2 2025/26	4 - Low performing	4 - Low performing

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Access to services	Cancer care	Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Q2 2025/26	72.98	%	-3.41 ↓	3.22	85 out of 118	76.04	80
Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	Q2 2025/26	60.93	%	-0.67 ↓	3.58	101 out of 118	69.28	75
Access to services	Elective care	Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Sep-25	4.39	%	-0.79 ↑	3.80	121 out of 131	2.07	1
Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Sep-25	22.95	%	-10.15 ↑	3.75	72 out of 79	0.54	
Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Sep-25	51.55	%	0.25 ↑	3.88	126 out of 131	61.18	
Access to services	Elective care	Difference between planned and actual 18 week performance	Sep-25	0.06	percentage points	-0.57 ↓	1.00	62 out of 131	-0.04	0
Access to services	Urgent and emergency care	Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q2 2025/26	70.60	%	-2.00 ↓	3.38	99 out of 123	75.70	78

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National Performance Assessment Framework and League Tables

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NHS Foundation Trust

Patient Safety

Select a trust

University Hospitals Sussex NHS Foundation Trust (RYR)

Select metric(s)

All

Quarter	Segment	Patient safety domain segment
Q2 2025/26	4 - Low performing	4 - Low performing

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Patient safety	Patient safety	Number of MRSA bacteraemia cases	Oct 24 - Sep 25	2.00	count	-1.00 ↑	2.33	39 out of 134	3.00	0
Patient safety	Patient safety	Proportion of E. coli bacteraemia	Oct 24 - Sep 25	1.12	rate	-0.04 ↑	2.43	48 out of 134	1.18	1
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.03	out of 10	0.00 →	3.75	123 out of 134	6.42	
Patient safety	Patient safety	Proportion of C. difficile infections	Oct 24 - Sep 25	1.31	rate	-0.03 ↑	3.26	95 out of 134	1.18	1

National Performance Assessment Framework and League Tables

University Hospitals Sussex NHS Foundation Trust

Effectiveness and Experience

Select a trust: University Hospitals Sussex NHS Foundation Trust (RYR)

Select metric(s): All

Quarter	Segment	Effectiveness and experience domain segment
Q2 2025/26	4 - Low performing	4 - Low performing

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Sep-25	1.78	days	0.08 ↓	3.76	115 out of 125	0.78	
Effectiveness and experience	Patient experience	Summary Hospital-level Mortality Indicator	Jul 24 - Jun 25		score		2.00			
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2024		score		2.00			

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National Performance Assessment Framework and League Tables

University Hospitals Sussex NHS Foundation Trust

Finance and Productivity

Select a trust: University Hospitals Sussex NHS Foundation Trust (RYR)

Select metric(s): All

Quarter	Segment	Finance and productivity domain segment
Q2 2025/26	4 - Low performing	2 - Above average

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Finance and productivity	Finance	Planned surplus/deficit	2025/26	-1.62	%	0.00 →	3.00	69 out of 134	-1.54	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 6 2025	0.00	%	-0.12 ↓	1.00	46 out of 134	0.00	
Finance and productivity	Finance	Combined finance	Q2 2025/26		score		2.00			
Finance and productivity	Productivity	Implied productivity level	Q1 2025/26 vs Q1 2024/25	5.93	%	-0.49 ↓	1.50	23 out of 134	1.77	

National Performance Assessment Framework and League Tables

University Hospitals Sussex NHS Foundation Trust

People and Workforce

Select a trust

University Hospitals Sussex NHS Foundation Trust (RYR)

Select metric(s)

All

Quarter

Q2 2025/26

Segment	People and workforce domain segment
4 - Low performing	3 - Below average

Return to overview

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
People and workforce	Retention and culture	Sickness absence rate	Q1 2025/26	4.34	%	-0.75 ↑	1.76	45 out of 134	4.72	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	6.59	out of 10	0.00 →	3.55	114 out of 134	6.88	

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University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	11.	**Meeting:**	Trust Board in Public	**Meeting Date:**	5 February 2026
Report Title:	Board Assurance Framework report Q4				
Executive Sponsor	Helen Brown – Chief Corporate Affairs Officer				
Author(s):	Glen Palethorpe – Company Secretary				
Purpose of the report: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For discussion**	**For Information only**	
	Yes	*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	*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 *(summary of current position / issue & why it matters and evidence to support that position etc)*

The Board at its meeting in June agreed the opening 11 Strategic Risks that make up the BAF, noting their alignment to the Trust's new strategic ambitions. Each strategic risk has an allocated Executive lead and oversight Committee.

The respective lead Executives have updated the BAF in respect of their review of the assurances received in quarter 3 allowing them to provide a look back and look forward summary in support of their proposed quarter 4 scores.

The Audit Committee continued to receive the BAF and a report in respect to the underpinning processes at its meeting in February. Each allocated oversight Committee also considered their element of the BAF agreed with the executives view that the reports and assurance received in quarter 3 supported the view to reduce marginally the scores of three strategic risks, risk 2 (culture), risk 5 (non-digital infrastructure) and risk 6 (performance) which sees these risks achieve their target score of the quarter.

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 over the underpinning BAF oversight processes.

The Board is asked to note the recommendations of the respective committees that there should be a reduction to the scores of three strategic risks, risk 2, 5 and 6 to each of their respective target scores.

The BAF reflects that five of the risks are above their target score and four risks remain significantly scored for the year, these being risk 1 (quality), risk 4 (finance), and risks 8 and 9 (both digital).

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

The Board should consider the recommendations from the respective Committees in relation to the quarter 4 scores.

The Board should note that work has commenced on determining the 2026/27 Strategic risks which will be discussed by the Board at a later meeting which will then be used to populate the 2026/27 BAF.

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Recommendation *(linked to What Next section)*	*The Board should **NOTE** the assurance provided by the process of Committee review of the BAF.* *The Board is asked **AGREE** the quarter 4 scores, noting the support for these scores by the relevant oversight committees, including a reduction in the score of risks, 2, 5 and 6 to their target scores for the year.* *The Board is asked to **NOTE** that five of the risks are above their target score and four risks remain significantly scored for the year, these being risk 1 (quality), risk 4 (finance), and risks 8 and 9 (both digital).*

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 February 2026* *Each of the respective oversight committees considered their element of the BAF at their meetings at the end of January 2026.*					
Link to Trust Strategy (note which theme)	**Patient**	**People**	**Future**	**Communities**	**One UHSussex**	**Culture**
	Yes	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*
Link to annual delivery plan	*The BAF provides a mechanism to consider the strategic risks to the strategy achievement and thus the delivery of the annual delivery plan.*					
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	*This report covers all BAF risks*					

Link to CQC domain	**Patients**	**Caring**	**Effective**	**Responsive**	**Well-led**	**Use of Resources**
	Yes	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*

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

University Hospitals Sussex NHS Foundation Trust

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 strategic ambitions.

2 BAF Structure

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

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

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

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

2.5 The Board has commenced its review of its risk appetite statements, and a workshop is to be arranged to enable the 2026/27 Strategic Risks to be considered alongside the respective risk appetite statement. Following feedback from the Audit Committee chair a slightly updated BAF format is in development with a view that this will be shared at the Board Workshop

3 BAF Quarter 4 Committee Review of the BAF

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 Each Committee met in January 2026 as planned and reviewed their allocated elements of the BAF and they each agreed with the Executive recommended score

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

3.3.1 Patient and Quality Assurance Committee

The Committee agreed that for the patient and quality strategic risk, the score should not change, recognsing that whilst the actions are progressing the score has not changed and that this score in line with the Board decision to set a target score for the year of 20.

The Committee reflected that there continued to be an improvement in the assurances reported which continues to bring greater clarity to the gaps in control and these link directly to the actions within the BAF and the reports being provided to the Committee.

3.3.2 People and Culture Assurance Committee

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

The Committee agreed that the reports it received and the detail within the BAF did support a marginal reduction in the strategic risk relating to Culture, to its target score for the year of 16. The Committee continued to discuss the cultural improvement plan and delivery actions to enable the Trust to move towards its goal score for this risk over the life of the Trust's Excellent Care Everywhere strategy.

3.3.3 Research, Innovation and Digital Assurance Committee

The Committee received assurances supporting the continued reduced score for the research strategic risk 7.

In respect of the two digital strategic risks the Committee agreed that the scores should not reduce noting the degree of action still to be completed and the Trust's continued digital immaturity.

3.3.4 Finance and Performance Assurance Committee

The Committee agreed that for the finance strategic risk, risk 3, that the reports it had received and the reports provided directly to the Board supported the view that this risk had not reduced. The Committee recognised that the risk score reflects the degree of risk within the delivery of the Trust's H2 financial plan.

The Committee did agree that based on the assurances received that there should be a marginal reduction in the other two strategic risks it has oversight of these being, risk 5 (non-digital infrastructure) and risk 6 (performance). The Committee did note that whilst these scores had reduced overall there did remain work to be delivered through the established Estates Improvement Plan and the Urgent Care Improvement Plan.

3.3.5 Strategy and Major Projects Assurance Committee

The Committee when it considered each of its two allocated risks agreed that the reports received supported that the risk scores should not reduce in quarter 4. The Committee agreed that the actions taken in the year whilst not yet reducing the risk score had improved the control environment which was reflected in the BAF.

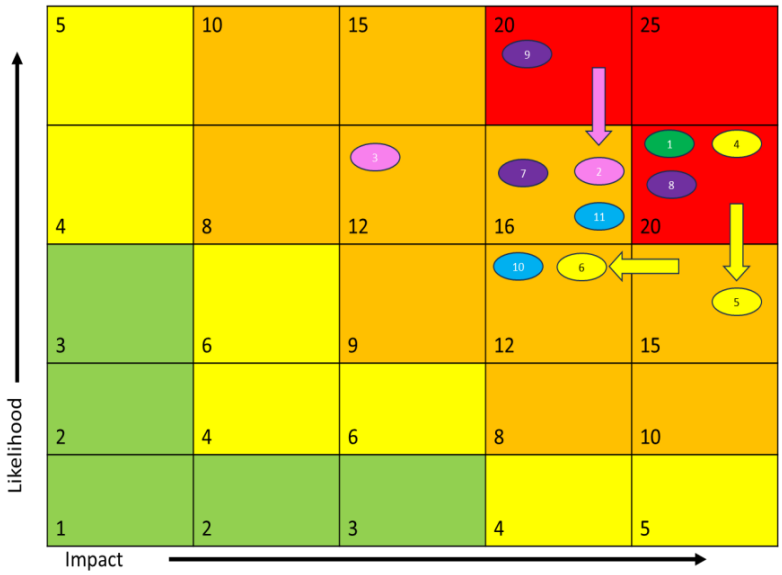
3.3.6 Audit Committee

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 undertook a complementary review of Strategic Risk 1 (quality).

4 BAF summary

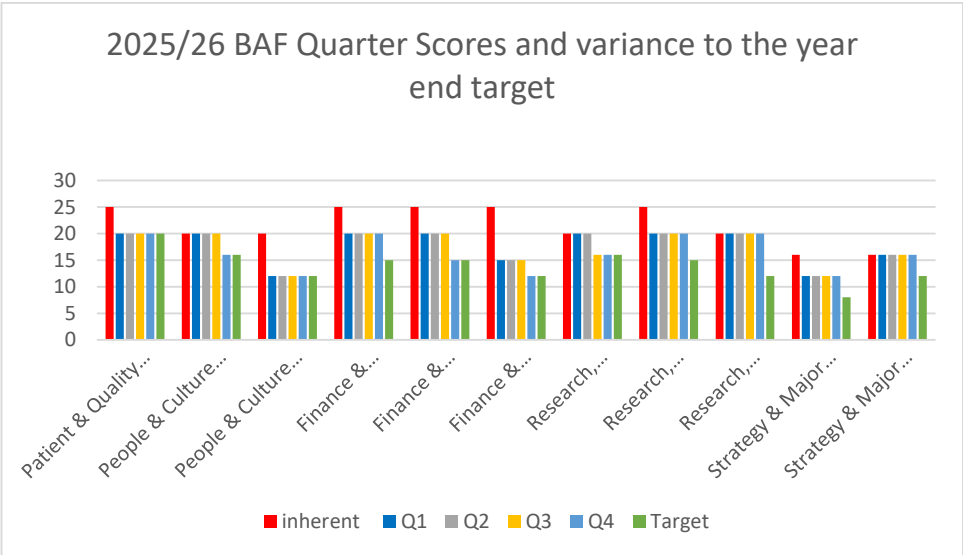
4.1 The BAF shows three change to the scores from those at quarter 3, these relate to risk 2 (culture) reducing to its target score of 16 for the year, risk 5 (non digital infrastructure reducing to 15 its target score for the year and risk 6 (performance) reducing to 12 as with the other two risks this sees this risk achieve its target score.

Strategic Risk Pictorial Summary



3.2 Below is a summary chart showing for the 11 Strategic Risks their quarter scores and the distance from their respective year-end target score. With the reduction in the three strategic risk scores, the reduction in the prior quarter to risk 7, and the maintenance of the scores for risk 1 and 3 there are six risks which are deemed to meet their 2025/26 target score.

3.3 This chart shows that there are five risks which are scored above their target score for the year, of which 3 are scored significantly these relate risk 4 (financial), risk 8 (digital infrastructure) and risk 9 (utilise digital as a drive for improvement).



5 Conclusion

5.1 The Board should **NOTE** the assurance provided by the respective Committee review of their BAF segments.

5.2 The Board is asked **AGREE** the quarter 4 scores, noting the support for these scores by the relevant oversight committees, including a reduction in the score of risks, 2, 5 and 6 to their target scores for the year.

5.3 the Board is asked to **NOTE** that five of the risks are above their target score and fur risks remain significantly scored for the year, these being risk 1 (quality), risk 4 (finance), risks 8 and 9 (digital).

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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, ⟷ an increase in risk ↑ and a decrease in risk ↓)

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	**Risk Scores**																	
	Inherent (uncontrolled)			**2025/26 Q1**			**2025/26 Q2**			**2025/26 Q3**			**2025/26 Q4**			**2025/26 Target**		
	I	**L**	**T**	**I**	**L**	**T**	**I**	**L**	**T**	**I**	**L**	**T**	**I**	**L**	**T**	**I**	**L**	**T**
Oversight provided by the Patient & Quality Assurance Committee																		
Risk 1 We are unable to maintain safe effective and compliant care.	5	5	**25**	5	4	**20**	5	4	**20** ⟷	5	4	**20** ⟷	5	4	**20** ⟷	5	4	**20**
Assessed strength of control				***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			at target score		
Oversight provided by the People & Culture Assurance Committee																		
Risk 2 We do not develop a culture that supports the delivery of the Trust's mission of excellent care everywhere	5	4	**20**	4	5	**20 ***	4	5	**20 *** ⟷	4	5	**20** ⟷	4	4	**16** ↓	4	4	**16**
Assessed strength of control				***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			at target score		
Risk 3 We do not attract, develop and retain enough people with the right skills, values and behaviours to deliver our ambitions	5	4	**20**	3	4	**12**	3	4	**12** ⟷	3	4	**12** ⟷	3	4	**12** ⟷	3	4	**12**
Assessed strength of control				***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			at target score		
Oversight provided by the Finance and Performance Assurance Committee																		
Risk 4 We are unable to progress towards medium-term financial sustainability, driven by a failure to deliver the in-year financial plan and/or actions to return to a break-even run rate by M12 2026/27 along with national funding realignment away from Sussex ICB	5	5	**25**	5	4	**20**	5	4	**20** ⟷	5	4	**20** ⟷	5	4	**20** ⟷	5	3	**15**
Assessed strength of control				***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***					
Risk 5 We are unable to maintain the condition of our non digital infrastructure or support the required capital investments to deliver our strategic ambitions	5	5	**25**	5	4	**20**	5	4	**20** ⟷	5	4	**20** ⟷	5	3	**15** ↓	5	3	**15**
Assessed strength of control				***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			at target score		
Risk 6 We are unable to configure our services and sites to enable us to deliver the Trust's annual performance plan	5	5	**25**	5	3	**15**	5	3	**15** ⟷	5	3	**15** ⟷	4	3	**12** ↓	4	3	**12**

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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
leading to patients having a poor experience and increased safety risks due to extended waits for their treatment.																		
Assessed strength of control				***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			at target score		
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**	4	4	**16**	4	4	**16**
Assessed strength of control				***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			at target score		
Risk 8 Our digital immaturity in our infrastructure, skill and technology threaten our cyber security, operational and clinical performance.	5	5	**25**	5	4	**20**	5	4	**20**	5	4	**20**	5	4	**20**	5	3	**15**
Assessed strength of control				***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***					
Risk 9 We are unable to capitalise the use of digital as a key driver for transformational improvement at the Trust.	4	5	**20**	4	5	**20**	4	5	**20**	4	5	**20**	4	5	**20**	4	3	**12**
Assessed strength of control				***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***					
Oversight provided by the Strategy & Major Projects Assurance Committee																		
Risk 10 We are unable to successfully develop and deliver our plans which configure our sites and services in a way that aligns with system partners and the ICS strategy	4	4	**16**	4	3	**12**	4	3	**12**	4	3	**12**	4	3	**12**	4	2	**8**
Assessed strength of control				***Some weaknesses***			***Some weaknesses***			***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	4	**16**	4	4	**16**	4	3	**12**
Assessed strength of control				***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***					

*Note * - the Board agreed to adjust the Q1 score for strategic risk 2 to 20 at its meeting on 4 September 2025 and adjusted the target score for the year to 16 at its meeting in November*

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Agenda Item:	12.	**Meeting:**	Trust Board in Public	**Meeting Date:**	5 February 2026
Report Title:	Maternity Assurance Reports				
Sponsoring Executive Director:	Dr Maggie Davies, Chief Nurse				
Author(s):	Stephanie White, Divisional Head of Quality and Safety, Women & Children Emma Chambers, Director of Midwifery				
Purpose of the report: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For discussion**	**For Information only**	
	Yes / N/A	*Yes / N/A*	*Yes / N/A*	*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)***

PQOM (formerly PQS) (reporting November 2025 data)

What:

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

So What:

Escalations for January meeting

- The National Maternity and Neonatal Investigation team have confirmed that they will not be able to visit all four sites in January (20th/21st), and will therefore, need to return to visit Worthing and Chichester sites in February, dates to be confirmed.
- Following the near miss incidents and escalations from clinical staff, as well as the CQC inspection findings, finding a solution for separate access to theatre for planned caesareans at Haywards Heath has become a significant priority. Planning is underway with a solution expected from early March, with interim mitigations in place.
- A relocation of some Special Care Activity babies (9 cots) from the Trevor Mann Baby Unit has been required to allow for preparatory work for the helipad opening. These babies are being cared for in the LMB. Mitigations are in place to ensure the quality and safety of care during this period.
- The Maternal Care Bundle was launched on 7th January. A gap analysis will be completed. Findings and action will be reported in the next PQOM report.

Celebrations for January meeting

- UHSussex maternity ranked 10th out of the 55 Trusts that use Picker to conduct the CQC Maternity Survey annually. This ranking has improved from18th in 2024 and 22nd in 2023.
- Approval of Safety Action six progress within the CNST Maternity Incentive Scheme (MIS) programme, was received from the ICB in December – this means that a fully compliant CNST MIS declaration can be submitted in March for the first time since 2022.

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- Brighton Maternity received an improved CQC rating, published in December following inspection in February, moving from Inadequate to Requires Improvement. Significant further progress has been made since the inspection, including a solution for planned caesarean lists away from labour ward, and permanent obstetric and midwifery leadership.

What Next:

- The maternity and neonatal service has achieved positive outcomes through the recent CQC inspection of Brighton, the CQC Maternity Survey and a fully compliant CNST MIS submission, reflecting the collective collaboration and commitment of all members of the maternity and neonatal teams and further evidencing the provision of high-quality, safe care.
- Outcome data also continues to evidence the safety of the service, with stable perinatal mortality rates significantly below national averages and sustained year-on-year reductions in potentially avoidable deaths, as well as robust governance processes to monitor and respond to changes in outcome data.
- The service remains vigilant and is actively progressing further improvement work to enhance outcomes and experiences for families, as well as the working environment and experience of staff.

What:

The MIS Year 7 was published on 2nd April and ended on the 30th November. Submission is due by noon 3rd March 2026.

So what:

Compliance update at end of CNST reporting period

- SA1, SA9 and SA10 (Governance standards – PMRT, MNSI, legal, PQOM) are compliant and are now well embedded as BAU processes
- SA2 Maternity Services Data Set – met in July
- SA3 – Transitional Care plan in place and ongoing ATAIN QI project progressing
- SA4 medical and neonatal workforce standards and SA5 midwifery workforce standards met
- SA7 – MNVP embedding into governance processes and plan in place to incorporate into guideline consultation process as capacity allows.
- SA8 – All maternity and neonatal staff groups achieved >90% compliance in all three training modules

ATAIN – reporting Q1 data

What:

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

So What:

- For the total of Quarter 1, the benchmark of <5% of admission to the Special Care Baby Unit was met for the duration at WH (2.5%, 2.9% & 1.2%) and for SRH it did not meet the benchmark in April (6.8%, 3.3%, 3.7%). PRH and RSCH only met the benchmark in May for Quarter 1 (PRH 6.67%, 3.57%, 7.64%, RSCH 8.57%, 3.90%, 7.34%).
- There were 33 admissions to NNU from RSCH, 28 admissions from PRH, 24 admissions from SRH and 11 admissions from WH which is a total of 96 term admissions to the SCBU/NNU.
- The majority reason for admission this quarter across all four sites was again due to respiratory support.
- Overall, 88.5% (85) of admissions across all four sites were considered unavoidable with appropriate management with 11.5% (11) considered as potentially avoidable.

What Next:

- There is an ATAIN/Transitional Care Steering Group as a part of CNST working groups.
- The chair of the meeting has transitioned to the Neonatology leadership team (in place since May).
- The steering group has worked through historic action and work is now underway to align practices across Neonatology and Maternity to build value into the audit being completed and to align QI to findings.

Transitional Care – reporting Q1 data

What:

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

So What:

- The audit reviewed 103 infant care pathways across all four sites (WH 9, SRH 32, RSCH 30, PRH 32); 20 of those babies were ultimately admitted to NNU mainly for respiratory support.
- Most of the cases were term gestation neonates and most were documented as needing IV Antibiotics for suspected sepsis as the reason for admission.
- Most babies received their initial reviews as expected; however, there was a slight spike at PRH for babies who missed daily review. This will be the focus of a watch and wait to see if a deeper dive is required – to review again in Q2.
- The audit team noted an ongoing trend with SBAR being completed upon step down from SCBU to TC – this is the subject of a QI project being overseen by the TC and ATAIN Steering Group.
- The audit team noted that 5 admissions of the 20 to NNU could have been avoided if TC was BAPM compliant across all sites.

What Next:

- Theme of the Month – started in July – focus on SBAR handovers

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	• QI project focussing on neonatal Care and reducing admissions for hypoglycaemia completed – outcome to be reported in Q3 report • Look at data collection and more depth of knowledge about when processes aren't followed. • Work undergoing to review this current TC audit to align, support and monitor the development of BAPM TC currently undergoing across all 4 sites and to inform the TC working group.
Recommendation *(linked to What Next section)*	*For the Board to NOTE the reports.*
Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*	All papers presented have been reviewed by the Patient & Quality Assurance committee (January 2026), QGSG (November 2025, December 2025, and January 2026) following presentation at the Maternity Quality & Safety Meetings (October 2025, November 2025, and December 2025).

Link to Trust Strategy (note which theme)	**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						
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**	**Caring**	**Effective**	**Responsive**	**Well-led**	**Use of Resources**
	Yes / N/A	*Yes / N/A*	*Yes / N/A*	*Yes / N/A*	*Yes / N/A*	*Yes / N/A*

Other impacts	**Equality and Diversity (*if yes has HEIA completed)***	**Environmental**	**Legal**	**External Registrations *(if yes please indicate which)***
	Yes / N/A (Yes / No)	*Yes / N/A*	*Yes / N/A*	*Yes / N/A*

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Agenda Item:	13.	**Meeting:**	Trust Board in Public	**Meeting Date:**	5 February 2026
Report Title:	Research, Innovation and Digital Assurance Committee Chair's Report				
Author(s):	Jackie Cassell – 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

What *(summary of current position / issue & why it matters and evidence to support that position etc)*

The report provides information over the business undertaken at the Research, Innovation and Digital Assurance Committee on 28 January 2026.

The Committee meeting was quorate 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 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 and use of the digital resource prioritisation tool and the collaborative approach being taken to incorporate digital in the Trust's business continuity plans.

The Board can also take confidence that through the work to develop the research delivery workstreams the Committee will through their regular reporting be able to provide assurance on the delivery against the Trust research strategic ambitions.

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

The Board can receive the BAF with confidence knowing that the content and score for strategic risks 7, 8 and 9 have been scrutinised by the Research, Innovation and Digital Assurance Committee.

Recommendation
(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 digital and research and innovation domains**
- **The Committee's recommendation that strategic risk 7 should be remain at 16 (its target risk score) and risks 8 and 9 should remain unchanged from the quarter 3 score.**

The Board is invited to APPROVE the Committee Terms of Reference (see appendix A)

Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*

Link to Trust Strategy (note which theme)	**Patient**	**People**	**Future**	**Communities**	**One UHSussex**	**Culture**
	Yes	Yes	Yes	Yes	Yes	*Yes*

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Link to annual delivery plan	The Committee provides oversight of the delivery of the Trust's research, innovation and digital domains that are aligned to the Trust's Strategy which supports the delivery of the Trust's annual plan.					
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	The Committee has oversight of the key assurances referred to within the BAF for strategic risks 7, 8 and 9 and through their scrutiny of these recorded assurances consider and recommend to the Board their relevant current scores.					
Link to CQC domain	**Safe**	**Caring**	**Effective**	**Responsive**	**Well-led**	**Use of Resources**
	N/A	*N/A*	*N/A*	*N/A*	*Yes*	*N/A*

Other impacts	**Equality and Diversity (*if yes has HEIA completed)***	**Environmental**	**Legal**	**External Registrations *(if yes please indicate which)***
	N/A	N/A	Yes	The Trust is required to maintain an effective system of governance, risk management and internal control (FT Code of Governance / FT Licence)

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Research, Innovation and Digital Assurance Committee Chair's Report

The Research, Innovation and Digital Assurance Committee met on 28 January 2026 and was quorate, with the required Non-Executive and Executive Directors present. The Committee received all scheduled business in line with its agreed programme of work. The meeting provided the Committee with assurance across the Trust's research, innovation and digital portfolios, with particular focus on digital transformation, cyber security, the Electronic Patient Record (EPR) programme, research delivery performance and the Board Assurance Framework (BAF). The Committee is able to provide assurance to the Trust Board that appropriate governance, risk management and oversight arrangements are in place across these domains, and that areas of risk are clearly identified, monitored, mitigated and escalated where required.

The key areas of focus for the Committee at its January 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 & Data Strategic Delivery Plan

The Committee **received** a comprehensive update on the Digital and Data Strategic Delivery Plan, aligned to the Trust Strategy and NHS England Medium Term Planning Guidance. The Committee **noted** the scale and complexity of the digital portfolio, with high and growing demand for digital support across the organisation, and the structured and active prioritisation mechanisms that are in use consideration to manage this demand. The Strategic Delivery plan had been cross referenced to digital plans and backlog adding further demand for digital support and the Committee acknowledged the overlap between complex capital schemes and the need to consider digital implications of each.

The Committee was assured that the majority of digital programmes are on track, with clear milestones, ownership and reporting. Two areas were examined in more detail. Positive milestones had been reached with the remote data centre reinstatement that is now ongoing, with initial production systems operating successfully, and full migration is planned by May 2026 following a delay in connection. For Laboratory Information Systems (LIMS), the Committee had **received a referral** from Patient & Quality Assurance Committee to oversee the risks and interdependencies, including links to the EPR programme. The Committee heard these considerations around the upgrade of LIMS are being actively managed at executive level, with further clarity to be brought back to the Committee as governance arrangements mature. An Artificial Intelligence steering group had met with a focus on improving corporate business procedures with automation opportunities. A paper to provide more detail on the framework for AI roll-out and the governance the plan would support remains awaited and will be **brought back** to the May meeting of the Committee

The Committee has been assured by the continued staff and particularly clinician engagement activity raising awareness that is key to the success of digital programmes and acknowledges that this represents significant risk mitigation and should form part of future assurance reports.

The Committee discussed the Data Usage and Access Act 2025 (DUAA) Legislative Impact and how this provides new opportunities to use data more effectively for care, operational planning, research, and innovation, while also introducing clearer obligations

on governance, transparency, and oversight. The Committee **endorsed** the proposed adoption of a four-phase project plan aligned with the ICO's DUAA 2025 review timeline (July 2025–October 2027)

Cyber security and resilience remain a key focus. The Committee **noted** progress against the Data Security and Protection Toolkit improvement plan, including strengthened governance, technical controls and training compliance. The Committee supported the proposal to integrate information governance and cyber security training into a single mandatory package to improve overall compliance and awareness, supplemented by ongoing communications and prompts. As of December 2025, IG training compliance reached 91% to capitalise on this compliance is fundamental since cyber security is an enabler of the Trust's strategic ambitions. Training frequency and reinforcement activity was debated, noting national requirements for frequency.

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

Patient-Facing Architecture

The NHSE 10-year plan commits to digital communications with patients in order to support more effective healthcare services through the use of the NHS App. The Committee **noted** the paper that supports a strategic discussion with Board on the multiple ways in which the Trust interacts with its patients and how this could be improved to meet the Trust strategic ambitions. This made recommendations for how UHSussex can bridge the gap between the current arrangements for managing our communications with future opportunities that would streamline access while maintaining parallel arrangements for those patients who are not digital adopters or who require more support. The Committee acknowledged significant opportunity for outpatients and also that the prioritising decision making around these complex digital projects alongside other strategic needs was at an early stage.

Electronic Patient Record

The Committee **received** a high-level overview of the EPR procurement that is working to schedule to be delivered in 2027 and is overseen by the Strategy & Major Projects Committee.

The Committee had been provided with the Full Business Case for the Electronic Patient Record. The Committee was assured by the robustness of the programme to date, including the extensive engagement of over 1,500 staff in defining requirements and evaluating solutions, and the careful procurement and assurance processes undertaken.

The Committee noted the decision to adopt a modular EPR approach, providing phased implementation and reducing operational and patient safety risk. The Committee was assured that supplier capability, contractual controls, cost management and resource planning have been thoroughly tested and benchmarked, with appropriate contingencies in place.

The Committee discussed the key risks associated with EPR implementation, including staff readiness, clinical engagement, usability, cyber security and benefits realisation. The Committee was **assured** that these risks are recognised and actively mitigated through sustained and embedded clinical involvement, structured change management, training and operational readiness planning. The Committee endorsed progression of the Full Business Case through the remaining governance stages and supported submission to the Trust Board.

Research and Innovation

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

Research Delivery Plan for research and innovation

The Committee **received** the Research Delivery Plan Q3 highlight report and the Research and Innovation performance report. The Committee was assured by continued progress across the research portfolio, including growth in active studies, Principal Investigators and participant recruitment. The internship fellowship had been an area of numerous successes.

Clinical Research Development and the Commercial Research Development Centre

The Committee **noted** the strong performance of the Commercial Research Delivery Centre, which has moved from establishment into delivery, with steady increase in supported studies, significant improvements in commercial study set-up times and strong feedback from partners and funders. The Committee was **assured** that the growth in commercial research is being managed alongside, and not at the expense of, non-commercial and academic research activity. The Committee tested the barriers to multi-site research sponsorship that often undermine broader recruitment across the Trust.

The Committee **noted** and welcomed that the CRDC has established a Patient & Public Involvement, Engagement and Plan (PPIEP) Stakeholder group, and developed and submitted to NIHR a PPIEP plan. This aims to bring together key stakeholders including patients, carers, and community representatives to collaboratively shape, review and enhance patient and public involvement in research. The Committee took **assurance** from the demonstrated ongoing commitment and plans for patient and public engagement, involvement and participation in research.

Clinical Research Facilities

The Committee **noted** progress on the Clinical Research Facility major project. The Committee was **assured** that a pragmatic and affordable hub-and-spoke model has been agreed, supported by NIHR funding, and that this significantly mitigates the previously identified estates risk to research delivery. The Committee **noted** that this project remains subject to ongoing scrutiny through the Strategy and Major Projects Committee, with this Committee focusing on the impact of delivery on research capability. The Committee welcomed recent identification of dedicated space at Worthing,

Quality, Safety and Risk

The Committee received the interim Research Quality and Safety report and noted that no quality or safety escalations were identified. The Committee was assured that robust governance and oversight arrangements are in place to ensure the safety and quality of research activity.

Board Assurance Framework

The Committee **scrutinised** its allocated element of the Board Assurance Framework relating to strategic risks 7, 8 and 9. The Committee **considered** the review undertaken at the research, innovation and digital steering group strategic risk 7 ‘We are unable to realise the benefits of transformation via research and innovation integration programmes’, should remain at its target score of 16. The Committee agreed that strategic risks 8 and 9, relating to digital immaturity, cyber security and digital transformation, should remain at a score of

20, recognising the scale of transformation still underway and the need for further delivery of key mitigations before risk reduction can be justified.

Committee Effectiveness

The Committee reflected on the findings of the effectiveness survey and identified that with minor changes the Terms of Reference for the Committee remain appropriate and are commended for approval.

Referrals to other Committees

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

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Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	28 January 2026	**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 Medical Officer 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			
Digital & Data Delivery Plan	Head of Programmes & Projects (IT) on behalf of the Chief Information Officer	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. And **noted** the programme is actively managed, with clear governance, prioritisation and risk mitigation
Electronic Patient Record Programme and Electronic Document Management System Projects Reports	Electronic patient record (EPR) Programme Manager on behalf of the Chief Information Officer	To provide assurance over the Trust's processes	The Committee was updated on the process being followed toward the rollout of the new EPR system, noting the supplier selection stage had concluded successfully. The Committee also noted the referral from Patient & Quality Committee for oversight of the LIMS system upgrade given EPR interdependencies are anticipated
Data Usage and Access Act and Data Protection Act Change	Head of Programmes & Projects (IT) on behalf of the Chief Information Officer	To note implications of legislative changes	**Noted** the implications and opportunities provided. Endorsed next steps of launching a structured DUAA 2025 readiness programme to update policies, processes and systems supported by governance and staff training
Cyber Security Training	Head of Programmes & Projects (IT) on behalf of the Chief Information Officer	To endorse	The Committee **endorsed** the proposal to align Information Governance Training with Cyber Security Training
Patient-Facing Infrastructure	Head of Programmes & Projects (IT) on behalf of the Chief Information Officer	To note and consider as a contribution to a strategic debate on the ways in which the Trust interacts with patients	**Noted** the contents of this report and opportunities to streamline communications. The Committee acknowledged the scale and complexity of the broader project that would require prioritising and consideration of rollout.

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Item	Presenter	Purpose of the paper	Action Taken
Research & Innovation			
Delivery plan for research & innovation for transforming research	Director of Research & Innovation	To provide information on the workstream activity since the last meeting	The Committee received the report giving an update on performance measures via the workstreams that have been established to meet the Trust's research ambitions. The Committee was **assured** by continued progress across the research portfolio
Research Performance Report Q3,	Director of Research & Innovation	To note a summary of research performance against agreed key indicators. .	The Committee noted the KPI performance. Recruitment to non-commercial interventional studies is slightly better than in 2024-5 but below target for the year due delays in opening a particular study.
Clinical research facility Commercial Research Development Centre milestone report And CCRDC NIHR Patient and Public Involvement, Engagement and Participation arrangements	Director of Research & Innovation	To provide information on this initiative	The Committee **noted** the delivery against the established KPIs for the Commercial Research Development Centre in the third quarter since opening with significant improvements in commercial study set-up times and strong feedback from partners and funders. The Committee **noted** that a Patient and Public Involvement, Engagement & Participation arrangements and **noted** the approval of the NIHR PPIEP plan and the establishment of a stakeholder group
Clinical Research Facility Major Project update.	Director of Research & Innovation	To Note	The Committee **noted** progress on the Clinical Research Facility major project. A hub-and-spoke model has been put forward as a preferred option, supported by NIHR funding that significantly mitigates the previously identified estates risk to research delivery.

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Item	Presenter	Purpose of the paper	Action Taken
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. The Committee **noted** the contributing elements of most risks were generally on a downward trend.
Board Assurance Framework	Company Secretary	To review and recommend to the Board the scores for strategic risks 7, 8 and 9	The Committee considered the relevant segments of the BAF and alongside the reports received at the meeting agreed with the executives view of the risk scores. The Committee agreed with the recommended scores for risk 7, 8 and 9 (no change from the quarter 3 scores). Risk 7 is at its target risk score.
Committee Effectiveness	Company Secretary	To note and confirm the continued suitability of the terms of reference	The Committee **reviewed** findings of the effectiveness survey. The Committee confirmed that with minor changes the Terms of Reference for the Committee remain appropriate and are **commended** for approval.

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Agenda Item:	14.	**Meeting:**	Trust Board in Public	**Meeting Date:**	5 February 2026
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: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For discussion**	**For Information only**
	Yes	*Yes*	*Yes*	*N/A*

Reason for not being taken in public *(indicate as appropriate)*	**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 ***(summary of current position / issue & why it matters and evidence to support that position etc)***

The report provides information over the business undertaken and the Patient and Quality Committee in December 2025 and January 2026.

The Committee meeting was quorate at each of these meetings and received its scheduled business. A timing issue between the evolving board and committee scheduling has meant this report describes two meeting primarily focussed on deep dive activities and continuous maternity governance oversight.

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)***

Quarterly reports for the main quality and patient safety domain areas were not received at these meetings and will come to the March meeting of the Committee. 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. Restructuring of the meetings has enabled deep dives for assurance in identified risk areas.

The Committee had referred to the Executive the requirement to bring back to the Quality Committee, evidence of activity and assurance on actions arising from CQC inspections, and where the oversight has moved to business as usual how this is being monitored for assurance. This is required in order to ensure we have sufficient assurance over regulatory requirements. The committee noted the work undertaken and agreed a deep-dive review of the CQC business as usual actions with the Committee NEDS to gain assurance on the process.

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

The Committee noted evidence that supports the Trust's eligibility for Clinical Negligence Scheme for Trusts (CNST) year 7 achievement. The Committee has examined risks in the areas of Ophthalmology at the December meeting and Pathology and Pharmacy in January and has identified assurances to be brought back. A referral is made to the Research, Innovation & Digital Committee in respect of oversight for the consolidation and upgrades required for the Laboratory Information Management Systems (LIMS).

The Committee noted the update provided on Mental Health and that emergency attendances have risen sharply across UHSx with significant and sustained deterioration in length of stay, patient experience and operational impact. There is an improvement programme left by SPFT across the ICB focussing on these areas and the committee have sought assurance that this has the resourcing and oversight required to make an impact and the key deliverables and timeline.

In response to an issue with external imaging contract the Committee has sought assurance on how Quality and safety standards are overseen for the Trust's contracts. Assurances were received on the quality oversight the Trust's wholly owned subsidiary (Pharm@Sea) at January meeting.

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	The committee received a report to provide assurance on Quality Impact Assessments (QIA's) completed for the 2025/26 Efficiency Programme and reflected on Board discussion on QIA and the benefits of further embedding QIA's to articulate the quality impact of changes such as investments and service change for assurance. The Committee asks the Board to consider how quickly the QIA process can be embedded to achieve this. 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.
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 increasing assurance over the Trust's processes for patient quality and experience and pursuit of learning from reported incidents and complaints but recognises the challenges of embedding the learnings across UHSussex;** - **The Committee's recommendation of the score for their allocated element of the BAF, strategic risk 1 for which the score remains at the target score of 20.** - ***The Board is to APPROVE the Committee Terms of Reference (see appendix A)***
Assurance / Scrutiny route already undertaken	

Link to Trust Strategy (note which theme)	**Patients**	**People**	**Future**	**Communities**	**One UHSussex**	**Culture**
	Yes	Yes	N/A	Yes	Yes	*Yes*

Link to annual delivery plan	*No specific link*
Link to BAF	*No specific link*

Link to CQC domain	**Safe**	**Caring**	**Effective**	**Responsive**	**Well-led**	**Use of Resources**
	Yes	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*

Other impacts	**Equality and Diversity (*if yes has HEIA completed)***	**Environmental**	**Legal**	**External Registrations *(if yes please indicate which)***
	N/A	*N/A*	*N/A*	*N/A*

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Patient and Quality Assurance Committee Chair's Report

The Patient and Quality Assurance Committee met in December 2025 and January 2026 and was quorate at each meeting, with attendance by at least two NEDs and two Executives and the relevant directors. At each meeting the Committee received its planned business. Since Committee meetings were restructured to distinguish deep dive meeting from routine business, the quarterly domain reports will come to the next meeting and are not therefore included in the meetings summarised below.

Reports on Maternity governance, Clinical Outcomes (by way of an interim update on GIRFT and the Health Inequalities Plan), Infection Prevention & Control, and quality scorecards including perinatal quality surveillance. The Committee also received reports from the Quality Governance Steering Group (QGSG) and reports from the Committee's main reporting group for information.

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

Infection Prevention and Control

The Committee **received** a report covering Infection Prevention and Control which containing the validated performance data across main infection types from Q2 2025-26. The Committee **discussed** the actions being taken to mitigate the risk of influenza outbreaks including the level of staff vaccination that represented improvement on last year.

Maternity

The Committee at its January meeting **received** the expected suite of maternity performance and assurance papers, including the Perinatal Quality Surveillance Reports & Dashboards; ATAIN & Transitional Care report, Perinatal Mortality Review tool assurance report, Maternity Incident report, Claims Scorecard, Perinatal Workforce bi-annual report and Saving Babies Lives Report along with an updated report on the Trust CNST year 7 position.

In respect of the Trust's Perinatal Quality Surveillance (PQS) Reports & Dashboards for all four of its maternity units, which included the Ockenden data sets within the current dashboards. 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. 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 quality improvement programme focus on learning from these admissions and the work being undertaken to continue to prevent wherever possible such avoidable admissions. The committee noted the challenges of providing Transitional Care and the impact this has on neo-natal fill rates and patient experience.

In Committee **received** the Maternity PSIRF Serious Incident Report for quarter 3 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 Q2 2025/26 Maternity Claims Scorecard recognising that these cases updated on a rolling basis reflect some very historic cases given the nature of the statute of limitations, but the Committee took assurance from the triangulation of incidents, claims and complaints data from the period. The review underway of midwifery levels using Birthrate Plus system was noted and is awaited by the Committee for the February meeting.

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 through an update from the Director of Midwifery was **assured** that the Trust was engaging with the national maternity investigation with a visit from Baroness Amos and her team having taken place in January 2026. 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 February.

Quality Assurance

The Committee continues to review the status of clinical documentation having previously noted limited assurance from the quarterly report. Positive progress was reported at the January meeting via the Quality Governance Steering Group scorecard data that showed oversight and noted a safety triage extension process assures ongoing use pending revision divisional trajectories are being developed; GIRFT where the limited compliance level had remained static, many actions remain overdue but an action inventory has been baselined with a priority to embed operational ownership in the new Trust Operating Model (TOM); trajectories are to be **brought back** in March 2026.

The Health Inequalities Plan 2025-2030 was endorsed with active clinical champions noted but there remains a corporate capacity gap for leadership in this area pending the TOM.

QGSG chairs report

The Committee at both its December and January meetings **received** a report from the QGSG chair providing assurance over the work of that group and the focus that group brings over divisional patient safety, quality and patient experience. The Statistical Process Control (SPC) charts have continued to assist targeted attention on risk areas avoiding distraction from common cause variations. Specific focus was given to regulatory compliance and risks in areas across the Trust, particularly around: mixed-sex accommodation and the circumstances that give rise to breaches out of hours, and work on antimicrobial stewardship work that is ongoing but the lack of EPMA in the Emergency Department is a **noted** barrier.

Care Quality Commission (CQC) action plans

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

The Committee discussed the process being applied to track the delivery of these actions and that a number of actions were now being tracked through business as usual processes

overseen by other Board Committees and awaits assurance following my previous referral to the Executive on this matter discussed at the last meeting of the Board.

Divisional Deep Dives

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

The committee were informed that Ophthalmology Services is now under one newly merged management structure and assured us are working together to integrate and share learnings around their complex demand management that blends high volumes and high risks in areas such as glaucoma which requires timely diagnosis and lifelong monitoring. It was reported that demand has continued to grow with a combination of chronic conditions and an ageing population. Capacity planning, patient flow, modelling, IT and estates are key to managing the large volume and it is recognised that problems in any of these scale quickly. The Committee heard that in Worthing, Southlands and Chichester, there had been thorough risk stratification of the waiting list and work is underway to develop short-, medium- and long-term strategies for a Trust-wide approach to improve glaucoma capacity and mitigate risk. The Committee asked for a report to be **brought back** to summarise the key quality and clinical risks and challenges faced across ophthalmology (additional to glaucoma), plans in place to address or mitigate these and clarity of confirmed funding and how we are measured against GIRFT.

At the January meeting, the Clinical Support Services Division presented a Deep Dive assurance session around Pathology and Pharmacy.

The committee was assured by the Divisions' oversight and scrutiny arrangements to for a considerable number of accreditations and regulated activities. The Committee heard about Haematology & Blood Transfusion having received positive UKAS feedback in January 2026, and were updated on the Microbiology inspection in December that had given positive indication of accreditation reinstatement. Mortuaries remain an area of challenge for regulatory compliance where there are increased requirements (Fuller/HTA) that pose particular estates challenges on some sites but the Committee heard about the Trust-wide plans to use the mortuary estate in a way that mitigates potential regulatory risks. The Committee also heard about inspection and assurance activity around Pharmacy particularly in Aseptics where RSCH is now low-risk but WGH/SRH still have 2 actions around a capacity plan and cleanroom garment supply dependency. It is also **noted** that Medicine Governance is a critical part of supporting Trust-wide clinical document recovery.

The mental health (MH) needs of attendances to the Trust's sites remains a critical risk. The Committee **noted** the continued deterioration in the situation of mental health Emergency Department attendances and the length of stay of these patients. The Committee were supportive of the Executive engagement with Sussex Partnership NHS Foundation Trust (SPFT) and the Integrated Care Board to secure a time-bound, resourced plan (including RSCH short-stay crisis capacity). The Committee would welcome a system reset via a SPFT-led 12-hour improvement programme around alternatives to admission; MH bed flow and requested the plans sets out explicitly the scope, resourcing, timelines & expected impact.

Risk registers

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

Board Assurance Framework

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

Following the review of the BAF itself and the reports received at the Committee January we 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 3 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 December and January meetings **agreed** there were the following matters it needed to refer to another Board Committees:

To Research Innovation & Digital Committee (RIDC) - Seeking assurance that, given the Electronic Patient Record (EPR) requires a single LIMS system, that the RIDC has oversight given the risks and EPR dependence

Escalation to Board – Quality Impact Assessment (QIA) implementation – To consider how quickly the QIA process can be embedded within all programmes and service change

Review of Terms of Reference

The Committee utilised the Committee Effectiveness questionnaire responses to **review** its Terms of Reference and **agreed** there were no changes to be recommended to the Board.

The Committee agreed with the recommendation to aid the operation of the Committee that reflective questions would be asked at the end of each meeting, covering timeliness and quality of papers along with a question on how the Committee demonstrated it acted within the developed Behavioural Compass to enable learning to be implemented across the year rather than wait until the formal effectiveness review to identify areas that could have been adjusted during the year

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Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**16 December 2025**	**Chair**	Lucy Bloem	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Focus, Operation and Priorities of the Committee			
QGSG reports	**Presenter** Chief Medical Officer/ Dep. Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted and assurance taken over the work of QGSG
Quality Dashboard (excl Maternity) Safety, Mortality Effectiveness, Experience,	**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted
Deep Dive: Ophthalmology	**Presenter** Chief Medical Officer; Surgery (RSCH/ PRH) Ophthalmology General Manager and Surgery (SWS) Division Directors of Operations and Clinical Director, Ophthalmology.	**Purpose** For assurance	**Outcome /Action taken** Noted articulated significant Ophthalmology department risks and mitigation underway includes stratification of the waiting list (currently SWS only), insourcing & establish an improvement group to oversee the work across the service. **Action**: A report to come back to summarise the key quality and clinical risks and challenges faced across ophthalmology (additional to glaucoma), plans in place to address or mitigate these and clarity of confirmed funding
Care Quality Commission (CQC) / Regulatory Update	**Presenter** Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted the update on CQC related activity and the delayed status of several 2024/25 reports. CQC Steering Group continues to review actions moved to a BAU classification and assurance from check and challenge of Medicines Management actions. Also noted preparations for National Maternity investigation
Patient Safety			
Infection Prevention and Control Q2 2025/26	**Presenter** Chief Nurse	**Purpose** For assurance	**Outcome /Action taken** Noted.

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Facilities & Estates- update reports including: an update on the progress of the Estate Improvement Plan, Ventilation Action Plan, Medical Devices Management Review (Final Report), Medical Equipment Action Plan and progress reported to Estates Improvement Group (Oct 2025)	**Presenter** Director of Estates and Facilities / Chief Finance Officer	**Purpose** For information	**Outcome/Action taken** Noted the update on work taking place and apparent progress towards an assurance report in the form required by the Committee. The Committee noted the formalised structure of Estates reporting through the Health and Safety Committee
Maternity Incentive Scheme Year 7 Compliance Update	**Presenter** Chief Nurse / Director of Maternity	**Purpose** To approve	**Outcome /Action taken** Noted the assurance update on Maternity Incentive Scheme Year 7 compliance and requested confirmation that Surrey Sussex ICB had accepted LMNS position that Trust has complied with Safety Action 6. Action: for Trust position on Theatre access to come back to January meeting.
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** No exceptional risk matters raised.

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Meeting Details					
Meeting Date	**27 January 2026**	**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			
Deep Dive: Pathology and Pharmacy	**Presenter** Chief Medical Officer; CSS Division AHP Director	**Purpose** For assurance	**Outcome /Action taken** Noted quality assurance activity inc. Pharm@Sea contract quality oversight. Noted directorate risks. Referral made to Research, Innovation & Digital Committee to invite oversight of LIMS system consolidation and upgrading.
Mental Health Update - stocktake across attendances and length of stay for patients	**Presenter** Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted update and executive priorities to address including: reduced 48hr+ stays through capacity solutions with SPFT, crisis alternatives, and fast-track MH bed allocation; Control inflow and escalation; ED safety for MH care; Strengthened staffing model and whole-system flow with ICB partners
Patient Safety			
Clinical Outcomes & Effectiveness & Health Inequalities Interim updates: Getting it Right First Time (GIRFT) Update Report	**Presenter** Director of Patient Experience for Director of Clinical Outcomes and Effectiveness	**Purpose** For Assurance	**Outcome /Action taken** Noted the compliance processes. Discussed how GIRFT can be better embedded into operational ownership and included as part of service re-design & directorate governance processes.
Health Inequalities Improvement Plan 2025 - 2030	**Presenter** Chief Strategy Officer; Director of Clinical Outcomes and Effectiveness	**Purpose** To endorse	**Outcome /Action taken** Endorsed the Delivery Plan.
Maternity			
National Maternity and Neonatal Infrastructure Review	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted
Perinatal Quality Surveillance Report and Dashboards to November 2025	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted and assured over the performance
ATAIN/Transitional Care Q1 2025/26	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted and assured over the review of these cases

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Maternity Claims Scorecard Q2 2024/25	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted
Perinatal Mortality Review Tool (PMRT) Q1 2025/26	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted and assured over the performance
Perinatal Mortality Review Tool (PMRT) Cases rated C & D 2024 Annual Report	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted and assured over the performance
Maternity PSIRF Q3 2025/26	**Presenter** Chief Nurse/ Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted and assured over the process for review, investigation and learning
Saving Babies Lives Q2 2025/26	**Presenter** CNO/ Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted and assured over the performance
CNST/ Maternity Incentive Scheme Year 7 Declaration	**Presenter** Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted the current position
Reporting Group			
QGSG Chair's Exception Reporting (includes quality scorecards, divisional summary reports)	**Presenter** Chief Medical Officer	**Purpose** For assurance	**Outcome /Action taken** Noted
CQC action tracking			
CQC Update / Action Plans	**Presenter** Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted and assured over the process for tracking actions
Risk			
Patient and Quality Risk Report	**Presenter** Chief Nurse/ Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** The Committee noted these
Board Assurance Framework	**Presenter** Chief Nurse/ Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** The Committee reviewed its allocated segments and agreed with and recommended the proposed score for BAF Risk 1 to the Board
Committee Effectiveness			
Review of the Terms of Reference	**Presenter** Company Secretary	To review and determine if there is a need for any changes and recommend to Terms of Reference to the Board	The Committee received the report including the feedback from the Committee effectiveness survey and **agreed** with the minor changes to the Terms of Reference and **agreed** to recommend these to Board.

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Agenda Item:	15.	**Meeting:**	Trust Board in Public	**Meeting Date:**	5 February 2026
Report Title:	People & Culture 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**	
	Yes	*Yes*	*N/A*	*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

What *(summary of current position / issue & why it matters and evidence to support that position etc)*

The report provides information over the business undertaken and the People and Culture Committee in January 2026.

The Committee meeting was quorate at this meeting and received its scheduled business and had a good discussion on the Trust's cultural improvement programme.

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 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 received and provided comment on the developing People scorecard to enable this to support the work of the Committee and Board into 2026/27.

Through the Committee's review the Board can take note that the behavioural framework has taken into account feedback given during its development and that there is a clear activation plan which is to be supported by a clear communication and engagement set of activities.

The Board through the Committees consideration and discussion with the Freedom to Speak up Guardians and Guardian of Safe Working can take assurance over the designed processes.

The Board should also note that the resident doctor lead was present for the meeting and their contribution was encouraged especially in respect of the work of the guardian of safe working.

The Board should note that the NHS Staff survey results will be shared with the Board in March and that the Committee was updated on the plans to cascade these benchmarked results within the organisation in support of locally driven team improvements alongside Trust wide initiatives.

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

The Board can have confidence in the Trust's delivery of the resident doctors 10 point plan and that there was active engagement in the meeting of the resident doctor lead.

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	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. *The Board can also be assured that the publicised safter staffing report has been scrutinised by the Committee prior to its publication.*
Recommendation *(linked to What Next section)*	***The Board is asked to NOTE*** - ***the Committee met and received the expected assurance reports*** - ***the Committee's recommendation of the scores for their allocated elements of the BAF, strategic risks 2 and 3, noting that the Committee recommended a reduction in risk 2 seeing this risk at its target score for the year of 16*** ***The Board is to APPROVE the Committee Terms of Reference (see appendix A)***
Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*	*A number of items presented to the Committee had been considered by the Committees reporting groups.*

Link to Trust Strategy (note which theme)	**Patients**	**People**	**Future**	**Communities**	**One UHSussex**	**Culture**
	Yes	Yes	Yes	Yes	Yes	*Yes*

Link to annual delivery plan	*The People and Culture Committee provide oversight of the Trust's delivery of many aspects that link to the delivery of the Trust's annual plan, not least those covered by the people promises, workforce wellbeing actions and those linked to staff training and development*
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	*The Committee has oversight for the allocated people related strategic risks, risks 2 and 3*

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

Other impacts	**Equality and Diversity (*if yes has HEIA completed)***	**Environmental**	**Legal**	**External Registrations *(if yes please indicate which)***
	N/A	*N/A*	*Yes*	*The Trust is required to maintain an effective council of governors (FT Code of Governance / FT Licence)*

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People and Culture Committee Chair's Report

The People and Culture Committee met on 27 January 2026. The Committee was quorate at this meeting as it was attended by at least two Non-Executive Directors and two Executives Directors. In attendance at these meetings were the respective report presenters including the Director of Workforce Planning & Deployment, Director of Human Resources, Director for Integrated Education, and the Associate Director of Leadership, Culture and Development, Director of Medical Education and for their respective items the Guardian of Safe Working, the Freedom to Speak up Guardians and the Director of Charities and Head of Volunteers.

At its meeting the Committee received its planned items including a report on the delivery of the people ambitions within the Trust's better care everywhere strategy, the cultural programme delivery plan, update. freedom to speak up guardian's report, the guardian of safe working quarterly report, an update on the delivery of the resident doctors 10-point improvement plan, voluntary services strategy, integrated education funding agreement, medical appraisal update, measuring staff experience and updates for the Committees respective reporting groups. The Committee also received the People Risk paper and the BAF for the Committee's oversight of their allocated strategic risks.

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

<u>People Performance Overview Report.</u>

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

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

<u>Culture Programme</u>

The Committee **received** an update on the cultural programme specifically on the continued development of a behavioural framework, which would establish a common baseline for all within the Trust to which cohort specific behaviours would be added. The Committee was assured that the framework had taken into account consultation feedback.

The Committee reviewed the measurement approach and discussed the need for a balance between qualitative and quantitative metrics. It also considered the activation plan and supporting communications and activities to create the environment for a successful launch.

The meeting acknowledged that securing wider awareness of the compass and framework will take time, and that following awareness there will be a push to secure advocacy for the framework all leading to a greater acceptance of its value.

The meeting discussed the value of using the behavioural compass and framework to guide people in the art of providing and hearing constructive challenge in support of them and the organisation moving to that of a learning driven Trust.

The Committee **endorsed** the developed Behavioural Compass and Leadership Framework and **agreed** the proposed activation plan and monitoring and evaluation processes.

Excellent Care Everywhere – people ambition delivery plan update

The Committee **received** an update on the on the aligned people plan to the Trust Excellent Care Everywhere People Strategic Ambitions. The Committee discussed the format of this report and noted that delivery is also tracked through the strategy delivery plan reporting the Trust's Strategy and Major Projects Committee. In recognition of this the Committee **asked** that the report to this Committee focus more on describing the impact of the actions being taken using where possible quantitative measures,

Voluntary Services Strategy

The Committee **received** an update on the work undertaken aligned to the current strategy and noted the works alignment to both the NHS 10 Year Plan and the Trust's own Strategy.

The Committee **noted** the improvements made in respect of the standardisation of recruitment, onboarding and support given to volunteers moving from four different and disparate approaches to one unified Trust way of working, led by the interim head of volunteers.

The Committee **discussed** the value that volunteers bring to the Trust and how support can be garnered for the further development of volunteering roles, not just as a route to work but also a route to access specific skills that can support patients wellbeing, such as activity volunteers.

The Committee sought information on the efficiency of the recruitment checks and training and were **informed** that they follow the same basic checks and employees and in regard to STAM undertaken a tailored subset of that all new employees undertake.

The Committee **asked** that the head of volunteers consider the establishment of a multi-disciplinary forum where the deployment and growth of volunteers could be discussed

NHS Staff Survey update

The Committee **received** an update on the NHS Staff Survey noting that plans are train that once the national results are released then these will be shared with the Clinical and Support Divisions both benchmarked nationally and internally at a Trust level.

The Committee **noted** that the final benchmarked results will be flowing to the Board in March 2026.

10 – point plan improving resident doctors working lives

The Committee **received** the Trust's updated assessment against a mandated 10 point plan to improve resident doctors working lives and was assured over the progress made to achieve compliance.

The Committee **heard directly from the resident doctor lead** and noted the planned work they are leading to improve engagement with the resident doctors' staff cohort.

The Committee **noted** the significance attached by the resident doctors to the developing policy to support those working extended hours as referred to in the Guardian of Safe Working Hours item and was reassured that the policy is being developed.

The Committee **endorsed** the Management's discussion being held on the resilience of the resident doctor lead. including extension of the Committee's membership to a resident doctor representative.

Guardian of Safe Working Hours report

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

The Committee **noted** the planned changes to the national exception reporting processes and recognised that this may if early pilot information is representative then an increase in reporting is likely. The Committee endorsed that management should review the level of Guardian resources needed to maintain the Trust's processes.

The Committee **noted** the work to develop a process to support resident doctors who work extended hours and that the Trust's Management Committee had received a draft of this policy and was scheduled to have an updated policy to their next meeting.

Freedom to Speak Up Guardian's report

The Committee **received** the report and **noted** the successful transition of the change of the Guardian.

The Committee discussed the benchmarking of the Trust's level of type of referrals and **noted** that these were in line with others and was provided assurance that the Trust responds to matters raised in line with the agreed response metrics. The report provided **assurance** over the action being taken in respect of issues raised.

The Committee discussed the planed communication improvements to seek support from more senior staff to provide reflections on how they have valued matters raised through this process to support staff to engage with the process as they would hear not only how matters were heard but also what was done as a result.

The Committee **noted** the report from the Freedom to Speak Up Guardian and the discussions with them and **noted** the **assurance** the report provided over the continued effectiveness of the underpinning reporting processes whilst recognsing that further work is being planned in support of improving the communications as to how concerns when raised how they are taken seriously by senior leaders in the Trust.

Risk report and Board Assurance Framework

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

The Committee scrutinised its allocated element of the Board Assurance Framework relating to strategic risks 2 and 3 these being *we do not develop a culture that supports the delivery*

*of the Trust's mission of excellent care everywhere **and** we do not attract, develop and retain enough people with the right skills, values and behaviours to deliver our ambitions*.

Following the review of the BAF itself the reports received, the Committee **agreed** with the recommendation to reduce the score for strategic risk 2. With the reduction in score and the maintenance of the score for risk 3 the Committee noted that both risks were tracking their target scores for the year.

Review of Terms of Reference

The Committee utilised the Committee Effectiveness questionnaire responses to **review** its Terms of Reference and **agreed** there were no changes to be recommended to the Board.

The Committee agreed with the recommendation to aid the operation of the Committee that reflective questions would be asked at the end of each meeting, covering timeliness and quality of papers along with a question on how the Committee demonstrated it acted within the developed Behavioural Compass to enable learning to be implemented across the year rather than wait until the formal effectiveness review to identify areas that could have been adjusted during the year

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.

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Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	27 January 2026	**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 provided feedback on the developing 2026/27 people scorecard The Committee **noted** this update and recognising the linkage between this update, the BAF strategic risks and the cultural programme development update.
CQC allocated actions oversight assurance register	**Presenter** Chief People Officer	**Purpose** For discussion and assurance over delivery	**Outcome** The Committee **agreed** the level of assurance of progress was reasonably stated, recognising that the oversight of many of these is provided through the workforce scorecard but where there was a need for specific actions it recorded how these had been taken and where this was reported.
Updates from work with system partners	**Presenter** Chief People Officer	**Purpose** For discussion and assurance	**Outcome** The Committee **noted** the verbal update in respect of the collaboration work being undertaken with the ICB and other NHS partners, noting that the ICB restructure to form NHS Surrey and Sussex.

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			The Committee discussed the potential impact changes to the funding for professional studies and the work being done across the system to better understand this along with local educational partners.
Culture Programme Update	**Presenter** Chief Strategy Officer / Director of Integrated Education (Cultural Improvement programme SRO)	**Purpose** For information	**Outcome /Action taken** The Committee **received** an update on the cultural programme specifically on the continued development of a behavioural framework, which would establish a common baseline for all within the Trust to which cohort specific behaviours are added. The Committee reviewed the measurement approach and discussed the need for a balance between qualitative and quantitative metrics. The Committee considered the activation plan and supporting communications and activities to create the environment for a successful launch. The meeting discussed the value of using the behavioural compass and framework to guide people in the art of providing and hearing constructive challenge in support of them and the organisation moving to that of a learning driven Trust. The Committee **endorsed** the developed Behavioural Compass and Leadership Framework and **agreed** the proposed activation plan and monitoring and evaluation processes.

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2025 NHS Staff Survey results update	**Presenter** Associate Director, Leadership, OD & Engagement	**Purpose** For discussion and assurance	**Outcome /Action taken** The Committee **received** the update on the initial Trust results. The Committee **noted** the plans to support the cascading of the results of the nationally and local benchmarked results once received to both clinical and support divisions. The Committee **noted** that the results are planned to come to the Board in March 2026.
Excellent Care Everywhere – people ambition deliver update	**Presenter** Director of workforce	**Purpose** For discussion and assurance	**Outcome** The Committee **received** the update and noted that the people ambition delivery plan has aligned with the Trust's strategy. The Committee discussed the format of this report and noted that delivery is also tracked through the strategy delivery plan reporting the Trust's Strategy and Major Projects Committee. In recognition of this the Committee **asked** that the report to this Committee focus more on describing the impact of the actions being taken using where possible quantitative measures, The Committee also **discussed** the need to use consistent wording where possible to show how national initiatives such as people promises fit within our delivery plan. The **agreed** to the continued receipt of this report but with a focus on outcome measures in respect of the actions being taken.

Voluntary Services Update	**Presenter** Charity Director and Head of Voluntary Services	**Purpose** For assurance	**Outcome** The Committee **received** the update and agreed the value volunteers bring to the Trust. The Committee was **informed** of the harmonisation of recruitment and on boarding processes. The Committee asked about the recruitment checks and training provided and was informed this followed the same basis checks required of all staff and had a tailored subset of training given to all staff. The Committee **asked** that the head of volunteers consider the establishment of a multi-disciplinary forum where the deployment and growth of volunteers could be discussed The Committee was **assured** that progress had been made to standardise the processes applied to volunteers
10-point plan improving resident doctors	**Presenter** Director of HR Operations and Director of Medical Education	**Purpose** For assurance	**Outcome** The Committee **received** the report and update on the delivery of the 10 point plan. The Committee heard from the resident doctor nominated lead and heard that work was being undertaken to support improvement engagement with resident doctor cohort given the size of our Trust and noted the work being led by the resident doctor lead. The Committee heard about the importance the resident doctors are attaching to the launch of a policy that is in draft to support resident doctors who work extra hours.

			The Committee supported that management should look at the succession planning for the resident doctor lead. The Committee **noted** the progress from the initial self-assessment through the delivery of the action plan and was **assured** over the oversight of the action plan delivery.
Freedom to Speak Up Guardian six monthly report	**Presenter** Freedom to Speak Up Guardian	**Purpose** For assurance	**Outcome /Action taken** The Committee **received** the report and noted the successful transition of the change of the Guardian. The Committee discussed the benchmarking of the Trust's level of type of referrals and **noted** that these were in line with others and was provided assurance that the Trust responds to matters raised in line with the agreed response metrics. The report provided **assurance** over the action being taken in respect of issues raised.
Guardian of safe working hours Q3 report	**Presenter** Guardian of safe working hours	**Purpose** For assurance	**Outcome /Action taken** The Committee **received** the report and noted the Guardian's assurance over the established processes for exception reporting. The Committee **noted** that exception reporting will be changing and that from the pilot sites this had seen an increase in instances of formal reporting and that the route to review these with these changes would see these exceptions reports only being seen by the Guardian within the report provided **assurance** over the action being taken in respect of issues raised.

Integrated Education Funding Agreement	**Presenter** Director of Integrated Education	**Purpose** To note	**Outcome /Action taken** The Committee noted the report which included a mapping of the application of these sources of funding. The Committee discussed the purpose of this paper and whist recognsing the value it gave future updates should provide information on how the use of these monies support service delivery sustainability and if income streams change their risk to Services.
Medical Appraisal Update	**Presenter** Not taken in the meeting	**Purpose** For information	**Outcome /Action taken** The Committee noted that this paper would be circulated separately to the Committee for information only
Measuring staff experience	**Presenter** Associate Director, Leadership, OD & Engagement	**Purpose** To note	**Outcome /Action taken** The Committee noted the report
Committee reporting group reports	**Presenter** Taken for information without wider discussion	**Purpose** For information	**Outcome /Action taken** The Committee **received** these and noted their correlation to the Chief People's oversight report
People Risks update	**Presenter** Chief People Officer	**Purpose** To note	**Outcome /Action taken** The Committee noted the report and recognised that work is to be undertaken to review the recording and management of risks within the organisation. The Committee reflected on thematic analysis of the recorded risks with a workforce implication when considering the workforce strategic risk.
Board Assurance Framework	**Presenter** Company Secretary	**Purpose** To review and recommend to the Board	**Outcome /Action taken** The Committee reviewed its allocated segments and agreed with and recommended score for both

			the culture risk (risk 2) workforce risk (risk 3) scores. The Committee **discussed** the scores and **agreed** with the proposed reduction to risk 2. The Committee **noted** that both strategic risk 2 and 3 were tracking their target score in this quarter.
Review of the Terms of Reference	**Presenter** Company Secretary	To review and determine if there is a need for any changes and recommend to Terms of Reference to the Board	The Committee received the report including the feedback from the Committee effectiveness survey and **agreed** with the minor changes to the Terms of Reference and **agreed** to recommend these to Board.

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Agenda Item:	16.	**Meeting:**	Trust Board in Public	**Meeting Date:**	5 February 2026
Report Title:	Finance & Performance Assurance Committee Chair's Report				
Author(s):	Philip Hogan, NED and Committee Chair Paul Layzell, deputising Chair Finance & Performance Assurance Committee				

Purpose of the report: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For discussion**	**For Information only**
	No	*Yes*	*Yes*	*N/A*

Reason for not being taken in public *(indicate as appropriate)*	**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 ***(summary of current position / issue & why it matters and evidence to support that position etc)***

The report provides information over the business undertaken at the Finance and Performance Assurance Committee across the meetings in November 2025 and January 2026 covering month 7 and month 9 year to date outcomes and forecasts for the full year. The Committee was quorate at each meeting and received its scheduled business.

The Committee in accordance with its Terms of Reference approved one investment decision in January:

• Radiotherapy Linac Replacement funds were approved for a 7th Linear Accelerator supporting resilience pending the opening of the new Cancer Centre (the first of six replacements as older devices reach end of life)

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 Committee commended other recommendations for Board approval that exceed the Committee's delegated authority:
- Blood Components, Reagents & Services award of contract
- Managed Service Contract for Pathology Services for the Princess Royal Hospital and the Royal Sussex County Hospital contract extensions
- Electronic Patient Record (EPR) Programme and Full Business Case and to direct the UH Sussex Procurement Team to complete contract negotiations with the preferred supplier as part of onward approvals before as part of the programme to introduce the EPR in 2027.

The Committee also approved the application for £5.1m Working Capital Cash Support public dividend capital to NHSE in March 2026.

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

The Board can take assurance from the oversight being provided by this Committee to the areas of financial and operational performance and the plans to address any risks to the achievement of the Trust annual delivery plan. The Board can also take assurance that the Committee has oversight of the Trust cash management actions.

The Board can receive the Trust's integrated performance report relating to operational and financial performance with confidence that the Committee has discussed the plans to address the risks in achieving the Trust's annual delivery plan and support the CFO's recommendation to enhance the current control environment.

The Board can receive the BAF with confidence that the content and score for strategic risks 4, 5 and 6 have been scrutinised and the current and target assessment score remain unchanged.

Recommendation *(linked to What Next section)*	***The Board is asked to NOTE***

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	- ***The Committee was quorate and considered all the expected reports in line with its schedule of business except for two item deferrals.*** - ***The Committee's assurance over the Trust's current plans and controls for the delivery of its annual financial and operational plan.*** - ***The Committee's recommendation of the scores for their allocated elements of the BAF, strategic risks 4, 5 and 6.*** - ***The Electronic Patient Record Full Business Case is supported by the Committee and is to be presented for approval at a future meeting.*** ***The Board is invited to APPROVE the Committee Terms of Reference (see appendix A)***
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	*The Committee provides oversight of the delivery of the Trust's annual financial and operational plan delivery.*
Link to BAF	*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.*

Link to CQC domain	**Safe**	**Caring**	**Effective**	**Responsive**	**Well-led**	**Use of Resources**
	Yes	*Not directly*	*Not directly*	*Not directly*	*Yes*	*Yes*

Other impacts	**Equality and Diversity (*if yes has HEIA completed)***	**Environmental**	**Legal**	**External Registrations *(if yes please indicate which)***
	N/A	*N/A*	*Yes*	*The Trust is required to maintain an effective system of governance, risk management and internal control (FT Code of Governance / FT Licence)*

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Finance and Performance Assurance Committee Chair's Report

The Finance and Performance Assurance Committee met in November 2025 and January 2026 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 except for the Environmental & Sustainability Report (Q3) and the update on CQC Actions oversight, both items have been deferred to the next meeting.

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

Whilst the Trust had a year to date £1m adverse position to the submitted overall financial plan up to month 9, the planned in-month deficit had been delivered. Delivery of this position has required the use of non-recurrent mitigations, and the Committee examined the extent and implications of these. There were areas of individual variance and operating divisions had remained collectively adverse to plan in-month 9. Particular risks to the underlying run rate continue to be workforce overspend and efficiency shortfalls.

The Committee noted an update on rapid, focused work (the "Sprint") led by the Chief Finance Officer to determine the actions required to deliver its year-end performance commitments including the financial position. The exercise aligns activity, finance, and workforce plans and a core working group will continue to provide central oversight. The Committee noted the Effectiveness of the non-pay controls with discretionary non-pay spend had remained below pre-control level. Overall pay expenditure exceeds financial plan and pay and non-pay run-rates both increased month-on-month, which is at odds with the requirement to reduce run-rate in H2 to hit the financial plan. It is essential that progress is accelerated in Q4 to mitigate risk of missing the financial target and the compounding penalising effect of this. The Committee **asked for an immediate assessment** to identify the actions that would be necessary to assure break even at year end.

In aggregate divisions have been £3.9m deficit to plan in-month. The Committee **noted** it had previously discussed that structural changes and rebasing of budgets should improve accountability and performance, but this has not yet translated to a positive impact on expenditure control in all areas. The Committee heard about the diligent budget setting work from the Finance team and enhancements to budget manager training programmes and finance business partnering.

The Committee further **discussed** the impact the Trust's current deficit position was having on its cash position. The Committee heard that reduction in the run-rate is also necessary to address the cash position which had been increasingly challenged. In January the Committee heard how the Trust's cash position had slightly improved at the end of Month 9 through a few sources of non-recurrent cash, primarily some reimbursement of the costs of industrial action, that has been used together with further measures to mitigate risk to prompt supply of goods and services. Payment to suppliers within 30 days remained below standard and work continued to support small, local or critical suppliers A multidisciplinary cash committee meets weekly to prioritise supplier payments. In November an application for revenue support to NHS England was supported by the Committee. This request was rejected on technical grounds and partially supported by Month 9 end when resubmitted.

The Committee supported a further application for revenue support at its January meeting having **recognised the risks** faced between now and year end and brings these to the attention of the Board. The Committee **endorsed** an application for revenue support from NHS England for the full amount allowable in the form of one-off working (public dividend) capital cash support. The Committee welcomed the scenario-based supplier payment position that now informs the Cash report to the Committee.

The Committee reflected that funds received for industrial action while covered direct costs but did not reflect the lost opportunity of transformed activity. The underlying efficiency programme has remained adverse to plan in-month and remains a considerable risk. Elective recovery funding had some risk of shortfall and while there was agreement for 2025/26 remains a challenge for future years. The Committee heard that discussions are ongoing with the NHS England regional team to discuss the delivery to be realised from major projects.

Efficiency and Productivity

The Committee **received** the scheduled efficiency and productivity reports at each of its meetings in the quarter. At month 9, the Committee noted that the in-month delivery against the £113m annual efficiency plan delivery had been £7.52m, which was £2.56m adverse to plan. The Committee heard that £103m efficiency is expected to have been delivered by year end.

The Committee remains **assured** of the process and diligence being applied to the review of the efficiency programme both centrally and divisionally and that external review had confirmed the accuracy of reporting. The Committee supported the continued focus on divisional accountability and welcomed the alignment of coding recovery plans with financial delivery.

The Committee has continued at each meeting to consider areas of opportunity across the Trust from which the 2026/27 Efficiency and Productivity Programme Target of £140m is expected to be derived and **noted** this represents a proposed governance framework which is being matured and aligned with operational groups to underpin delivery Clinical productivity continues to be highlighted as an area of significant opportunity.

The Committee Examined the Quality Impact Analysis (QIA) report for impacts around efficiency programmes and this was triangulated with the report to Patient & Quality Committee that revealed this activity needs further completeness. The Committee looks forward to receiving further information on anticipated intervention activities.

Capital

The Committee **noted** that the Trust at month 9 was £9.8m behind its capital plan delivery, the major contributor being delayed theatre works pending the regional and national approvals that support the ventilation replacement plan. Whilst the Trust waits for approval of the scheme, the Trust has been in discussion with NHSE regarding the scheme. The Committee heard about the proactive work and due diligence in in order to mobilise the scheme by year end. The Committee head about reprofiling of other schemes into 2026/27 in agreement with NHSE. The regional team of NHSE have been briefed on the associated activity implications and reprofiling of plans that may be required by changes to the Southlands plan. The Committee was assured by the focussed forecast by week for each scheme and welcomed the previously requested milestones in the Capital report.

Planning 2026/27

The Committee **noted** progress with the developing plan towards expected submission in February. Following the Board discussion the plan profile has been revised to reach break-even position at the end of year 2. The plan included the adjusted efficiency programme. The Committee also noted the workforce plan was predicated on a reduction in year 1 headcount through efficiency plans and heard about progress of work with Newton to identify opportunities to release beds and was **assured** by the scrutiny activity of the schemes to avoid double counting. The Trust will submit a compliant plan but the Committee notes there is further work required on the capital plan. Income allocations from 2026/27 are highlighted as a risk and discussions with partner Trusts in the Sussex system continue in relation to allocations for growth. The Committee acknowledged the ambitious plan but welcomed the engagement activity that had been undertaken with the Trust leadership to date.

The Committee scrutinised the handling of growth assumptions and also considered the Wholly Owned Subsidiary major project and the extent to which progress can be assured given the need for NHSE approval and local trade union support not currently received. The Committee continues to recognise progress to date as well as the continued challenge on efficiency and need to have a different approach to deliver what is needed. i.e. a step change required for the most significant cross-cutting transformations and **will invite this discussion at a meeting of the Board.**

Commercial Report

The Committee heard how food concessions were key areas of partnership working and recognise the importance to learn from the national staff survey and staff experience of the restaurants and vending. The Committee heard that trade unions are on the relevant steering groups. The Committee heard how the procurement team will look to align to the new trust operating model (TOM) to ensure that the procurement and supply chain service are aligned to and enabling the new divisions.

The Committee had previously sought more assurance on expiring contracts and the route for contract renewal assurance and welcomed the dashboards that provide the committee with this awareness.

Investment decisions

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

• Radiotherapy Linac Replacement funds were approved a 7th Linear Accelerator supporting the preparatory works for installation at RSCH, to ensure resilience pending the opening of the new Cancer Centre (the first of six replacements)

The Committee commended other recommendations for Board approval that exceed the Committee's delegated authority**:**

- Blood Components, Reagents & Services award of contract

- Managed Service Contract for Pathology Services for the Princess Royal Hospital and the Royal Sussex County Hospital contract extensions

- Electronic Patient Record (EPR) Programme and Full Business Case and to direct the UH Sussex Procurement Team to complete contract negotiations with the preferred supplier as part of onward approvals before as part of the programme to introduce the EPR in 2027.

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Quarter 3 2025/26 Operational Performance

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

- Urgent and Emergency Care (UEC) performance deteriorated in December from November. Overall, the Trust performance remains lower than national average and behind our planned trajectory to meet the 78% 4-hour target by the end of the year. The Committee acknowledged considerable site variation and discussed the factors.
- The trust has maintained ambulance hand overs and has made further progress on reducing patients in non-clinical areas (Corridor care) with necessary use of such spaces having been more dynamic and short term than previously.

- The Committee considered the UEC Performance through the winter. The winter planning assumptions had been tested. System support had not delivered the impact that had been hoped for although internal plans had held true.
- Other relative successes through the challenging winter period had been avoidance of infections leading to bed loss that had previously impacted capacity.

- Referral to treatment performance saw deterioration for month 9 to 51.1% which is below the national performance level but was marginally ahead of the Trust's improvement trajectory. The Committee **noted** significant progress in reducing the cohort of patients at risk of waiting over 65 weeks. The Committee received reassurance that specialty level plans are in place to reach the zero 65 week target.

  - A particular risk concern has been total waiting list growth from October /November with issues identified around the handling of referrals and that suggested Seen underlying demand growth faster than plan assumed. IF demand continues through Q4 there would be a waiting list at year end of 117,000 from what had been planned 101,000. The Committee heard why this had not been sufficiently visible in the data to take timely action and the recovery actions that have since been initiated to halve the impact of this risk.

- Cancer performance remains broadly on track but despite improvement in quarter 3 narrowly missed the local recovery trajectory of the 62-day target with a performance of 66.8% in November 2025. The faster diagnostic standard performance improved to 78.3% at month 8, exceeding the national average.

- 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.

Overseeing delivery through H2 delivery meetings fully aligning performance with the financial ask. The 5% growth in demand is unsustainable and there is concern about demand reduction system coordination being removed with ICB changes. Asked about understanding referral activity analysis and there are a number of GP practices with exception.

Environmental Sustainability Report

The Committee did not **receive the expected report** on the Trust delivery against its Green and this is deferred to the next meeting.

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Risk and the Board Assurance Framework

The Committee **reflected** on the reports received and the key operational and financial risks, and scrutinised 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 January meeting the Committee **agreed** their quarter 4 scores should not reduce from those recorded at quarter 3.

The Board workshop activity had agreed risk appetite statements and work was underway to overlay these to associated tolerances and to the risks above.

Committee Effectiveness

The Committee reflected on the findings of the effectiveness survey and identified that with minor changes the Terms of Reference for the Committee remain appropriate and are commended for approval. The Committee identified that it has discretion to widen its scope to non-RTT wait performance and will assign time in its cycle of business accordingly.

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.

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Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**27 November 2025**	**Chair**	Philip Hogan	**Quorate**	Yes
Meeting Date	**29 January 2026**	**Chair**	Paul Layzell	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

2025/26 Quarter 3 Financial Performance Report - monthly position - cash reporting - grip and control reports	**Nov**	**Jan**	**Presenter** Chief Finance Officer / Director of Operational Finance	**Purpose** For assurance	**Outcome /Action taken** **Noted** M9 position and delivery that was in line with the submitted plan but the year to date plan is in deficit. Progress on recovery activities were noted.
2025/26 Quarter 3 Efficiency & Productivity Reporting - monthly position and assurance process	**Nov**	**Jan**	**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 and implications for 2026/27 plans
Capital Investment Progress Report Update on Capital Plan for 2025/26 delivery at Month 7 (Nov) and Quarter 3 (Jan)	**Nov**	**Jan**	**Presenter** Director of Strategic Finance	**Purpose** To update on the implementation of the 2025/26 capital plan & set out actual position at Q3 end.	**Outcome /Action taken** **Noted** the delivery of the was slightly behind the plan in quarter 3 but that this was not a cause for concern.
Commercial Progress Report Q3 2025/26 including Procurement Update	**Nov**	**Jan**	**Presenter** Chief Procurement Officer	**Purpose** To Note	**Outcome /Action taken** Noted activity undertaken by the commercial directorate
Operational Performance Reporting ▪ Performance Scorecard ▪ Constitutional Standards Performance Report	**Nov**	**Jan**	**Presenters** Chief Operating Officer; Director of Performance/ BI Managing Director Planned Care	**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. The Committee were

					informed of identified growth in elective Demand that had emerged through Oct/Nov 2025 and the risk this poses to the size of the waiting list and achievement of targets.
Operational Performance Deep Dive ▪ Urgent and Emergency Care Performance	**Nov**		**Presenters** Chief Operating Officer; Director of Performance/ BI Deputy Chief Operating Officer	**Purpose** For information	**Outcome /Action taken** Noted that improvement has been made across key UEC metrics but that 4-hour performance delivery is behind plan YTD. There is partial assurance to deliver the 4-hour standard by Mar-26. Noted that the work with Newton just begun and any in-year benefit has yet to be factored in
Emergency Preparedness Resilience and Response Annual Report 2025		**Jan**	**Presenters** Chief Operating Officer; Head of EPRR	**Purpose** To approve	**Outcome /Action taken** Noted and **approved** the EPRR annual report 2025 and the confirmation of the 'substantially compliant' rating against National Core EPRR Standards from NHS England.
Planning Approach 2026/27 – 2028/29 (reflects planning for 3 years of revenue plans 2026/27 - 2028/29 and 5 years of capital plans 2026/27 – 2030/31 January Update also reflects workforce, activity and efficiency numbers being submitted in the full plan submission.	**Nov**	**Jan**	**Presenters** Chief Finance Officer/ Director of Strategic Finance	**Purpose** For approval	**Outcome /Action taken** In November Noted the approach to preparing the 2026/27 – 2027/28 medium term plan. Action taken: The Committee recommended to the Board the assurance gained in development of the plan. In January the Committee **approved** the full submission of the Financial Plan in February 2026.
ICS System Update	**Nov**	**Jan**	**Presenter** Chief Finance Officer/ Chair of Committee	**Purpose** For information	**Outcome /Action taken** Noted the work being undertaken within the ICS. Noted the final Committee in Common was due to take place in late January 2025 to

					be replaced by new meeting arrangements.
Investment Decisions & Contract Recommendations - Blood Components, Reagents & Services	**Nov**		**Presenter** Chief Finance Officer	**Purpose** To Agree and recommend for Board approval	**Outcome /Action taken** The Committee **commended to Board** award of the contract for the supply of blood components and services to NHS Blood & Transplant
Investment Decisions & Contract Recommendations - Managed Service Contract for Pathology Services for the Princess Royal Hospital and the Royal Sussex County Hospital	**Nov**		**Presenter** Chief Finance Officer	**Purpose** To Agree and recommend for Board approval	**Outcome /Action taken** The Committee **commended to Board** award of the contract to the incumbent supplier under a procurement regulations compliant procurement framework. The contract extension for Point of Care Testing and Third Parties contract elements for the duration of 7 years so they can be novated into Sussex Pathology Network Managed Service Contract (MSC)
Investment Decisions & Contract Recommendations - Sussex Cancer Centre Radiotherapy Linear Accelerator Replacement		**Jan**	**Presenter** Divisional Operations Director (Cancer Division)	**Purpose** To Approve	**Outcome /Action taken** The Committee **approved** the capital and revenue funding associated with the purchase of a 7th Lin-Ac' installation in the existing RSCH Cancer Centre within the Committee's delegated Authority. And noted this is the first of 6 Lin-Ac's to replace before opening of the new Sussex Cancer Centre.
Investment Decisions & Contract Recommendations - Electronic Patient Record (EPR) Programme and Full Business Case		**Jan**	**Presenter** Chief Strategy Officer; Chief Information Officer; EPR Programme Manager	**Purpose** To Note	**Outcome /Action taken** The Committee **commended to Board** approval of the full business case and to direct the UH Sussex Procurement Team to

					complete contract negotiations with the preferred supplier as part of onward approvals before as part of the programme to introduce the EPR in 2027.
Risk and Board Assurance Framework		**Jan**	**Presenter** Chief Finance Officer / Company Secretary	**Purpose** To agree whether risks at the end of Q3 are fairly stated.	**Outcome /Action taken** The Committee **reviewed** their allocated elements and examined reduction in some component risk scores but **agreed** with the Executives' recommendation that in respect of the Trust wide BAF risks there are no changes for Q4 from the Q3 scores.
Committee Effectiveness		**Jan**	**Presenter** Company Secretary	**Purpose** To note and confirm the continued suitability of the terms of reference	**Outcome /Action taken** The Committee **reviewed** findings of the effectiveness survey. The Committee confirmed that with minor changes the Terms of Reference for the Committee remain appropriate and are **commended** for approval. **Action:** cycle of business to assign time to review non-RTT waiting list and its risks.

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Agenda Item:	17.	**Meeting:**	Trust Board in Public	**Meeting Date:**	5 February 2026
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

What ***(summary of current position / issue & why it matters and evidence to support that position etc)***

The report provides information over the business undertaken at the Strategy and Major Projects Assurance Committee in January 2026.

The Committee meeting was quorate and received its scheduled business, including the routine reporting on the major project portfolio delivery, reporting on a sample of the major projects and the Strategy Delivery Plan.

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 Strategy Delivery Plan.

The Board can be assured over the progress of the major projects within the major projects' portfolio, which for the majority were delivering as expected. For those flagged by the Strategy and Major Projects Programme Board as having some degree of delivery risk the Committee discussed these and received assurance on the ratification plans.

The Board should note that the Committee reviewed the drivers of the rationalisation of a small number of projects within the portfolio and endorsed this process.

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 plan 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 4.

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 review of the Strategy Delivery plan and endorsement of the rationalisation of a small number of interrelated projects***

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	- ***The Committee's recommendation of the scores for their allocated elements of the BAF, strategic risks 10 and 11.*** ***The Board is asked to APPROVE the Committee Terms of Reference (see appendix A)***
Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*	

Link to Trust Strategy (note which theme)	**Patient**	**People**	**Future**	**Communities**	**One UHSussex**	**Culture**
	Yes	Yes	Yes	Yes	Yes	*Yes*
Link to annual delivery plan	*The 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.*					
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	*The Committee has oversight of the key assurances referred to within the BAF for strategic risks 10 and 11 and through their scrutiny of these recorded assurances consider and recommend to the Board their relevant current scores.*					

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

Other impacts	**Equality and Diversity (*if yes has HEIA completed)***	**Environmental**	**Legal**	**External Registrations *(if yes please indicate which)***
	N/A	*N/A*	*Yes*	*The Trust is required to maintain an effective system of governance, risk management and internal control (FT Code of Governance / FT Licence)*

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Strategy and Major Projects Assurance Committee Chair's Report

The Strategy and Major Projects Assurance Committee met on the 29 January 2026 and was quorate with at least five NEDs and two Executives being present including the Chief Strategy Officer as the lead executive for the Committee. The Committee received all its planned business. In attendance were also the Director of Strategy, Director of Capital, Director of Facilities and Estates, Director of Strategic Finance, Company Secretary and for the item on the Electronic Patient Record Project the Chief Information Officer.

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

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

Trust Strategy Delivery Plan

The Committee **received** the Strategy Delivery Plan progress report showing for each Strategic Ambition the key deliverables and progress being made against each of these.

The Committee discussed the proposed alignment and thus rationalisation of a small number of projects and **endorsed** this approach as it offered a more meaningful way for the Committee to track overall progress.

The Committee **discussed** the format of the document recognising that this had iteratively taken on board the prior meetings feedback. The Committee **provided comments** to aid further reporting of progress to the Committee, principally to include references to the imperatives that are driving the plan which will give assurance to the Committee over the key choices being made in determining the delivery programme and to add to the information on the immediate and short-term delivery information on how this may impact on the overall 5 year strategic ambitions.

The Committee **noted** the delivery plan milestone tracking update.

Major Projects

The Committee **received** reports on the overall major project portfolio **noting** that the portfolio was broadly on track, and where there were variations **noted** the drivers for these and the actions being taken.

The Committee **received** and discussed the lessons learnt for past project delivery challenged and **noted** how these lessons were being applied to the current projects and the project portfolio.

The Committee **received** specific project reports covering the RSCH Acute Floor Reconfiguration, SRH RAAC remediation and the Trust Electronic Patient Record (EPR) implementation.

The Committee **discussed** the report on the Acute Floor Reconfiguration (AFR) noting the complexity of the project and the need to reconcile the work specification, timescales and cost of the remaining phase. The Committee noted the high level of clinical engagement and the ongoing work to place the remaining stage of the project on a sound footing. With partial assurance, the Committee welcomed a consolidated review and report on the project,

agreed by all parties, to show the reconciliation of competing demands and to gain full assurance on the project's plan and delivery. This would be presented at the next meeting of the Committee.

The Committee **discussed** the SRH RAAC remediation project and was **assured** that this work had been brought within the major project portfolio and project management oversight discipline. The Committee **endorsed** the approach being taken to disaggregate the various conflated issues in terms of the building remediation to the challenges of the service operating out of that space.

The Committee **discussed** the Electronic Patient Record project and was **assured** over the supplier section processes applied supported by extensive staff evaluator support. The Committee **noted** the application of the learning from the launch of the electronic document management system that was being applied to the change processes in support of the subsequent phases of this project and the work that had already commenced in preparation for the EPR in respect of system consolidation.

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 this meeting and whilst noting the actions taken **agreed** that with the Executives view that there remains work to do to enable a change in risk score. The Committee **agreed** to recommend to the Board that there is to be no change to the quarter 4 scores from those agreed at Board for quarter 3.

Review of Terms of Reference

The Committee utilised the Committee Effectiveness questionnaire responses to **review** its Terms of Reference and **agreed** there were no changes to be recommended to the Board.

The Committee **agreed** with the recommendation to aid the operation of the Committee that reflective questions would be asked at the end of each meeting, covering timeliness and quality of papers to enable learning to be implemented across the year rather than wait until the formal effectiveness review to identify areas that could have been adjusted during the year

Referrals to other Committees

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

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Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	29 January 2026	**Chair**	Paul Layzell	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Item	Presenter	Purpose of the paper	Action Taken
Trust Strategy Delivery Plan	Chief Strategy Officer and Director of Strategy	To discuss and provide feedback	The Committee **received** the strategy delivery plan progress update. The Committee discussed the proposed alignment and thus rationalisation of a small number of projects and **endorsed** this approach as it offered a more meaningful way for the Committee to track overall progress. The Committee **discussed** the format of the document recognising that this had iteratively taken on board the prior meetings feedback. The Committee **provided comments** to aid further reporting of progress to the Committee. The Committee **noted** the delivery plan
Major Project Portfolio Overview report including the application of lessons learnt	Director of Strategy	To note and be assured over the application of lessons learnt	The Committee **noted** the update which summarises for the portfolio as a whole and for each project their position, the interdependencies between projects and the key project delivery risks. The Committee **discussed** project progress and **noted** the remedial actions proposed to bring projects back on track. The Committee **discussed** the lessons learn for prior projects and their project management and were **assured** over the application of these lessons into current projects and the major projects portfolio management itself.

Acute Floor Reconfiguration update	Chief Operating Officer	To note the project governance and oversight	The Committee **discussed** the report on the Acute Floor Reconfiguration (AFR) noting the complexity of the project and the need to reconcile the work specification, timescales and cost of the remaining phase. The Committee noted the high level of clinical engagement and the ongoing work to place the remaining stage of the project on a sound footing. With **partial assurance,** the Committee welcomed a consolidated review and report on the project, agreed by all parties, to show the reconciliation of competing demands and to gain full assurance on the project's plan and delivery. This would be presented at the next meeting of the Committee.
SRH RAAC Remediation Project	Director of Capital	To be assured over the project management and governance	The Committee **discussed** this project and was assured that this work had been brought within the major project portfolio and project management oversight discipline. The Committee **endorsed** the approach being taken to disaggregate the various conflated issues in terms of the building remediation to the challenges of the service operating out of that space.
Electronic Patient Record Project	Chief Information Officer	To be assured over the project management	The Committee **discussed** this project and was assured over the supplier selection process applied. The Committee **discussed** and **noted** the application of the learning from the launch of the electronic document management system that was being applied to the change processes in support of the subsequent phases of this project The Committee noted the work being undertaken in preparation for the EPR in respect of system consolidation. The Committee **noted** the project risks and mitigations.

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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, noting that recent feedback from partners had been positive about the level of engagement from the Trust.
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 that the score of these risks should not change for quarter 4.
Strategy and Major Projects Programme Board Chair's report	Chief Strategy Officer	For information only	The Committee noted the update
Review of the Terms of Reference	**Presenter** Company Secretary	To review and determine if there is a need for any changes and recommend to Terms of Reference to the Board	The Committee received the report including the feedback from the Committee effectiveness survey and **agreed** there were no changes needed to the Terms of Reference and **agreed** to recommend these to Board.

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Agenda Item:	19.	**Meeting:**	Trust Board in Public	**Meeting Date:**	5 February 2026
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**	
		Yes		***Yes***	
Reason for not being taken in public *(indicate as appropriate)*	**Commercial confidentiality**	**Staff confidentiality**	**Patient confidentiality**	**Other exceptional circumstances (please detail)**	
Regulatory Reporting Requirement					

The following is a summary update of matters not covered elsewhere within the agenda

Governor Elections

We are about to commence our next round of governor elections. The elections will open for nominations on 12 March 2026 with a deadline for nominations to be made by 13 April 2026. Following the receipt of nominations the formal election process will open on 6 May with elections concluding on the 1 June 2026.

The positions open for election are Public Governors for Brighton and Hove, Chichester, Mid Sussex and Worthing.

The undertaking of these elections will ensure that the Council of Governors has sufficient elected governors to function.

Board and Council of Governors meetings in 2026/27

The Trust is retaining its current cadence for its Board and Council of Governors meeting in public but is moving the Board meetings back by a week in the month they fall to allow for the Committee meetings in the week before the Board meetings to be better serviced by their specific reporting groups. The Council of Governors meetings will continue to fall quarterly and be held after the Board meetings that are focused on operational delivery.

Therefore, the meetings for 2026/27 are summarised below and will be held in the Boardrooms at Trust HQ, Worthing Hospital. The papers as they are prepared for each of these meeting can be found on the Trust's website here: https://www.uhsussex.nhs.uk/about/board/board-meetings/

Board Meetings in Public which commence at 10:00 will be held on 14 May 2026, 11 June, 17 September, 12 November, 10 December, 11 February 2027 and 18 March 2027.

Council of Governors meetings in public which commence at 14.00 will be held on 28 May, 1 October, 3 December 2026 and 25 February 2027.

It should be noted that the final timetable for the auditing of the Trust's annual report and accounts and the timetable for the laying of these before parliament has not been set and therefore the date for the Annual General Members Meeting has yet to be set. However, as was reported to the Board and Governors previously

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	the Trust intends to hold this virtually given the drive to make this as accessible as we can. ***NED recruitment*** *We are about to commence the recruitment to our vacant NED positions. With the recent retirements we will be looking for upto three NEDs. We are working with a recruitment consultant to support us in securing a diverse and credible field of candidates especially as we are looking for a clinically skilled NED and one with significant transformational / change management skills.*
Recommendation *(linked to What Next section)*	***The Board is asked to NOTE*** - ***The timings of the 2026/27 Board and Council of Governors meetings being held in public*** - ***The timeline for the next round of Governor elections*** - ***The commencement of the process for the recruitment to our NED vacancies***
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	*Not directly*
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**
	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 have an effective Board and Council of Governors as part of its provider licence and therefore there is a need to both recruit to fill our vacant NED positions and to hold elections to maintain sufficient elected governors to operate effectively.*

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Perinatal Quality Oversight Model (PQOM)
Trust wide summary report

November 2025 Data

Purpose and background

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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

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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

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Escalations for January meeting

- The National Maternity and Neonatal Investigation team have confirmed that they will not be able to visit all four sites in January (20th/21st), and will therefore, need to return to visit Worthing and Chichester sites in February, dates to be confirmed.
- Following the near miss incidents and escalations from clinical staff, as well as the CQC inspection findings, finding a solution for separate access to theatre for planned caesareans at Haywards Heath has become a significant priority. Planning is underway with a solution expected from early March, with interim mitigations in place.
- A relocation of some Special Care Activity babies (9 cots) from the Trevor Mann Baby Unit has been required to allow for preparatory work for the helipad opening. These babies are being cared for in the LMB. Mitigations are in place to ensure the quality and safety of care during this period.
- The Maternal Care Bundle NHS England » The Maternal Care Bundle was launched on 7th January. A gap analysis will be completed. Findings and action will be reported in the next PQOM report.

Celebrations for January meeting

- UHSussex maternity ranked 10th out of the 55 Trusts that use Picker to conduct the CQC Maternity Survey annually. This ranking has improved from18th in 2024 and 22nd in 2023.
- Approval of Safety Action six progress within the CNST Maternity Incentive Scheme (MIS) programme, was received from the ICB in December – this means that a fully compliant CNST MIS declaration can be submitted in March for the first time since 2022.
- Brighton Maternity received an improved CQC rating, published in December following inspection in February, moving from Inadequate to Requires Improvement. Significant further progress has been made since the inspection, including a solution for planned caesarean lists away from labour ward, and permanent obstetric and midwifery leadership.

2. Risk register updates

New and closed risks:

The following risks were opened during November with a score of 16 and above: **None**

The following risks were closed during November with a score of 16 and above: **None**

Domains

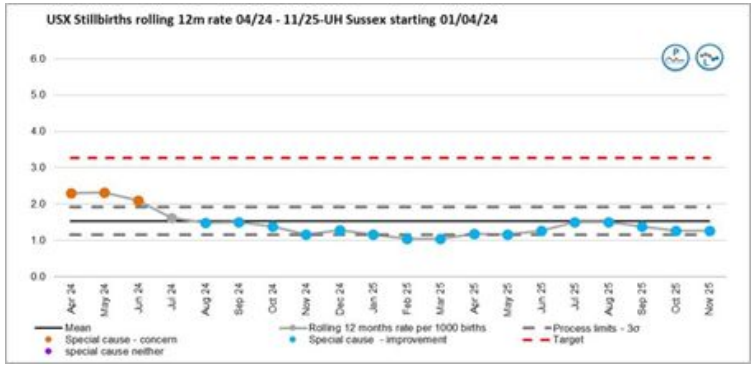
3a) Deaths and Harm

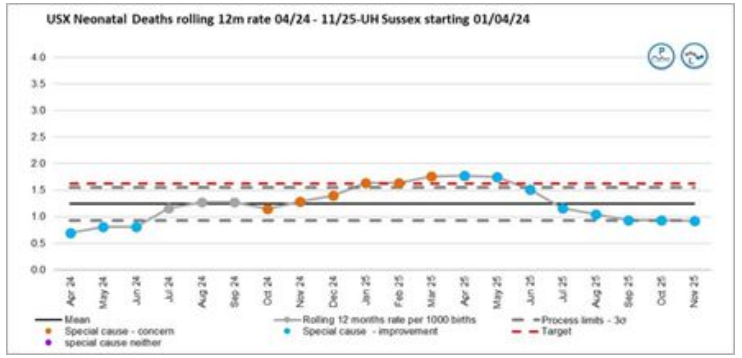
- Perinatal Mortality cases for November 2025
  - **PRH**: **PMRT case. Neonatal Death**
  - **RSCH**: **PMRT and LLR case. Neonatal Death**

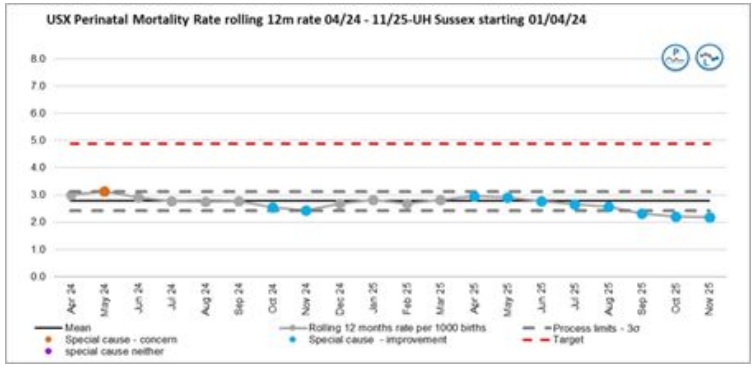
- Perinatal Morbidity cases for November 2025
  - Nil

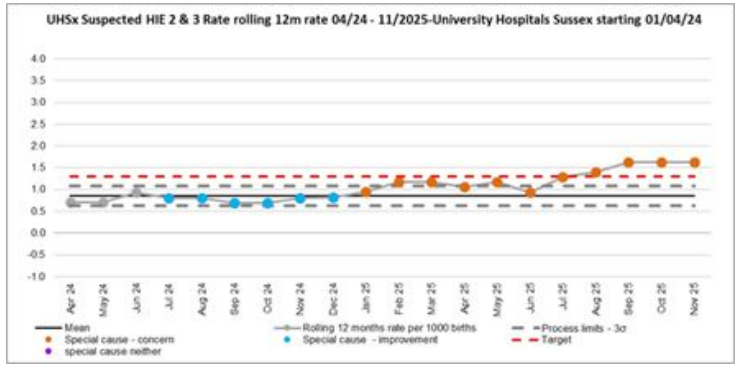
3a) Deaths and Harm
Perinatal Mortality Statistical Process Control (SPC) charts

University Hospitals Sussex NHS Foundation Trust









Outcomes over a 20-month period using 24/25 data as a baseline.

Analysis:

The Board can take assurance that perinatal mortality and stillbirth rates remain stable, significantly below national rates and better than aspirational national targets for 2025.

As previously reported, a thematic review has been completed for suspected HIE (brain injury) cases. No cases have occurred on any site in November.

Due to the small numbers recorded per 1000 births, Special Cause Concerning Variation continues to be registered until more than 1000 births have occurred. The intention is to start including a rare events chart which will provide more context to the SPC.

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

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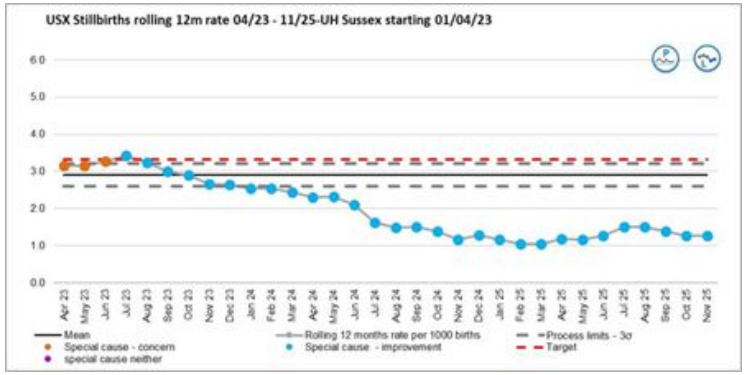
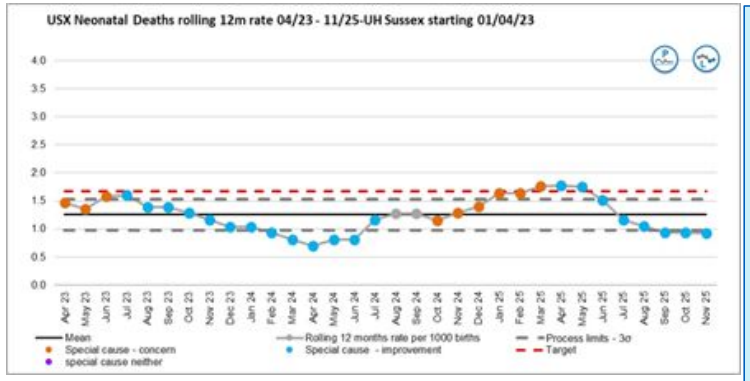
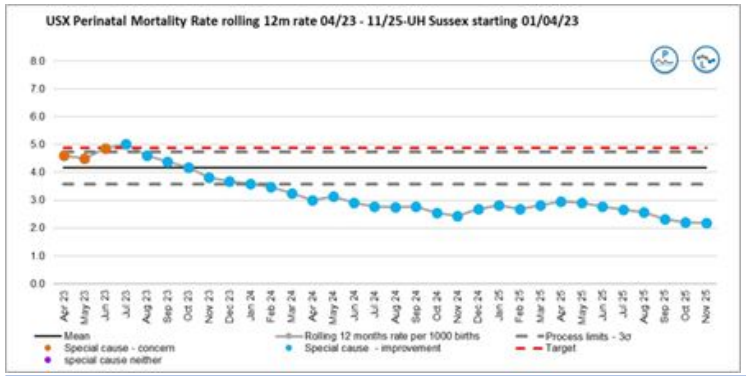
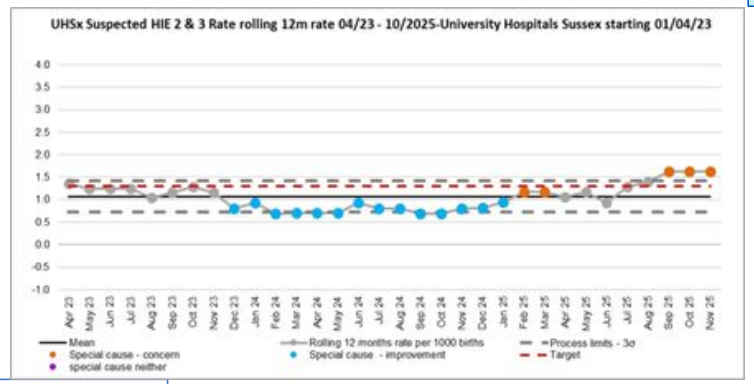




Due to the small numbers involved, site specific Rare Event SPC charts are now included in appendix 1, to allow for monitoring of mortality and morbidity outcomes.





Outcomes over a 32-month period using 23/24 data as a baseline.

Health inequalities

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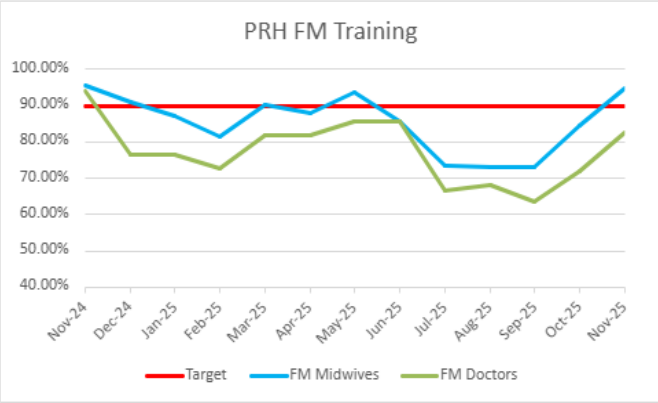
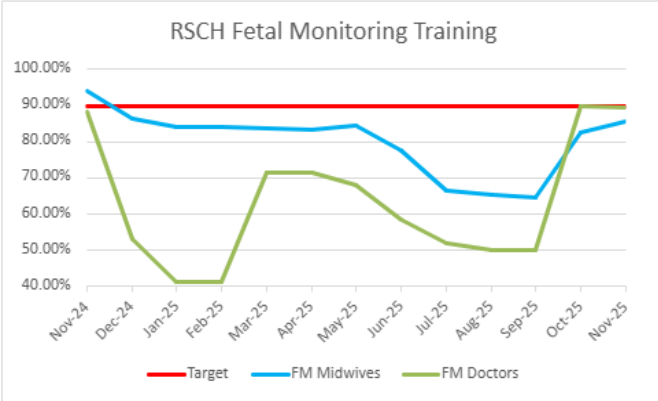
- Statistical Process Control (SPC) charts for key indicators stratified to Global Majority groups and most deprived groups are compiled by the Local maternity and Neonatal System (LMNS) for individual sites. These charts are now included in appendix 2.

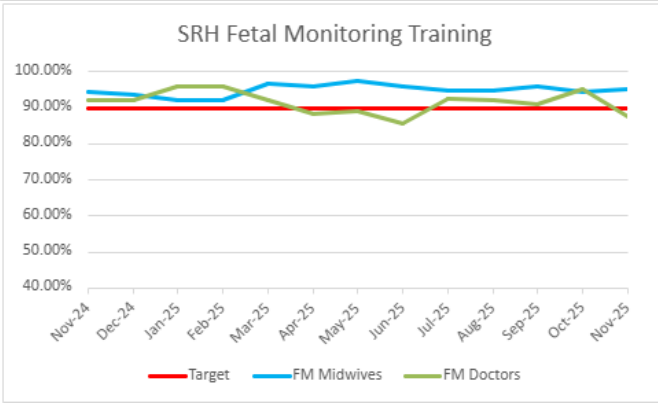
Analysis of November data:

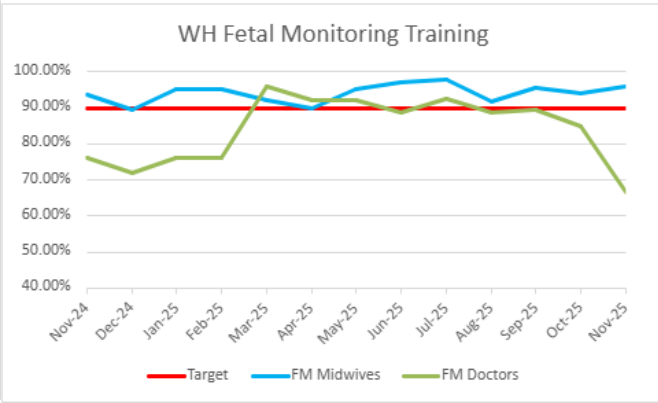
- None of the charts for 10% or 20% most deprived areas, nor Global Majority have showed "Special Cause for Concern", which is encouraging
- Areas for celebration: Trust (particularly at SRH & WH) rates of Smoking at the Time of Delivery and ATAIN are showing Significant Improvement

3b) Leadership and training: Fetal Monitoring







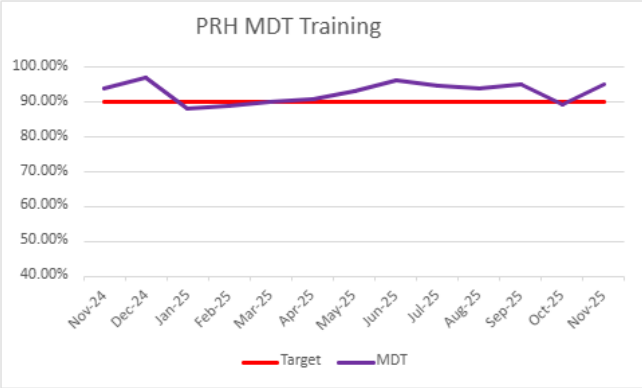


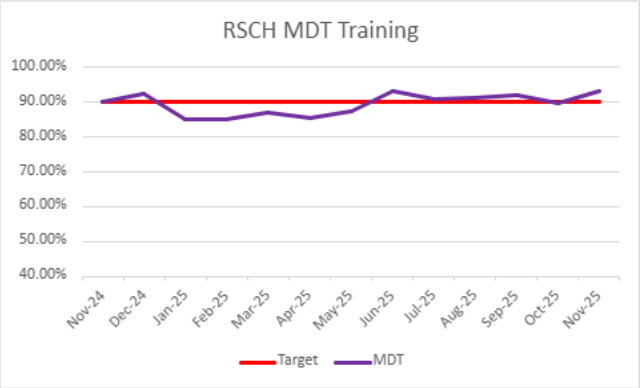
Compliance improvements have been achieved for all groups; however, this takes considerable work from the education team to achieve, due to a lack of booking or attending, particularly within medical staffing groups.

A working group has been established to resolve this issue and ensure responsive communication and accountability .

3b) Leadership and training: Multidisciplinary Training

University Hospitals Sussex NHS Foundation Trust

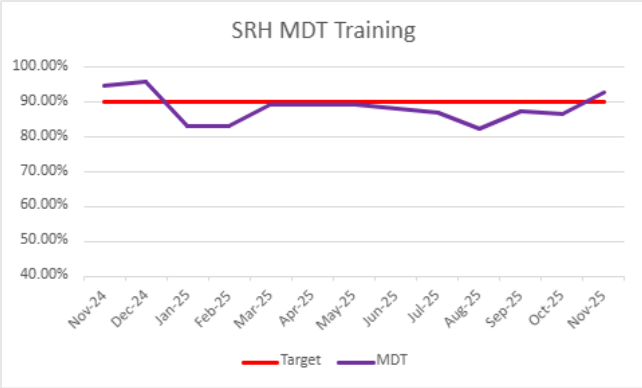


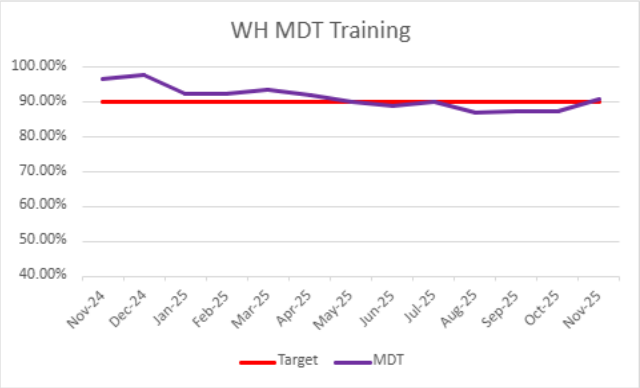


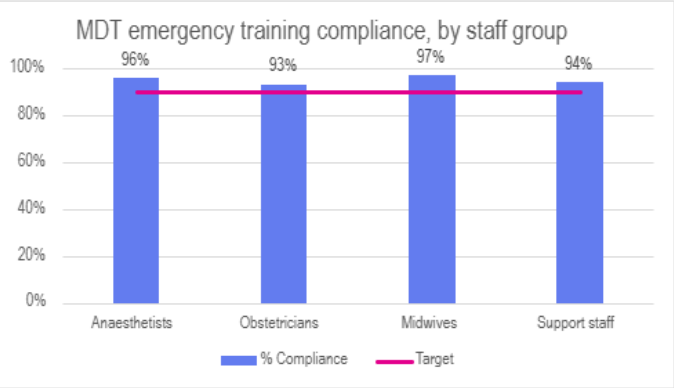
Charts to left display all staff groups combined compliance,

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

Obstetric and Anaesthetic compliance was challenging to achieve due to large number of doctors who train in November and teams are working to spread out doctors throughout 2026.







3c) Voice of the user

Voice of the user	Princess Royal, Haywards Heath	Royal Sussex County Hospital, Brighton	St Richards Hospital, Chichester	Worthing Hospital, Worthing
FFT (% and response rate)	100%	100%	100%	81.8%
Complaints	1	4	3	3
Legal Claims	2	0	0	0
MNVP concerns	2	0	1	0

A successful IT fix to the way the FFT SMSs were distributed post birth to service users has been implemented. Texts are now reaching 97% of all women and birthing people, compared to 40-50% in the preceding 4 months. However, the response rate could see improvement, during November was 12% and the Trust has an aim for 25%. Worthing FFT rates are lower than usual, out of 22 responses 1 scored 5 Very poor, 1 scored poor and 2 scored neither good nor bad. Unfortunately, there was no narrative for the scores of 4 & 5 and 1 comment with regards to staff not introducing themselves on the PN ward for the 3. The score for PN care was 100%. There is a plan to have a postnatal working party across all 4 sites to improve service users experience, Worthing will start work on ensuring appropriate introductions are made and clear communication is shared on care pathways.

Higher numbers of complaints the usual have been received this month (15 vs approximately 8-10). *Themes from complaints include discussion of traumatic birth, communication and complex intrapartum care provided.*
The actions generated from service user feedback in any form will be progressed and monitored under the Maternity and Neonatal Improvement Group.

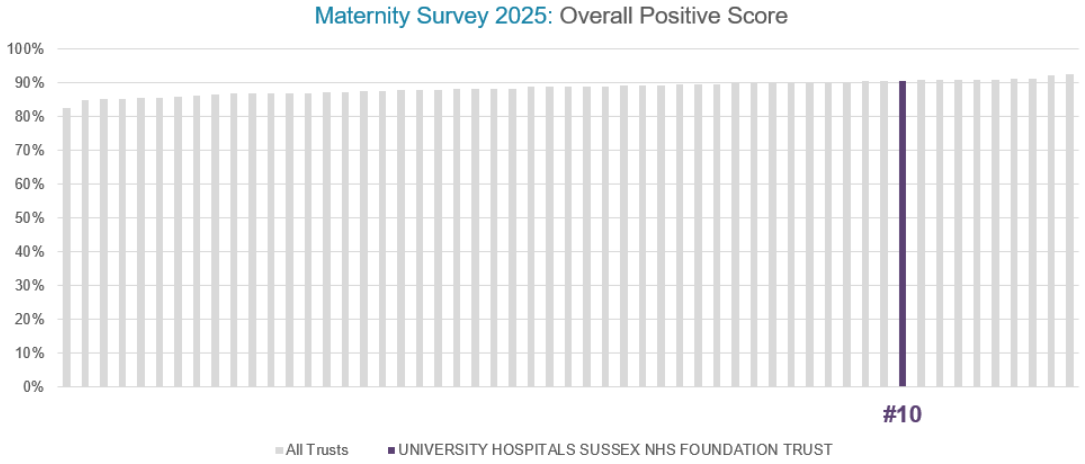
Service user experience – CQC Maternity Survey

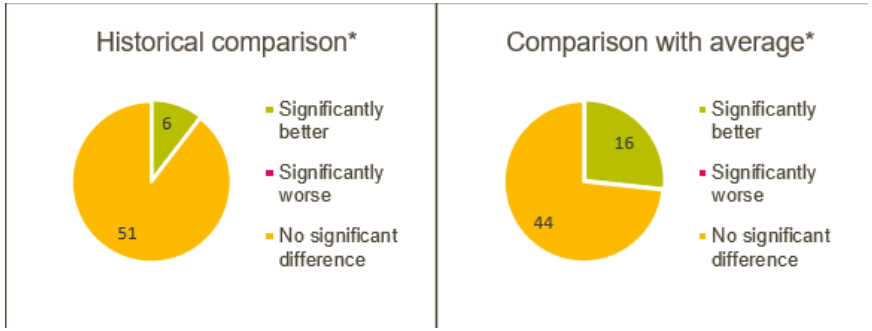
University Hospitals Sussex NHS Foundation Trust

The CQC Maternity Survey 2025 was published in December, UHSussex was **ranked #10th –** improving from #18 in 2024, and #22 in 2023

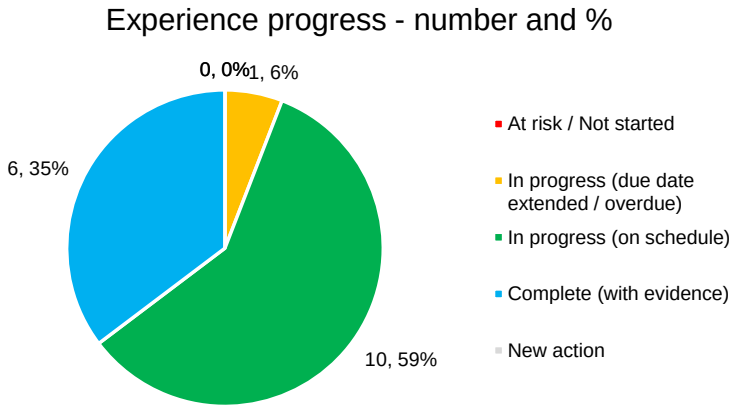
League table: overall positive score

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 2025 with Picker. The overall positive score is the average positive score for all positively scored questions in the survey.





MatNeo Improvement Plan – Service User Experience workstream



- Working group meets monthly, chaired by Head of Midwifery and MNVP strategic lead and reports into MatNeo Improvement Group
- Action will be reviewed in light of most recent CQC Maternity Survey results, including a theme of postnatal care developments
- Bereavement actions have been developed and will be prioritised across Maternity, Neonatal and Gynae (Early Pregnancy Unit)

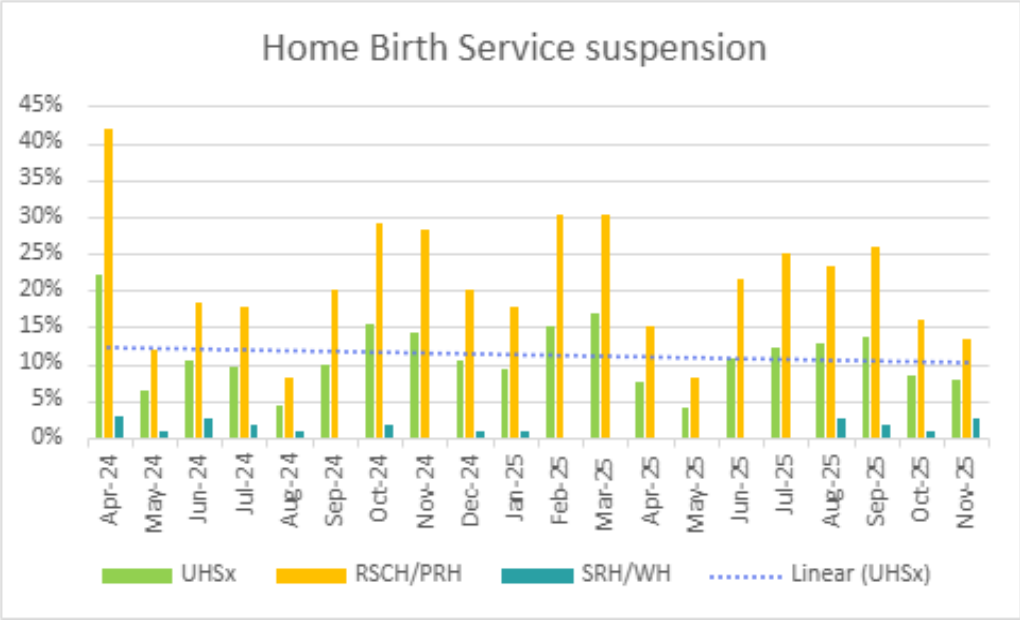
Escalations:

- Increase in complaints in the last few months, some referencing the National Maternity and Neonatal Investigation.
- Accommodating meals for families with babies on TMBU is challenged by size of estates.

Celebrations:

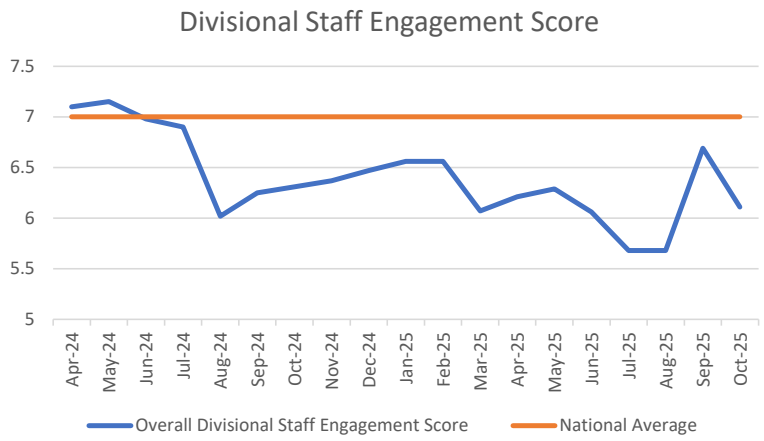
- UHSx rated 10th in the 2024 CQC Maternity Survey results, improvement from 18th in 2023.

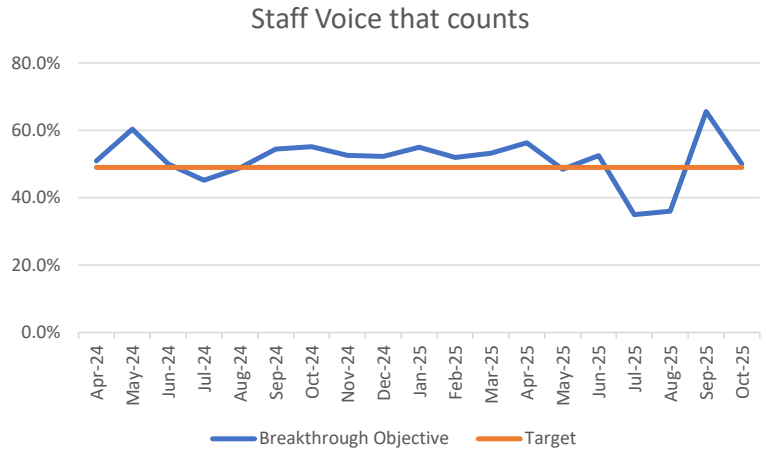
Homebirth suspensions



- November showed further improvement in suspension rate of only 13% compared with 16% the previous month.
- This meant that the Homebirth service was cancelled for 8 shifts out of 60. This translated to 6 women/people out of 29 (21%) having to give birth outside of their preferred birth location as a result of suspending the homebirth service. The homebirth rate had increased to above national rate of 2.3% from 1.2% in October.
- Continuity of care team continue to cover the gaps within the homebirth team to further reduce the suspension rate.
- Rotation of passionate core/community midwives taking bank shifts to continue to cover vacancy within the Homebirth team.
- 3 Full time Midwives have now started in the Homebirth Team with 2 Further Full time Midwives joining the team in January and March.
- From January 2026 the team will be fully staffed with 10WTE.

3d) Team feedback





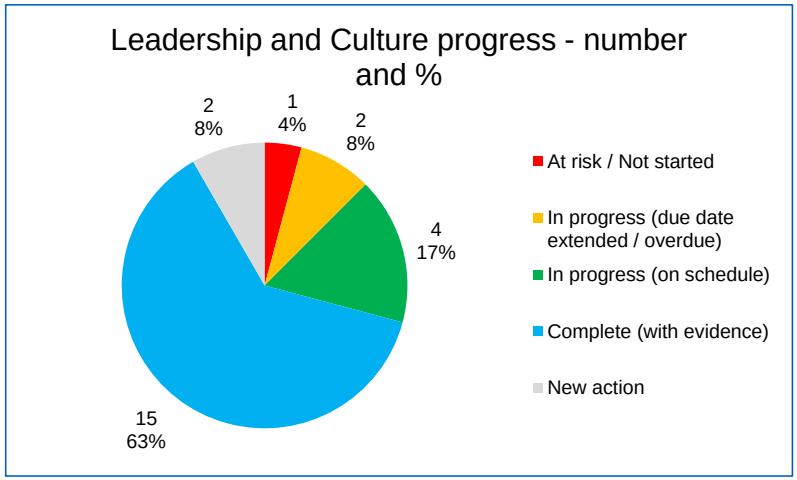
Position

- November 25 data is unfortunately unavailable due to a break in the survey link on the platform meaning the response rate low and therefore insignificant.
- Division returned a response to the staff survey that was slightly less than last year but the same or better than other divisions in the Trust. Once the results are available, the Divisional Leadership team will develop action plans to address issues of concern.

Actions

- Leadership Programme being delivered by the Organisational Development Team took place during November and December, this was well attended and well evaluated.
- Listening Events being held across Directorates. Bespoke Listening Events have been held for the perinatal teams to brief the team on the National Maternity and Neonatal investigation. These events included talks from the legal team regarding social media safety, and the communications team regarding media coverage and behaviour.

3d) Perinatal Leadership and Culture update



- This workstream is part of the MatNeo Improvement Plan
- Actions were developed based of themes from the MSSP deep dive and SCORE survey results and now oversee Staff Survey actions.
- A review and refresh of this and other MNIG workstreams will take place using more recent data and recommendations from recent reports.

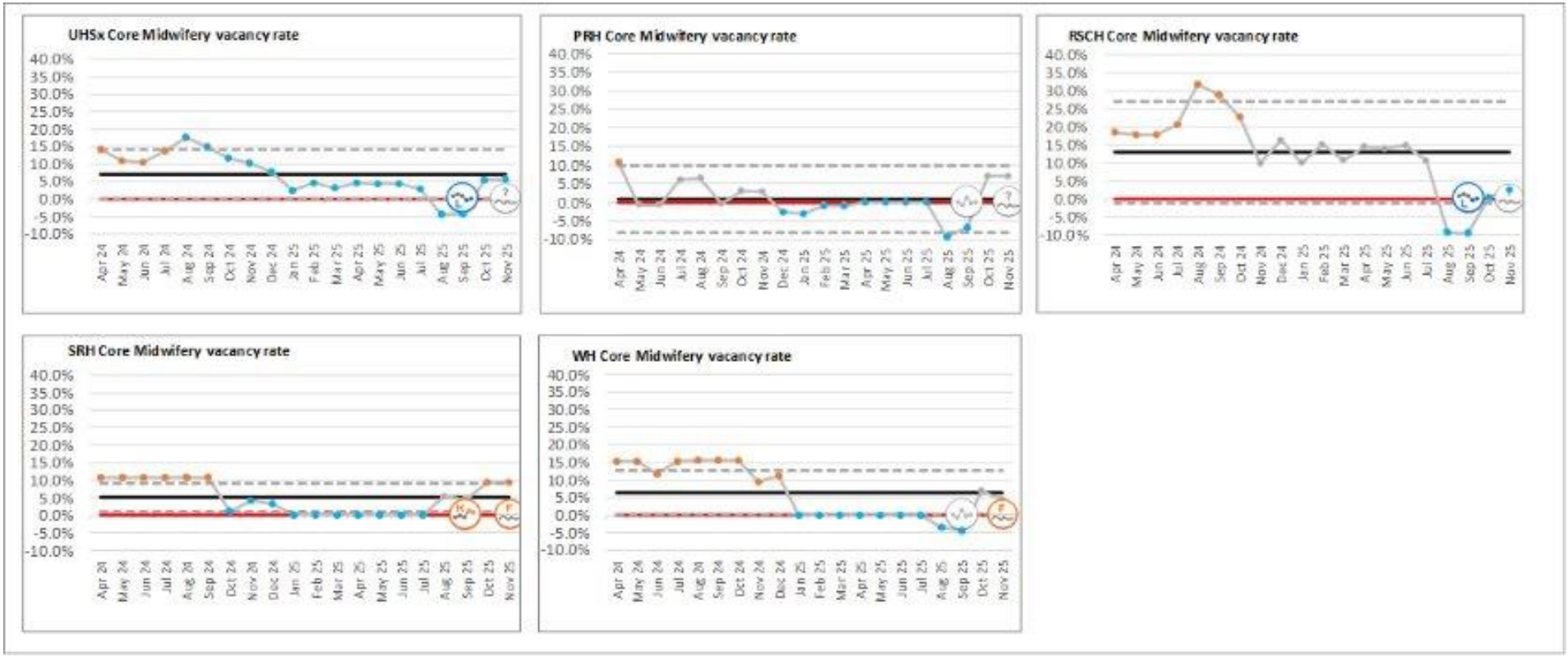
Escalations:

- Infrastructure issues impacting starting rotational posts (IT, swipes etc.).
- No progress on discussions nationally regarding apprenticeship backfill.
- Anything else Seb

Celebrations:

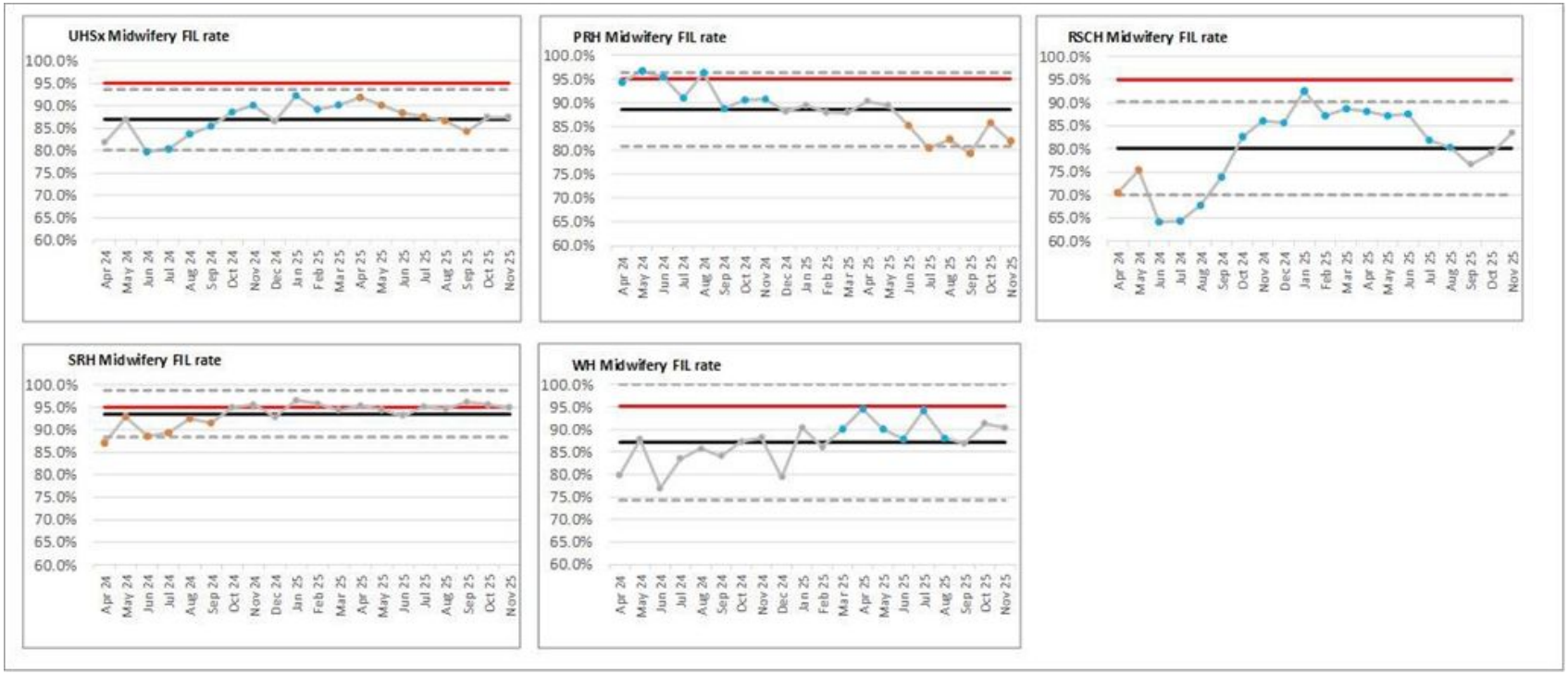
- All consultants now job planned, increasing leadership capacity at each site.
- Restorative culture programme continues.
- Anything else Seb

Perinatal workforce – Midwifery vacancy rate



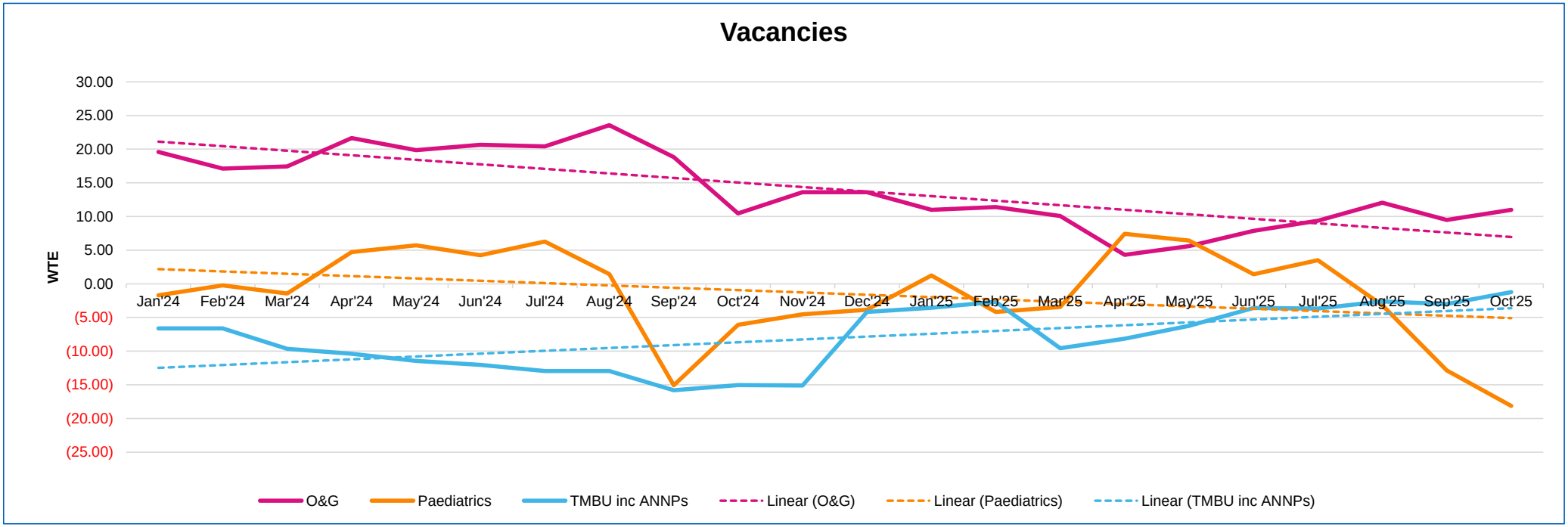
Previous concern was raised about the financial impact of over-recruitment as these figures were provided for substantive vacancies not considering the impact of maternity leave and career breaks. Reporting on those contributors to the vacancy rate demonstrates that the financial impact of over-recruitment is minimal as the over-recruitment is backfilling in those areas, resulting in improved fill rates.

Perinatal workforce – Midwifery Fill rate



Fill rates have improved on all sites except PRH (due to high sickness levels) since the onboarding of the newly qualified midwife cohort. PRH unvalidated December data reflects further improvement, this will be formally shared in the next report.

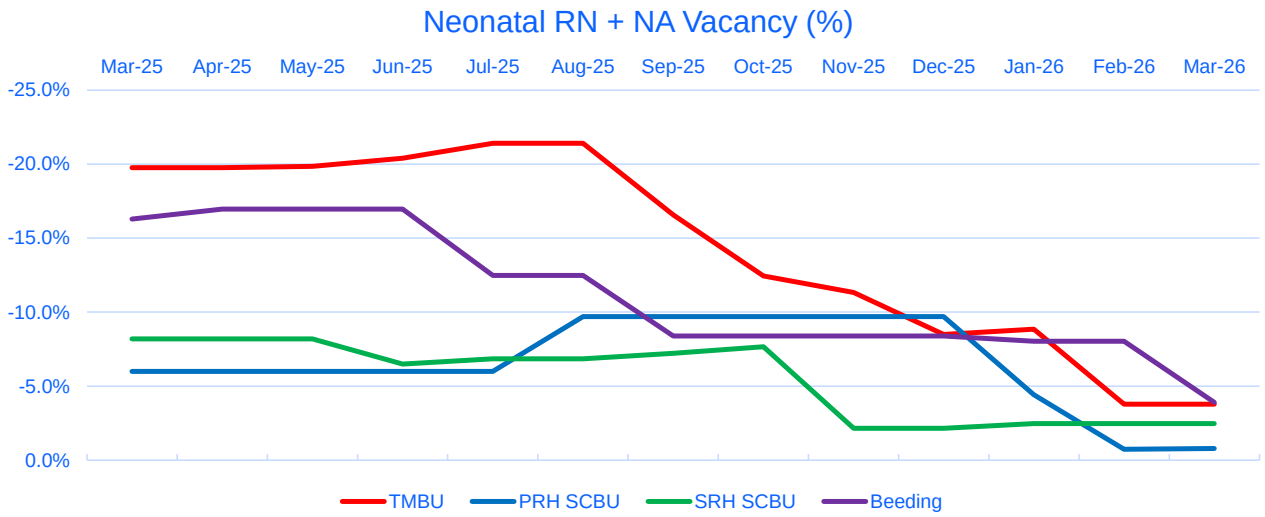
Perinatal workforce - medical



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

Neonatology: Recent work has aligned demand for required staff to undertake the workload. We are actively recruiting to identified vacancies and are nearly at full establishment. Numbers are being affected at PRH because of ANNP sickness in Maternity.

Perinatal workforce – Neonatal Nursing



In November, the clinical registered nursing vacancies across a 4 sites (B7-B4) average of 7.9%. Band 6 QIS coverage at TMBU remains static at 42%, 9 WTEs began the QIS course in September this year.

Actual verses Planned
Overall, November there was no large variation.

TMBU refusals

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	Surgical Babies	Extreme Prem 22Wks-29wks	Refused - Staffing	Refused - Maternity refusal	Refused - TMBU Full	Refused from Worthing	Out of Network	Refused Unknown	Refused Other	Total number of babies refused
Refusals IN Utero	0	13	1	3	6	2	4	4	1	15
Refusals Ex Utero	1	0	1	0	2	0	2	1	0	4

September 31 referrals (20 IUT/11 EUT, 5 being surgical)September 31 referrals (20 IUT/11 EUT, 5 being surgical)
October 52 referrals (25 IUT/27 EUT, 10 being surgical)
November 30 referrals (23 IUT/7 EUT, 3 being surgical)

Referrals Accepted November

IUT 35% (8/23) accepted

EUT (1/5) accepted

EUT (surgical) (2/3) accepted

There was a 94% occupancy rate overall in November for TMBU of which 91% ITU, 85% HDU and 86% SCBU days. During November there were 3 occasions where the Unit was Black. 1 x capacity (27 babies), 2 occasions where it was workforce related (reduced number of QIS staff for the ITU/HDU babies).

Quality Improvement

CNST (separate paper), MSSP, MNIP

Maternity Safety Support Programme

Maternity and Neonatal Improvement Plan (Bi-monthly – next round)

Maternity Safety Support Programme (MSSP) and National Maternity and Neonatal Investigation

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- The MSSP 'exit' meeting planned for 5th August 2025 hasbeen delayed following the announcement by the Secretary of State (SoS) that UHSussex will be included in the National Maternity and Neonatal Investigation.
- A deep dive of evidence and assurance of embedding of closed actions was completed on 14th July, with evidence commended by the MSSP Maternity Improvement Advisor.
- **The MSSP transitioned to the MatNeo Improvement Support Team (MNIST) on 1st January 2026. It is currently unclear where this leaves UHSussex maternity services in relation to programme exit, further information is awaited.**
- The maternity and neonatal services continue to prepare for the investigation visits from Baroness Amos and her team on 20th and 21st January and February. Regular staff briefings and Listening Events have been completed to inform and support staff. Evidence submissions will be completed on 16th January.
- Media coverage related to the investigation has been challenging for families using our services currently, and our teams. Support and evidence-based information is signposted to both groups. Improving maternity care - University Hospitals Sussex NHS Foundation Trust Feedback from families - University Hospitals Sussex NHS Foundation Trust

CNST Maternity Incentive Scheme (MIS) overview

(Separate paper)

Conclusion and recommendations

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The maternity and neonatal service has achieved positive outcomes through the recent CQC inspection of Brighton, the CQC Maternity Survey and a fully compliant CNST MIS submission, reflecting the collective collaboration and commitment of all members of the maternity and neonatal teams and further evidencing the provision of high-quality, safe care.

Outcome data also continues to evidence the safety of the service, with stable perinatal mortality rates significantly below national averages and sustained year-on-year reductions in potentially avoidable deaths, as well as robust governance processes to monitor and respond to changes in outcome data.

The service remains vigilant and is actively progressing further improvement work to enhance outcomes and experiences for families, as well as the working environment and experience of staff.

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

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Appendix 1

Morbidity and Mortality Outcome Data

November 2025

Note that HIE rates in these charts also include HIE 1.

UHSx

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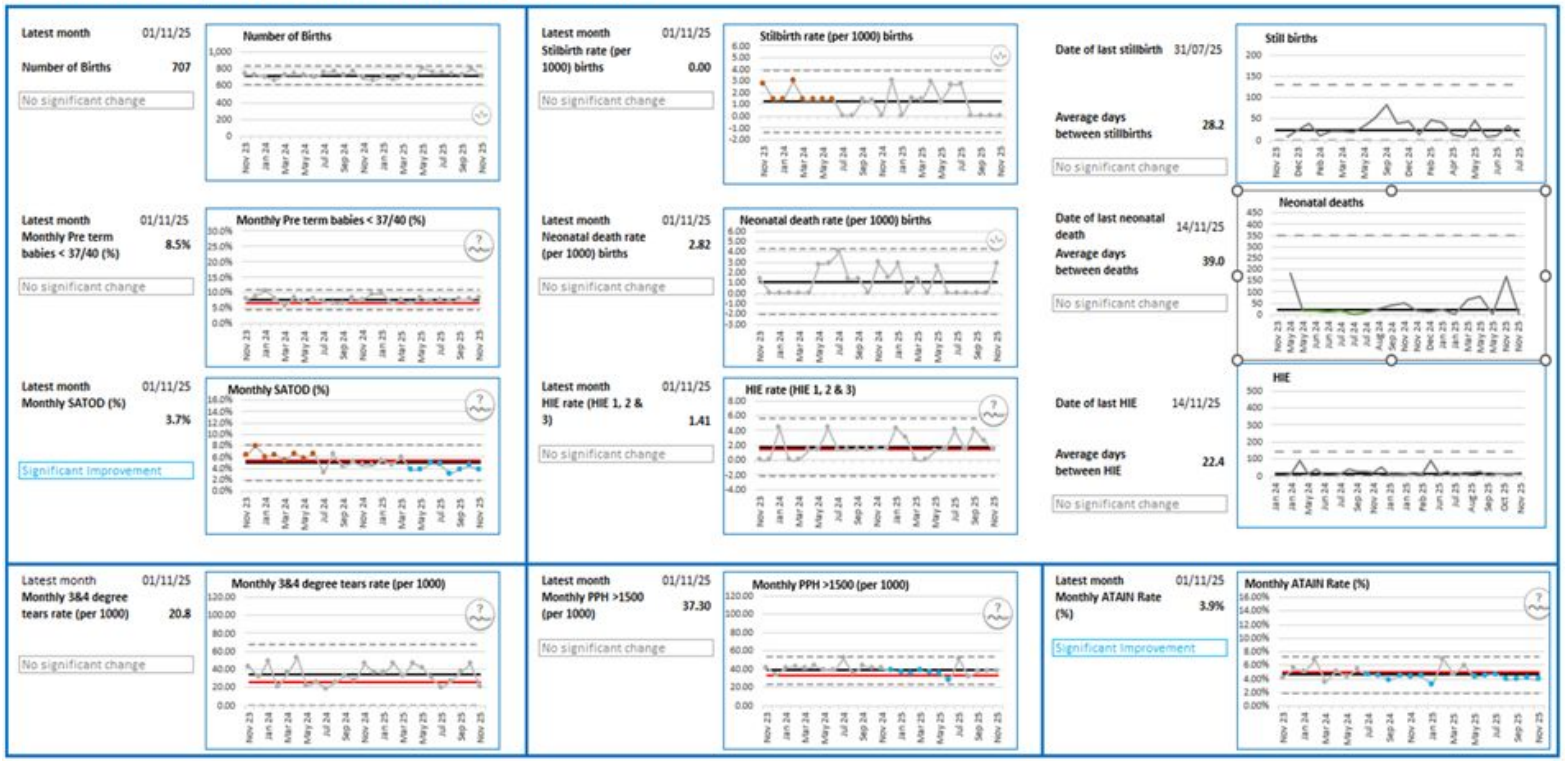
Maternity overview — UHSX NHS Foundation Trust (monthly SB & NND rates)



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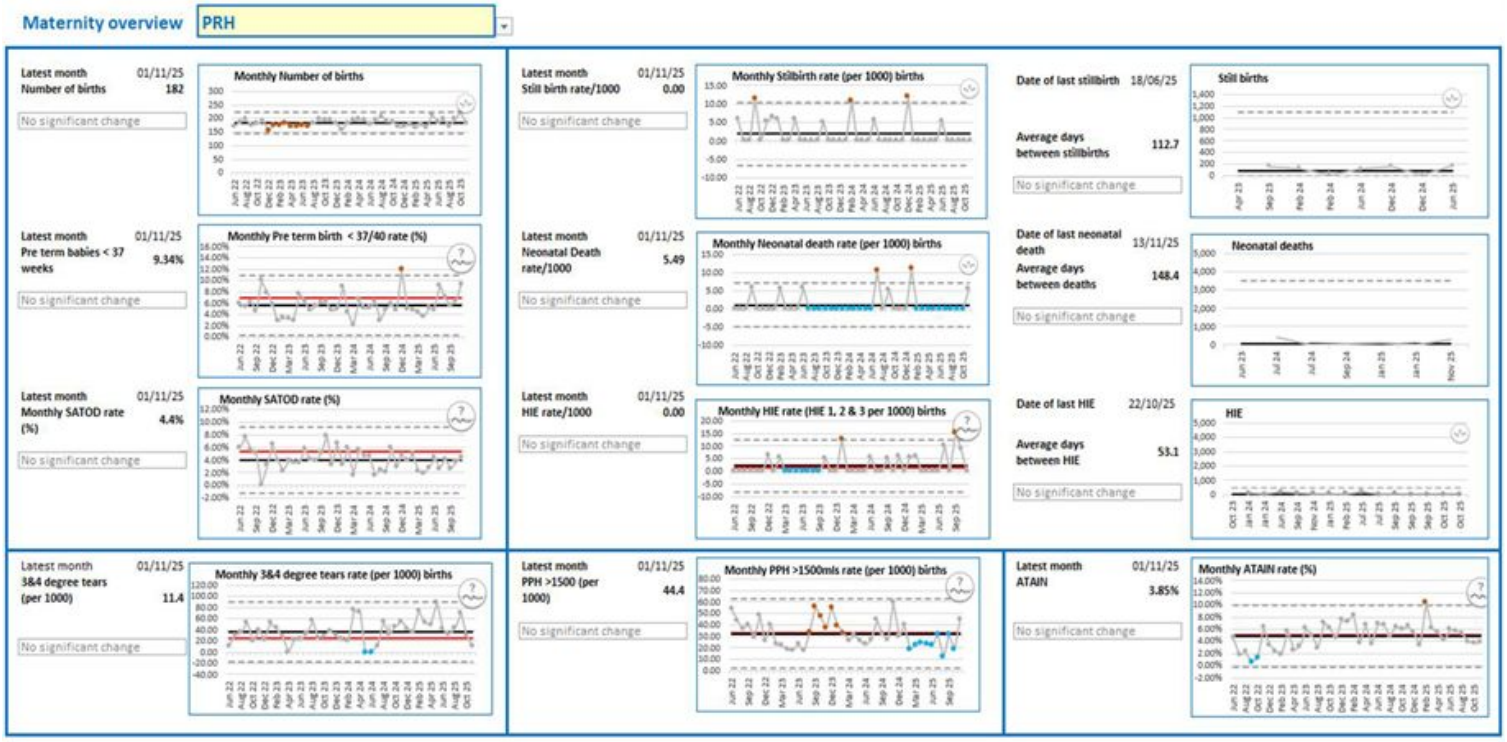
Haywards Heath



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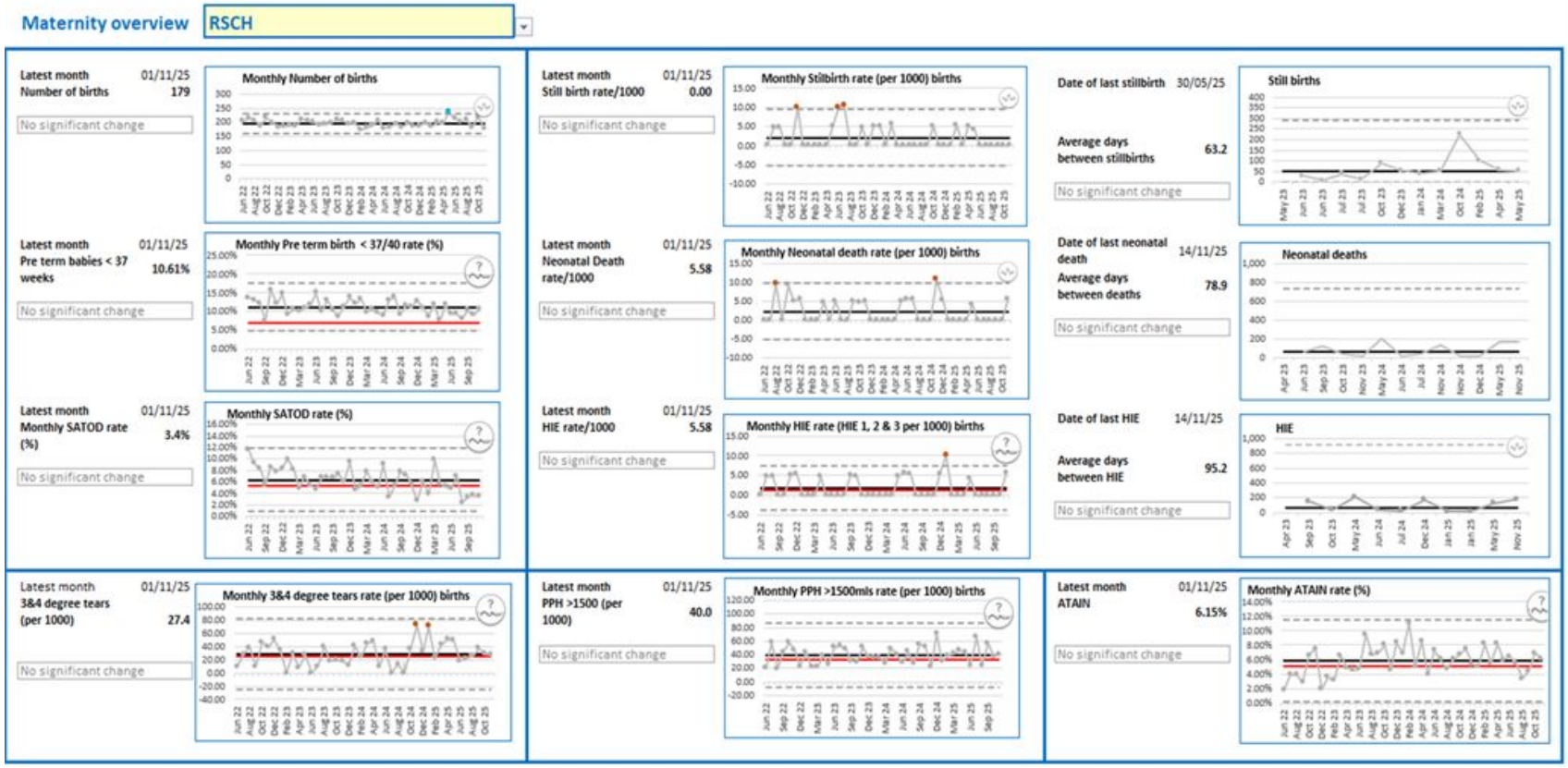
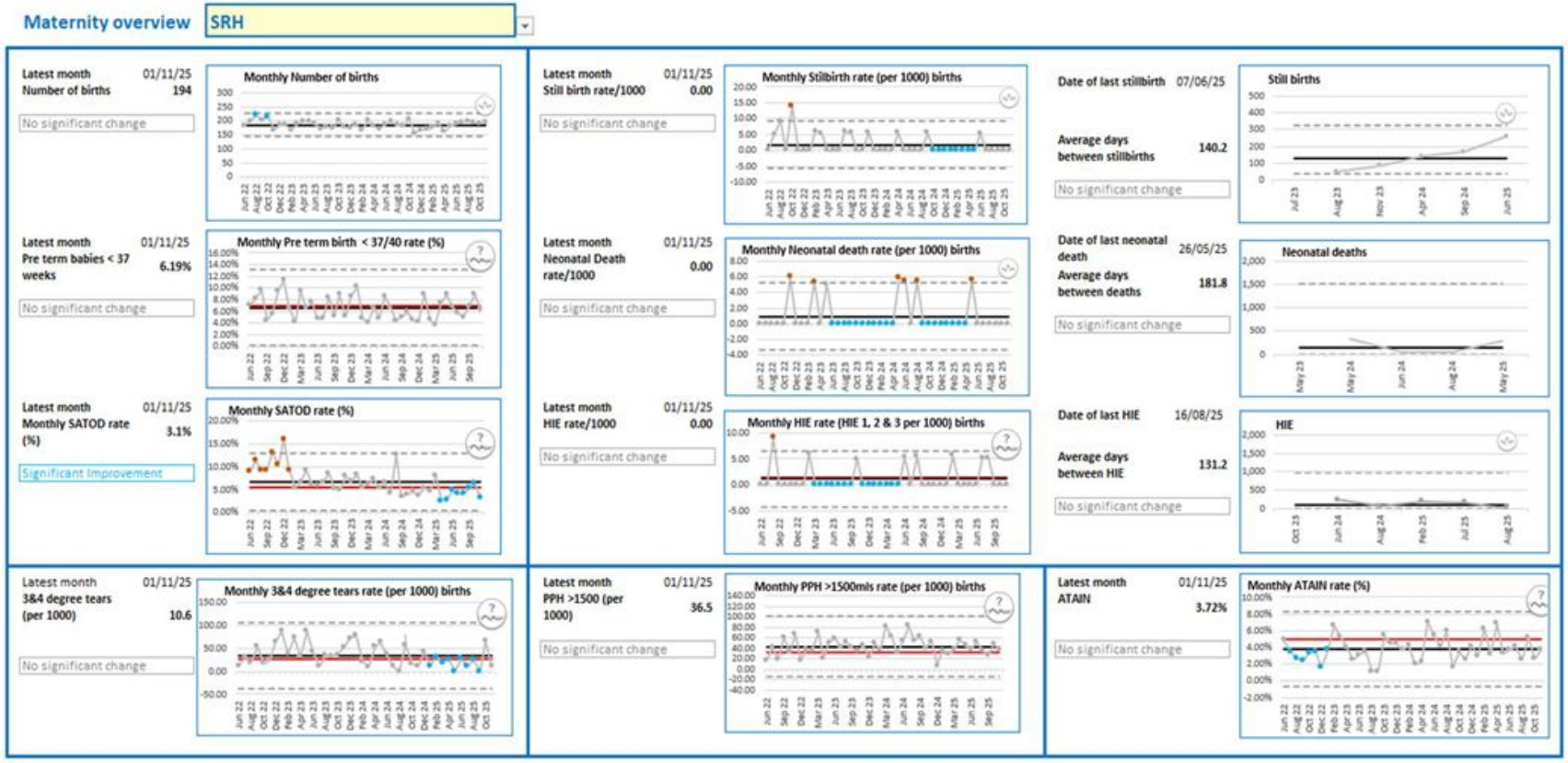
Brighton



Chichester


Maternity overview
SRH
Latest month 01/11/25
Number of births 194
No significant change
Monthly Number of births
Latest month 01/11/25
Pre term babies < 37 weeks 6.19%
No significant change
Monthly Pre term birth < 37/40 rate (%)
Latest month 01/11/25
Monthly SATOD rate (%) 3.1%
Significant Improvement
Monthly SATOD rate (%)
Latest month 01/11/25
Still birth rate/1000 0.00
No significant change
Monthly Stillbirth rate (per 1000) births
Latest month 01/11/25
Neonatal Death rate/1000 0.00
No significant change
Monthly Neonatal death rate (per 1000) births
Latest month 01/11/25
HIE rate/1000 0.00
No significant change
Monthly HIE rate (HIE 1, 2 & 3 per 1000) births
Date of last stillbirth 07/06/25
Average days between stillbirths 140.2
No significant change
Still births
Date of last neonatal death 26/05/25
Average days between deaths 181.8
No significant change
Neonatal deaths
Date of last HIE 16/08/25
Average days between HIE 131.2
No significant change
HIE
Latest month 01/11/25
3&4 degree tears (per 1000) 10.6
No significant change
Monthly 3&4 degree tears rate (per 1000) births
Latest month 01/11/25
PPH >1500 (per 1000) 36.5
No significant change
Monthly PPH >1500mls rate (per 1000) births
Latest month 01/11/25
ATAIN 3.72%
No significant change
Monthly ATAIN rate (%)

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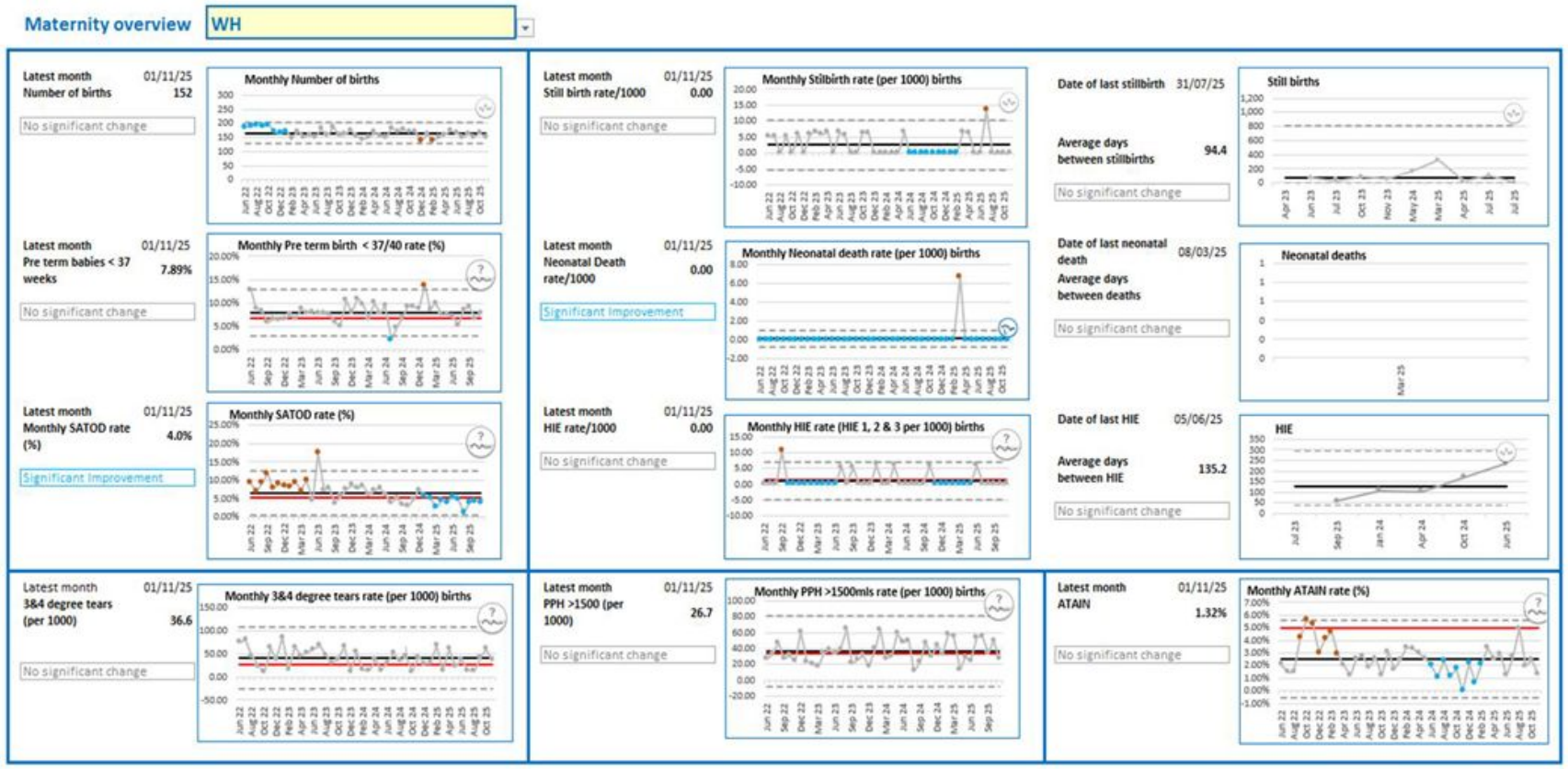
Worthing



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Appendix 2

Health Inequalities Segmented Data

October 2025

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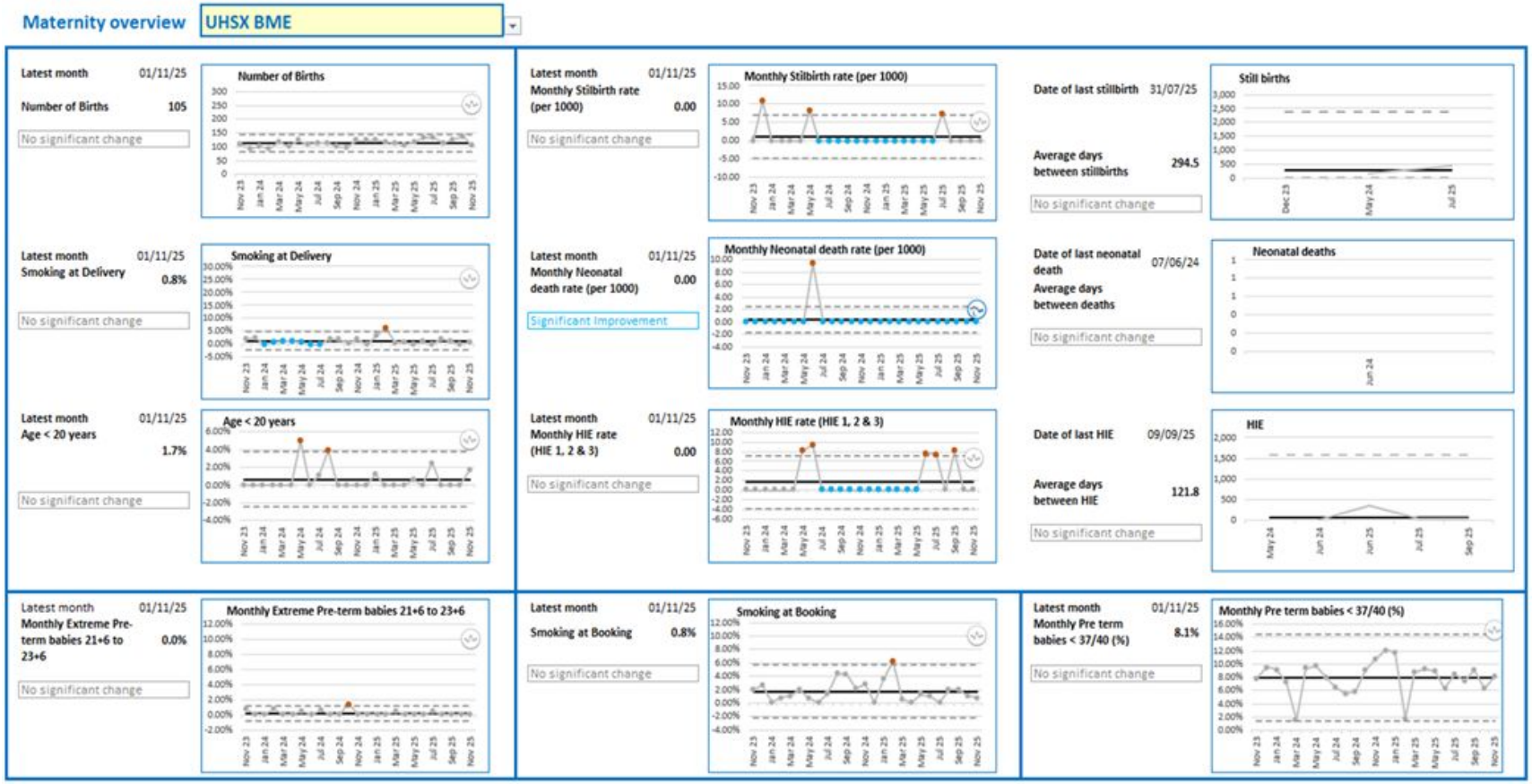
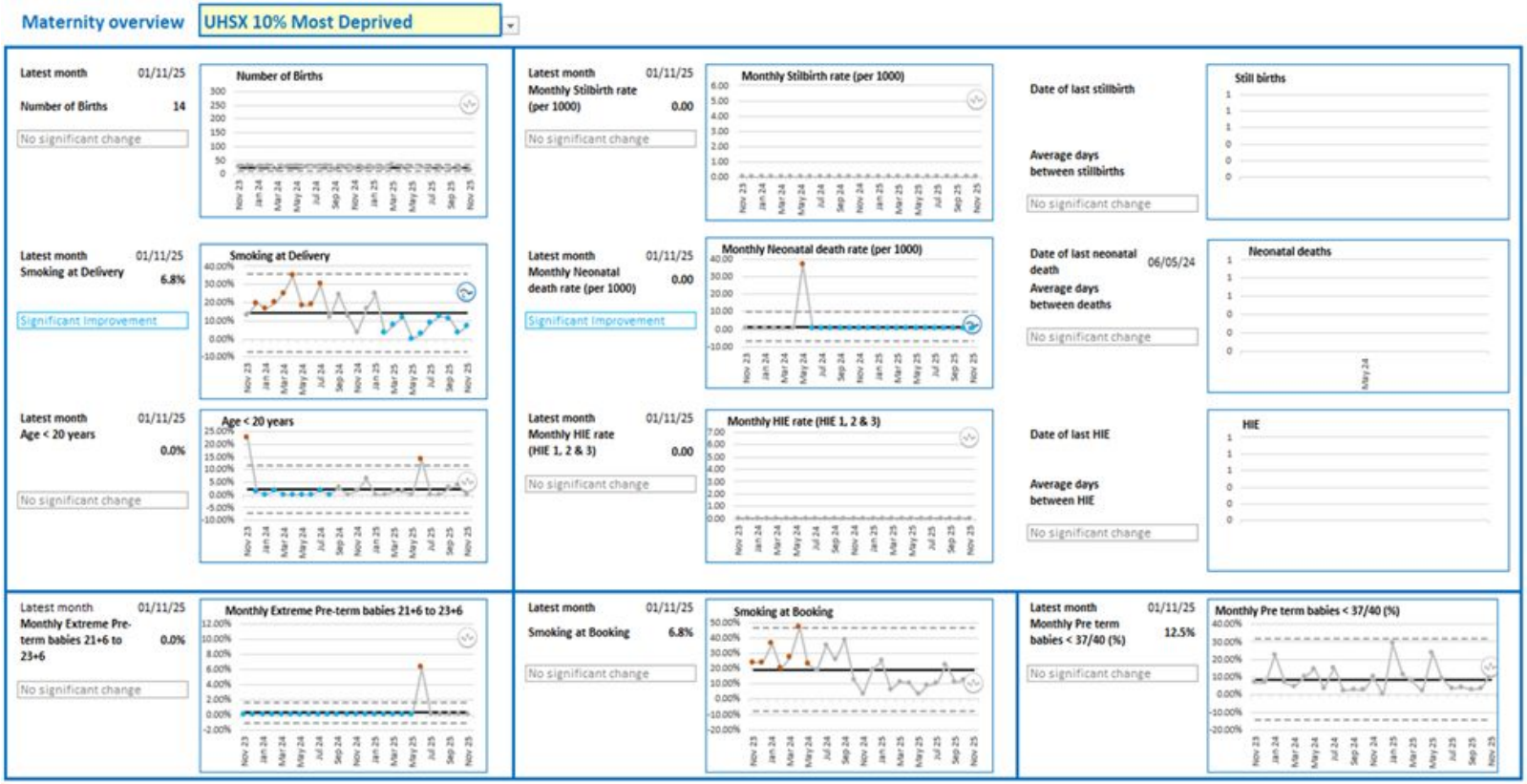
UHSx– Global Majority



UHSx– 10% most deprived



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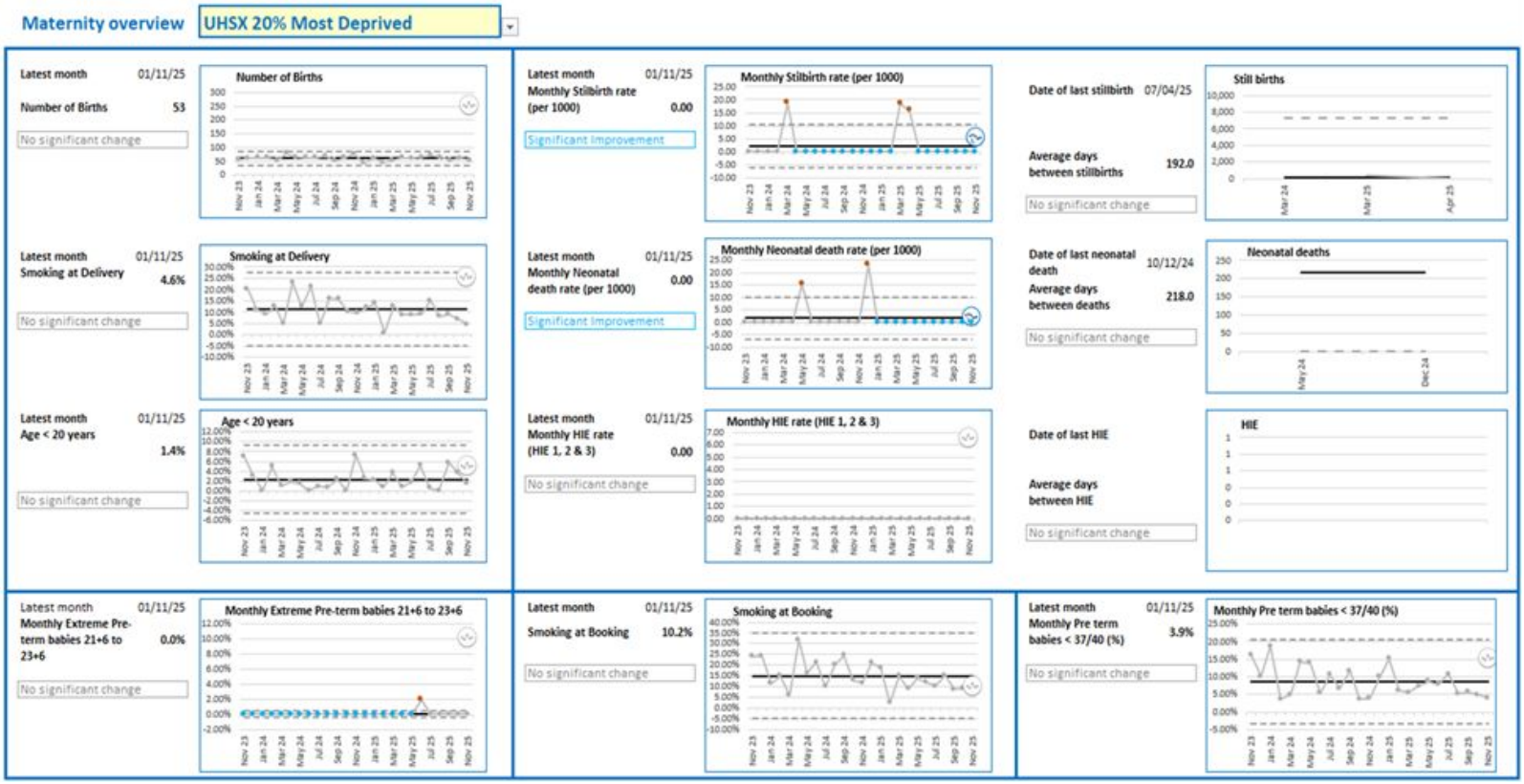
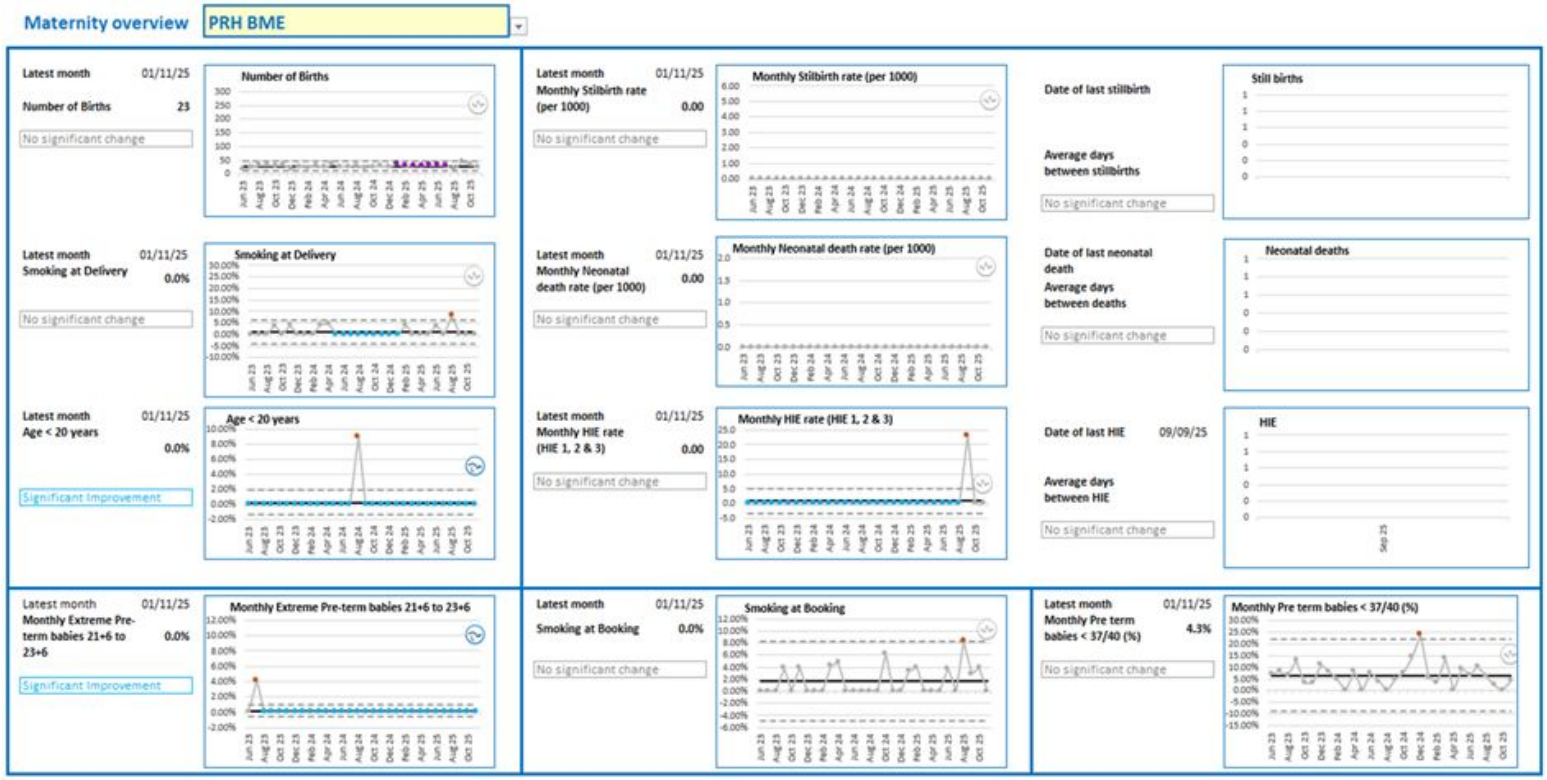
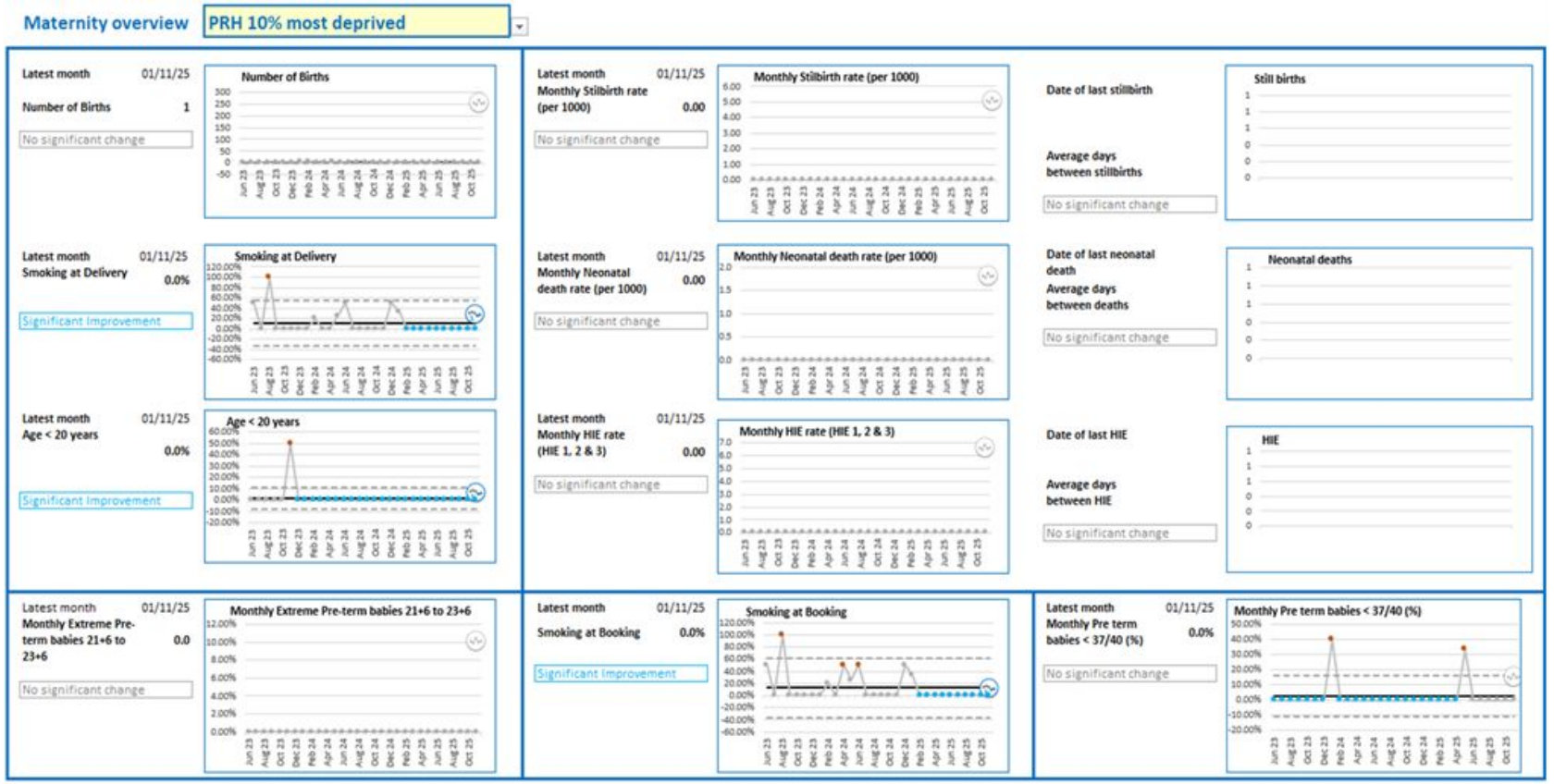
UHSx – 20% most deprived



Haywards Heath – Global Majority



Haywards Heath – 10% most deprived



Haywards Heath – 20% most deprived

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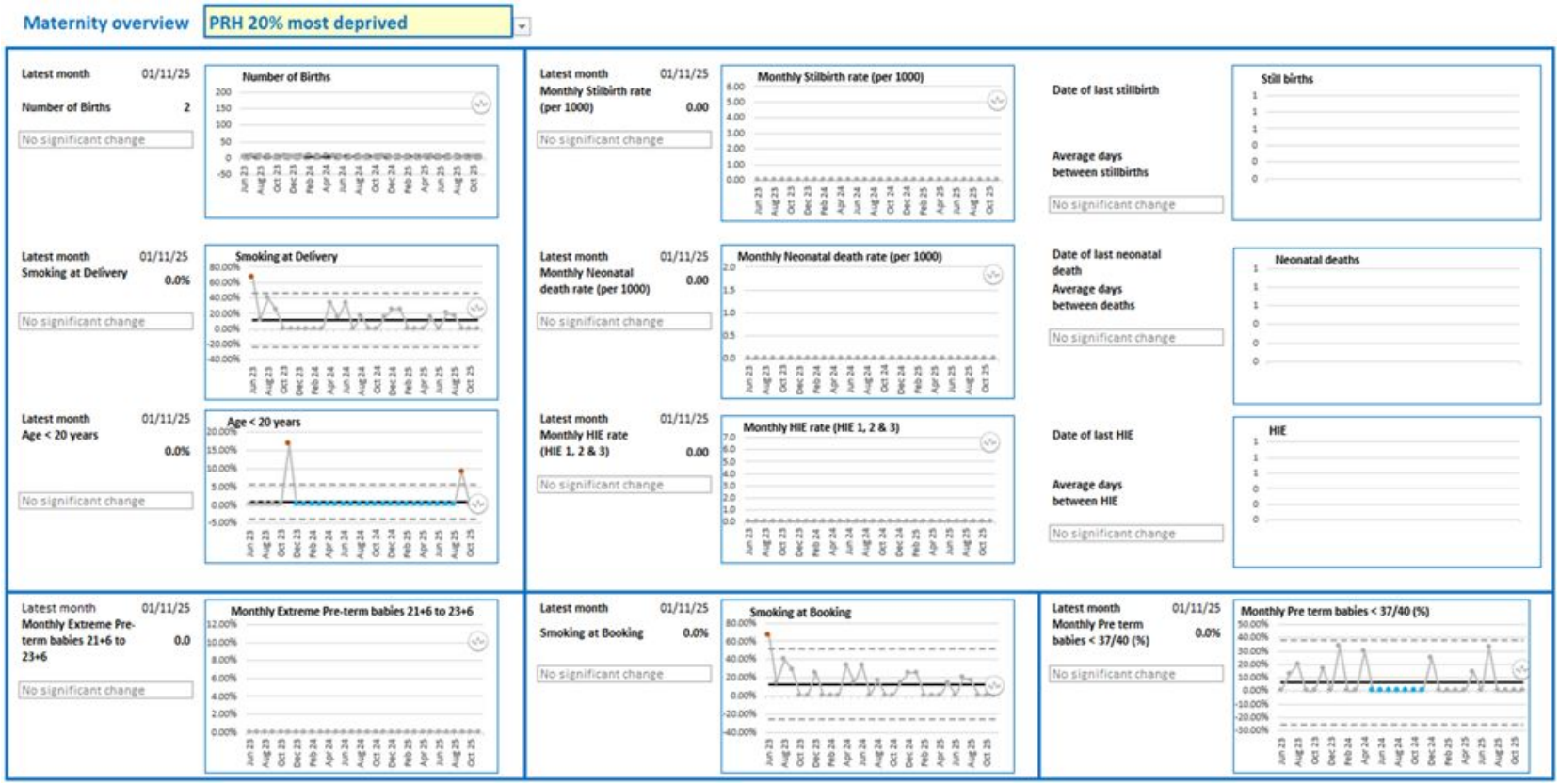

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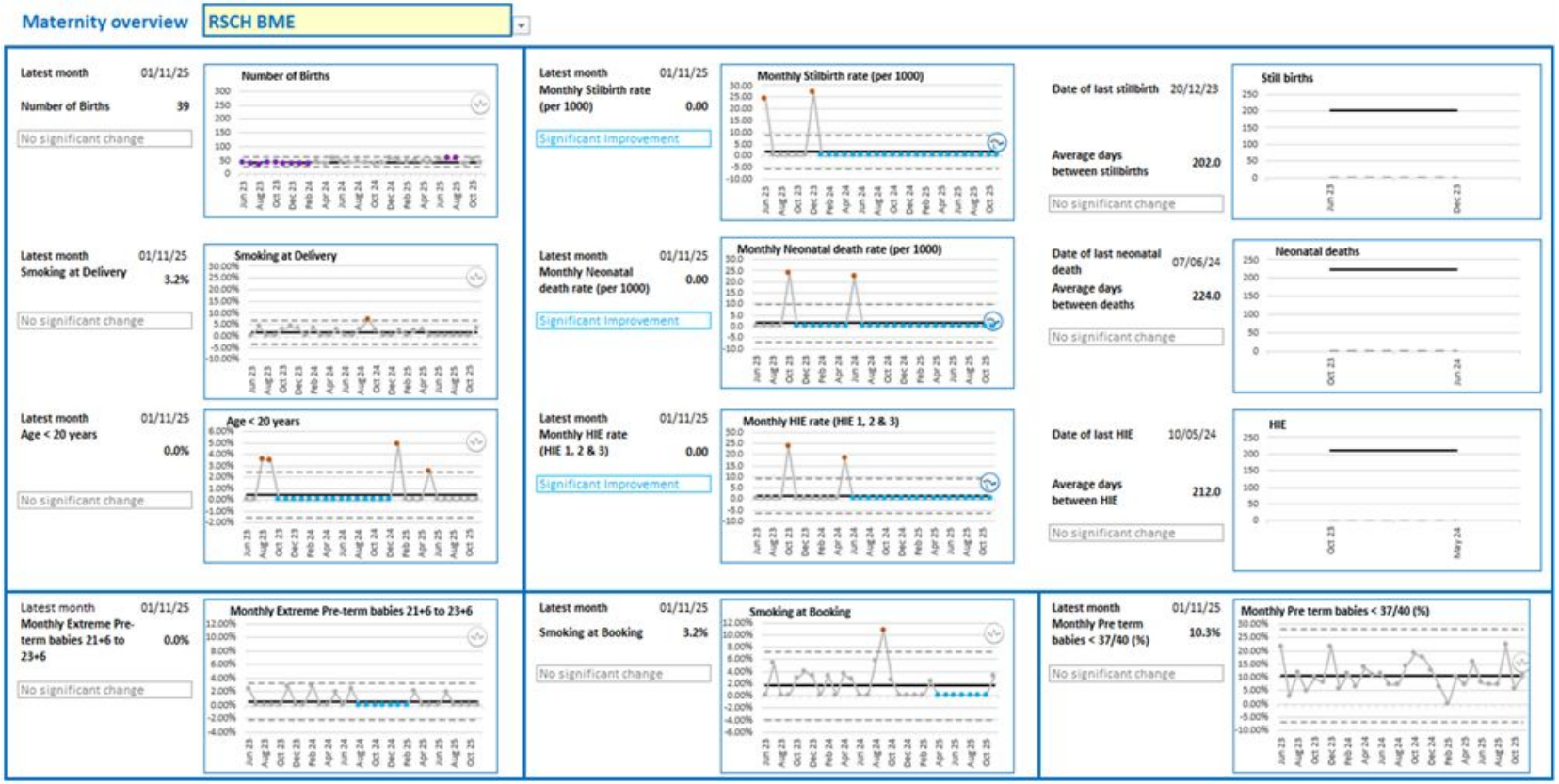
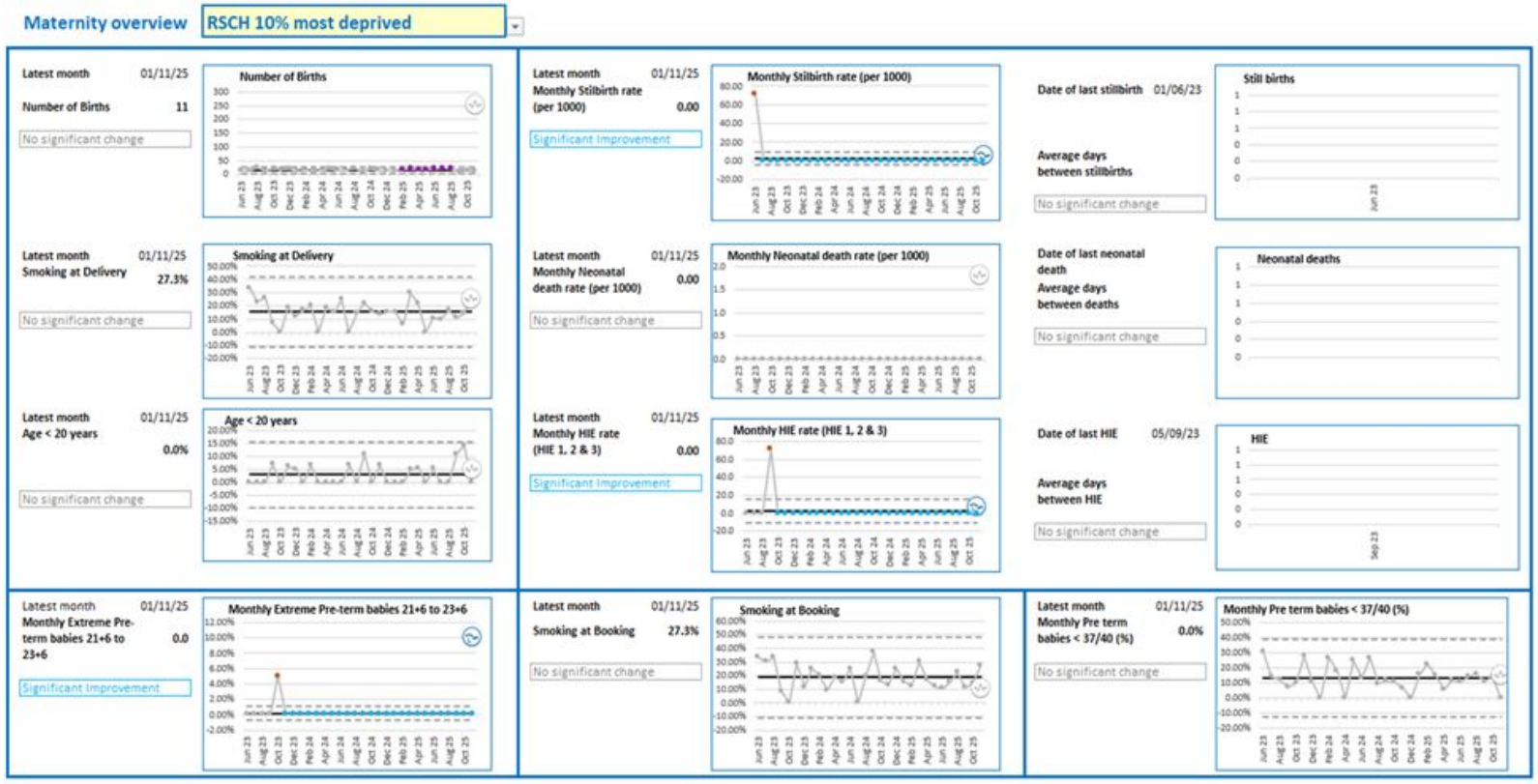
Brighton – Global Majority



Brighton – 10% most deprived



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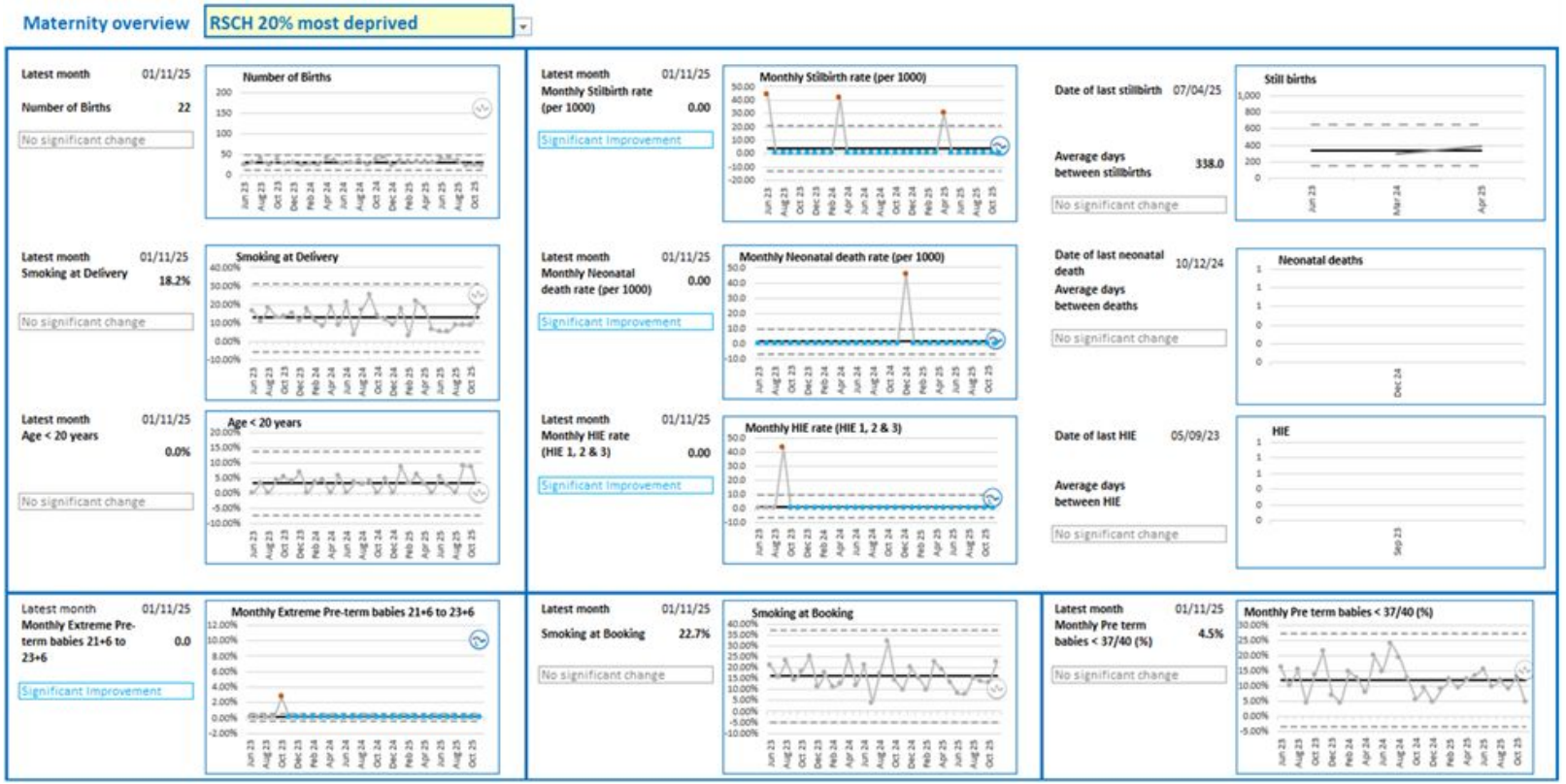
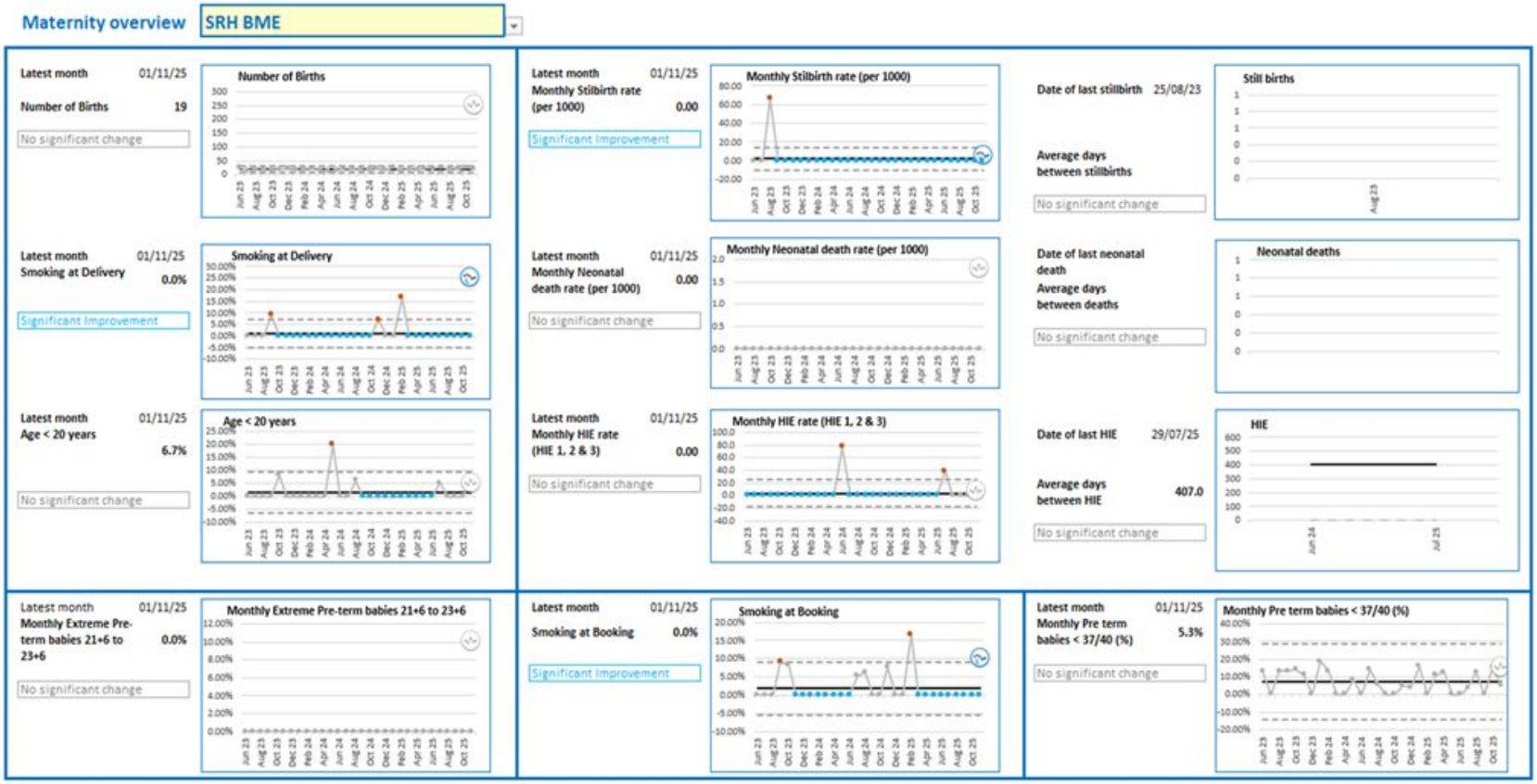
Brighton 20% most deprived



Chichester – Global Majority



Chichester – 10% most deprived

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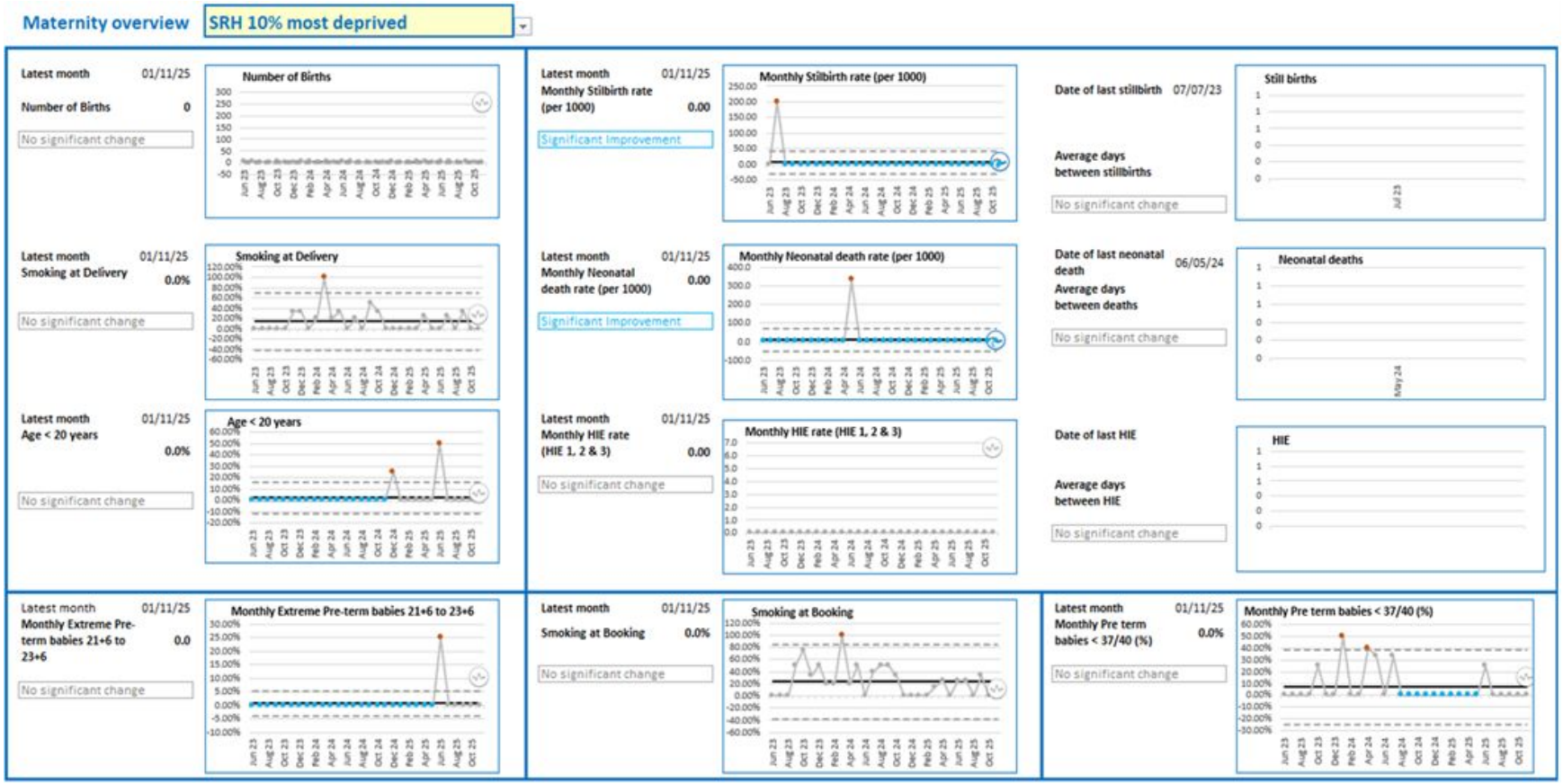
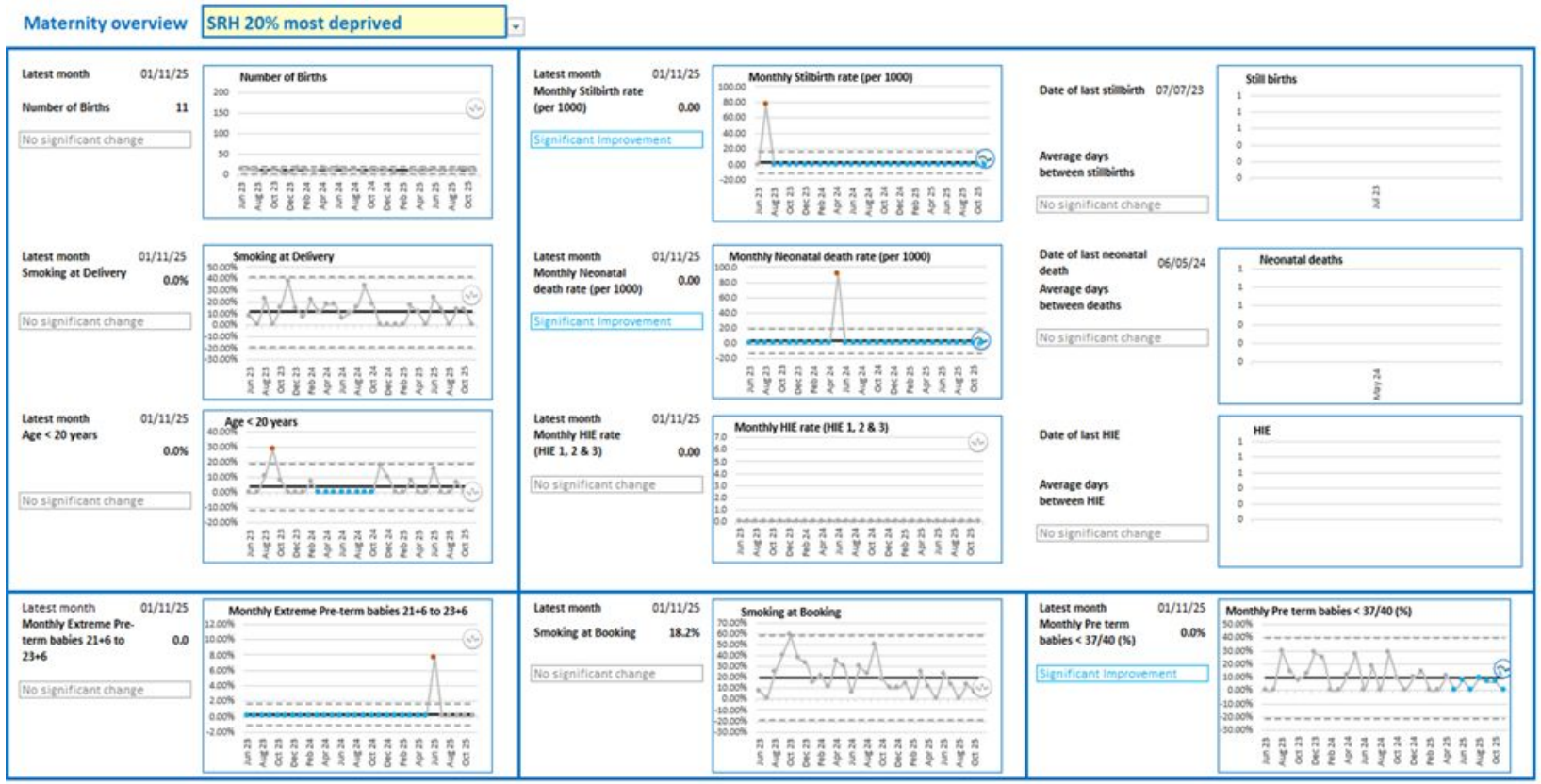
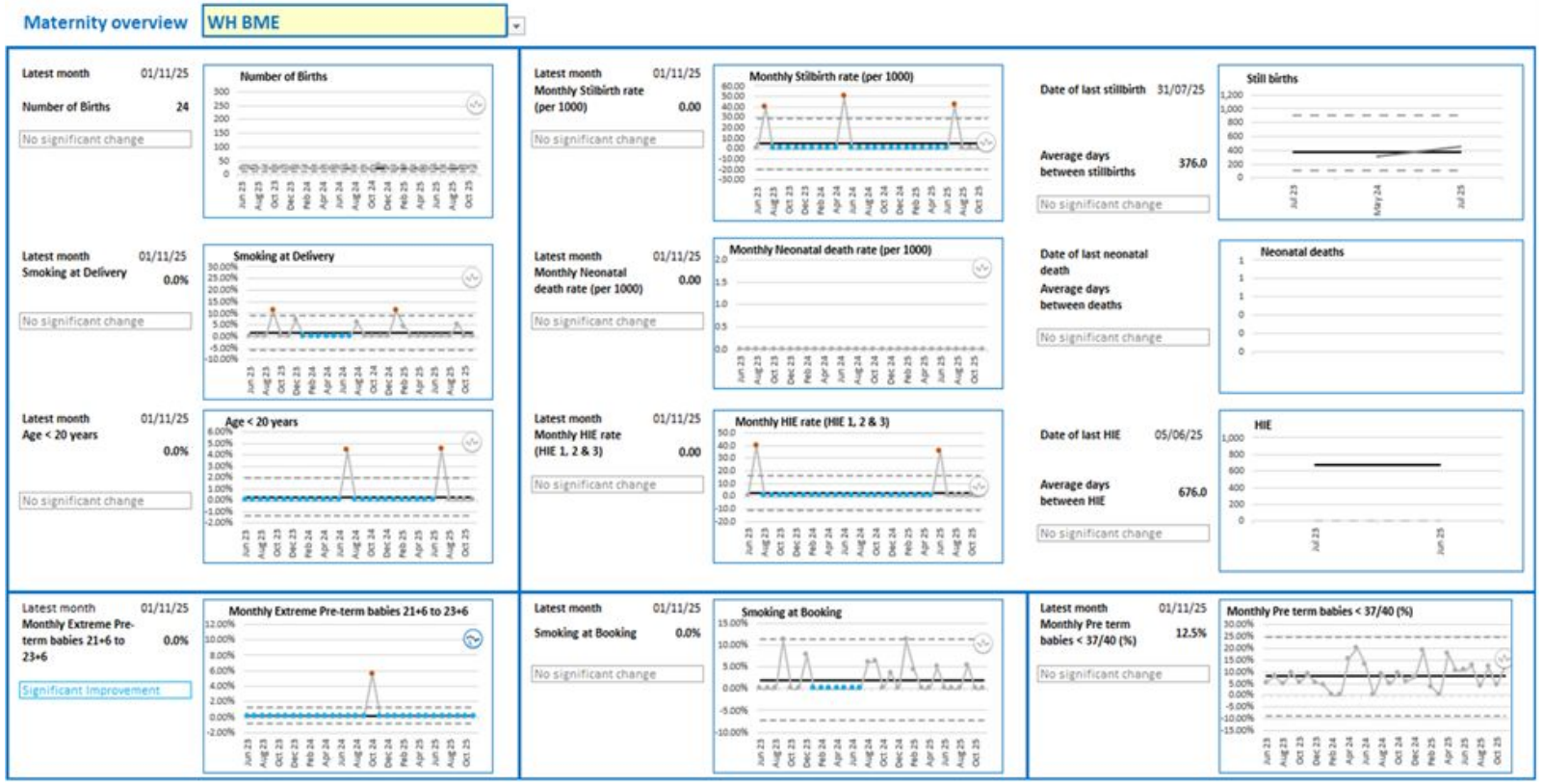


Chichester – 20% most deprived



Worthing – Global Majority



Worthing – 10% most deprived

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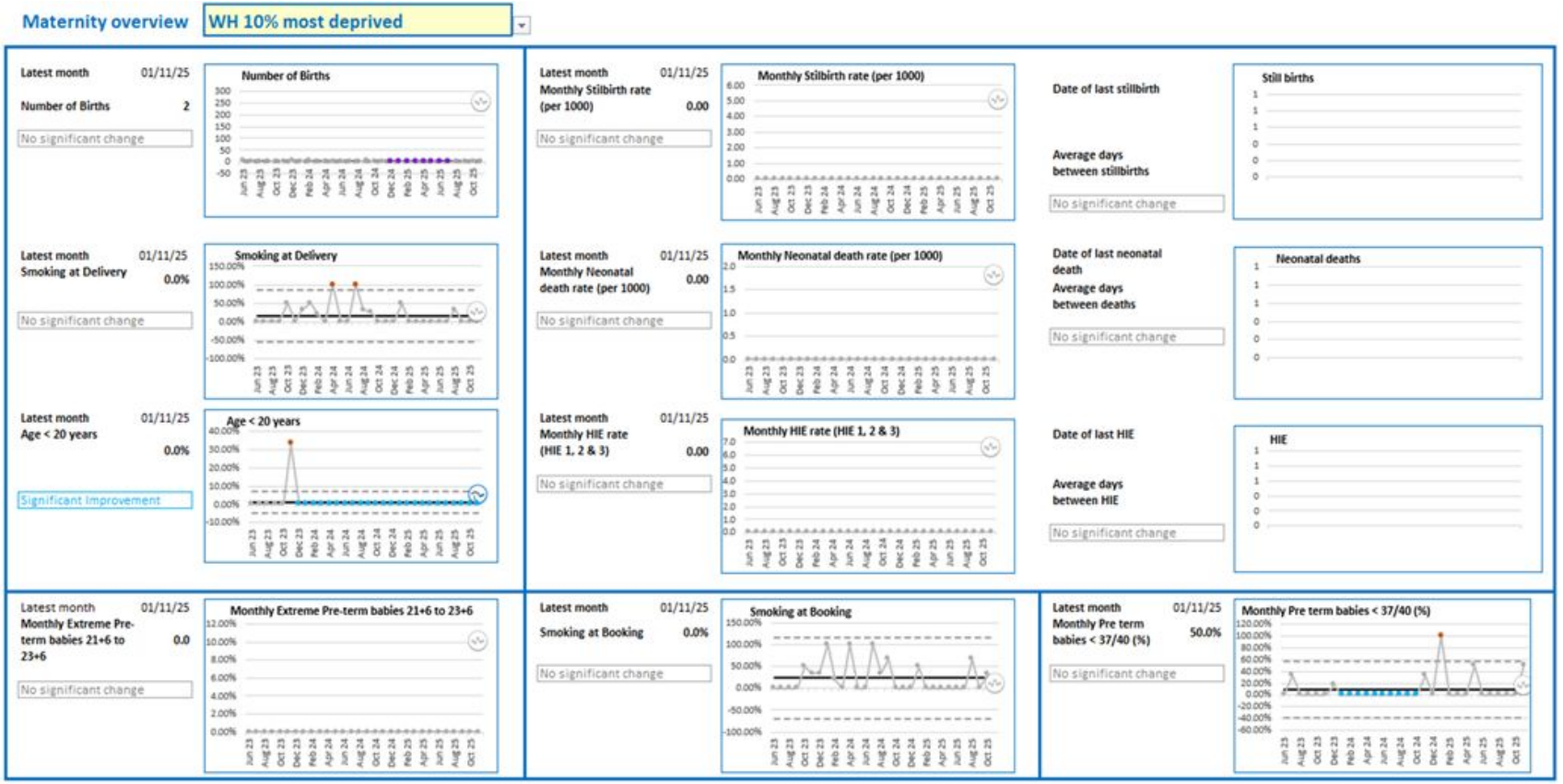

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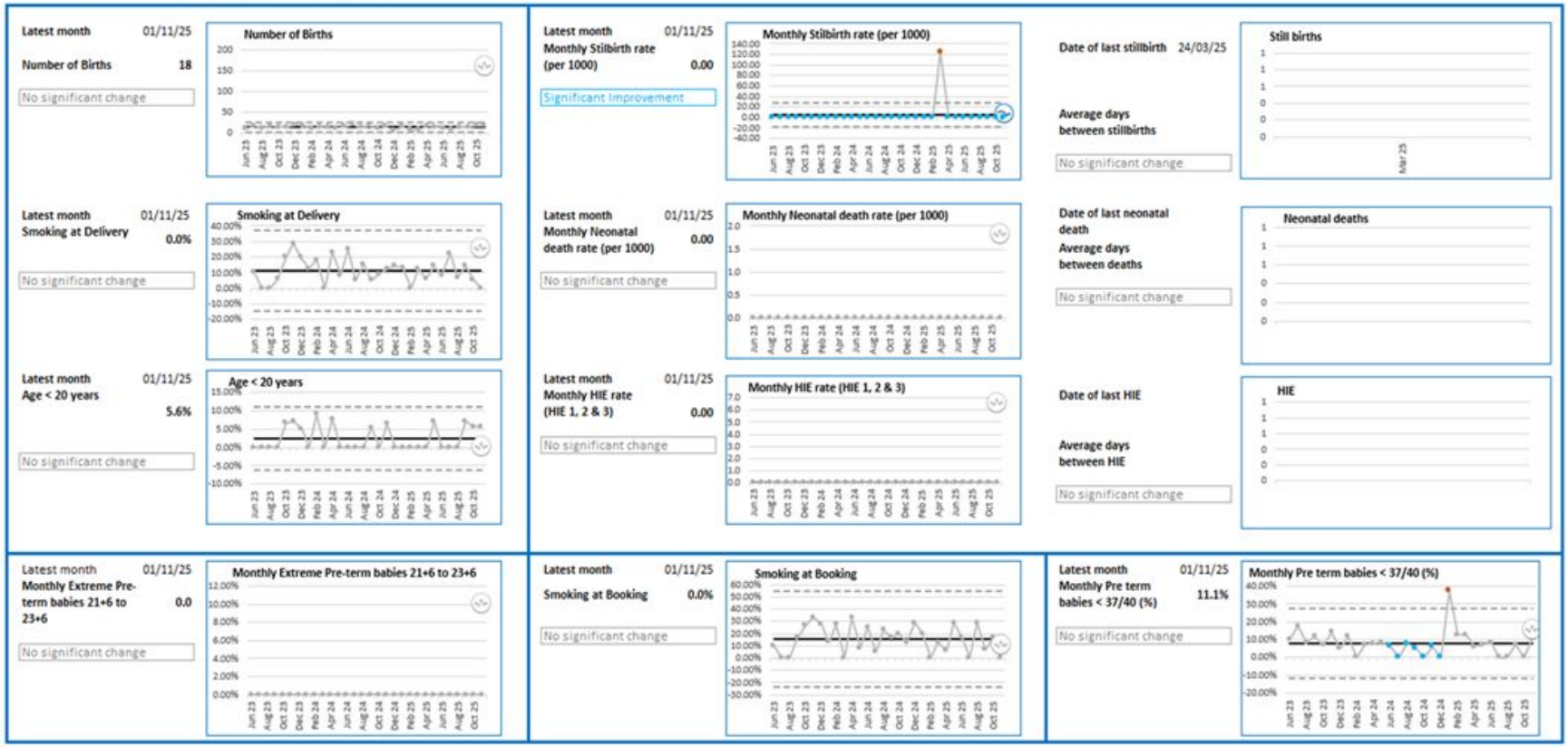
Worthing – 20% most deprived

Maternity overview | WH 20% most deprived



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ATAIN Q1 25/26
Executive Summary

QGSG/PQC

August 2025

Summary of findings

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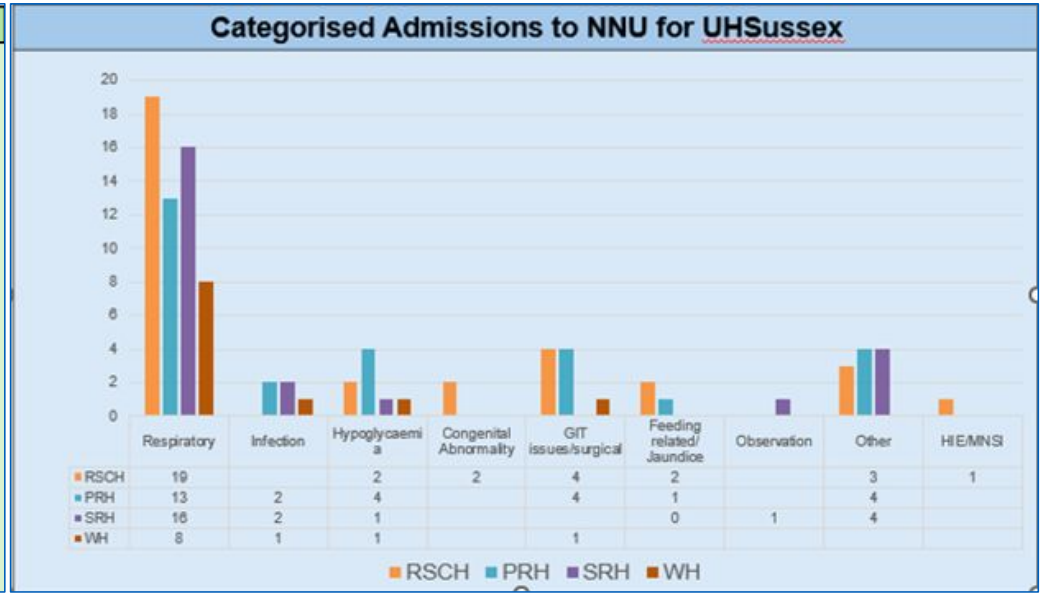
- Expected rates of term admission have risen across all sites compared to Q4 but remained within the benchmark for the quarter only at WH.
- The most prevalent issue initiating admission across all sites was Respiratory

Term Admission Rate (Target <5%)

UHSussex	APRIL	MAY	JUNE
PRH	6.67%	3.57%	7.64%
RSCH	8.57%	3.90%	7.34%
SRH	6.80%	3.30%	3.70%
WH	2.50%	2.90%	1.20%



Summary of findings

- For the total of Quarter 1, the benchmark of <5% of admission to the Special Care Baby Unit was met for the duration at WH (2.5%, 2.9% & 1.2%) and for SRH it did not meet the benchmark in April (6.8%, 3.3%, 3.7%). PRH and RSCH only met the benchmark in May for Quarter 1 (PRH 6.67%, 3.57%, 7.64%, RSCH 8.57%, 3.90%, 7.34%).
- There were 33 admissions to NNU from RSCH, 28 admissions from PRH, 24 admissions from SRH and 11 admissions from WH which is a total of 96 term admissions to the SCBU/NNU.
- The majority reason for admission this quarter across all four sites was again due to respiratory support.
- Overall, 88.5% (85) of admissions across all four sites were considered unavoidable with appropriate management with 11.5% (11) considered as potentially avoidable.

Recommendations/Actions

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- There is an ATAIN/Transitional Care Steering Group as a part of CNST working groups
- The chair of the meeting has transitioned to the Neonatology leadership team (in place since May).
- The steering group has worked through historic actions and work is now focussed to align practices across Neonatology and Maternity to build value into the audit work being completed as well as to align QI focus and findings.

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University Hospitals Sussex NHS Foundation Trust ATAIN Quarterly Report Quarter: 1 Date: April - June 2025

University Hospitals Sussex
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The ATAIN Programme: Background

In 2017, NHS England identified that over 20% of admissions of full-term babies into neonatal units 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.

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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	APRIL	MAY	JUNE
PRH	6.67%	3.57%	7.64%
RSCH	8.57%	3.90%	7.34%
SRH	6.80%	3.30%	3.70%
WH	2.50%	2.90%	1.20%

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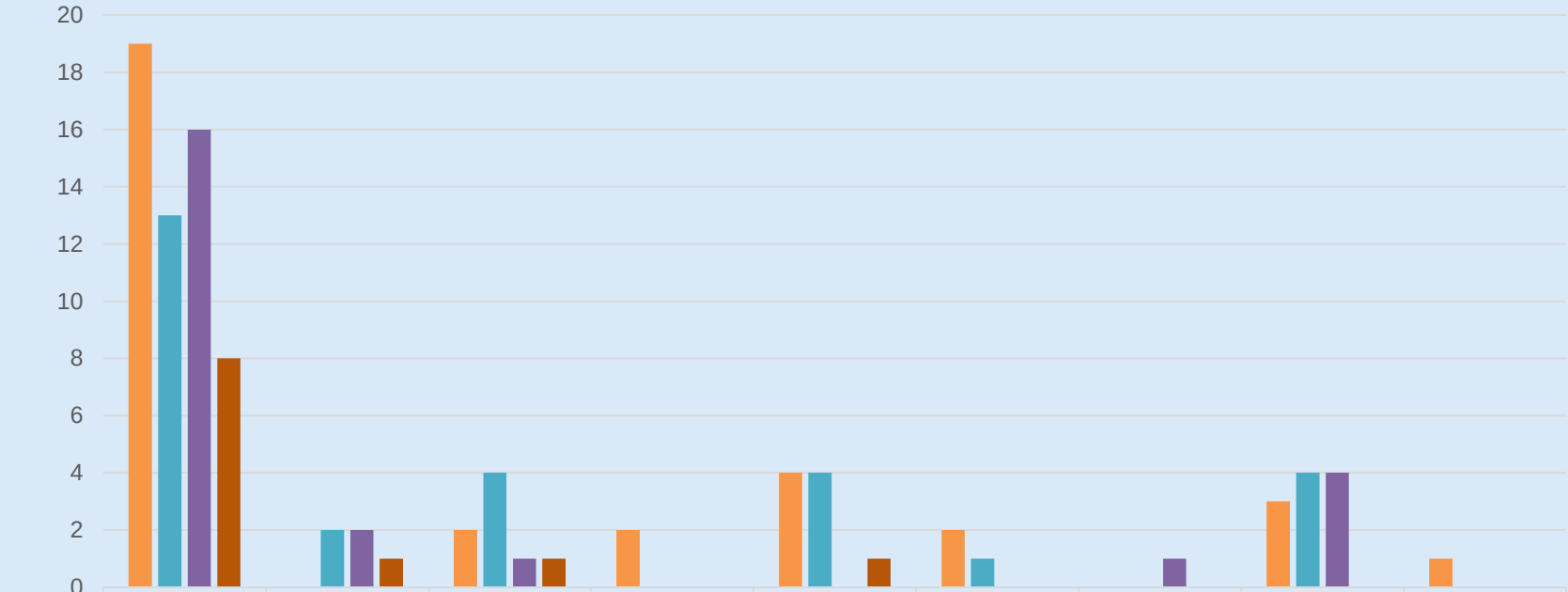
Categorised Admissions to NNU for UHSussex



	Respiratory	Infection	Hypoglycaemia	Congenital Abnormality	GIT issues/surgical	Feeding related/ Jaundice	Observation	Other	HIE/MNSI
RSCH	19		2	2	4	2		3	1
PRH	13	2	4		4	1		4	
SRH	16	2	1			0	1	4	
WH	8	1	1		1				

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Royal Sussex County Hospital (RSCH)

ATAIN Progress Report

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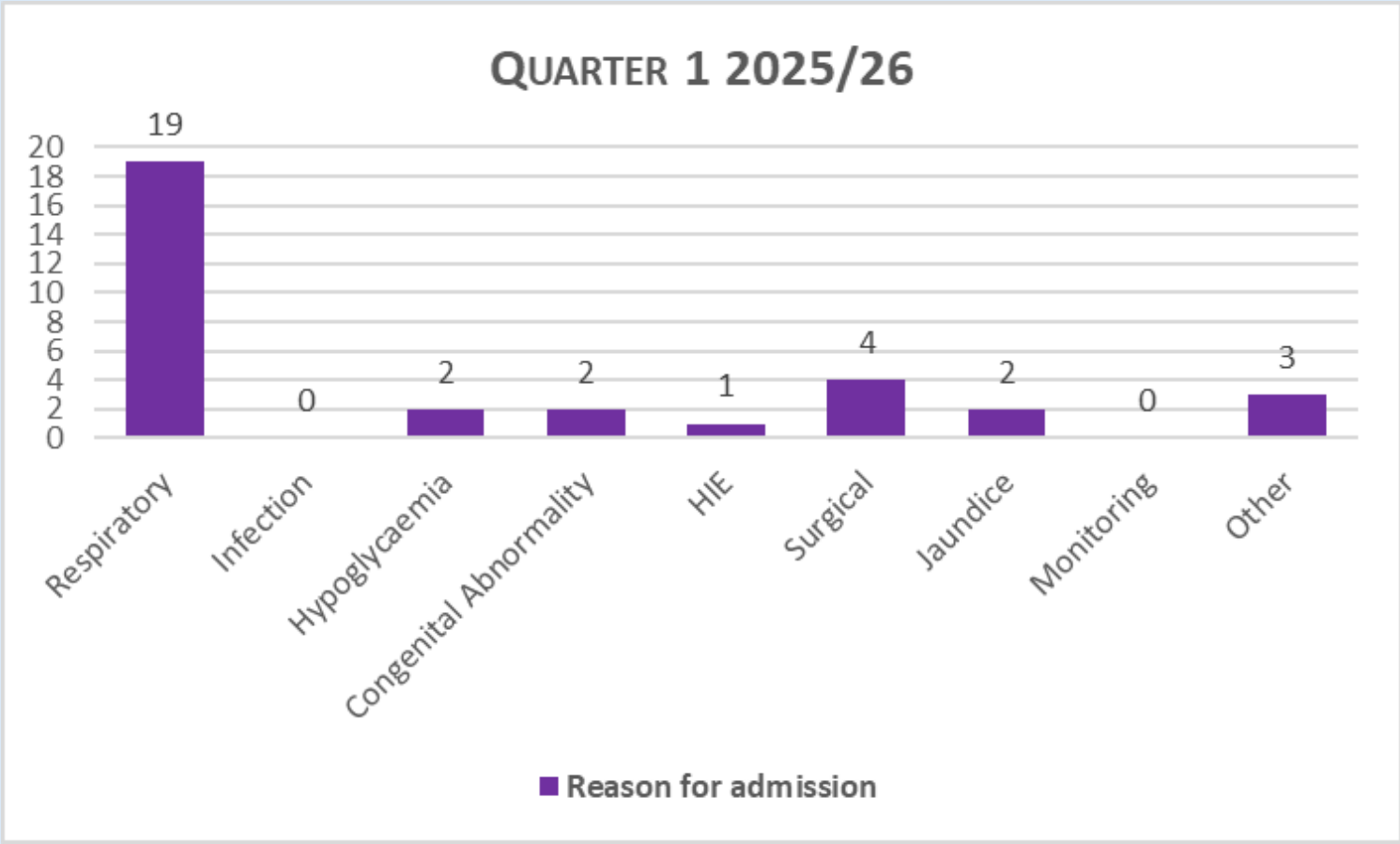
Categorised Admissions to NNU



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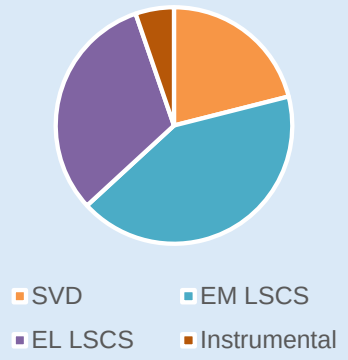
RSCH – Learning from the review of term admissions to NNU

Respiratory Symptoms

Number of admissions = 19

What type of respiratory symptoms:
- Low sats
- RDS

Type of delivery they were: 4 SVD, 8 EMCS, 6 ELCS, 1 VENT



Learning extracted

18 of the admissions to the NNU for respiratory reasons were deemed as **appropriate**. 1 was avoidable as treated for sepsis and never required respiratory support

Although the majority of the admissions were deemed appropriate, following a QI project by TMBU a decision making tool has been implemented. There will be an ongoing audit.

RSCH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Hypoglycaemia / Jaundice
Number of admissions = 2 hypoglycaemia / 2 Jaundice Maternal/Neonatal risk factors increasing the risk of hypoglycaemia in the newborn: •Maternal beta blockers •GIDDM •IUGR •Rapidly rising antibodies
Learning extracted
It was identified that **1** admissions was <u>avoidable.</u> If DAT positive result had been communicated to neonates treatment would've been commenced earlier and therefore may have avoided admission to NNU.

RSCH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Asphyxia (perinatal hypoxic-ischaemia)
1 Admissions with suspected HIE.
Learning extracted
Ongoing investigation with MNSI. No immediate learning recognised. Baby home and doing well.

RSCH – Learning from the review of term admissions to NNU

University Hospitals Sussex
NHS Foundation Trust

Other
Number of admissions = 9 Type of delivery they were: 4 SVD, 2 EMCS, 3 ELCS Reasons for admission: • 4 surgical admission - 3 bilious vomiting - 1 renal • 4 excluded as had antenatal plans for admission – gastroschisis, exomphalos & 2 renal • 1 social admission – mother inpatient on cardiac ward and social concerns with father
Learning extracted

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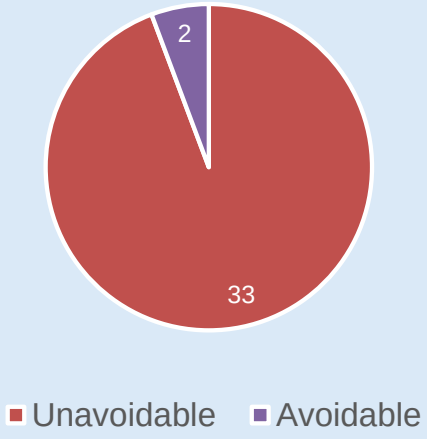
RSCH Avoidable Admissions

RSCH Avoidable Admissions

Total number of avoidable admissions: 2

Themes:

- Handover of blood results from midwifery teams to neonates
- Appropriate use of implemented decision making tool for respiratory Admission.
- 2 babies could have stayed with mothers if BAPM TC implemented as required increased observations.



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Princess Royal Hospital (PRH)
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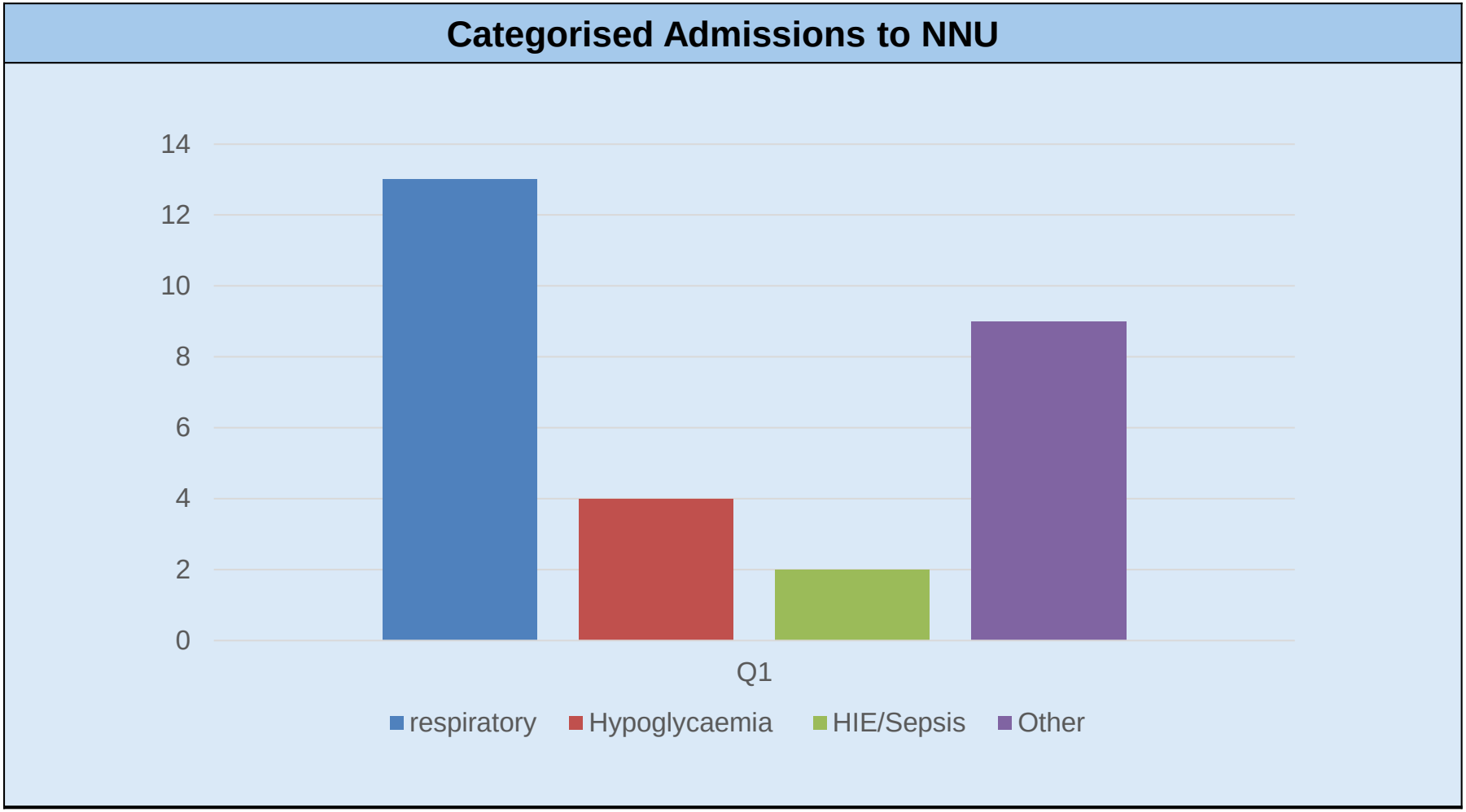

PRH – Learning from the review of term admissions to NNU

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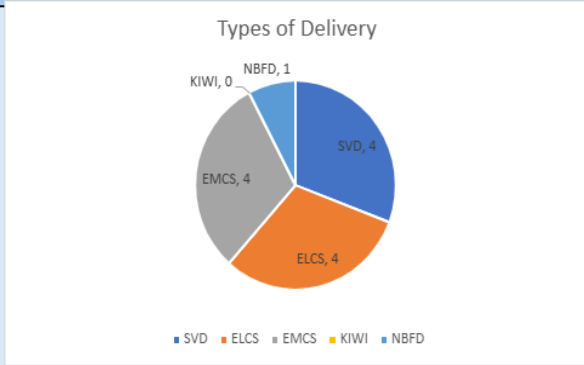
Respiratory Symptoms

Number of admissions: 13 this quarter a reduction from Q4 where we had 23 admissions

Risk Factors found:
- PROM
- MEC

Type of delivery: 4 SVD, 1 NBFD, 4 ELCS, 4 EMCS



Learning extracted

8 babies transferred to the NNU directly from delivery suite, **5** from Postnatal ward. All given appropriate time to adjust to extra uterine life (>30mins) with additional respiratory support by means of facial O2, prone positioning

2 out of the **4** babies delivered by ELCS DID NOT receive steroids prior to their birth at 37/40,
Theme for early delivery this quarter was varied with no clear themes identified

QI project to produce a decision-making tool in an aim to reduce term admissions to PRH SCBU for RDS, is now reflective on this quarter. Which has reduced the admissions for RDS.

Avoidable admission this quarter was **1** as this was felt not to have needed admission if the decision tool was followed.

PRH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Hypoglycaemia

Number of admissions = 4.
Type of delivery they were: 1 EMCS, 1 ELCS, 2 FORCEPS

Risk Factors
- PROM
- GDM/GIDDM
- Maternal Sepsis

Learning extracted

3 Babies were admitted to SCBU wit6h a BM ,1.7 which triggers an automatic admission to SCBU.

1 baby had persistent Low BM's despite glucoboost and feeds

PRH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Asphyxia (perinatal hypoxic-ischaemia) /sepsis
2 admission for Sepsis, Delivered by EMCS SROM/PROM, MEC No reported cases of Asphyxia
Learning extracted
Both Appropriate admissions however, **1** was felt could have stayed with mum if TC facility was as PRH as was admitted for 24hrs **1** Baby was admitted for 15 days with RDS, Meconium aspiration Syndrome and persistent Hypertension of the Newborn. Discharged with a follow up in the Neonatal Outpatients Clinic for 6 week's time no further ECHOs were needed

PRH – Learning from the review of term admissions to NNU

University Hospitals Sussex
NHS Foundation Trust

Other
9 babies admitted under Other: 1 cardiac 4 Surgical review 2 Abnormality 1 jaundice 1 Polycythemia
Learning extracted
Cardiac admission was detected on failed Sats transferred to Evilina, **Surgical reviews**, **1** baby was transferred to St Georges due to Large Gastric Bubble. The other **3** were admitted for Bilious vomiting, of which **1** had bowel obstruction, **1** Did not open bowels for 48hrs since birth had bowel washout, developed bilious aspirates and Rectal Suction biopsy, discharged having bowel washouts. **1** Had an Atresia and stenosis of small intestine transferred to ST Georges. **Abnormality: 1** had undiagnosed cleft palate, **1** admitted with large Occiput and concerns regarding maintaining a Patent Airway also had Dysmorphic features, prominent lamboid suture, low set ears and high Arched Palate, had genetic testing. **Jaundice:** late diagnosis of maternal antibodies and baby sbr was above the transfusion line remained admitted for 15 days **Polycythemia:** Initially admitted Transient Tachypnoea of Newborn however found on blood tests that Haematocrit was high at 70 with symptoms and a partial exchange transfusion of 43mls.

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PRH Avoidable Admissions

PRH Avoidable Admissions
1 case were deemed as avoidable Put as appropriate as the New decision making tool was not followed correctly **Themes** • Implement BAPM TC facility, A business case is ongoing • QI project to aid in reducing PRH term admissions Led by Neonatal consultant is now implemented and already shown improvements in our RDS admission rates • We Continue to have NO Obstetric presence at PRH/RSCH Atain meetings and continues to be escalated • Neonatal team presence in staff huddles has improved giving a more robust MDT approach to care

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Worthing Hospital (WH) ATAIN Progress Report

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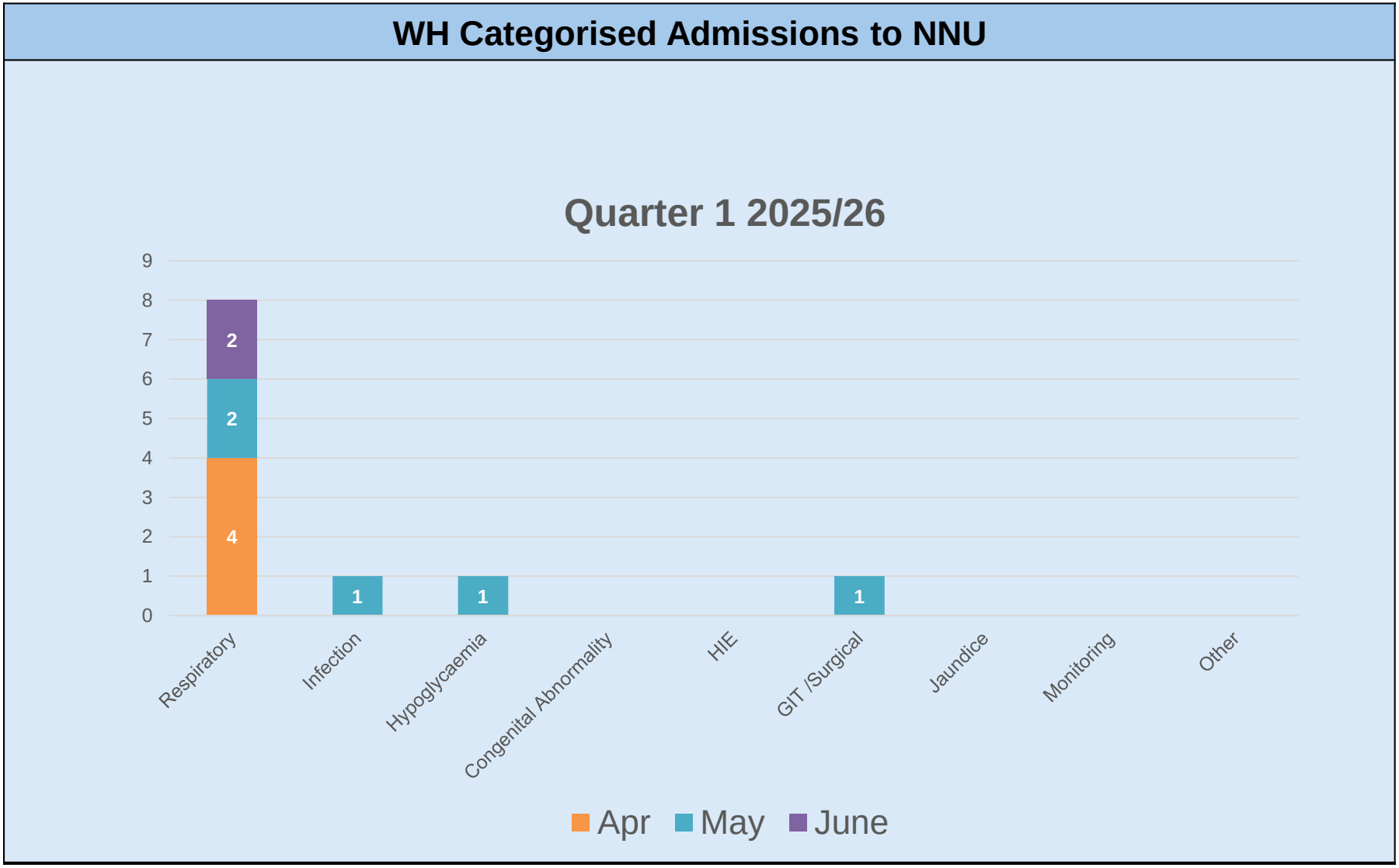
WH Categorised Admissions to NNU



WH – Learning from the review of term admissions to NNU

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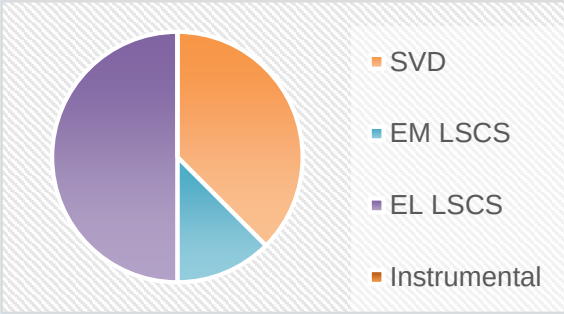
Respiratory Symptoms

Number of admissions = **8**

What type of respiratory symptoms:
- Subcostal recession/ Nasal flaring (increased WOB)
- Grunting
- Low saturations



Types of delivery: 3 SVB, 1 Emergency LSCS which was an elective done early due to spontaneous rupture of membranes with thick meconium (38 weeks) and 4 x Elective LSCS, 2 performed at 37 weeks due to gestational diabetes 1 had steroids the other declined following discussion. 1 was due to a low lying placenta (37 weeks) and the other attended with reduced fetal movements reporting scar pain therefore delivered (37+2 weeks)

Learning extracted

2 admissions to the NNU for respiratory reasons were potentially deemed as **unavoidable.** 1 was due to the baby becoming hypothermic at the time of birth and another had a dusky episode at 4 minutes of age requiring PEEP and this wasn't escalated at the time. Paediatric support was sought at 15 minutes of age when the baby had increased work of breathing with oxygen saturations of 87%. Earlier intervention may not have prevented the admission however may have supported the baby's transition.

All babies received were commencing on optiflow for respiratory support once on SCBU.

All babies were directly admitted from Delivery Suite / Theatre.

1 baby could have been escalated sooner – considered this may not have prevented admission as baby required optiflow for 4 days

All babies treated with prophylactic IV antibiotics

WH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Hypoglycaemia
There was 1 admission to NNU for hypoglycaemia. This was considered unavoidable. This mother was a planned elective LSCS due to breech presentation. Attended with spontaneous rupture of membranes at 38+1 weeks, cord prolapse diagnosed > category 1 LSCS. Baby was born in good condition with no resuscitation required. Was admitted to SCBU for blood glucose management, IV fluids and antibiotics from the postnatal ward within the first 24 hours of age.
Learning extracted
This admission was considered unavoidable. There had been appropriate escalation and management plans made. Despite additional measures the BM remained low and baby required admission to SCBU for enhanced input.

Jaundice & Asphyxia (perinatal hypoxic-ischaemia)
0 Admissions to NNU for jaundice or asphyxia
Learning extracted
N/A

WH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Other
Number of admissions = **2** Type of delivery: 2 x Em LSCS > Cat 1 (although one stepped down to cat 2 in theatre - IOL for SROM / GBS +ve – fetal bradycardia) Reasons for admission: • 1 x baby born following abnormal AN CTG. Born in poor condition with low cord gases. Treated for sepsis due to raised maternal markers (WCC 27.4 and CRP 168). Had attended with D & V and reduced fetal movements. • 1 x baby was admitted from the postnatal ward due to bilious vomiting at 12hours of age. Transferred to tertiary centre for suspected infection relating to ileus.
Learning extracted
Both admissions were considered **unavoidable**

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WH Avoidable Admissions

WH Avoidable Admissions

There were 2 admissions that was considered **avoidable** following review (18%).
Themes identified throughout review:

- Small numbers > 1 may have potentially been due to delayed escalation, the other due to inadequate thermoregulation at the time of birth.
- Worthing have consistently low rates of admission to NNU in comparison to all other sites – this needs to be explored further.

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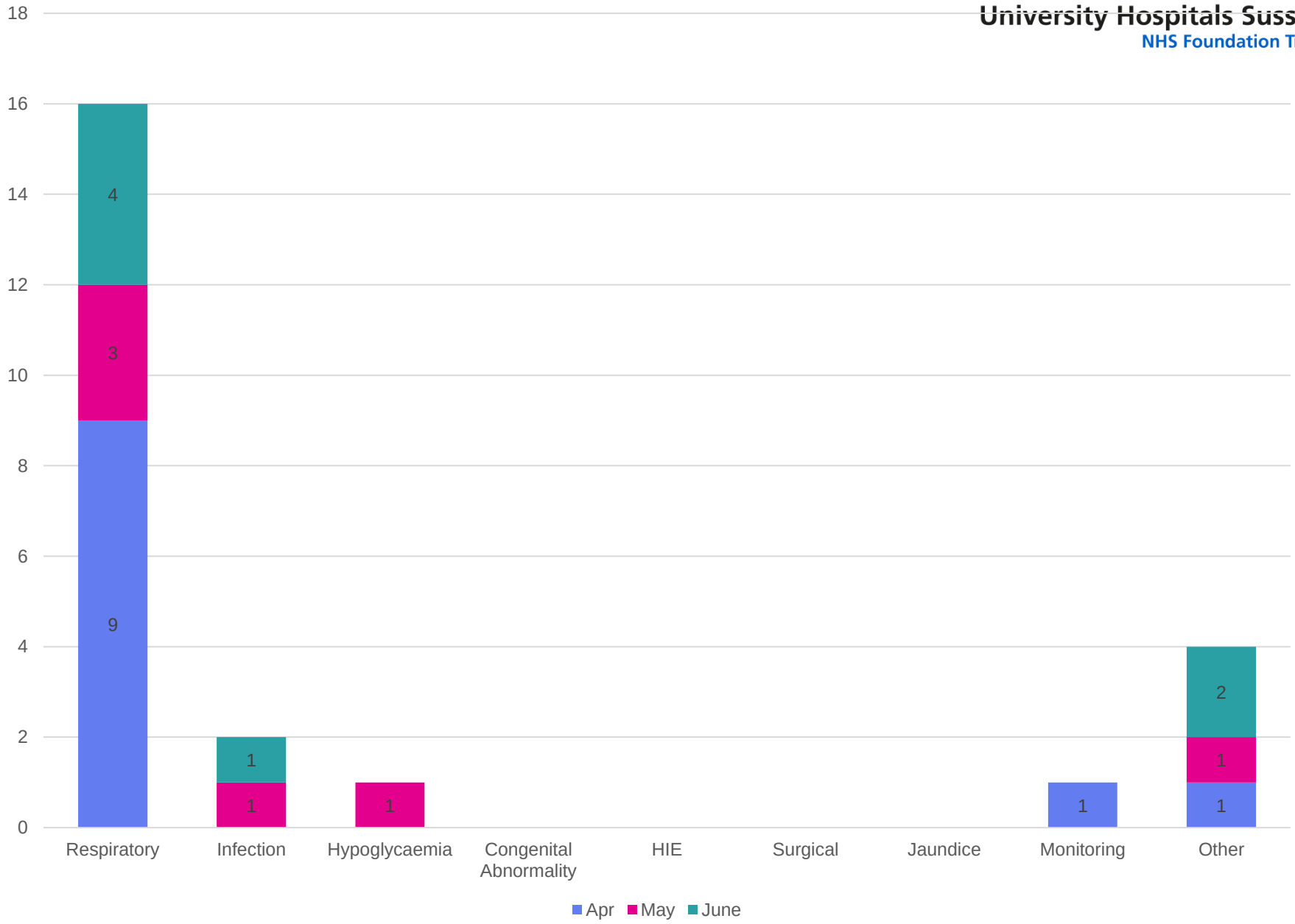
St Richards Hospital (SRH)
ATAIN Progress Report

SRH Categorised Admissions to NNU



SRH – Learning from the review of term admissions to NNU

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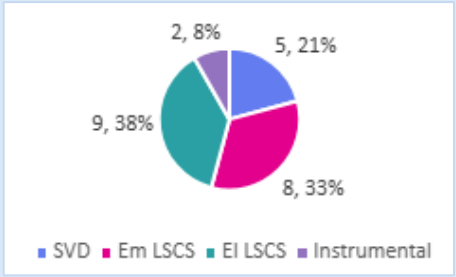
Respiratory Symptoms

Number of admissions = 16
Types of delivery: 4 x SVB, 6 x Em CS, 6 x El LSCS and 0 x Instrumental



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 Tachypnoea of the Newborn (TTN) and meconium aspiration.

Learning extracted

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

Of the 16 babies transferred (15 from labour ward, 0 from the birth centre, 1 from postnatal ward) 6 of the 16 admitted directly from labour ward 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. 1 baby required immediate intubation.

All babies required additional oxygen in order to maintain saturations above 90% necessitating admission to NNU for respiratory support with optiflow in 6 cases and high flow nasal oxygen in 10. 1 baby was intubated at birth.

1 baby required intubation and was transferred to a tertiary centre. Extubated on D3 of life, commenced on high flow oxygen on D4 as tachypnoeic, discharged home on D10.
1 baby was transferred to a tertiary unit on Optiflow – diagnosed with Treacher Collins Syndrome.

SRH – Learning from the review of term admissions to NNU

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Hypoglycaemia
Number of admissions = 1 Type of delivery: EL LSCS Baby born to a gestational insulin dependent diabetic mother – given Glucoboost and EBM top-ups, commenced on NG feeds 2 hourly, tongue tie snipped.
Learning extracted
The admission was potentially **avoidable** - baby was admitted from the postnatal ward and commenced on NG feeds; maintained blood glucose levels and was then transferred back to the postnatal ward.

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

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Observation
Number of admissions = 1 Type of delivery they were: El CS Reasons for admission: • Baby was admitted with poor colour, low SATS and respiratory concerns - required PEEP in theatre, transferred to NNU @ 40 minutes of age. PEEP discontinued on admission as SATS 99% in air - observed with no further concerns.
Learning extracted
• Appropriate escalation to paediatric team noted • Monitored on NNU to exclude TOF • Consideration of enhanced transitional care/increased skill set on PN ward may have allowed baby to remain with their mother i.e. – supporting NG feeds.

SRH – Learning from the review of term admissions to NNU

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Infection
Number of admissions = 2 Type of delivery they were: 1 x SVB, 1 x Em CS Reasons for admission: • 2 babies were admitted with signs of infection (1 x ?chorio with increased wob, nasal flaring and grunting) requiring enhanced monitoring and further treatment/investigations. 1 baby was transferred to NNU but stepped down and transferred back to CLS.
Learning extracted
• Appropriate escalation to paediatric team noted. • Consideration of enhanced transitional care/increased skill set. Could have been assessed for sepsis on NNU and returned to mother.

SRH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Other
Number of admissions = 4 Type of delivery they were: 1 SVB, 2 Em CS, 1 instrumental births Reasons for admission: • 2 babies were admitted with feeding concerns and weight loss requiring enhanced monitoring and further treatment/investigations. • 1 baby was admitted with birth trauma (subgaleal haematoma from ventouse) - HC 33.6cm which gradually increased over 12 hours 35cm>35.5cm>36cm>37cm, baby remained clinically well Hb 188 and 195 • 1 baby was admitted via the postnatal ward @ 18 hours of age with bilious vomit (?sepsis ?malrotation of the bowel) - AXR and upper GI contrast study NAD, monitored on PN ward in TC
Learning extracted
• Appropriate escalation to paediatric team noted. • Consideration of enhanced transitional care/increased skill set on PN ward and earlier recognition/escalation of feeding concerns could have kept baby with mother.

SRH Avoidable Admissions

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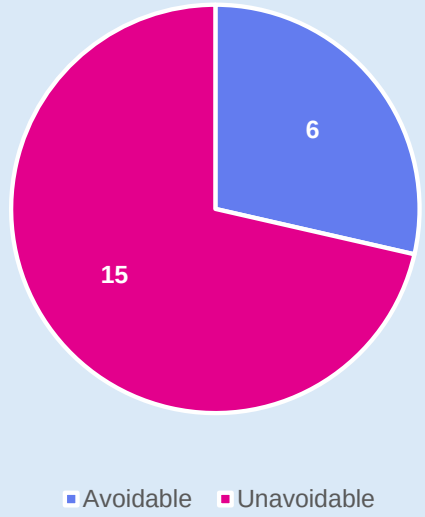
SRH Avoidable Admissions

Total number of avoidable admissions: **6 of the 24** admissions were deemed **avoidable** (37.5%)

Themes identified throughout review:

- Earlier intervention with feeding/hypoglycaemia management may have prevented admission for 3 babies.
- Enhanced monitoring facilities and increased skillset on the PN ward may allow babies to remain with their mothers, for example supporting NG feeding



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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 mother/birthing person sooner under transitional care and if there is anything that hinders this process.

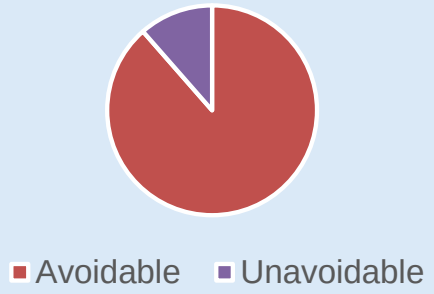
Summary

For the total of Quarter 1, the benchmark of <5% of admission to the Special Care Baby Unit was met for the duration at WH (2.5%, 2.9% & 1.2%) and for SRH it did not meet the benchmark in April (6.8%, 3.3%, 3.7%). PRH and RSCH only met the benchmark in May for Quarter 1 (PRH 6.67%, 3.57%, 7.64%, RSCH 8.57%, 3.90%, 7.34%).

There were 33 admissions to NNU from RSCH, 28 admissions from PRH, 24 admissions from SRH and 11 admissions from WH which is a total of 96 term admissions to the SCBU/NNU.

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

Overall, 88.5% (85) of admissions across all four sites were considered unavoidable with appropriate management with 11.5% (11) considered as potentially avoidable.



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Transitional Care Audit Q1 25/26 Executive Summary

QGSG/PQC

November 2025

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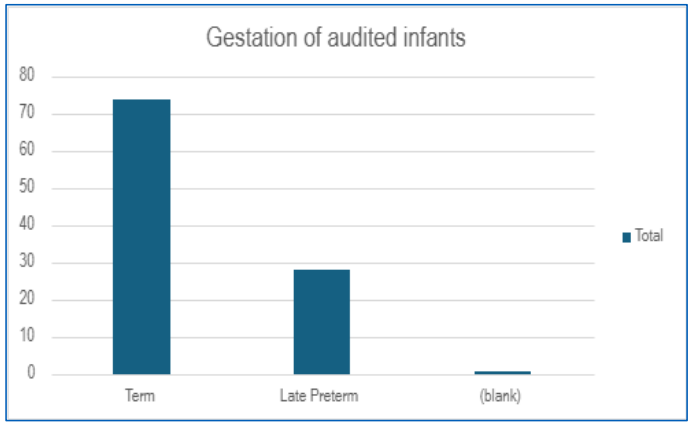
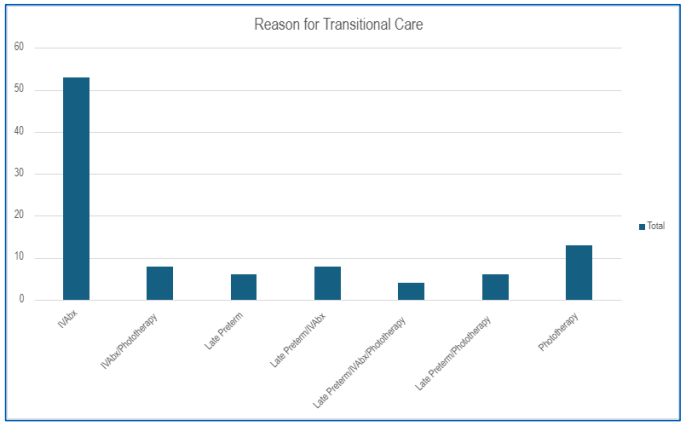
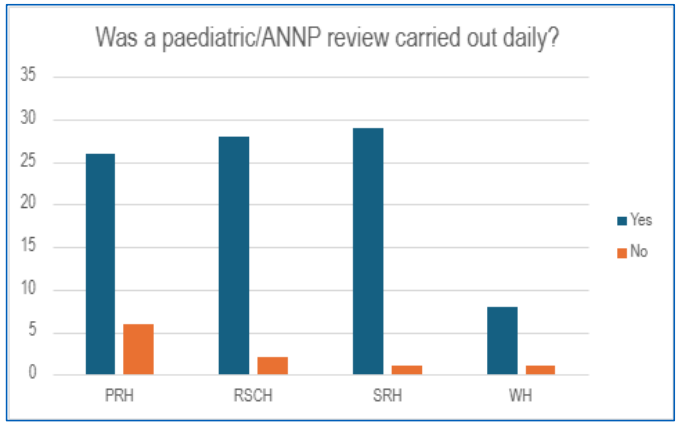
Summary of findings

- 103 births included across all four sites – most were term neonates with some late preterm
- Most babies needed Transitional Care for IV antibiotics for suspected sepsis
- Initial and daily reviews
  - Initial: most babies reviewed initially (WH 1, PRH 0, RSCH 1, SRH 1)
  - Daily reviews: all sites missed some (WH 1, PRH 6, RSCH 2, SRH 1)







Thematic observations

Across the audit several themes were identified:

- Treatment with IV antibiotics was the main course of treatment across site.
- Daily neonatal reviews not being completed has risen again at PRH. PN Leads to identify what issues have led to an increase.
- Ensure all staff aware of escalation process at RSCH
- 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/Actions

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- 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.
- PN Leads to look at issues that have been identified for their areas.
- 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
- Work undergoing to review this current TC audit to align, support and monitor the development of BAPM TC currently undergoing across all 4 sites and to inform the TC working group.

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Transitional Care

Quarter 1 (April, May June 2025)

PRH, RSCH, SRH, WH

Contents

Background

Neonatal Transitional Care (NTC) is defined as care additional to normal infant care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals.

Keeping mothers and babies together should be the cornerstone of newborn care. NTC supports resident mothers as primary care providers for their babies with care requirements more than normal newborn care, but who do not require care in NNU.

Implementation of NTC has the potential to prevent thousands of admissions annually to UK neonatal units, and to provide additional support for small and/or late preterm babies and their families. NTC also helps to ensure a smooth transition to discharge home from the neonatal unit for sick or preterm babies who have spent time in a neonatal unit, often at some considerable distance from home.

NTC is multidisciplinary and should be flexible and responsive to mother and baby's physical and emotional needs as well as the rest of the family. A recent systematic review concluded that "transitional care benefits the health outcomes of moderately compromised infants and mothers in terms of de-medicalising care, improving mother and baby attachments, avoiding separation, developing parenting skills for dependent infants and raising the potential for shorter length of hospitalisation". *British Association of Perinatal Medicine (BAPM) Neonatal Transitional Care - A Framework for Practice (2017). A BAPM Framework for Practice.* Potential benefits of transitional care:

For mother and baby:

- Optimised attachment process.
- Maximal opportunities for skin-to-skin contact.
- Facilitation of baby-led feeding and establishment of breast feeding.
- Access to 24-hour practical support with feeding and /or prompt medical review if required– helping to build self-efficacy and thus confidence in parenting.
- Immediate access to skilled midwifery support for routine postnatal care.
- Family-friendly environment.
- Potentially reduced risk of hospital-acquired infection.

For maternity and neonatal services:

- Reduced length of neonatal stay.
- Improved team working within maternity and neonatal services.
- Greater parental confidence, with reduced rates of re-admission.
- Increased breast-feeding rates.
- Improved neonatal patient flow with potential for more efficient use of NNU cots.
- Additional professional opportunities for midwives.

Criteria for Neonatal Transitional Care

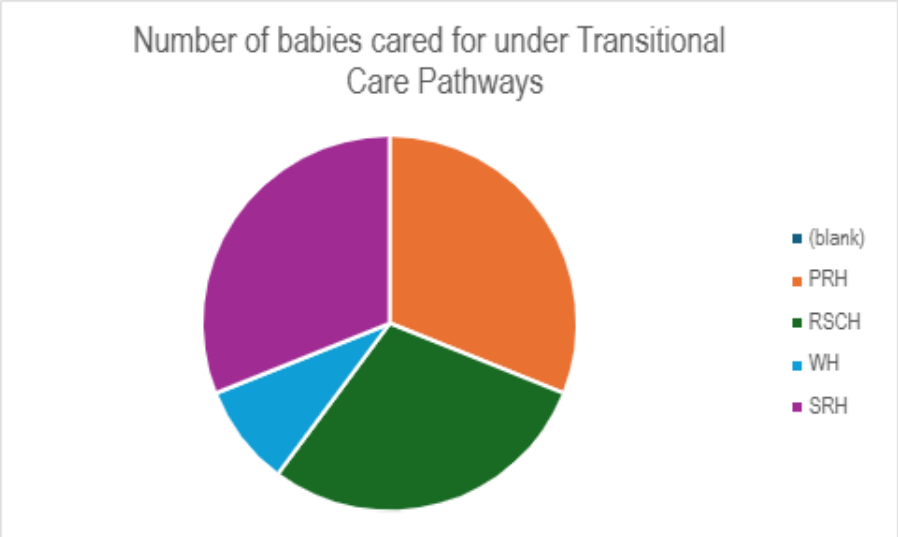
- Gestation 35-36+6 weeks at birth who do not fulfil criteria for intensive or high dependency care.
- Risk factors for sepsis requiring IV antibiotics, but clinically stable and/or stable baby who has developed (or been identified as having) risk factors for sepsis, requiring IV antibiotics
- At risk of haemolytic disease requiring immediate phototherapy or requiring phototherapy following identification on the ward or in community.
- Excessive weight loss.

Objective

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

Data collection

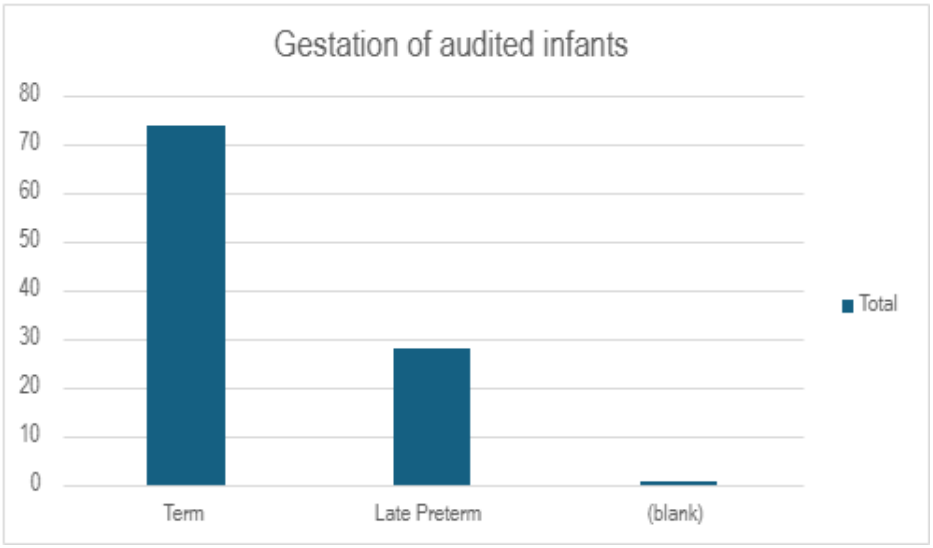
A sample of neonatal medical records of babies who met the criteria for Neonatal Transitional Care were audited between a 3-month period of April to June 2025.

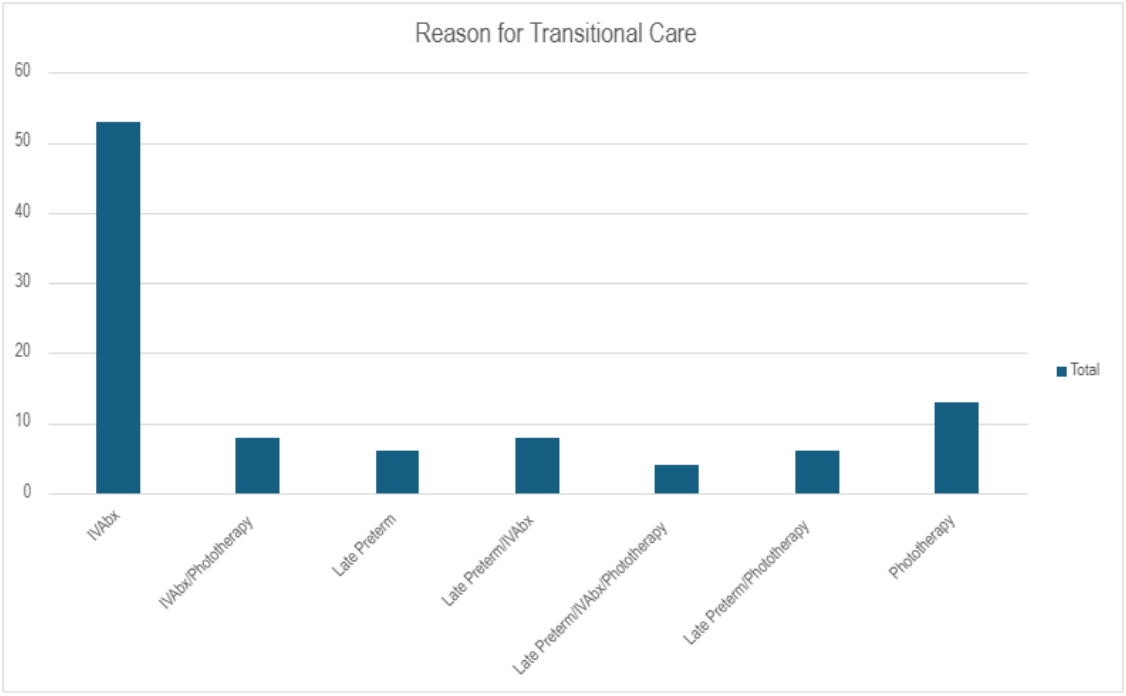


Infant's care pathways, via their neonatal medical records on Badgernet were audited: PRH 32 sets, RSCH 30 sets, SRH 32 sets and WH 9 sets.

Results

Most of the cases audited across all sites were term gestation neonates.



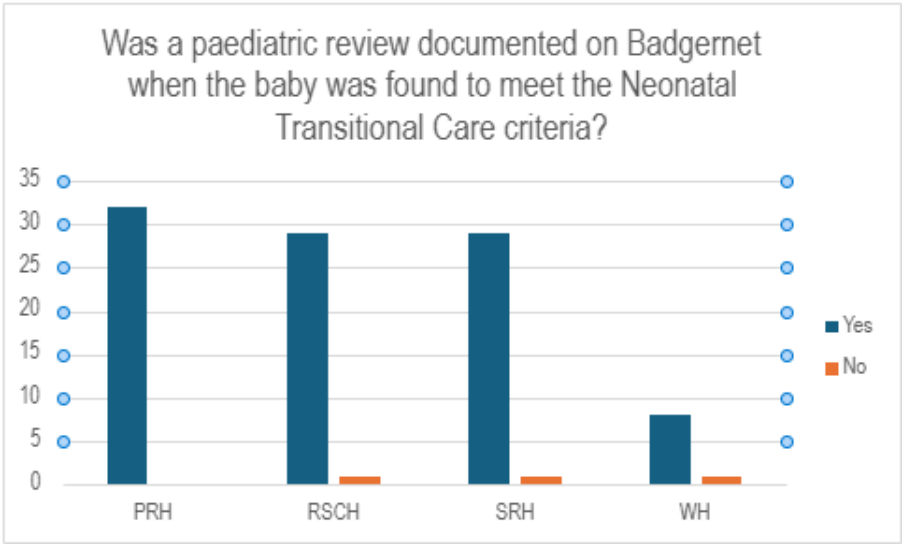


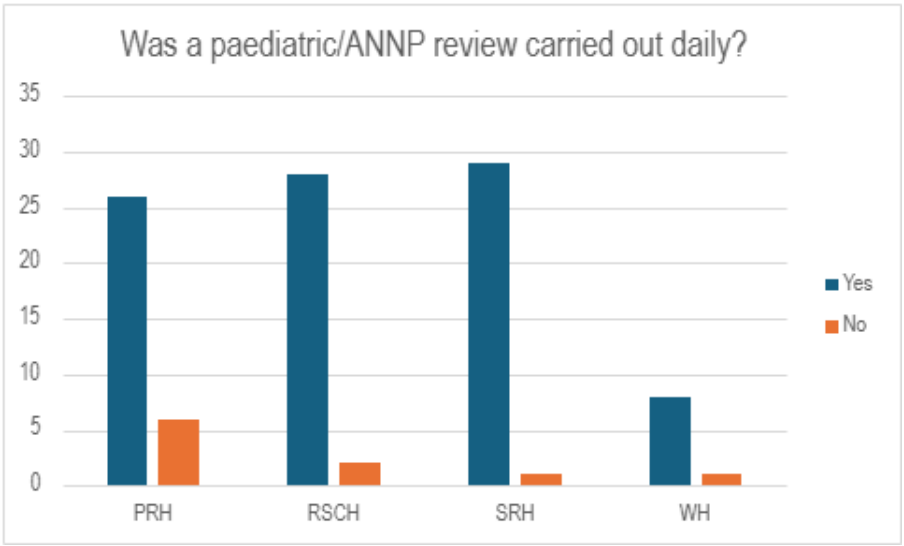
Most babies under Transitional Care, as shown in the graph above, were found in the category of receiving intravenous antibiotics for suspected sepsis. Other babies had a combination of treatments during their admission.

Record of Neonatal Medical Involvement

4

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.



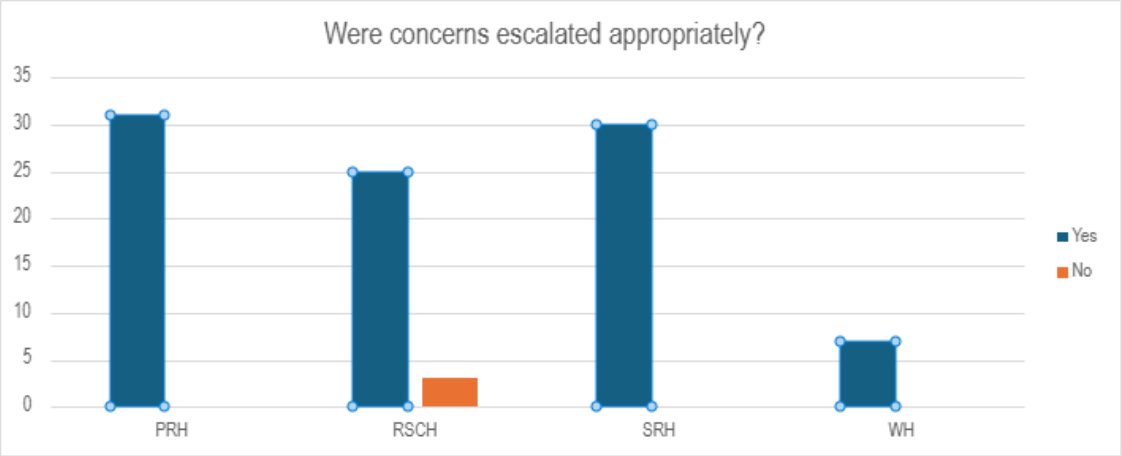


All babies at PRH cases were appropriately reviewed when found to meet the Neonatal Transitional Care criteria. However, documentation of Initial Neonatal/Paediatric reviews were not completed on 1 baby at each of the other sites. At RSCH the baby was admitted to the NNU unit and transferred to TC later, so this review and plan to admit to TC would be documented on metavision.

5

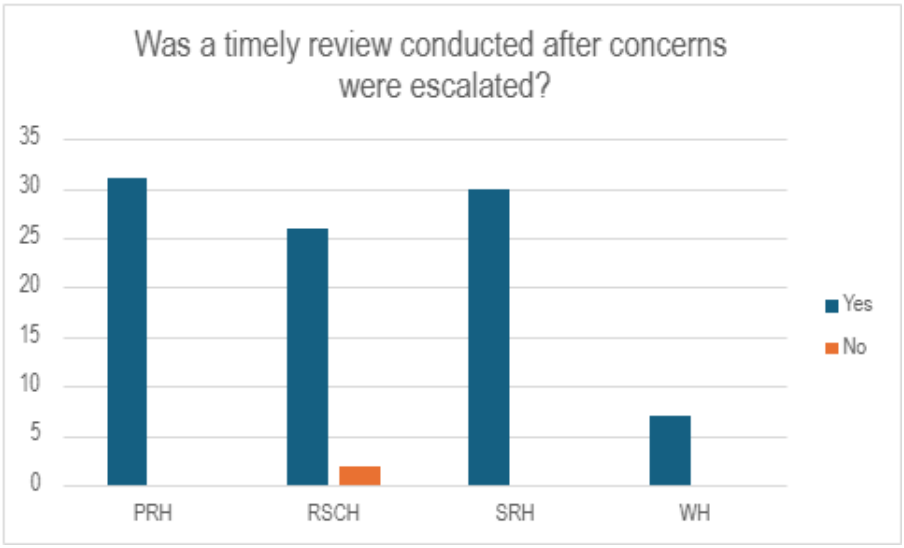
10 babies in total did not receive daily reviews. 6 at PRH, 2 RSCH, 1 SRH & 1 at WH.

This aspect of care had been improving, so it may be necessary to have a deeper dive especially at PRH if this persists. It has however, already been identified that the ANNP availability for the postnatal ward can be difficult in periods of high acuity.

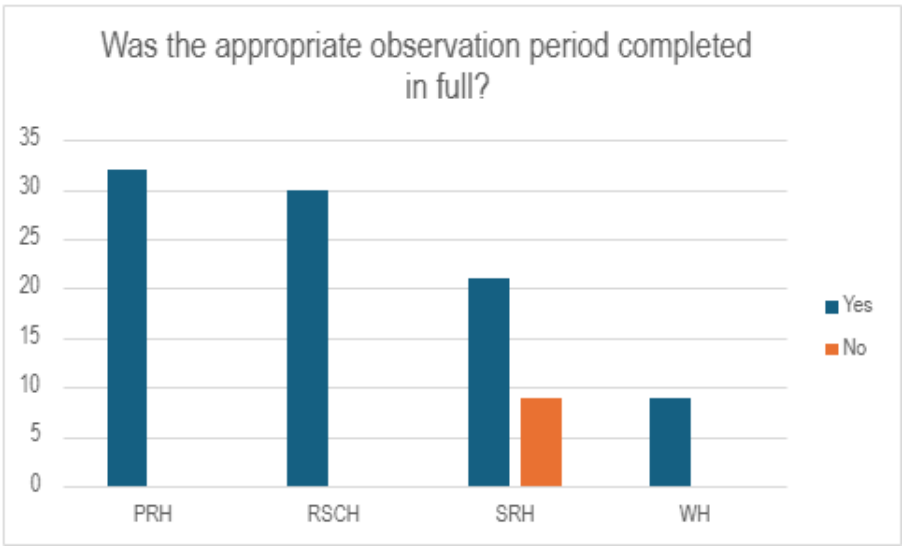


All cases reviewed at PRH and SRH and WH were escalated appropriately. However, at RSCH there were 3 cases where concerns were not escalated appropriately. This involved lack of escalation when respiratory rates were out of normal range.

6

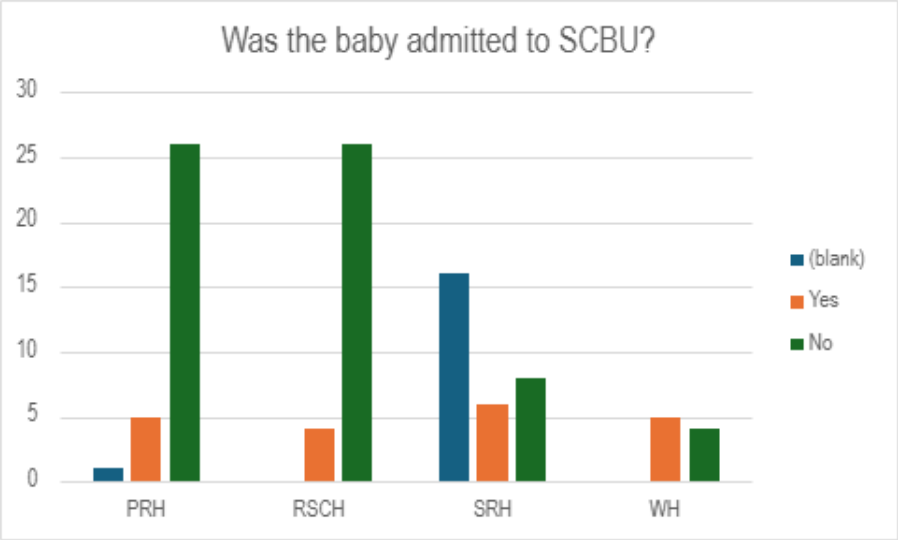


There were 2 babies at RSCH that did not receive a timely review from the neonatal team when this was escalated to them.

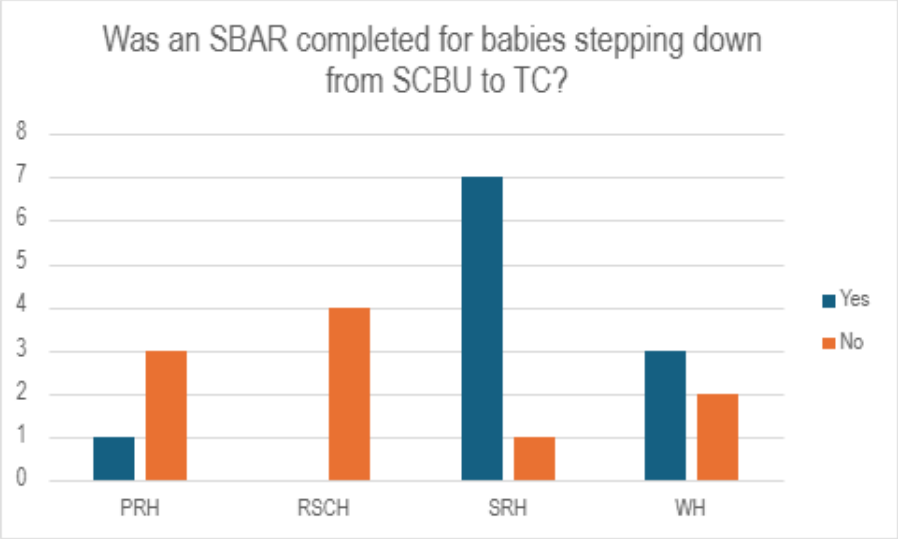


All sites were compliant with regards to completing observations in full with the exception of SRH where 9 cases observations were not completed in full. This will require a more in depth look into why this occurs.

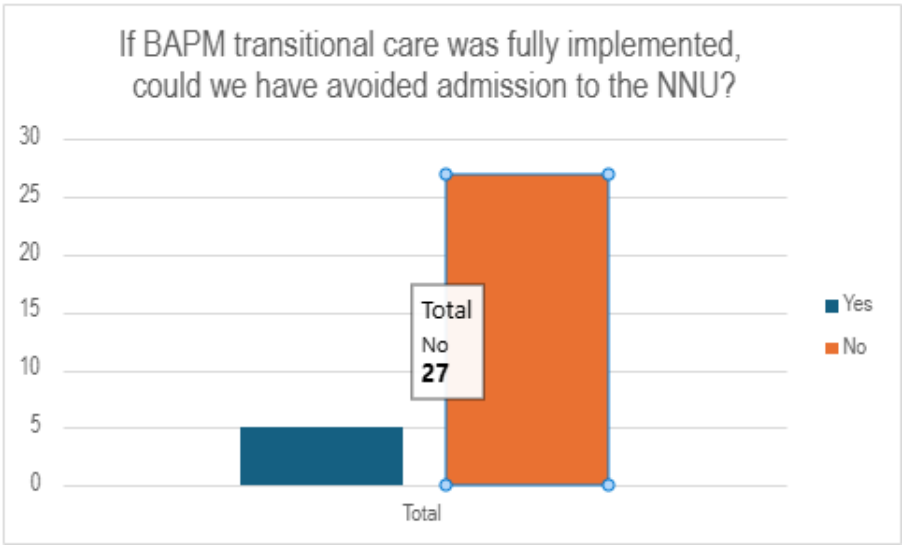
7



In total 20 babies were admitted to NNU across all 4 sites. With the main reason for admission being respiratory support.



Of all the babies that were readmitted to the postnatal wards after a special care it is identified that there remain ongoing issues with an SBAR being completed. 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.



5 babies in total across all 4 sites could have remained on the postnatal ward if TC was BAPM compliant.

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 not being completed has risen again at PRH. PN Leads to identify what issues have led to an increase.
- Ensure all staff aware of escalation process at RSCH
- 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 & ATAIN UHSx Steering group.

- 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.

- PN Leads to look at issues that have been identified for their areas.
- 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
- Work undergoing to review this current TC audit to align, support and monitor the development of BAPM TC currently undergoing across all 4 sites and to inform the TC working group.

Agenda Item:		**Meeting:**		**Meeting Date:**	
Report Title:	UHSussex – MIS CNST Year 7 – January Trust MIS Year 7 Declaration				
Sponsoring Executive Director:	Dr Maggie Davies, Chief Nurse				
Author(s):	Emma Chambers, Director of Midwifery Dr Tim Taylor, Chief of Service Hugh Jelley, Director of Operations Claire Hunt, Divisional Director of Nursing Raili Frost, Programme Manager				
Purpose of the report: ***(indicate as appropriate)***	**For Decision**	**For Assurance**	**For discussion**	**For Information only**	
	N/A	Yes	*N/A*	*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

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)***

<u>What</u>:
The Maternity Incentive Scheme (MIS) encourages safer maternity care by rewarding NHS Trusts that follow ten specific safety rules. Developed alongside national maternity experts, Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent IBE, the scheme offers financial rewards to hospitals that meet these best-practice standards for mothers and babies.

Whilst the maternity incentive scheme (MIS) is a self-certified scheme, with all scheme submissions requiring sign-off by Trust Boards following conversations with Trust commissioners, all submissions also undergo an external verification process. Given the Trust's recent CQC inspection, inclusion in the National Maternity and Neonatal Investigation and history with CNST evidence, it is possible that NHSR will review our evidence in full too.

The MIS Year 7 was published on 2nd April and ends on the 30th November. Submission is due by noon 3rd March 2026.

This paper has been prepared for the Trust Board to agree and sign off the Trust's declaration – compliance detail was first considered by the Quality Committee in December and then be submitted to Board in January 2026.

The paper was presented to the Trust Board in Private in January 2026 with a recommendation for a signed declaration by both the Trust Chief Executive Officer and Integrated Care Board Accountable Officer. Once complete it must be sent to nhsr.mis@nhs.net **by 3rd March 2026 at 12 noon.**

<u>So what</u>:
The previous report to the Quality Committee in December 2025 noted, BDO (the Trust internal auditors), undertook the first phase of an assurance audit of UHSussex evidence against current MIS CNST guidance. Having completed their second stage review, their final report (see appendix 1) provides assurance in support of the Trust's overall declaration.

NHSR require the Trust to submit the year seven declaration using a self-assessment template. The summary page of this is listed below with the full template including each individual Safety Action tab in

appendix 2. The responses on this template are based on the Trust's ability to evidence compliance against current MIS CNST requirements. Evidence is catalogued against each Safety Action and reviewed by BDO with the latest evidence index included in appendix 3 for reference and stored on corporate folders, available via the Company Secretary. Within appendix 3 is a 'report triangulation' tab which compares findings or recommendations from external reports against the MIS CNST standards as required when declaring compliance:

'There are no reports covering either year 2024/25 or 2025/26 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period.'

The Board is asked to note the review of these reports and confirm they are satisfied these reports don't contradict the Trust's compliant submission. This information will also be shared with NHS Resolution.

Given that the end of the reporting period was 30/11, evidence is still being collated at time of writing this paper (eg. Patient and Quality Committee and Trust Board minutes). All outstanding evidence is outlined in red with expected submission dates included for the Committee's information.

The Board is asked to note that significant progress has been made across all safety actions, with many standards now embedded as business as usual and those areas previously reported at risk, including training compliance, are now compliant. Further, the ICB confirmed on 16/12 that they deemed progress against Saving Babies Lives v3.2 implementation sufficient to declare compliance with this safety standard.

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes

Now what:
Following review and approval of final position and following Executive approval, the Trust will submit its proposed declaration to the ICB for approval and submit paperwork including action plans to NHSR by 3rd March 2026 at 12 noon.

Members of the Committee are asked to discuss and agree proposed declaration against the 10 Safety Action Standards. Following the

	Board meeting on 15th January 2026, the Trust CEO is required to include an electronic signature on Tab D of the MIS Board Declaration Form, (rows 39 to 43) - see appendix 2.
Recommendation (*linked to What Next section)*	The Public Board is to note that the Trust CEO has signed a compliant MIS CNST Year 7 declaration form
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						
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**	**Caring**	**Effective**	**Responsive**	**Well-led**	**Use of Resources**
	Yes	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*

Other impacts	**Equality and Diversity (*if yes has HEIA completed)***	**Environmental**	**Legal**	**External Registrations *(if yes please indicate which)***
	Yes / N/A (Yes / No)	*Yes / N/A*	*Yes / N/A*	*Yes / N/A*

University Hospitals Sussex
NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust

RESEARCH, INNOVATION and DIGITAL STRATEGY ASSURANCE COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Research, Innovation and Digital Strategy Assurance Committee is to support the Trust in achieving its strategic objective**:**

Where required, the Committee will support the Board and cooperate with the Strategy & Major Projects Assurance Committee to gain assurance, through routine reporting, of the delivery of improvement actions in pursuit of the Trust's Strategy.

1.02 The Committee will do this through;

- Alignment of the UHSussex Research and Innovation strategy with NHS Sussex and partner organisations, under the auspices of the Health Research Partnership.
- Monitoring progress against the Research and Innovation Strategic Delivery Plan.
- Monitoring progress against the Digital and Data Strategic Delivery Plan.
- Supporting the Trust to enhance its digital capabilities to support innovation in patient care, experience and the experiences of staff.
- Supporting digital inclusion and increase understanding of the ethical use of clinical data to improve health outcomes.
- Supporting an approach to achieve high data quality within the Trust.
- Developing an operational plan, including stakeholders to deliver the key strategic priorities.
- Ensuring the risk register reflects the depth and breadth of risks to delivery of the strategic plans, with mitigations and actions aligned to the Trust's Strategy covering Research & Innovation and Digital; and
- Assisting the Board in its oversight of achievement of the Research and Innovation and Digital and Data Strategic Delivery Plans.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- At least two further nominated non-executive Directors, one of which shall be the Brighton and Sussex Universities nominated NED
- Chief Strategy Officer (Lead Executive for the Committee)
- Chief Medical Officer (Alternate Lead Executive for the Committee)
- Chief People Officer

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

2.05 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Clinical Director of Research and Innovation
- Director of Operations - Research and Innovation
- Commercial Director
- Director of Integrated Education
- Managing Director of Planned Care
- Chair of Brighton and Sussex Health Research Partnership
- Chief Information Officer
- Data Protection Officer

2.06 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.07 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.08 Other Trust managers and clinicians may be invited to attend for particular items on the agenda that relate to areas of risk or operation for which they are responsible.

2.09 Attendees will only ordinarily be asked to attend where they have an item on the agenda, noting that for personal development their attendance at any meeting would be encouraged.

2.10 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is

restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

Quality

3.05 To receive incident reporting in relation of clinical trials or research which shows the level of harm and near misses, thus providing a robust picture of the quality of care provided through the research activities of the Trust. Noting the link to the Patient & Quality Committee's oversight through the high level reporting through the Quality Assurance reporting.

3.06 To receive information and reports to ensure that the patient voice is being used to influence the shape of the research programme.

3.07 To receive reporting in relation to research and innovation activity that the trust sponsors, to ensure that all regulatory responsibilities of 'Sponsor' are met.

3.08 Ensure Trust framework of policies and procedures facilitate compliance with the relevant ethical and regulatory standards.

3.09 To review the themes and trends in research outcomes in order that the learning drives improvements to the Trust's processes.

People

3.10 To link with the People Committee in the oversight of the Trust education and learning plans, in so far as they impact and enhance research and innovation.

Finance

3.11 To ensure that there are robust costing and contracting processes applied to research and innovation projects undertaken in the trust, including the management of commercial research and innovation.

3.12 To ensure that effective processes are established and applied for the stewardship and use of research grant income or the provision of grants to others for the purpose of research.

Information Management and Technology

3.13 To review the Digital and Data strategies and recommend to the Board for approval.

3.14 To monitor the implementation of the Trust's Digital plans as enablers to Efficiency and Transformation, and to receive regular progress reports to scrutinise delivery and the meeting of key milestones.

3.15 To review the application of the Trust's digital capabilities to drive innovation

3.16 To ensure that appropriate oversight and risk assessments are undertaken for all digital enhancements and where risks of implementation are assessed as high the Committee approval for progressing is required.

Systems and Partnerships

3.17 Receive and review reports covering the Brighton and Sussex Health Research Partnership and other networks and wider research collaborations the Trust engages and takes part in.

3.18 Review reports on joint working with BSMS in delivery of the UHSussex Research and Innovation strategy.

3.19 Receive and review reports covering the alignment of the Trust's Digital Strategy with that of the wider system and the drive for intra operability where it benefits the Sussex patient community and our staff.

Well led

3.20 To ensure the Trust's research activities are undertaken in compliance with mandated standards and requirements.

3.21 That the reputation of the Trust is protected through appropriate due diligence into planned research and digital system changes.

3.22 To maintain oversight of research and innovation activity, ensuring that it is well governed and is focused on and delivers improvement in respect of the Trust's clinical quality priorities.

3.23 To ensure that all digital activity is well governed and delivers the intended service and staff improvements.

3.24 To ensure that the EPR programme and project is given adequate and effective senior management oversight.

Risk

3.25 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High-Level Operational Risks with a significant potential for impact on the Trust's Research, Innovation and Digital objectives.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the Audit Committee, Patient & Quality Assurance Committee, People& Culture Assurance Committee, or Strategy & Major Projects Assurance Committee any matters requiring review or decision-making in that forum.

4.04 The Committee shall receive reports from all sub-groups setting out any matters requiring escalation to the Research, Innovation and Digital Committee.

4.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual report disclosures and will be submitted in the first quarter of the following financial year.

4.06 The Committee Chair shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead Executive for the Committee, or the alternate Lead Executive for the Committee. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 4 times in each financial year and dates will be set by the end of the previous financial year.

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

5.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions are to be formally ratified the Committee and/or Board at the next meeting.

5.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting which is taking place without all parties being physically present the Chair shall be responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

5.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual) during a meeting. Members conflicted on any items of business on a committee

meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

5.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members. Papers should be provided not less than five calendar days before the meeting and the agenda and papers should be circulated not less five calendar days before the meeting, to provide sufficient time for due consideration.

5.09 Proceedings and decisions made will be formally recorded by the Company Secretary in the form of minutes and distributed to Committee Members within 10 working days of the meeting.

6.00 TERMS OF REFERENCE

6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by the Research, Innovation & Digital Assurance Committee January 2026

6.04 Next full review: by March 2028 (recognising that these will be subject to review during the annual review of Committee effectiveness)

University Hospitals Sussex
NHS Foundation Trust

Appendix - Mandated items considered by the Committee

Below is a list of the minimum items the Committee would receive over the year

Research & Innovation:

- Research & Innovation Strategic Delivery Plan
- Research and Innovation Annual Review
- Research incident reports
- Research activity reports
- Research training reports
- Research finance reports

Digital & Data:

- Digital & Data Strategic Delivery Plan
- EPR business case delivery reports
- IM&T activity reports
- Cyber security compliance reports (Data Security Protection Toolkit improvement actions)
- Information Governance reports – DPA including FOI, SAR

University Hospitals Sussex
NHS Foundation Trust

University Hospital Sussex NHS Foundation Trust

PATIENT AND QUALITY ASSURANCE COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Patient & Quality Assurance Committee ("the Committee") is to support the Trust in achieving its strategic core ambition: "Excellent care for our patients - Fast, fair, high-quality treatment for all".

1.02 The Committee will do this through:

- Providing input and recommendations to the Board for the development of the Quality Strategy and Clinical Framework and Strategy, ensuring there is alignment between the two;
- Assisting the Board in its oversight of achievement of the True North Targets, breakthrough objectives and strategic initiatives pertaining to the Quality domain;
- Ensuring robust clinical governance structures, systems and processes are in place across all services and in line with national, regional and commissioning requirements;
- Driving a culture of learning and continuous improvement across the organisation;
- Obtaining assurance that the quality strategy is being implemented; and
- Review of soft intelligence, narrative and data relating to the NHS Quality Assurance Framework and Darzi principles of quality (patient and family experience, patient safety and clinical effectiveness) to enable integrated quality performance reporting to the Board.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Three further nominated non-executive Directors
- Chief Medical Officer (Lead Executive for the Committee)
- Chief Nurse (Alternate Lead Executive for the Committee)
- Chief Operating Officer

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's Annual Report.

2.05 Core Corporate Director attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Deputy Chief Medical Officer (Quality)
- Deputy Chief Nurse (Quality and Safety)
- Director of Clinical Effectiveness
- Director of Patient Safety and Learning
- Director of Patient Experience, Engagement and Involvement
- Corporate Director Infection Prevention and Control
- Associate Director of Safeguarding
- Director of Midwifery
- Director of Facilities and Estates

2.06 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Committee Chair.

2.07 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.08 Other Trust managers and clinicians may be invited to attend for particular items on the agenda that relate to areas of risk or operation for which they are responsible.

2.09 Attendees will only ordinarily be asked to attend where they have an item on the agenda, noting that for personal development their attendance at any meeting would be encouraged.

2.10 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

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3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary.

3.05 All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

Trust Strategy

3.06 Where required, the Committee will support the Board and cooperate with the Strategy & Major Projects Assurance Committee to gain assurance, through routine reporting, of the delivery of improvement actions in pursuit of the Trust's Strategy.

Statutory requirements

3.07 Review the annual Quality Account.

External reviews

3.08 The Committee shall receive assurance from other significant assurance functions, both internal and external to the organisation, on its review of the findings and consider the implications to the organisation. These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors.

3.09 To monitor the Trust's responses to all relevant external assessment reports and the progress of their implementation, including the reports of the Care Quality Commission (CQC).

3.10 To receive exception reporting from sub-groups regarding the CQC's insight report in respect of any potential changes to the Trust's quality risk profile.

Safe

3.11 To obtain assurance that there are effective systems and processes in place which embed learning from incidents and near misses in a way that reduces risk thereby improving outcome measures and quality of care.

3.12 To receive a summary report, using a standard template, which includes identification of areas of concern and escalations from the Committee's determined sub-groups.

3.13 To receive triangulated reports and review the themes, trends, management, and improvements relating to serious incidents, 'never' events, post-mortem reports, medico-legal cases and to seek assurance that remedial action plans are being implemented and learning is embedded and shared across the organisation. Assurance to be obtained through incident reports, Learning from Deaths reports, Duty of Candour audits and Patient Safety reports.

3.14 Review and monitor Equality and Quality Impact Assessments (EIA) (QIA) relating to Efficiency and Transformation programmes to gain assurance that there will be no unforeseen detrimental impact on quality of care for patients.

3.15 Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act.

3.16 Obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and young people and vulnerable adults.

3.17 To consider reports from the Committee's reporting groups, e.g. Safeguarding, in the context of quality risks and assurances over the Trust's system of internal control as reflected within the BAF.

3.18 Review the annual Infection Prevention and Control report.

3.19 Obtain assurance over the Trust's maternity services including receipt of reports from the Executive Maternity Champion and the relevant maternity safety and performance dashboards

3.20 Obtain assurance over the safe delivery of the Trust's Dementia strategy.

3.21 To receive of relevant reports from national bodies in relation the standards or practice of clinical care.

3.22 To receive reporting from the Committees established reporting groups and ensure that the patient voice is being used to influence, change and shape practice.

3.23 To approve the Trust's patient and public engagement plans and the patient experience plans/strategy and ensure that these plans are incorporated into the quality and clinical governance teams across the Trust.

3.24 To consider reports from the Customer Relations Team, the Patient Advice & Liaison Service and other sources of feedback (such as Healthwatch) on all formal and informal patient feedback, both positive and negative, and to consider action in respect of matters of concern.

3.25 To consider the results and the issues raised and the trends in all patient surveys (including real-time patient feedback systems), of in-patients and out-patients activities (e.g. Inpatient, Cancer, Maternity and ED) and estate surveys such as PLACE that may impact on clinical quality, and to gain assurance of the development of robust improvement plans and the subsequent completion of action taken to address issues raised.

Effective

3.26 To ensure there is a comprehensive clinical audit programme in place to support and apply evidence-based practice, implement clinical standards and guidelines, and drive quality improvement, including through approving and monitoring progress against the Clinical Audit Strategy.

3.27 In response to requests from the Board, or where appropriate as decided by the Committee, monitor the implementation of action/improvement plans in respect of quality of care, particularly in relation to incidents and similar issues.

Well-led

3.28 To receive and consider the Trust's clinical governance and risk management reports and agree recommendations on actions for improvement.

3.29 To monitor and obtain assurance as to the effectiveness of the processes, systems and structures for good clinical governance at the Trust, and to seek their continuous improvement.

3.30 To consider reports from Service Governance Reviews, to ensure that the reviews are effective and that actions arising from them are addressed in a timely and appropriate manner.

3.31 To ensure that the Board Assurance Framework reflects the assurances for which the committee has oversight, and that risks highlighted are appropriately reflected on the risk registers.

Responsive

3.32 To obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented.

3.33 To review the Complaints Procedure in conjunction with the periodic review of the Complaints Policy.

3.34 To seek assurance that complaints are managed in a way that promotes a culture of openness, learning and continuous improvement across all divisions.

3.35 To review the themes and trends in complaints and the learning and improvements made relating to complaints raised and trends identified.

Integrated Care System (ICS) and system collaborations

3.36 To receive and review reports from the ICS meetings, Sussex Acute Collaboration Network and Sussex Health and Care Partnership meetings.

Sub-Groups

3.37 To oversee and scrutinise the performance of relevant sub-groups through a range of formal and informal activities.

3.38 The Committee shall approve all sub-groups' terms of reference annually or as recommended otherwise by the Trust Company Secretary.

Risk

3.39 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High Level Operational Risks with a significant potential for impact on the Trust's quality risk appetite, and promote continuous quality improvement with regard to the management of quality risk and the control environment throughout the Trust.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the Audit Committee, Finance & Performance Assurance Committee, People & Culture Assurance Committee, Research, Innovation & Digital Strategy Assurance Committee, Strategy and Major Projects Assurance Committee or Charitable Funds Committee any matters requiring review or decision-making in that forum.

4.04 The Committee shall receive reports from all sub-groups, which set out any matters requiring escalation to the Committee and provide assurance of effective standards and performance in their respective Departments.

4.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual Report disclosures and will be submitted in the first quarter of the following financial year.

4.06 The Committee Chair shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead or Alternate Lead Executive for the Committee, the Chief Medical Officer or Chief Nurse. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 8 times in each financial year and dates will be set by the end of the previous financial year.

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

5.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions are to be formally ratified the Committee and/or Board at the next meeting.

5.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting which is taking place without all parties being physically present the Chair shall be responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

5.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual) during a meeting. Members conflicted on any items of business on a committee meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

5.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members to provide sufficient time for due consideration.

5.09 Proceedings and decisions made will be formally recorded by the Company Secretary in the form of minutes and distributed to Committee Members within 10 working days of the meeting.

6.00 TERMS OF REFERENCE

6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by Committee: January 2026

6.04 Next full review: by March 2028

University Hospitals Sussex
NHS Foundation Trust

Appendix - Mandated reports considered by the Committee

In addition to the reports referenced in the Committee's Cycle of Business, below is a list of the mandated reports the Committee would receive over the year

- Annual Quality Account
- Adult, Children and Maternity Safeguarding annual report (including the Annual Mental Health Act Compliance Report) and quarterly reports
- Infection Prevention and Control Annual Report and quarterly reports
- Learning from Deaths Annual Report and quarterly reports
- Annual Patient Safety Incident Report
- Duty of Candour Compliance Report
- Annual Complaints Report
- Quality Dashboards, covering Maternity and Key Indicators
- Dementia Strategy
- Patient Survey Reports
- PLACE Reports
- Parliamentary and Health Service Ombudsman Reports
- HealthWatch Reports
- Patient Experience and Engagement Annual Report

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PEOPLE AND CULTURE ASSURANCE COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the People & Culture Assurance Committee is to support the Trust in achieving its people strategic objective.

1.02 The People & Culture Assurance Committee will do this through;

- Providing input and recommendations to the Board for the development, monitoring and assurance of plans and activities related to People; and
- Where required, the Committee will support the Board and cooperate with the Strategy & Major Projects Assurance Committee to gain assurance, through routine reporting, of the delivery of improvement actions in pursuit of the Trust's Strategy.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- Two further nominated non-executive Directors
- Chief People Officer (Lead Executive for the Committee)
- Chief Strategy Officer (Alternate Lead Executive for the Committee)
- Chief Nurse
- Chief Medical Officer

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

2.05 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Director of Human Resources Management
- Director of HR Operations
- Associate Director of OD and Leadership
- Director of Integrated Education
- Director of Medical Education

- Deputy Chief Nurse - Workforce and Professional Standards

2.06 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.07 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy unless stated will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.08 Other Trust managers and clinicians may be invited to attend for particular items on the agenda that relate to areas of risk or operation for which they are responsible.

2.09 Attendees will only ordinarily be asked to attend where they have an item on the agenda, noting that for personal development their attendance at any meeting would be encouraged.

2.10 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

People Plans

The Committee has oversight for the development and delivery of the Trust's plans supporting the people theme of the trust's strategy covering the main areas of

Leadership

3.05 To ensure the Trust develops and effective staff structure and operating model across the organisation.

3.06 To monitor delivery of staff engagement plans to ensure there are clear communication channels across the organisation which provide staff with key information.

3.07 To monitor organisational integration and cultural development, using methods such as pulse surveys and Town Halls, and implement action plans as necessary.

Culture

3.08 To consider reports from the Guardian of Safe Working and Freedom to Speak up Guardian in the context of the Trust's quality, safety and patient experience processes to ensure that there is a genuinely open culture in which all safety concerns raised are highly valued as integral to learning and improvement.

3.09 Consider reports on national and local surveys including the staff survey and GMC survey as they relate to workforce, and to monitor the implementation of actions taken to address issues raised.

3.10 To gain assurance that appropriate feedback mechanisms are in place for those raising incidents and that a culture of openness and transparency in respect of incident reporting is encouraged by supporting the Speak Up agenda and receiving reports from the Freedom to Speak up Guardian.

3.11 Receive assurance that clinicians, managers and staff promote and advance equality and diversity, whilst working closely with patients, the public, local communities, voluntary organisations, staff and staff side organisations.

3.12 Receive assurance on the Trust's wellbeing and staff safety initiatives and ensure they support staff retention, development and wellbeing.

3.13 Obtain assurance over the Trust's Security and those raising incidents against violence and aggression.

Integrated Education

3.14 To ensure that education and training-related issues, themes and trends are addressed, to promote high standards of care quality through approval of the education and training delivery plan(s) and monitoring delivery of the strategy.

3.15 To receive assurance that training and educational opportunities are available and staff are encouraged to participate in local, national, and international programmes as appropriate.

Workforce Transformation

3.16 To monitor all Workforce Transformation programmes, including to obtain assurance that no programme has an unforeseen detrimental impact on workforce or on the performance of the Trust especially in respect of constitutional and key operational metrics; and to make recommendations as necessary to the Board about action required in-year.

3.17 To receive and monitor the Trust's suite of workforce indicators, including Recruitment, Retention / Turnover, Sickness, Appraisals, Training, along with reports relating to the efficient use of the Trust's workforce.

Mandated Annual Reporting oversight

3.18 To oversee and monitor progress against national NHS England workforce standards and reporting e.g. Workforce Race Equality Standard (WRES), Workforce Disability

Equality Standard (WDES), NHS England guidance on Whistleblowing and the government introduced Apprenticeship Levy.

3.19 To consider reports from the Trust's Caldicott Guardian and Data Protection Officer where people risks have been identified.

3.20 To review the Trust's Equality and Diversity annual report.

3.21 To review and develop action plan from statutory Pay Gap Reports (gender and ethnicity).

3.22 To review the people elements of the Trust's Annual Report.

3.23 To review the annual Responsible Officer and Medical Revalidation report.

3.24 To review the annual and quarterly reports of the Guardian of Safe Working

3.25 To review the annual report of the Freedom to Speak up Guardian

ICS and system collaborations

3.26 To receive and review relevant reports from Regional meetings, Sussex Acute Collaboration Network and Surrey and Sussex ICB meetings.

Risk

3.27 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High-Level Operational Risks with a significant potential for impact on the Trust's People objectives.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the Audit Committee, Patient & Quality Assurance Committee, Finance & Performance Assurance Committee, Research, Innovation & Digital Strategy Assurance Committee or Strategy & Major Project Assurance Committee any matters requiring review or decision-making in that forum.

4.04 The Committee shall receive reports from the Committee's sub-groups setting out any matters requiring escalation to the People & Culture Assurance Committee.

4.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual report disclosures and will be submitted in the first quarter of the following financial year.

4.06 The Committee Chair shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead Executive for the Committee, the Chief People Officer or the Alternate Lead Executive for the Committee that being the Chief Strategy Officer. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 6[1] times in each financial year, and dates will be set by the end of the previous financial year[2].

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

5.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions are to be formally ratified the Committee and/or Board at the next meeting.

5.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting which is taking place without all parties being physically present the Chair shall be responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

5.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual) during a meeting. Members conflicted on any items of business on a committee meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

5.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members. Papers should be provided not less than five calendar days before the meeting and the agenda and papers should be circulated not less five calendar days before the meeting, to provide sufficient time for due consideration.

5.09 Proceedings and decisions made will be formally recorded by the Company Secretary in the form of minutes and distributed to Committee Members within 10 working days of the meeting.

6.00 TERMS OF REFERENCE

[1] The minimum number of Committee meetings in a financial year was amended to 6 (from 4) further to the cancellation of Strategy Deployment Meetings as of week commencing 22 May 2023.
[2] The wording ", noting that in between the quarterly Committee meetings the members of the Committee will hold strategy deployment meetings focusing on the patient True North" was deleted in June 2023 to reflect the decision to stand down Strategy Deployment Meetings as of week commencing 22 May 2023.

6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by Committee January 2026

6.04 Next full review: by January 2028 (recognising that these have been reviewed at the end of the first year of operation of this Committee and will be subject to review during the annual review of Committee effectiveness)

University Hospitals Sussex
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Appendix - Mandated reports considered by the Committee

Below is a list of the mandated items the Committee should receive over the year:

- Trust Annual Equality Report – incorporating:
    - Pay Gap Reports (gender and ethnicity)
    - Workforce Race Equality Standard Annual Report
    - Workforce Disability Equality Standard Annual Report
- NHS National Staff Survey
- GMC Survey (medical trainees and undergraduates)
- National Education & Training Survey (all students)
- Freedom to Speak up Annual Report / Whistleblowing report
- Guardian of Safe Working Annual Report
- Security Management – violence and aggression (bi-annual)
- Annual Responsible Officer and Medical Revalidation report

University Hospitals Sussex
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FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Finance and Performance Committee is to support the Trust in achieving both of its Finance & Performance objectives these being;

"We will use our resources efficiently and effectively for the benefit of our patients and their care and to ensure our services are clinically, operationally, and financially sustainable."

"We will deliver timely appropriate access to acute care as part of a wider integrated care system."

1.02 The Committee will do this through;

- Providing input and recommendations to the Board to enable delivery of the Finance and Performance objectives and the supporting operational plans, ensuring there is alignment between the two;
- Assisting the Board in its oversight of achievement of the Trust's Targets, pertaining to the Finance and Performance Domains;
- Monitoring risks relating to the effective use of resources, including financial performance and risks to the effective delivery of constitutional access standards; and
- Providing oversight and assurance to relevant major strategic programmes to support the collaboration and partnership development with other partners as part of the wider Integrated Care System priorities.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- At least two further nominated non-executive Directors
- Chief Finance Officer (Lead Executive)
- Chief Operating Officer (Alternate Lead Executive)
- Chief Medical Officer
- Chief Strategy Officer
- Chief People Officer
- Chief Corporate Affairs Officer

2.02 The Trust Chair shall propose which non-executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations. At least one of the Committee members should have recent and relevant financial experience.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

2.05 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Directors of Finance
- Director of Improvement
- Director of Workforce, Planning & Deployment
- Director of Capital & Property
- Commercial Director
- Director of Facilities & Estates
- Managing Director of Planned Care and Cancer
- Director of Performance and Information
- Director of Strategy and Planning

2.06 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.07 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting.

2.08 Other Trust managers and clinicians may be invited to attend for particular items on the agenda that relate to areas of risk or operation for which they are responsible.

2.09 Attendees will only ordinarily be asked to attend where they have an item on the agenda, noting that for personal development their attendance at any meeting would be encouraged.

2.10 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee shall have delegated authority to award Contracts and approve Business Cases up to the value delegated to it by the Trust Board.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.05 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

RESPONSIBILITIES

3.06 Where required, the Committee will support the Board and cooperate with the Strategy & Major Projects Assurance Committee to gain assurance, through routine reporting, of the delivery of improvement actions in pursuit of the Trust's Strategy.

Financial and operational performance

3.07 To obtain assurance over the use of the Trust's resources (physical, workforce and financial) to ensure that they are being used economically, efficiently and effectively, considering as necessary; activity, productivity, sustainability and safety.

3.08 To receive and monitor activity reporting on the use of the Trust physical, workforce and financial resources. This will include effective reporting of service line costs, model hospital and benchmarking to inform unwarranted cost variation, productivity and efficiency opportunities across operational services.

3.09 To review and approve the annual plan and medium-term financial plans.

3.10 To keep the Board updated on any identified regulatory and statutory duties related to financial performance for the Trust and how this impacts delivery against the control total.

3.11 To monitor the Trust's Risk Forecasting against the Financial plan including I&E, Balance Sheet and Cash.

3.12 To monitor and receive assurances over the progress of the Trust's efficiency programme.

3.13 To receive reports setting out any changes to the financial reporting framework and gain an understanding of the risk associated with any changes including any implications on the Trust and how these regulatory changes can be met.

3.14 Review delivery progress and obtain assurance that patient access targets are being delivered (through reviewing performance of A&E, RTT, Cancer and Diagnostics).

3.15 To monitor and receive assurance over the wider suite of relevant operational targets including operational productivity and specific non-constitutional standards.

3.16 To receive reports setting out any changes to the NHSE Performance Framework and gain an understanding of the risk associated with any changes including any implications for the Trust and how these regulatory changes can be met.

3.17 To review and receive assurance over the data quality systems and processes that supports the Trust's operational performance management and reporting.

Capital

3.18 To review and approve the Trust's capital programme, including 3Ts builds and to monitor progress and risks associated with the delivery of the operational and strategic capital programmes and to escalate to the Board / other relevant committee any significant risks within its delivery.

3.19 To review the estates strategy and Estates masterplan, recommend to the Board, and to monitor progress against and risks associated with the strategy and monitor other estates-related improvement plans.

Environment

3.20 To review the Environment, Social and Governance activities of the Trust with reference to national requirements and reporting frameworks and the formulated Trust response to those.

3.21 To monitor the implementation of the Trust's Environmental sustainability plans (carbon reduction) and to receive regular progress reports to scrutinise delivery and the meeting of key milestones.

Commercial Activities

3.22 Oversight of commercial activities including Joint Ventures, Business Developments and wholly owned subsidiaries.

3.23 To review the development and delivery of commercial strategies of the Trust, including partnership arrangements with other organisations.

Procurement

3.24 To review the Trust's procurement strategy and policies on a biennial basis and to make recommendations to the Board.

3.25 To review the effectiveness of the Trust's procurement systems and processes.

Business cases and Significant Investments

3.26 To evaluate and scrutinise the financial viability of business cases (for both revenue and capital spend). This includes receiving recommendations from the Business Scrutiny Panel and Trust Management Committee (TMC), approving business cases

and recommending for approval by the Trust Board those in line with Standing Financial Instructions.

3.27 To review the return on investments and benefits realised from major investments made.

Provider Collaboration activity

3.28 Receive and review the collaboration and integration activity for the Trust as part of the developing Integrated Care System, and local Place development.

3.29 Where relevant Receive and review reports from the ICS meetings, Sussex Acute Collaboration Network and Sussex Health and Care Partnership meetings.

3.30 Oversee arrangements for the development of any formal partnership arrangements with other statutory organisations as part of the Trust or ICS agreed strategy.

Emergency Planning and Responsiveness

3.31 To assure and approve the Trust's EPRR arrangements and required operational resilience plans including the Winter Plan.

Risk

3.32 To review regularly the Board Assurance Framework (including through in-depth reviews of specific risks) and the High-Level Operational Risks with a significant potential for impact on the Trust's Finance & Performance objectives.

4.00 REPORTING AND RELATIONSHIPS

4.01 The Committee shall be accountable to the Board of Directors of the Trust.

4.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

4.03 The Committee shall refer to the Audit Committee, Patient and Quality Committee, People and Culture Committee, Research, Innovation and Digital Committee, or Strategy and Major Projects Committee any matters requiring review or decision-making in that forum.

4.04 The Committee shall receive reports from all sub-groups setting out any matters requiring escalation to the Committee.

4.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual report disclosures and will be submitted in the first quarter of the following financial year.

4.06 The Committee Chair or Executive lead shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5.00 CONDUCT OF BUSINESS

5.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

5.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead or Alternate Lead Executive for the Committee. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

5.03 The Committee shall meet not less than 10 times in each financial year and dates will be set by the end of the previous financial year.

5.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

5.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions re to be formally ratified the Committee and/or Board at the next meeting.

5.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting which is taking place without all parties being physically present the Chair shall be responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

5.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual) during a meeting. Members conflicted on any items of business on a committee meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

5.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members. Papers should be provided not less than five calendar days before the meeting and the agenda and papers should be circulated not less five calendar days before the meeting, to provide sufficient time for due consideration.

5.09 Proceedings and decisions made will be formally recorded by the Company Secretary in the form of minutes and distributed to Committee Members within 10 working days of the meeting.

6.00 TERMS OF REFERENCE

6.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

6.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

6.03 Approved by Finance & Performance Committee in January 2026

6.04 Next full review: by March 2027 (recognising that these will be subject to review during the annual review of Committee effectiveness)

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Appendix - Mandated reports considered by the Committee

Below is a list of the regulatory mandated reports the Committee would receive over the year

- Annual Financial Plan, including the Trust's Operational, Capital and Workforce, Efficiency Programme
- Operational Plan
- Financial and Operational Performance Reports
- Capital Programme and Annual Plan
- Environmental Sustainability Annual Report
- Annual EPRR Report
- Commercial and Procurement Activities Report
- Subsidiary (Pharm@sea) information (prior to AGM)

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EMERGENCY PREPAREDNESS, RESILIENCE and RESPONSE ANNUAL REPORT 2025

Julie Ferguson, Head of Head of Emergency Preparedness, Resilience and Response

1. INTRODUCTION

1.1 This report covers the Trust's Emergency Preparedness, Resilience and Response (EPRR) activities from 01 January 2025 to 31 December 2025, providing assurance on compliance with EPRR Core Standards, statutory requirements and the work programme undertaken in 2025.

2 APPROVAL

2.1 The Board **approved** the EPRR annual report 2025.

3 CONTEXT

3.1 During the 2025 there were a number of ongoing challenges for the team that included staffing changes within the team, the ongoing Resident Doctor industrial actions, all whilst ensuring compliance with the Core Standards. The EPRR team is highly aware that these challenges need to be met within an environment of increasing budgetary and workforce pressures across the Trust.

3.2 The EPRR Team continued to work to meet the portfolio demands, ensuring readiness and resilience in response to disruptions or emergencies affecting service delivery.

4. Risk Management

4.1 The EPRR Team hold a number of risks on the Trust risk register, and these are reviewed and updated as per the Trust's Risk Management Policy and Emergency Preparedness, Resilience and Response Policy, or as needed following an incident or changes in national guidance.

4.2 Current Emergency Planning and Business Continuity risks on Datix include:

Risk	Risk Score
Pandemic Influenza or other new and emerging pandemics	16
Multiple or Mass Casualty Incident	16
Incident involving CBRN or Hazardous material	12
Adverse Weather	9
Evacuation	12
Lockdown	12
Business Continuity – service disruption affecting critical services	16

4.3 The Head of EPRR reviews the EPRR Corporate Risk Assessment, submitting reports to the UHSussex Health and Safety Committee of which they are a member.

5.0 EPRR Assurance - Substantially Compliant

5.1 UHSussex received a **substantially compliant rating** in the EPRR Assurance Process. This rating was endorsed and validated by the NHS Sussex ICB EPRR Team, recognising the efforts of the Trust's EPRR team and the collaborative working relationship in place with NHS Sussex.

5.2 The following advisories were identified as part of the substantially compliant rating:

Core Standard	2025 rating	Rationale
Lockdown	Partially Compliant	Plan has expired in June 2025. Plan needs to be updated, and a risk assessment for the manual locking of external doors needs completing.
Decision Logging	Partially Compliant	There are a limited number of loggists with no 24/7 on call availability. Therefore, there is a risk to operational continuity and assurance during out of hours incidents. The Trust is required to recruit and train a minimum of 30 loggists and to establish 24/7 on call availability.
Business Continuity Plans	Partially Compliant	Not all department business continuity plans had been reviewed and updated. All departmental business continuity plans need to be reviewed and updated as per the Trust BCMS, with all plans reviewed/updated by Summer 2026

Core Standard	2025 rating	Rationale
Data Protection and Security Toolkit (DPST)	Partially Compliant	UHSx assessed as “standards not met” in 2024-2025 DPST assessment. NHSE confirmed review of improvement plan. Subject to a satisfactory review, assessment will be changed to “approaching standards”. UHSx IG improvement plan to address outstanding areas to be completed by December 2025
Equipment and Supplies	Partially Compliant	The decontamination tent at PRH has been damaged due to the storage facility environment. Concerns were raised by the CBRN peer review about condition of the tent. Tent to be fixed or replaced. The PRPS storage at PRH needs improving to minimise the risk of further/future damage of decontamination equipment. A new tent has been purchased following Sussex ICB EPRR endorsement for national funding, subject to storage facility being made fit for purpose.

5.3 NHS Sussex EPRR team will develop an action plan to address the advisories. The EPRR annual work programme has been updated to reflect the additional workstreams and co-working with the ICB.

5.4 The Trust was successful with their bid for national funding of £57,573 to replace three decontamination tents, including the tent at PRH. PRH have also confirmed a new storage facility to mitigate the issues with the previous storage facility which was not fit for purpose.

6.0 Policies and Plans

6.1 The EPRR Policy identifies the approach to undertaking EPRR across the Trust. This is reviewed every three years, or sooner due to changes in legislation or within the Trust affecting the policy.

6.2 Task and finish groups have been established to review and further develop the following plans, ensuring required detail and processes are in place and meeting new legislative requirements:

- Lockdown
- Mass Casualty
- Evacuation and Shelter

6.3 The EPRR team represents the Trust on the ICB Policies and Plans Working Group.

7. Business Continuity Management

7.1 Business Continuity (BC) plans continue to be developed across all services/divisions and reviewed as required. BC is embedded within the Trust and work continues to support areas in the developing and achieving a level of maturity in the plans.

7.2 The following documents were reviewed, updated, and approved for UHSussex in 2024 and due for review in Summer 2026:

- Business Continuity Management Policy
- Corporate Level Critical Activities
- Trust Business Continuity Plan

7.3 Work continues to raise awareness within the Trust of BC and following and certain incidents have aided raising staff awareness. The BC Lead works with individual departments to ensure their business continuity service level plans are reviewed and updated as necessary.

7.4 It is noted that some departments, due to continued operational pressures, have further work to do to complete their plans and the EPRR team continues to liaise with these departments to progress the outstanding plan.

7.5 A Business Continuity Audit was undertaken and since January 2025, the EPRR team has delivered a Trust-wide programme to fully redevelop and re-baseline Business Continuity Plans for all clinical and non-clinical services, in line with NHS England Core Standards and ISO 22301 principles.

7.6 Overall RAG Status: Amber — reflecting strong progress and improving assurance across many services, with targeted action required to address dependency risks associated with Estates and IT in order to achieve a Trust-wide Green position.

8.0 Training and Exercising

8.1 The 2025 programme of training and exercising had changes to the approach introduced, with EPRR training moving away from Teams/Classroom based training to the e-learning platform, consisting of three modules. Once the modules are completed, delegates can book to attend a tabletop exercise to reinforce the learning from those modules.

9.0 EPRR Work Programme

9.1 The work programme has been updated to reflect the recommendations from the EPRR Assurance advisories and findings from the Business Continuity Audit.

9.2 Progress against the EPRR work programme is monitored through EPRR team meetings and the EPRR Committee.

10.0 Next Steps for 2026

- Review the work programme for EPRR to ensure it is meeting the needs of the Trust and the NHS England EPRR Framework
- Further develop EPRR training in the digital space considering workforce pressures and time restrictions attending training.
- Work with the Lockdown Planning Group to advance the Lockdown Plan for UHSussex incorporating the requirements from Martyn’s Law.
- Work closely with Fire Safety and Estates and Facilities to finalise the Shelter and Evacuation Plan for UHSussex.

- Collaborate with the Mass Casualty Steering Group to address all advisories from the 2025 EPRR Assurance; finalise the Trust Mass Casualty Plan and action cards/departmental service plans for the 2025 EPRR Assurance process.
- Review and update all EPRR Policies and Emergency Plans as necessary throughout 2026.
- Ensure the completion of all recommendations from the Business Continuity Audit.
- Work with all departments to review and comply with Business Continuity Service Level plans during 2026.
- Increase the public profile of the EPRR Team across the Trust.

11.0 Conclusion

11.1 The EPRR Team have had a challenging year with the Head of EPRR leaving in September 2025 and the new Head taking up the role in January 2026. The team have delivered against the EPRR framework, have supported a number of planned and urgent continuity risks, and continue to have close collaborative working relationships with NHS Sussex and other partners in the Sussex and Surrey footprint.

11.2 The team have faced challenges across 2025 and continue to develop and deliver EPRR across the Trust whilst recognising the challenges other colleagues face across the services.

Julie Ferguson
Head of Emergency Preparedness, Resilience and Response
January 2026

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STRATEGY AND MAJOR PROJECTS ASSURANCE COMMITTEE

TERMS OF REFERENCE

1.00 PURPOSE

1.01 The purpose of the Strategy and Major Projects Assurance Committee is to support the Trust in achieving its strategy.

1.02 The Strategy and Major Projects Assurance Committee will do this through;

- Oversight of the Strategy Delivery Plan;
- Oversight of Major Projects aligned to the key milestones within the Trust's established strategy;
- Oversight of delivery of the strategic commitments within Trust's strategy; and
- Ensuring the Trust learns from, and applies any lessons for improvements to future projects.

2.00 MEMBERSHIP AND ATTENDANCE AT MEETINGS

2.01 The membership of the Committee shall be:

- Chair: a nominated non-executive Director
- A minimum of three further nominated non-executive Directors
- Chief Strategy Officer (Lead Executive for the Committee)
- Chief Financial Officer (Alternate Lead Executive for the Committee)
- Chief Nurse

(noting that the executives' membership is here representing the whole executive team)

2.02 The Trust Chair shall propose which Non-Executive Directors will be most suitable for nomination as Chair and members of the Committee. The Trust Board shall approve the appointment of the Committee Chair and members, based on the Chair's recommendations.

2.03 In the absence of the Committee Chair one of the remaining non-executive members present shall elect themselves to chair the meeting.

2.04 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

2.05 Core Corporate Directors attendees will be those who are presenting reports to the Committee but are not voting members of the Committee. These will include:

- Director of Capital Development

- Director of Facilities and Estates
- Director of Strategic Finance
- Director of Workforce Planning and Deployment
- Director of Strategy
- The respective project SROs

2.06 Any member of the Board of Directors shall have the right to attend any meeting of the Committee by prior agreement with the Chair.

2.07 The executive members of the Committee may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. Those who are in attendance may exceptionally send a deputy to the meeting to present their reports.

2.08 Other Trust managers and clinicians may be invited to attend for particular items on the Agenda that relate to areas of risk or operation for which they are responsible, especially project SROs if specific projects are being discussed.

2.09 Attendees will only ordinarily be asked to attend where they have an item on the agenda, noting that for personal development their attendance at any meeting would be encouraged.

2.10 The Company Secretary or their nominee shall act as Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

3.00 ROLES AND RESPONSIBILITIES

DELEGATED AUTHORITY

3.01 The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee and subject to the rules on reporting, both as defined below.

3.02 The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are required to co-operate with the Committee in the conduct of its enquiries.

3.03 The Committee should challenge and ensure the robustness of information provided.

3.04 The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Company Secretary.

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4.00 RESPONSIBILITIES

Strategy

4.01 The Committee will provide assurance to the Board on the strategy delivery plan achievement though the receipt of a routine oversight report.

Major Project Governance

4.02 The Committee will consider the adequacy and effectiveness of the governance of each major project, to provide assurance to the Board that these will support the projects' successful delivery of its stated outcomes.

4.03 The Committee will consider the adequacy of established project oversight and performance reporting and that the established key performance indicators are aligned to the project outcomes.

4.04 The Committee will seek assurance that for major service redesign consideration has been given to the need for mandated or local consultation.

4.05 The Committee will seek assurance that projects have incorporated any identified learnings from previous major projects benefits realisation reviews.

Major Project Delivery

4.06 The Committee will seek assurance that each project will deliver its stated outcomes, this will be through the receipt of routine information on

- feedback from any public, service users and staff consultation,

- the delivery against the established project key performance indicators across the various related workstreams, covering workforce, operations and finance and organisational / team development especially for service change,

- the reported project risk management actions, and

- any escalated issues from the established management group.

Major Project Benefits realisation

4.07 The Committee will receive post implementation benefits realisation reports for each major project. It will consider the breadth of the review undertaken, the learning identified and the process for cascading this learning for future projects (not just major projects) and any significant learning points are retro applied to current projects.

4.08 The Committee will seek assurance through routine reporting on the delivery of all identified improvement actions.

4.09 The Committee will seek assurance that effective communication has been undertaken to promote the success of the project and any learnings.

ICS and system collaborations

4.10 To receive and review reports from the ICS meetings, Sussex Provider Collaboration on the inter-relationship between their major projects and those within the Trust's Strategy.

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5.00 REPORTING AND RELATIONSHIPS

5.01 The Committee shall be accountable to the Board of Directors of the Trust.

5.02 The Committee shall make recommendations to the Board of Directors concerning any issues that require decision or resolution by the Board.

5.03 The Committee shall refer to the where appropriate any matters requiring review or decision-making to other Board Committees or management groups with appropriate delegated authority to take any management decision.

5.04 The Committee shall receive reports from the Committees sub-groups setting out any matters requiring escalation to the Major Projects Committee.

5.05 On an annual basis the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Annual report disclosures and will be submitted in the first quarter of the following financial year.

5.06 The Committee Chair shall present a report summarising the proceedings of the meeting at the next Trust Board meeting. This should draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

6.00 CONDUCT OF BUSINESS

6.01 The Committee shall conduct its business in accordance with the Standing Orders of the Trust.

6.02 The Committee shall be deemed quorate if there are at least two non-executive Directors and two executive Directors present, one of whom should be the Lead Executive for the Committee, or the Alternate Lead Executive for the Committee. A quorate meeting shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

6.03 The Committee shall meet not less than 4 times in each financial year and dates will be set by the end of the previous financial year.

6.04 The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress.

6.05 In exceptional circumstances where delaying actions or decisions would have a negative impact on the Trust's business, certain items of business requiring an urgent decision, or the taking of the decision itself, may be conducted outside of formal meetings, in line with the requirements set out within the Trust standing orders. This will normally be agreed by the Committee in advance and executed by either: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions are to be formally ratified the Committee and/or Board at the next meeting.

6.06 The Committee business may be transacted through virtual media (using either teleconference or other collaboration and meeting tools). At the start of each meeting

which is taking place without all parties being physically present the Chair shall be responsible for determining that the quoracy arrangements has been achieved and that members can effectively contribute.

6.07 The Committee Chair, with the support of the Company Secretary, is responsible for taking appropriate actions to manage conflicts of interest (perceived and actual) during a meeting. Members conflicted on any items of business on a committee meeting agenda shall declare their conflict and withdraw from discussions and/or the decision-making as required. Conflicted members are not to be counted for quorum.

6.08 The Company Secretary is responsible for preparing the agenda and collating and circulating papers to Committee Members. Papers should be provided not less than five calendar days before the meeting and the agenda and papers should be circulated not less five calendar days before the meeting, to provide sufficient time for due consideration.

7.00 TERMS OF REFERENCE

7.01 The Committee shall review its own performance, constitution and terms of reference at least every two years to ensure it is operating at maximum effectiveness. Any proposed changes to the terms of reference should be agreed by the Trust Board.

7.02 It is the Company Secretary's responsibility to make the necessary updates to the terms of reference.

7.03 Approved by Committee May 2025. Interim review November 2025.

7.04 Next full review: by April 2026, recognising that this will be the first year of operation of this Committee.

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Appendix - Items considered by the Committee

Below is a list of the expected items the Committee would receive over the year

- Strategy Delivery Plan showing significant project portfolio
- Strategy Ambition and major project delivery scorecards
- Project Benefits Realisation Reports