Board of Directors Meeting in Public – 14 May 2026

Questions received.

Question from Members of the Public				
	From	**Question**	**Assigned to:**	**Response:**
1.1	**Ms T Johnson**	The minutes of 5th February say 65-week waits were at their lowest levels, but the national RTT data for the end of January show 349 people waiting over 65 weeks, which is an 86% rise from December 2025. Why was the board not advised of this at the board meeting in February? How has the board been advised of this change since, is the board assured of the reasons for the change and can the board explain what it is going to do now to help the public understand this? If there are still any patients waiting over 65 weeks after midnight tonight (31st March), how many are there, and why has the plan promised to the board at the February board meeting failed?	Chief Operating Officer	The comment that "65-week waits were at their lowest level" was in reference to the latest published position (December). Monthly waiting list data is subject to a validation process to ensure accuracy, and the January position had not been finalised on the date of this meeting. It is true that the number of 65ww breaches increased in January 2026. However, this should be viewed in the context of the trend: there were 1,633 fewer breaches than in January 2025 and 4,085 fewer breaches than January 2024. University Hospitals Sussex has not yet finalised the position for March, which is still being validated. The trust expects to report a position of around 50 65-week waits, compared to a total waiting list size of >113,000. On 01/03 there were 1,074 pathways that would potentially be a 65-week breach if not treated by 31/03. More than 95% will have had their clock stopped as planned. The pathways that were still open on 31 March reflect a variety of issues including patients who were unable to attend their appointment and receive first definitive treatment, despite this capacity being available.
1.2	**Ms T Johnson**	A&E 4 hour and 12-hour performance has deteriorated since March 2025. Whilst improvements in corridor care are to be celebrated, why did the board choose to have this presented by overall numbers and by hospital site, effectively saying the same thing multiple times rather than giving a more balanced view of the overall A&E picture. How has the board been advised of this deterioration, is the board assured of the	Chief Operating Officer	It is recognised that the ED performance has deteriorated since March 2025 although it is now improving because of the significant amounts of focussed work that has been delivered, particularly in relation to maintenance of patient safety. Corridor care is a significant factor in this for us; one which we are intent on eradicating. It is important to clarify that we do not provide corridor care by choice, it is a symptom of a number of factors, the most salient one being the limitations that we have around full use of our bedstock, which causes delayed transfer of patients out of our EDs. Each hospital site has different influences and factors which the individual clinical and site teams contend with. These site-based issues are partly the reason that reports to Board are produced on an individual

		reasons for the deterioration and can the board explain what it is going to do now to help the public understand this in light of the congratulatory tone of the corridor care improvements?		site-basis. In terms of reporting the deterioration to Board, there is a very clear governance route, via the UEC Improvement Board to the Finance and Performance Committee and then to the Trust Board. Performance is reported monthly with responsive plans and mitigations being proposed to improve performance. The overall tone is one of impetus to maintain maximum patient safety despite the challenges that are presented to our Emergency and Assessment areas. The maintenance of patient safety is the key driver to achieving the 4hr and 12hr Clinical Safety Standards although the ongoing objective to provide maximum safety for all patients even when we aren't achieving the standards is also a key objective.
1.3	**Ms T Johnson**	Now that the trust is in segment 5, is there a level of missed commitments on operational performance that the board considers acceptable, and how will it be held to account when those commitments are not met?	Chief Operating Officer	The Board does not consider any of the missed commitments to be acceptable and maintains close scrutiny and expectation of both the clinical and the operational teams to improve performance. Both the executive and operational teams will continue to liaise with the national NPIP team to agree a plan which assists us improving our performance and sustaining it.
2.1	**Mr Strand**	Helipad at Brighton - What are the detailed fire safety procedures and actions for the arrival and departure of a helicopter on the hospital roof.	Company Secretary	We would not publicise such documents but we can confirm that these have been considered by all relevant parties, including the West Sussex Fire and Rescue Service and the Kent, Surrey and Sussex Air Ambulance all prior to the opening of the Helipad.
2.2	**Mr Strand**	PFI - Please will the Board provide a full and detailed list about where PFI has been applied both within the hospital group and any other associated premises or financial transaction.	Company Secretary	The only element of PFI within the Trust is the Royal Alexandra Children's Hospital and we do provide some information about this within our Annual Accounts.
2.3	**Mr Strand**	BAF The Risk Register does not show any references to any computer threat against "hacking" etc. risk to the organisation so will the board please provide: a) Details of any location where the computers of any department or speciality are not compatible with each other and where records and information about patients are unable to be accessed.	Company Secretary	The BAF does have a strategic risk in relation to Digital, this folds into it the risk of cyber security. We complete the national Data Protection and Security Toolkit assessment each year and this national assessment requires the Trust to consider its cyber security arrangements. We are currently undertaking this assessment, but we can confirm that the prior assessment was assessed by NHS Digital as "standards met". We do provide some summary information about this within our annual report within the annual governance statement. In respect of your detailed questions we do not release this information into the public domain given as you note there is an increasing risk of cyber attack and

		b) Details of if there are any computers or IT equipment which are not currently provided with or do not not have current or appropriate anti-virus software updates.		supported by the information commissioner, they agree the public interest of releasing this information is not outweighed by the public interest in protecting the NHS
2.4	**Mr Strand**	Give an update on the West Sussex Fire and Rescue Service Enforcement Notice for Chichester due for review in February 2026.	Company Secretary	We are pleased to be able to say that West Sussex Fire and Rescue Service have provided confirmation that the Trust has undertaken the action required of the notice. They recognise that some of the matters raised involve longer term building work and they are content with our plans and the timeline for this work to be completed as they recognise the constraints on the Trust's annual capital programme
2.5	**Mr Strand**	Provide an up to date Register of Interests Schedule for Board Members and within future Board papers.	Company Secretary	We provide a link to this register within our Annual Report and seek confirmation at each meeting of any changes and record if there are any declared interests along with how the Chair agrees to deal with any declared interest, which may see the person being asked to leave the meeting for that item, as you will see within our minutes we have not had to enact this in the past year.
3.1	**Mr Gooderham**	What progress has been made on the provision of DEXA scanning for osteoporosis at Royal Sussex County Hospital and at Princess Royal Hospital, following discussions between the Royal Osteoporosis Society and the clinical lead for rheumatology at the Trust earlier this year when proposals by the Royal Osteoporosis Society were welcomed by the Trust?"	Chief Medical Officer	University Hospitals Sussex is not commissioned to provide DEXA scanning. The Trust can access DEXA through community providers that Sussex ICB has commissioned: RSCH: Patients are referred to the DEXA scanning service provided by Sussex Medical Chambers in Brighton. The current arrangement is that patients have to be referred back to their GP, and then referred by GP to the DEXA service. This is viewed by the ICB as an unnecessary anomaly arising from legacy contractual arrangements, and work is almost concluded to enable direct referral from the Trust to the DEXA service. PRH: Patients from PRH can access DEXA services from three locations: Crawley Hospital, or Queen Victoria Hospital CDC in East Grinstead, and the SMC service in Brighton that also serves RSCH patients (as with RSCH patients, currently patients from PRH are referred back to their GP and then on to the DEXA service; this will shortly be changed to enable direct referrals from the hospital to the DEXA service). All partners within the Sussex health system (providers and ICB) are currently working together to redesign the osteoporosis pathway. This will help us to standardise access and quality of service (including access to DEXA) for patients

				across the whole county. We welcome the support that the Royal Osteoporosis Society is providing in this endeavour.
3.2	**Mr Gooderham**	Given the national shortage of interventional neuro-radiologists, does the Trust have any plans to extend the times of services for Stroke Thrombectomy at the Royal Sussex County Hospital, or to introduce AI or robot-assisted surgery to this service?"	Chief Medical Officer	We have a local Mechanical Thrombectomy service based at the Royal Sussex County Hospital and which provides a service to patients from Eastbourne, Brighton and Worthing. As of January 2025 we implemented an arrangement which secured access to Mechanical Thrombectomy 24/7 for all patients through agreements with other thrombectomy centres in London and Southampton. As of September 2025, we extended the hours of our local service to 7 days, 12h a day and have since treated more patients locally. Our mechanical thrombectomy rate is similar to the national average at 4.7%. We use Brainomix AI technology to support consultants to interpret CT scans and identify patients who may be eligible for thrombectomy. We don't use AI or robots for thrombectomy and there is no current plan to do so. I am not aware that any centre is using robots for this procedure to date. We have a team of 4 consultant interventional neuroradiologists who provide our local service. We have a plan to recruit to 2 more consultant posts and we are expecting to be able to do so from doctors currently in training. Our current team is committed to provide a 24/7 service when we are able to do so – this is not the most significant constraint to service development locally. We are actively pursuing a plan to extend the hours of our local service to 24/7. We have drafted a business case to support this and are awaiting a decision from NHS England on a plan to fund this service development. This plan will need additional staff from across the multi-disciplinary team needed for the thrombectomy service and which includes theatre nurses, theatre ODPs, anaesthetists, recovery nurses, neuro-angio nurses, radiographers, stroke consultants, stroke nurses aswell as interventional neuroradiologists. Some of these staff groups have more significant recruitment challenges but we expect to be able to recruit to these posts too.
3.3	**Mr Gooderham**	What changes in the provision of dermatology services by University Hospitals Sussex NHSFT	Chief Medical Officer	The Trust is aware of the long-term vision around BGH however, these plans are still at an early stage. The trust leases space at BGH and will be given notice when

		at Brighton General Hospital are envisaged in the light of redevelopment of the site?" I'm aware that SCFT are also involved, but I am concerned about this Trust's work.		any development progresses. There are no changes planned at this time in relation to the provision of dermatology services at BGH. As and when the landlord provides notice under the lease for the Trust to vacant, the Trust will engage with service users around alternative location for provision of the service.
3.4	**Mr Gooderham**	Is the Board satisfied with the adequacy of Diabetic Retinopathy Screening services at Horsham Hospital delivered by DESP Brighton and Sussex, part of University Hospitals NHSFT, in view of persistent delays to appointments being experienced at Horsham Hospital in recent months?	Chief Medical Officer	Thank you for your question on this service. We are pleased to be able to confirm that there are no persistent delays to appointments. Like all our services our teams keep a close eye on performance and for the year 25/26 our performance was 98.7% of patients being seen within there expected recall time. There has been a national change to the length of time between recalls moving from one year to two and it is possible this may have been perceived as a delay, however, we do seek to make this recall timeframe clear in our patient information. In terms of the Board oversight should there be an issue with performance then this would be reported through our Finance and Performance Committee who would then track the delivery of the improvement plan but as noted by the performance of over 98% for the last year this has not been needed.
4	**Sands & Tommy's Policy Unit**	How confident are we that the board has full visibility of maternity and neonatal safety and outcomes data? What further information or assurance do we need to strengthen oversight and improve outcomes? Does this guide meet your needs, or should it include anything else that would be helpful? How does the board assure itself that actions and recommendations arising from maternity and neonatal reviews are tracked, implemented and effective?	Chair	Each month, the Perinatal Quality Oversight Model (PQOM) is presented at Quality Governance Steering Group and at each Patient and Quality Committee and Trust Board in Public. The Director of Midwifery and Chief of Service attend these meetings and present the reports. The PQOM report includes each of the required elements: • Listening to women and families (includes complaints and complements, Friends and family test responses, Maternity and neonatal Voices Partnership (MNVP) feedback) • Workforce (includes workforce availability and vacancy data, training compliance, staff surveys and feedback) • Culture of learning, safety and support (thematic reviews, Culture surveys and culture improvement work, CQC position, CNST Maternity Incentive Scheme position, Maternity and Neonatal Improvement Support Team progress, Regulation 28 reports, benchmarked perinatal and maternal mortality and morbidity outcomes, this included data stratified into Health Inequality groups. Much of the data is presented in Statistical

				Process Control or Rare Event charts to allow for early recognition of concerning changes in outcomes) In addition, the Trust Board receives: • Saving Babies Lives quarterly report and action plans • Avoiding Term Admissions Into Neonatal units (ATAIN) and Transitional Care quarterly reports and action plans • Perinatal Workforce bi-annual report • PSIRF quarterly report which include investigation reports from all PSIIs and MNSI cases • Maternity Claims scorecard which includes triangulation of all complaints, incidents and claims in each quarter, and action plans • Perinatal Mortality Review Tool quarterly report • Annual report of all cases graded C & D under the PMRT process and action plans The Board Maternity and Neonatal Safety Champions (executive and non-executive) attend monthly Safely Champion meetings where site specific PQOM data is presented and discussed. The Board Safety Champions also complete frequent visits to service areas to deeply engage with staff and service users, earing direct feedback on experience. The Board Maternity and Neonatal Safety Champions (executive and non-executive) as well as ICB and regional leads, the CQC, MNVP attend a bi-monthly Maternity and Neonatal Improvement Group (MNIG) to monitor progress of the Maternity and Neonatal Improvement Plan (MNIP) – progress is reported to Board monthly within the PQOM. External scrutiny of actions and assurance evidence that closed actions remain embedded has been recently undertaken. External inspections of each site by CQC, Regional Insights visits, and the National Maternity and Neonatal Investigation (Baroness Amos) have been completed over the last 12 months. Actions from recommendations received are monitored and progress under the MNIP/ MNIG process. The maternity service has a comprehensive Governance Framework which describes the process of tracking, monitoring and escalating actions.

				In summary, the service meets the recommendations of the Sands and Tommy's report, however, are keen to remain open to suggestions for further improvement.
5.	**Mr Graham**	I'm aware that several groups & organisations, including Brighton & Hove City Council, have a keen public & City Planning interest in the Brighton General Hospital Site. I understand that the Sussex Community NHS Foundation Trust has an overriding need to provide and ensure finance for a modern Health & Care Facility within the site. I understand that the Community Trust Board are currently discussing options for the development of the overall site. A few years ago, I was present at a UHSussex Board discussion of staff Recruitment & Retention. I believe that one key problem referred to was the high cost of renting in the Brighton area, both for potential & for existing staff... **1. Does the UHSussex Board still see local rental prices as a significant issue for staff Recruitment & Retention?** **2) If that applies, has the Board been in dialogue with the Community Trust &/or BHCC about this NHS interest in common? Will the Board press the case for NHS key worker housing to be an important element of provision from the 200 units that BHCC's Development Plan envisages?**	Interim Chief People Officer	UHSussex recognises that housing affordability and the cost of living in Brighton and the surrounding area can be a challenge for some staff groups. At present, we have a healthy supply pipeline for nursing roles, supported by the strength of the UHSussex brand and the wider recruitment context, including the fact that some neighbouring trusts are not currently recruiting as actively. However, while we do not see local rental costs as affecting recruitment across all roles, there are specific areas where this can be a significant challenge. This is particularly the case for roles that are in high demand or harder to recruit to, such as sonographers, security officers and drivers based in Brighton. These roles can be affected by the combination of Brighton's high cost of living and competition from nearby trusts that may offer London fringe payments. On the question of discussions with Sussex Community NHS Foundation Trust and Brighton & Hove City Council, we recognise that the Brighton General Hospital site is of significant public interest and that there may be shared NHS workforce considerations linked to any future development. In that context, UHSussex would be supportive of constructive dialogue regarding site development considerations, where there is a common interest in supporting the recruitment and retention of NHS staff.