University Hospitals Sussex NHS Foundation Trust

Meeting of the Board of Directors

10:00 to 13:30 on Thursday 14 May 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: Rox Smith, Katie Urch Philip Hogan and Mike Driver*	*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 31 March 2026**	*To approve*	Enclosure	Presenter: Philippa Slinger
Item:4	10:05	**Matters Arising from the Minutes**	*To note*	Enclosure	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	10:20	**Report from Chief Executive**	*To receive and note overview of the Trust's activities*	Enclosure	Presenter: Dr. Andy Heeps
Item:7	10:35	**One UHSussex / Integrated Improvement Plan**	*To note*	Enclosure	Presenter: Dr.Andy Heeps / Helen Brown
		REPORTS FROM COMMITTEES			
Item:8	10:55	**Report from Audit Committee from the meeting held on the 28 April 2026**	*To note assurance from Committee and action recommendations*	Enclosure	Presenter: Glen Palethorpe

			from the Committee		on behalf of Mike Driver
Item:9	11:00	**Report from the Research Innovation & Digital Strategy Assurance Committee from the meeting held on the 6 May 2026**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Prof. Jackie Cassell
Item:10	11:10	**Report from Strategy & Major Projects Assurance Committee from the meetings held on the 7 May 2026** ***(including the recommendation of the Green Plan for approval)***	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Prof. Paul Layzell
	11:20	***5 Minute Break***			
Item:11	11:25	**Report from Patient & Quality Assurance Committee from the meetings held on the 5 May 2026**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Lucy Bloem
Item:12	11:35	**Report from People & Culture Assurance Committee from the meetings held on the 5 May 2026** ***(including the recommended Workforce Equality Standards Report for submission to NHSE)***	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Prof. Paul Layzell
Item:13	11:45	**Report from Finance & Performance Assurance Committee from the meetings held on the 7 May 2026**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Lucy Bloem *(on behalf of Philip Hogan)*
		PERFORMANCE AND RISK			
Item:14	11:55	**Maternity Assurance Report**	*To receive papers and triangulate with P&Q Committee chair's report*	Enclosure	Presenter: Emma Chambers
Item:15	12:05	**Integrated Performance Report**	*To triangulate with Committee reports and agree actions*	Enclosure	Presenter: Dr. Andy Heeps
Item:16	12:30	**Board Assurance Framework**	*To approve*	Enclosure	Presenter: Helen Brown / Glen Palethorpe
		WIDER COMPLIANCE			
Item:17	12:40	**Company Secretary Report** For information only	*For information only*	Enclosure	Presenter: Glen Palethorpe

OTHER

Item:18	12:50	**Any Other Business** To receive any notified urgent business and action	*To receive any notified urgent business and action*	Verbal	Presenter: Philippa Slinger
Item:19	13:00	**Date and time of next meeting:** The next meeting in public of the Board of Directors is scheduled to take place at **10.00 on Thursday 11 June 2026.**		Verbal	Presenter: Philippa Slinger

Supporting Appendices:

Item: 8	Audit Committee	Declaration of Interest for Board	*To receive and note*	Enclosure
Item:10	Strategy & Major Projects	Green Plan 2026-2030	*To receive and approve*	Enclosure
Item:11	Patient & Quality	Mortality and Learning from Deaths Q4	*To receive and note*	Enclosure
Item:12	People & Culture	Guardian of Safeworking Annual Report Workforce Equality Standards Report (WRES and WDES Gender Pay Gap)	*To receive and note and approve the Workforce Equality Standards Report for submission to NHSE*	Enclosures
Item:14	Maternity	Perinatal Quality Oversight Model Report & Dashboard Perinatal Workforce	*To receive and note*	Enclosures

Minutes

University Hospitals Sussex NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public at 10.00am on Tuesday 31 March 2026, held in the Washington Suite Boardroom, Worthing Hospital, Lyndhurst Road, Worthing and via Microsoft Teams Live Broadcast.

Present:

Philippa Slinger	Chair
Bindesh Shah	Non-Executive Director
Professor Gordon Ferns	Non-Executive Director
Professor Jackie Cassell	Non-Executive Director
Lucy Bloem	Non-Executive Director
Mike Driver CB	Non-Executive Director
Professor Paul Layzell CBE	Non-Executive Director
Philip Hogan	Non-Executive Director
Dr Andy Heeps	Interim Chief Executive
Professor Catherine (Katie) Urch	Chief Medical Officer
Helen Brown	Interim Chief Corporate Affairs Officer
Maggie Davies	Chief Nurse
Nigel Kee	Chief Operating Officer
Roxanne Smith	Chief Strategy Officer
Sarah-Jane Taylor	Chief People Officer

In Attendance:

Karen Seabridge	Director of Strategic Finance
Jonathan Keeble	Director of Communications (joined for item 8 only)
Tori Cooper	Hospital Director for Worthing (joined for item 8 only)
Martyn Clarke	Director of Integrated Education (joined for item 8 only)
Michelle Offen	Head of Occupational Therapy (Trustwide)
Sebastian Adamson	Clinical Director for Obstetrics (joined for item 14 only)
Frances Barnes	Head of Midwifery RSCH (joined for item 14 only)
Glen Palethorpe	Company Secretary
Tamsin James	Board and Committees Manager
Rachel Robertson	Board and Committees Manager (meeting support)

TB/03/26/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chair welcomed all those present to the meeting including Michelle Offen who had been matched with the Chair as part of the Trust's mentoring programme.

1.2 The Chair noted apologies for absence were received from Jonathan Reid and that Karen Seabridge as Director of Strategic Finance was in attendance in Jonathan's absence.

TB/03/26/2 DECLARATIONS OF INTERESTS

2.1 There were no interests declared.

TB/03/26/3 MINUTES OF THE MEETING HELD ON 05 FEBRUARY 2026

3.1 The Board received the minutes of the meeting held on 05 February 2026.

3.2 The Board **APPROVED** the minutes of the meeting held on 05 February 2026.

TB/03/26/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

4.1 There were no matters raised for discussion.

TB/03/26/5 QUESTIONS FROM THE PUBLIC

5.1 The Chair acknowledged there had been a number of questions raised, however two individuals submitted questions outside of the stated deadline therefore those would be taken and responded to at our next meeting on 14 May 2026.

5.2 The Chair acknowledged the questions raised by Mr Gooderham and Mr Cooper which were shared in the meeting and the corresponding responses provided in the meeting can be seen here on the UHSussex Trust website: https://www.uhsussex.nhs.uk/about/board/board-meetings/

TB/03/26/6 PATIENT STORY

6.1 Maggie Davies explained that the patient story put the patient voice at the front and centre of the Board meeting and went on to share the feedback from experiences of three patients, in their own words, when they required urgent stroke and mechanical thrombectomy services. Maggie advised that mechanical thrombectomy was a highly effective, minimally invasive procedure used to remove large blood clots from brain arteries during an acute stroke, to restore blood flow and improve outcomes.

6.2 Maggie outlined the Trust strategic commitment to the stroke reconfiguration project as it would deliver two enhanced stroke centres, by expanding the Acute Stroke Centre at St Richard's Hospital in Chichester (SRH) and increase capacity at the Comprehensive Stroke Centre at Royal Sussex County Hospital (RSCH). In response to the consultation, the two expanded stroke centres would ensure patient access in Sussex was within short distance of a nationally compliant stroke centre which could improve outcomes for patients by providing access to specialist stroke services 24 hours a day, seven days a week.

6.3 Maggie added that there was increased focus on understanding the Trust's current role in stroke care and rehabilitation, desired future outcomes, and the balance between inpatient rehabilitation, community provision, and the role of community and voluntary sector partners. Katie Urch added that the Trust provided the initial phase of intensive stroke rehabilitation within inpatient units at the Trust's hospitals in Haywards Heath and Chichester. She noted that onward community residential rehabilitation and adapted housing within community services fell under the care of Sussex Community Foundation Trust (SCFT). A recent refresh and review of therapy services aimed to create more seamless, integrated pathways, with therapists following patients into the community and providing in-reach services to support confidence and safety at home. The Board further discussed the enhanced supportive discharge, emphasising the principle of getting people home as quickly as possible with appropriate support in place in order to reduce hospital length of stay.

6.4 The Chair noted this was timely, given the presence at the meeting today of Michelle Offen as the Head of Occupational Therapy, and invited Michelle to comment on the discussion just held. Michelle acknowledged that improvements were required to the current community care programme and highlighted the integrated working with SPCCF required further review to clarify service boundaries.

6.5 The Board also noted progress with the Brainomix digital imaging platform, enabling rapid specialist decision-making and direct access to 24/7 stroke expertise which enabled early testing of out-of-hospital assessment by ambulance crews which was improving access to specialist care and supporting a more streamlined stroke pathway.

6.6 The Chair thanked Maggie and outlined that the Board would be reviewing the stroke business case in private Board due to its commercial nature, later in the day.

TB/03/26/7 CHIEF EXECUTIVE REPORT

7.1 Dr Andy Heeps introduced the report and provided wider context to the Board's discussions by highlighting recent national and regional developments that were relevant to the Trust's plans and performance, and firstly paid tribute to the Trust's workforce after what had been an operationally difficult winter.

7.2 The Board was informed that in early March NHSE formally confirmed that University Hospitals Sussex would join the National Provider Improvement Programme (NPIP), reflecting the Trust's current position within Segment 4 of the National Oversight Framework. Andy Heeps shared an update on discussions with Mark Brassington, Director of NHSE Operational Improvement, and Anne Eden, NHSE Regional Director for the Southeast which had focussed on the Trust's improvement approach to the NPIP, and how the programme would align with existing improvement activity, and it was recognised by NHSE that the Trust was focused on the appropriate priorities, which are aligned to improving outcomes for patients and workforce.

7.3 Andy explained that maternity services at Worthing Hospital had been rated Good by the Care Quality Commission, thus recognising the significant improvement undertaken, it was shared that CQC inspectors had praised the maternity teams for delivering safe, compassionate care, involving families in decision-making, and fostering a more positive culture, leading to an upgrade to Good in the Well-led domain. Andy then reflected on the National Maternity and Neonatal Investigation whereby the Trust was expecting a trust specific report in June 2026 but that a later report would national findings by Baroness Amos.

7.4 Andy reflected on sustained capacity pressures and high demand for acute services, consistent with pressures across the NHS. It was noted that NHSE had introduced a national definition of corridor care, with performance now being reported through the Integrated Performance Report. Andy confirmed the Trust's commitment to eliminating corridor care during 2026/27 through continued flow and capacity improvements.

7.5 Andy highlighted that the helipad at the Royal Sussex County Hospital became operational at the beginning of March 2026, enabling air ambulances to land on site and significantly reduce transfer times for those patients. The successful go-live followed complex and sustained work by multidisciplinary teams across the Trust, and particular recognition was given to estates, capital, strategy and major trauma teams, as well as partners and charities.

7.6 It was highlighted that the Trust had secured £1.3 million from the National Institute of Health and Care Research to strengthen and expand clinical research across Sussex, which would support the delivery of enhanced research facilities for emergency and specialist services across the Trust.

7.7 Andy shared that Chief People Officer, David Grantham, had now departed the Trust for a new national role and thanked David for shaping the Trust-wide

people and education functions; and confirmed that Sarah-Jane Taylor had joined as interim Chief People Officer.

7.8 Andy referred to the Local Government Review and the Trust's response to the consultation, noting the consultation proposed moving to a four-unitary authority model across Sussex, including a division of West Sussex and an expanded Brighton & Hove authority. Andy outlined the ongoing work with Sussex system colleagues, including Chief Executives, to consider the implications of the proposals, particularly for Adult and Social Care across the system.

7.9 Andy explained that the industrial action by resident doctors was expected to begin in early April and last for six days, and that operational plans were underway to support colleagues during this challenged time to ensure patient safety. Andy explained that continued consultant support and by some resident doctors had enabled the Trust to maintain significant elective and operational activity during this time.

7.10 Gordon Ferns sought clarification on the Trust's NPIP segmentation and the nature of national support. Andy Heeps confirmed that the Trust had been advised it was in Segment 4, and that any references to Segment 5 appeared media-led. Support would focus on specialist expertise and t there is no financial benefit flowing to the Trust by being in this programme. Andy said that he would, keep the Board updated as national arrangements became clearer.

7.11 Paul Layzell sought assurance that UHSussex had sufficient resource to strengthen external relationships given the focus on expanding networks. Andy explained that associations with local authorities had improved significantly, alongside increased focus on system partnerships bolstered by the NHS Sussex and Surrey transition and future local government and integrated neighbourhood team arrangements. Andy also acknowledged the solid parliamentary and local authority relationships built by the Trust's communications leadership who continued to support and advocate for the opportunity for the Trust to place an active role in system work.

7.12 Philip Hogan, building on Mr Cooper's earlier questions referencing IPR reporting, emphasised that the focus should be on performance, culture and leadership and working with partners on improvements to advance elective care performance through step changes in RTT performance, UEC pathway improvements, and diagnostic pathways as key performance priorities for 2026/27.

7.13 Lucy queried the escalating pressures including the newly introduced corridor care 45-minute standard in ED and the need for more timely flow through to the most appropriate care environment, particularly in relation to increases in mental health demand. Andy updated on discussions with the SPFT regarding crisis resolution plans and confirmed that a multi-agency summit was planned to agree short term mitigations and identify longer-term, sustainable solutions.

7.14 Jackie Cassell emphasised the importance of reducing those patients with long length of stays across UHSussex hospitals whilst acknowledging there is work to do in respect of cultural challenges with families around discharge expectations. Andy confirmed substantial work was underway on a discharge information service, led by hospital directors, with early evidence suggesting that setting expectations at admission was more effective. Maggie reported progress on acute information boards and earlier discharge planning with patients and families. She stressed the importance of fundamental standards of care being delivered and monitored, improved communication, and

supporting families to prepare earlier for the patient discharge, particularly for vulnerable patient groups.

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

TB/03/26/8 VALUES AND BEHAVIOURS FRAMEWORK

8.1 The Board welcomed Victoria Cooper, Martyn Clarke and Jonahtan Keeble to the meeting to support the presentation of the Vaues and Behaviours framework.

8.2 Rox Smith introduced the item and outlined the Trust's approach to cultural improvement focusing on workforce, patients and organisational culture. It was emphasised that the Trust had committed colleagues and that the programme was central to creating the conditions for them to be effective and for patients to receive the best possible care. The programme aimed to support performance through positive behaviours.,

8.3 Victoria Cooper drew attention to the presentation and the first slide described the extensive work being undertaken to inform the framework, which included focus on what mattered most to colleagues from organisational strengths and weaknesses, to what colleagues wanted to see change, of which had followed on from the "big conversation" which supported the shaping of the strategy and drew on multiple sources of feedback.

8.4 Slide 2 set out the Trust's cultural ambition whereby Victoria explained that the organisation aspired to move forward to focus on how challenges were addressed and culture was described as a continuous journey, and the framework aimed to support a clear, dynamic culture striving for excellence.

8.5 Martyn Clarke then talked through slide 3 and highlighted that the Values and Behaviours framework acted as a behavioural compass, setting clear expectations for all roles and how psychologically safe behaviours manifested in practice. Values were described as driving behaviours, shaping culture and enabling performance, inclusion and accountability.

8.6 Martyn referred to slide 4 and described the ambition to "raise the ceiling and fix the floor" and explained that raising the ceiling focused on excellence, aspiration and aligning leadership capability, management practice and corporate systems to high standards. Fixing the floor focused on operational integrity and empowering teams to diagnose and resolve friction points.

8.7 Slide 5 highlighted what mattered most to the organisation focusing on patients, colleagues, partners and external stakeholders. The values were described as essential to delivering high-quality care, regardless of seniority or role.

8.8 Victoria shared slide 6 which provided detail that the behavioural compass was the central tool within the programme which would be embedded into recruitment and induction for those joining the organisation, and integrated into appraisals, recognition and reward, and STAR events. It would also be used within the senior leadership team under the new Trust Operating Model structure and applied consistently to Non-Executive Director and Executive appointments.

8.9 Slides 7 and 8 focused on leadership responsibilities, which outlined the leadership modelling of expected behaviours, guiding others and strengthening trust and accountability. At Board level, the framework was positioned as integral to governance, system leadership and partnership working across Sussex.

8.10 Martyn went on to describe the managers toolkit (slides 9 to 10) as a practical development resource to help leaders notice behaviours aligned or misaligned with the compass and address issues early, fairly and constructively. Martyn drew attention to the “experimenteers” initiative as a learning approach based on try, learn, share methodology focusing on peer-to-peer learning and empowerment of the workforce to support learning and confidence-building aligned to the compass.

8.11 Jonathan Keeble outlined a phased communications plan covering preparation, launch and ongoing evaluation, with materials designed to be accessible, engaging and aligned with the behavioural compass, with the overall approach emphasising transparency and leadership role-modelling.

8.12 Rox outlined an evolving approach to measurement, including awareness, recognition, usage and belief, alongside the development of longer-term outcome and performance metrics. It was acknowledged that cultural measures were complex and that work was underway with external experts and peers, including University Hospitals Birmingham, to develop appropriate baselines and scorecards.

8.13 Philip Hogan welcomed the clarity and coherence of the programme and noted that it was ambitious and well-constructed, with a genuine intention to improve organisational performance. He highlighted the inherent challenge for the Board in assuring itself that the programme would have a tangible and positive impact on staff experience, patient care and performance outcomes. He sought clarity on how and when the Board would begin to see evidence of impact and progress. Rox acknowledged that cultural change would not deliver instant results and that the Board would need to have balanced but disciplined oversight, using both early indicators and longer-term outcome measures.

8.14 Paul Layzell thanked the team for the evident effort and depth of thinking behind the programme and raised two specific challenges. Paul stressed that leaders had to be seen actively supporting and living the framework, particularly through the “experimenteers” advocates. He also questioned that some of the language, concepts and tools felt a little abstract or alienating to busy frontline teams and asked how accessibility, simplicity and relevance were being actively tested.

8.15 Maggie Davies reinforced the importance of linking culture to patient outcomes and patient experience, alongside workforce measures. She highlighted opportunities to draw more explicitly on staff survey data and patient experience metrics, including complaints and FTT feedback. Maggie welcomed the alignment with nursing and midwifery priorities and emphasised the need for plain, inclusive language that could galvanise frontline teams. Mike Driver also echoed the importance of measurement, acknowledging the difficulty of directly linking culture to performance outcomes while stressing the need to map behaviours and culture to operational challenges wherever possible.

8.16 The Chair raised a specific question about how the framework would apply to staff groups such as healthcare assistants, porters and the catering services workforce, and how relevant the framework would feel to those roles and how impact would be measured meaningfully at that level.

8.17 Rox responded to all the comments received that establishing baselines for culture was inherently challenging and that the Trust was approaching this in stages, starting with awareness and recognition measures before progressing to usage, understanding and composite indicators, and that work was underway with external experts and peer organisations to support this. Rox

emphasised that the framework was deliberately designed to be applicable across the entire Trust workforce, with clear expectations for everyone, regardless of role, aimed at improving confidence and enabling people to challenge behaviours constructively.

8.18 Bindesh Shah reflected on the importance of culture during organisational change, noting how behaviours could deteriorate under pressure. Rox responded that the framework was intentionally designed for challenges, enabling colleagues and leaders to pause, reflect and return to expected behaviours more quickly, supporting faster and more sustainable results.

8.19 Andy noted that there was no perfect composite metric for culture and agreed that the organisation would need to rely initially on process and leading indicators while longer-term outcomes emerged. He welcomed the Trust's willingness to subject the programme itself to learning and improvement, consistent with its stated values. Andy shared that early informal feedback suggested the framework was meeting an unmet need, helping colleagues to reset difficult conversations, especially during service change and periods of stress.

8.20 Lucy highlighted the challenge of delivering this programme whilst launching and embedding the new Trust Operating Model structure; it was asked how the framework would be embedded early within the newly formed teams. Rox confirmed that recruitment into senior roles was already aligned to the framework, with leadership expectations made explicit during selection, and that assessments were being introduced to support personal development plans aligned to the compass.

8.21 The Chair welcomed the approach being taken and stressed that the Board must hold itself to account, and to model the values consistently in its own interactions. It was asked that the framework with progress and measurement should be reviewed regularly by the People & Culture Assurance Committee and progress reported back to the Public Board within four months.

ACTION: Rox Smith / People & Culture Assurance Committee

8.22 The Board **NOTED** the update.

[The Board held a short break at this time, and Victoria Cooper, Martyn Clarke and Jonathan Keeble left the meeting at this point. Upon return the Board remained quorate.]

TB/03/26/9 MULTI-YEAR FINANCIAL PLANNING 2026/27 – 2028/29

9.1 Karen Seabridge presented the plan and explained that the Trust's Medium-Term Plan was submitted to NHSE in March 2026 in line with new NHSE guidance having moved from annual to three-year planning, and that it supported delivery of the NHS 10-Year Health Plan and aligned with the Trust's strategy, Excellent Care Everywhere.

9.2 Karen drew the Board's attention to the number of times the Board had seen versions of the plan in sub committee or informal workshop sessions and had been involved in its development. Karen then drew out the key priorities within the plan which included recovery and performance improvement, , reducing long waits, strengthening urgent and emergency care, improving flow and reducing length of stay through system partnership working. Karen explained that the financial plan delivered a capital programme of c.£150m in Year 1, including enabling works for stroke services, theatre capacity and digital investment.

9.3 Karen highlighted the income and cash management arrangements, whereby weekly monitoring meetings were place, with a strong focus on cash and supplier engagement.

9.4 Key risks and mitigations were shared by Karen which also included the scale of change and delivery of efficiencies, along with the mitigating actions of strengthened Board oversight, additional senior finance support, active system demand management schemes, and provider alliance working.

9.5 Philip Hogan as Chair of the Finance & Performance Assurance Committee concurred with the strong summary of the principles underpinning the plan, and added that the Board had agreed to support the strengthening of management grip and control from Month 12, establishing this as a baseline with a more rigorous approval and assurance approach being applied to requests for growth, particularly to understand associated quality and operational risks, given that a compliant performance plan was to be submitted, with the exception of RTT performance.

9.6 The Chair reflected that the plan represented the culmination of significant work undertaken to refine proposals and meet the requirement to achieve breakeven over the three years, and that multiple iterations had been reviewed through the Finance & Performance Committee and the Board, with risks examined in detail. Andy Heeps agreed, stating that the framing accurately reflected the direction of travel, with ongoing discussions to help de-risk delivery.

9.7 Bindesh Shah asked how the plan accounted for the significant impact of the wider energy cost pressures nationally and globally. Andy Heeps reflected on previous years, inflation and energy volatility had a material impact and that whilst future costs could not be fully predicted, the risks were recognised and actively discussed within the planning process. Andy further highlighted mitigating actions aligned to the Trust's strategy included the Worthing heat network and wider green agenda to de-risk energy exposure, alongside progress in decarbonisation such as the transition to a largely electric vehicle fleet.

9.8 Mike Driver stated that he was keen to understand the assessment of the financial capability of budget holders and whether they required additional support from Finance, including more tailored training. Karen Seabridge confirmed that work on budgetary support was underway with more detailed operational planning to follow. Karen added that the Divisional Leadership Teams would approve budgets in the coming weeks, followed by the roll out of budget-holder training and induction support targeted at all senior workforce levels.

9.9 Andy Heeps questioned the finance accreditation process, as Jonathan Reid had previously expressed an ambition to progress this further. Karen confirmed that Year 1 accreditation had been achieved; however there was now the focus this year to embed financial learning into Year 2, and that this aligned with leadership and management development sessions, six-month career progression follow-ups, identification of development areas, and support from the Leadership Academy in building a structured framework for accountants and encouraging further training.

9.10 Paul Layzell reflected on the efficiency programme, and its associated risks, and queried whether a review of the programme's overall ambition would be beneficial at the Finance & Performance Assurance Committee, and it was agreed that multi-year efficiency projects should be reviewed through the Committee.

9.11 Jackie Cassell questioned the lack of financial management focus and financial language within the Values & Behaviours framework, and that it would welcome the need to improve fiscal awareness so financial responsibility was shared more widely. Karen Seabridge emphasised the importance of a clear financial narrative, supported by encouraging additional education on key financial concepts.

9.12 The Chair concluded the discussions agreeing that further work was required to strengthen financial capacity, capability and responsibility at divisional levels whilst recognising the complexity involved, and that additional support would be required to ensure confidence in the financial data, and that the introduction of a new structure and new roles presented the best opportunity for success.

9.13 The Board agreed that the plan could be approved in principle, with the understanding that while it represented value for money, performance was not currently meeting the RTT requirement however the Trust continued to work on improving this area of performance taking all steps possible within the year to accelerate the improvement of the Trust's RTT performance. The Board **APPROVED** the Multi-Year Financial Plan 2026/27 – 2028/29

TB/03/26/10 ONE UHSUSSEX - WELL LED DEVELOPMENTAL REVIEW UPDATE

10.1 Andy Heeps presented the paper which set out the Trust's response to the developmental Well-Led review, including progress made to date, an update on related workstreams since the previous Board meeting in public, and a detailed summary of the recommendations and actions underway.

10.2 Andy shared that the consultation on the TOM had concluded since the last Board meeting, and that feedback had been shared with the workforce, and executive colleagues had led that follow-up engagement, with appointments expected to be confirmed by the end of the week. Andy explained further that work was underway on the infrastructure required to underpin the TOM, with a phased transition planned over the next six months. It was added that the newly formed Executive Management Committee (EMC) was scheduled to go live the following day and Andy advised that outputs from these EMC meetings would be shared weekly with directors, executive colleagues and senior leaders, with the intention of making decision-making more transparent and accessible.

10.3 Andy updated the Board on the external review of HR systems and function undertaken, and that a draft report had been received and shared with senior colleagues and Paul Layzell as Chair of the People & Culture Committee. Andy explained that the key themes included the need to align HR Business Partners more effectively supporting the Trust Operating Model, establishing a clear blueprint for the HR function, and simplify core HR processes to enable quicker impact.

10.4 The Chair reflected on the 2022 CQC well led inspection outcome, and the CQC well-led inspection from 2025, the outcome report of which had not yet been published, and asked how the Trust intended to address the risk of being judged against a historic position. Andy responded that despite being just under a year since the CQC well led review the Trust had made significant progress, and he highlighted the improvements reflected in staff survey results and organisational delivery, whilst acknowledging that the CQC Well-Led outcome remained unknown at the time.,

10.5 Philip Hogan commented that the paper presented was detailed and helpful and asked where the recommendations and delivery plan were being scrutinised to ensure progress was being maintained. Andy responded that

oversight sat with the Executive Recovery and Governance Group (ERGG) and that, as previously agreed by the Board, detailed Board-level scrutiny had been for the first six months while implementation gathered pace. He acknowledged the point and agreed that clearer reporting on completed actions and remaining priorities would be helpful and committed to bringing a high-level update to the Board in September 2026.

10.6 Helen Brown noted that the NICHE review was at a particular point in time with a defined set of recommendations, but that further work was continuing on improving the Trust risk management maturity which included alignment with the Board Assurance Framework and outlined that the improvement plan would clarify priorities, forward plans and assurance arrangements, with oversight primarily through the Audit Committee.

10.7 Mike Driver commented that there was a strong case for proactively sharing evidence of the Trust's improvements made since the 2022 CQC well led review, and he suggested this should be positioned as a constructive update rather than a defensive response, potentially enabling the CQC to acknowledge progress or include an addendum to its findings. Andy agreed that this was helpful and important, and it was confirmed that this update report had already been shared with the CQC and that further proactive engagement was underway with the CQC to ensure improvements and actions taken since the review were clearly understood.

10.8 The Board **NOTED** the update.

TB/03/26/11 NHS STAFF SURVEY RESULTS

11.1 Sarah-Jane Taylor presented the 2025 NHS Staff Survey results that highlighted increased participation and overall improvement in staff engagement with 47% of staff completing the survey, representing the highest number of responses since the Trust's formation and indicating increased engagement year on year. The results showed that 83% of scores improved compared to the previous year, with the People Promise elements performing particularly strongly. Improvements were noted in areas including flexible working, safer and healthier working environments, staff morale, and clarity of organisational direction, supporting the Trust's longer-term cultural ambitions.

11.2 Andy Heeps welcomed the progress, noting clear year-on-year improvement and movement within the national comparator group, but went on to draw out the challenge the lower scores on speaking up continue to reflect, stressing its importance as one of the Trust's five core behavioural commitments. It was highlighted that the Freedom to Speak Up Guardian activity was comparable with organisations of similar size, thus suggesting increased confidence among staff to use formal routes.

11.3 Sarah-Jane highlighted targeted programmes underway to address raising concerns and compassionate culture, and identified diversity and inclusion as an area requiring more detailed focus in the coming year, and added that as speaking-up culture matured, reported activity may initially increase, however the Trust's focus remained on prevention, early support, and enabling staff to raise concerns confidently and safely. She added that the results and associated actions were being reviewed through the People and Culture Committee, with a further update scheduled for May 2026, including more detailed diagnostic work and progress against action plans.

11.4 The Chair welcomed the improved results but emphasised the importance of better understanding the gap between formal processes and staff perceptions on speaking up and stressed the need for more granular analysis to understand

how staff interpreted and experienced speaking up in practice and welcomed the alignment with insights from the Big Conversation. The Board reaffirmed its commitment to focusing sharply on staff experience, pace of improvement, and fostering a culture of trust and good intent.

11.5 The Board **NOTED** the update.

TB/03/26/12 STRATEGIC RISKS AND BOARD ASSURANCE FRAMEWORK DEVELOPMENT 2026/27

12.1 Helen Brown presented an update on the development of a refreshed Board Assurance Framework for 2026/27 which set out the revised 12 Strategic Risks, aligned to the Trust's strategy and reviewed through the ERGG.

12.2 It was noted that this was a critical point in the process, with limited opportunity to materially change the strategic risks, unless there was a significant change in the environment, once the BAF had been fully populated and embedded during the coming year. The finalised BAF would then be brought to the Board in May 2026 for approval, following development and committee scrutiny.

12.3 The Chair emphasised the risks related to urgent and emergency care and patient flow, and acknowledged the significant impact on the local community when reasonable flow through the hospitals was not achieved, and that included ambulance delays and the knock-on effect on the Trust's ability to respond to those ambulatory handovers and the potential consequences for public safety if these risks are not effectively managed.

12.4 Lucy noted the risks across multiple pathways and system partners, raising the question of how partnership risks were being articulated and understood. It was agreed that these risks are not solely within the Trust's control and that the BAF should promote awareness of shared and system-level risk, rather than implying sole ownership.

12.5 Mike Driver as Chair of Audit Committee welcomed the progress made and commented that the Trust was in a stronger position than previously. However, he emphasised the need for further work to test the adequacy of mitigations, clarify ownership of actions, and ensure that contributing factors were well evidenced, given the importance of mapping interrelated risks and ensuring Board and Committee time was focused on the most material issues.

12.6 The Board **NOTED** the proposed approach to updating the Board Assurance Framework and supported the continued development and **AGREED** the 12 Strategic Risks.

TB/03/26/13 ANTI-MICROBIAL STEWARDSHIP REPORT

13.1 The Board received the report which outlined the recommended areas for improvement and NOTED these whilst recognising that the detailed improvement objectives and KPI's would continue to be received and scrutinised at the Patient & Quality Assurance Committee.

TB/03/26/14 MATERNITY ASSURANCE REPORT

14.1 The Board welcomed Sebastian Adamson and Frances Barnes to the meeting who presented the Quarter 2 ATAIN (Avoiding Term Admissions into Neonatal Units) and Transitional Care reports and provided assurance on performance and improvement activity. Sebastian shared that 11.5% of neonatal admissions were assessed as potentially avoidable, which was better than the national benchmark. The predominant reason for neonatal admissions

continued to be respiratory distress, with additional contributors including hypoglycaemia and suspected sepsis, with one case of hypoxic ischaemic injury also reported.

14.2 Sebastian shared an update regarding the optional use of antenatal steroids prior to elective caesarean section, and that the uptake of steroids had reduced, with more families declining treatment, reflecting evolving evidence and risk benefit discussions, including weaker evidence of longer-term impact. The Board discussed the balance between clinical risk, parental choice, and public understanding, particularly around steroid use and elective delivery timing, and the Board recognised the cultural and communication challenges in conveying nuanced risk information to families, while ensuring informed consent in line with the Montgomery ruling.

14.3 It was noted that transitional care was not currently deliverable consistently on all wards, and that a business case was in development to increase the neonatal workforce and ward-based support which would enable more babies to remain with their mothers, thus reducing neonatal unit admissions, and further improving ATAIN performance. The Board were assured regarding current performance, and the support of the continued development of the transitional care business case and communications approach to strengthen informed choice and reduce avoidable neonatal admissions.

14.4 The Board **NOTED** the Transitional Care and ATAIN Quarter 2 2025/26 reports.

[Sebastian and Frances left the meeting at this point.]

TB/03/26/15 COMPANY SECRETARY REPORT INCLUDING USE OF THE TRUST SEAL

15.1 Glen Palethorpe introduced the Company Secretary Report, which reflected the commencement of the Trust's next round of governor elections, that the Non-Executive Director recruitment and interview process would be aligned to the values and behaviours framework, and concluded the update by drawing out the use of the Trust's seal in 2025/26 has been in compliance with the Trust Standing Orders, informing the Board since the report was draft two further uses of the seal had occurred before the year end relating to the use of land on Park Road in Worthing.

15.2 The Board **NOTED** the update and that the use of the Seal had been undertaken in accordance with the Trust's Standing Financial Instructions.

TB/03/26/16 OTHER BUSINESS

16.1 There were no additional items received or raised for discussion.

TB/03/26/17 DATE OF NEXT MEETING

17.1 It was noted that the next meeting of the Board of Directors in Public was scheduled to take place at **10.00** on **Thursday 14 May 2026 in Worthing**

Tamsin James
Board & Committees Manager
March 2026

Signed as a correct record of the meeting.

…….. Chair

…… Date

University Hospitals Sussex NHS Foundation Trust

MATTERS ARISING

Trust Board in Public

	Meeting Date	Minute Ref	Action	Person Responsible	Deadline	Update	Status
1	31-Mar-26	TB/03/26/8 Values & Behaviours Framework	It was asked that the Values & Behaviours framework with progress and measurement should be reviewed regularly by the People & Culture Assurance Committee and progress reported back to the Public Board within four months.	Chair of People & Culture Assurance Committee	Q2 2026/27	The People & Culture Assurance Committee received assurance at their May meeting that the Culture Programme was progressing to plan, with strong governance, delivery and engagement; and the Committee supported the next phase of activation, including the rollout of the Manager Toolkit and Experimenteer programme.	Propose to close

NHS
University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	6.	**Meeting:**	Trust Board in Public	**Meeting Date:**	14 May 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 new maternity standards and reviews of Trust services; the receipt of the CQC Well Led report; the launch of the new Surrey and Sussex ICB; the introduction of the new UHSussex operating model and the expansion of MRI capacity at our Southlands CDC.
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.

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*	

NHS
University Hospitals Sussex
NHS Foundation Trust

Chief Executive's Report – May 2026

It has been another busy period for University Hospitals Sussex since our last Board meeting. This report highlights key developments over that time at national, regional and Trust level, which will provide useful context for our discussions today.

National Policy and Regulation

Industrial action

Resident doctors across England staged a six-day strike in April as part of their long-running dispute with the Government over pay and conditions. This was their 15th and longest round of industrial action and created additional difficulties for trusts in coming directly after the long Easter weekend.

At UHSussex, although infection control restrictions made responding to the strike particularly challenging, the willingness of colleagues to again go the extra mile enabled us to prioritise patient safety and maintaining access to emergency care while keeping as much planned care running as possible.

New maternity clinical standards

At the end of April, the NHS announced new clinical standards for maternity services across the country aimed at significantly reducing the number of women who die each year during or after pregnancy.

The new standards focus on risks relating to venous thromboembolism, epilepsy, mental health and haemorrhage or significant bleeding after birth. A national roll-out over the next 12 months is expected to reduce the number of deaths caused by blood clots, strokes, cardiac disease, suicide, sepsis, obstetric haemorrhage and pre-eclampsia, which together account for 52% of maternal deaths.

CQC Worthing maternity service inspection

The Care Quality Commission (CQC) spent two days at Worthing Hospital last month inspecting our maternity service there. The Commission last visited in February 2025, when they rated the service as Good in a report published earlier this year. CQC inspectors praised the maternity team for "going above and beyond to support women" and making sure families feel involved in their care. They also highlighted a "more positive culture" in which colleagues feel confident speaking up, sharing ideas and raising concerns, and recognised the role of the service's leaders in fostering that safe and inclusive environment.

Externally validated quality and safety data indicates that the service our teams provide across all our sites today is objectively good: national data shows our neonatal death and stillbirth rates are low and falling, and MBRRACE monitoring ranks the UHSussex service among the safest in the country.

As I will recognise in the next item, however, this has not always been the case, so it is natural that our regulators want to assure themselves that the improvements in maternity care identified by the last CQC report are embedded and that further progress is being made. I hope the inspectors will see this is the case.

Independent review of baby deaths

Since we last met it has been announced that senior midwife Donna Ockenden will lead an independent review of the circumstances and causes of a number of tragic baby deaths at our hospitals in past years.

The review is part of the national investigation into NHS maternity and neonatal care commissioned by the Secretary of State last June. Alongside the system-wide assessment of standards of care being carried out by Baroness Amos, specific case reviews are also taking place at up to 10 trusts around the country, one of which is UHSussex.

While it is not possible for anyone to guarantee that every birth will have the very best outcome, we know that in at least some of the cases under review the outcome could have been different, and we have apologised to the affected families for that. In engaging with the review, we will reiterate our commitment to listening to and learning from the experiences of everyone in our care. Giving parents an opportunity to be heard through service user groups like our Maternity and Neonatal Voices Partnership has played a key part in the important changes that have underpinned recent quality and safety improvements, such as the introduction of a centralised telephone triage service and the development of our restorative culture programme. We will continue to support all bereaved families as best we can and help the review provide the further answers the families involved seek.

CQC Well-led Inspection Report

The CQC's has also published its well-led inspection report, increasing the trust's rating from *Inadequate* to *Requires Improvement.* While I welcome this step forward, it is also very clear that there is much more to do.

The report is clear that we need to strengthen leadership, culture, risk management, and learning from incidents. It is particularly concerning that some colleagues reported not feeling able to raise concerns. We need to ensure people feel confident and encouraged to speak up, given the direct link to improvements in care quality and safety.

Since the inspection last summer, we have strengthened our executive and Board, launched our new strategy setting our direction until 2030, and introduced a new operating model with clearer accountability for services and patient care.

We have also begun a new drive to set clearer expectations for how we work with each other, with the launch of our new behavioural compass. Our staff do extraordinary work for patients every day, and our responsibility is to give them the support, culture, and confidence they need to provide consistently excellent care.

I will of course, continue to keep the board updated on progress in this area and look forward to welcoming the CQC back in the future.

Regional and ICB update

NHS Surrey and Sussex ICB

The new NHS Sussex and NHS Surrey Integrated Care Board (ICB) was launched on April 1 following a merger of NHS Surrey Heartlands and NHS Sussex. It also incorporates Surrey Heath, Farnham and Ash areas of Surrey which were previously part of NHS Frimley ICB.

The creation of the new organisation is part of wider NHS reform announced by the Government last year aimed at strengthening roles and responsibilities and reducing duplication so more funding can be directed to frontline care. The new ICB will be a leaner organisation focused on its role as a strategic commissioner and priorities of making sure local health and care spending has a direct impact on improving people's health and reducing the inequalities we know exist in how some people access and receive care. We look forward to working closely with the ICB to achieve our common goals.

Local government elections

Following the Government's recent decision not to delay further local elections, a number of our local authorities held elections at the beginning of May. I would like to take this opportunity to thank the outgoing councillors we have worked with during their time in office and look forward to working with those now elected.

University Hospitals Sussex

New Trust operating model

On April 1, we laid one of the cornerstones of our Excellent Care Everywhere strategy by beginning the transition to our new Trust operating model. This has been designed to address colleagues' frustrations at unclear lines of accountability and inconsistencies in service leadership, management and support on different sites that came through loud and clear in our Big Conversation and Developmental Well-led Review.

The new model is central to the strategy's commitment to building a unified organisation with a shared culture and common way of working, and will see us provide services through four cross-site divisions instead of the current (and largely site-specific) eight. It is accompanied by a new senior leadership structure, appointments to which were announced at the end of April.

Most colleagues will not see any immediate changes in how they work as we focus in the immediate term on establishing leadership, governance, accountability and reporting through the four new divisions, while maintaining the safety and stability of all services. However, this is still a fundamental change in how we operate: it is how we will strengthen our grip on performance and service delivery, and how we will achieve our strategy's vision and ambitions over the five years ahead. I would like to publicly thank everyone who has been

involved in the new model's development or who will play a part in the next phase of its implementation as we establish 28 cross-site directorates and appoint their leadership teams.

Cultural development programme

Introducing a new operating model and leadership structure will not resolve all the issues we face, many of which relate to the culture of our organisation and how we act and lead. I am therefore pleased to report that we are this month introducing a trust-wide programme designed to promote and enable the values and behaviours our new strategy places at the heart of how we will provide excellent care everywhere.

The new operating model's appointment process has been aligned with that ambition in focusing on ensuring our leaders demonstrate the values and behaviours it expects. We are also introducing a Behavioural Compass – a handy tool that will help us act on our core values – being compassionate, inclusive and respectful – in our everyday work lives. Ahead of its launch, we recruited 60 'experimenteers' to test the compass in real-life situations and share with everyone what they learn so it evolves in ways that will maximise its relevance and effects. The number of people interested in becoming an experimenteer has been a positive early indicator of its potential and I look forward to sharing how colleagues are using it.

Southlands Community Diagnostic Centre expansion

I am pleased to report that we are doubling the MRI capacity of our Southlands Hospital Community Diagnostic Centre (CDC) with the installation of a second scanner. Our MRI service at the CDC runs seven days a week from 8am to 8pm for patients aged five and up, giving people more flexibility to fit appointments around work, school and home life, while avoiding the need to travel to a busier acute hospital. The second scanner and its advanced imaging software will help reduce scan times and improve image quality, including for cancer staging.

Cardiac catheterisation laboratory service modernisation

Since we last met, the Trust and our ICB have confirmed a modernisation of the cardiac catheterisation service in West Sussex to align local care with the latest national guidance from NHS England.

This recommends catheterisation laboratories should be in hospitals with two or more labs to improve safety and efficiency. Worthing Hospital already has two state-of-the-art labs which can safely accommodate more patients. The single lab at St Richard's Hospital has been closed since January 2025 due to a major issue with the air exchange system that enables its safe use. As a result, most patients from the Chichester area who need cath lab treatment already travel to larger centres in Worthing, Brighton or Portsmouth. We have now agreed with the ICB that the 300 patients a year who would previously have undergone pacemaker procedures at St Richard's will now be treated at Worthing. There is no change to urgent or emergency heart attack care at St Richard's, or to other cardiology services there, including the cardiology ward and outpatients clinics.

Ophthalmology visit

As part of the Trust's programme to develop Centres of Excellence, a multidisciplinary ophthalmology team from the trust visited Exeter Eye Centre, a national GIRFT (Get It Right First Time) exemplar site. The centre has successfully redesigned its diagnostic pathways, eliminating a backlog of many thousands of patients.

The visit was highly impactful with the team inspired by the clarity of the model and its practical delivery. They are now keen to adapt this approach locally and will begin work on reviewing current pathways to address our backlog, while also improving training, staff engagement and patient care.

This work is a clear example of improvement, overseen by our Clinical Transformation Programme Board, with support from national expert partners.

New clinical research collaboration

As part of our strategy commitment to building our position as a regional research leader, we have recently launched our first Joint Clinical Academic Directorate (JCAD), focused on Critical Care and Peri-Operative Medicine (CCPOM). This brings together hospital clinicians with university and community partners to advance research that improves care for people who are critically unwell or undergoing major surgery. By working across clinical and academic boundaries, the multidisciplinary team aims to accelerate the translation of innovation into practice – delivering safer treatments, faster recovery and better long-term outcomes for patients.

New prostate cancer treatments

In other research news, patients with advanced prostate cancer are receiving highly personalised and innovative new treatments at RSCH as part of a major national trial. This introduces two new treatment approaches to Sussex patients: a radiopharmaceutical drug that actively seeks out cancer cells, and a high-precision form of radiotherapy, both delivered alongside hormone therapy.

One of the most important commitments of our new Trust strategy is to make more clinical research trials available to more local people so it is good news that our multidisciplinary teams can offer patients opportunities like this one.

Filipino nurses' anniversary

We have in the last month marked 25 years of service by our Filipino colleagues at Worthing and Southlands hospitals. Some 18 of the first cohort of 25 nurses who arrived in March 2001 are still working here and have paved the way for many more to follow them. Today, international colleagues make up around a third of our workforce, and the Philippines is the second largest represented country. I am sure you will join me in thanking them all for the incredible contribution they make to the lives of our hospitals.

End-of-life volunteer service

Colleagues and volunteers also marked an important anniversary for A Friend in Need, a service that provides companionship to hospital patients in their final days and hours. The service is a partnership between UHSussex, the Friends of Brighton & Hove Hospitals and the Anne Robson Trust and is provided by a team of 17 volunteers. Over its first year, A Friend in Need supported 994 people, including 383 patients and 611 family members, through nearly 900 bedside visits. It is a remarkable service that these volunteers provide and impossible to overstate the effect their care has on patients and relatives. I am very pleased that our palliative care team is now looking at ways in which the service can be extended to all our hospitals, starting with the Princess Royal.

Douglas Chamberlain Education Centre opening

The official opening of the Douglas Chamberlain Education Centre at RSCH has given us a new professional development hub for colleagues across the Trust and provides a fitting legacy for a pioneering cardiologist and educator with a lifelong commitment to improving patient care. The new facility includes lecture theatres and teaching spaces designed to support high-quality education for staff in all roles. Going forward, it will also play an important role in supporting the Integrated Education Plan we will launch this year to help us build a sustainable, highly skilled workforce by strengthening education and training for all.

Malcolm Brett

Finally, some sad news from last month as we learned of the passing of Malcolm Brett, the long-serving chairman of the League of Friends of Southlands Hospital. Malcolm was a true and dedicated friend of Southlands for so many years and a presenter on its Seaside Hospital Radio station across five decades. I would like to extend the Board's sincere condolences to Malcolm's family and friends, and put on record our gratitude for all his work on behalf of patients and staff.

Dr Andy Heeps
Chief Executive
May 2026

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	7.	**Meeting:**	Trust Board in Public	**Meeting Date:**	14 May 2026
Report Title:	Building One UHSussex – our response to the 2025 developmental well-led review – Progress Update May 2026				
Sponsoring Executive Director:	Dr Andy Heeps, Chief Executive				
Author(s):	Helen Brown, Interim Chief Corporate Affairs Officer				
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 (***review at appropriate subcommittee which is not public***)**	
	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)***	This paper summarises progress since March 2026 in delivering the Trust's response to the developmental well-led review. It focuses on what has materially moved forward over the last 4-6 weeks and where the next phase of work will need to concentrate.				
Recommendation *(linked to What Next section)*	For the Board to note the contents of the paper.				
Assurance / Scrutiny route already undertaken (*please explain where matter*					

University Hospitals Sussex
NHS Foundation Trust

previously considered, and assurance provided)						
Link to Trust Strategy (note which theme)	**Care**	**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:* NHS Provider licence*)***	
	Yes / N/A (Yes / No)		*Yes / N/A*	*Yes / N/A*	*Yes / N/A*	

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

Progress Update – May 2026

1. Purpose of this update

This paper summarises progress since March 2026 in delivering the Trust's response to the developmental well-led review. It focuses on what has materially moved forward over the last 4-6 weeks and where the next phase of work will need to concentrate.

Key areas of progress include:

- Continued focus on progressing Trust Values and Behaviours work, with formal communications launch of 'Behaviour Compass' scheduled for early May. Engagement continues to be very strong, with positive feedback from 'Experimenteers' and colleagues across the Trust.
- TOM Phase One now operational, with colleagues transitioning into new roles from early May. Interim arrangements are in place for posts not filled substantively through the internal appointment process.
- Confirmed start dates for 4 x Divisional Managing Directors (May & June)
- Successful appointment to substantive Chief Delivery Officer post.
- Significant progress with 'go-live readiness' to enable transition to the new 4 x Divisional structure from 1st April.
- Final report has been received from Dearden on the Trust's HR function.
- CQC Well Led Inspection report has now been received, showing an improvement from the previous rating of 'inadequate' to a revised rating of 'requires improvement'.

2. Values and behaviours

The Trust is progressing through the activation phase of the Behavioural Compass and Leadership Framework, with delivery advancing across all workstreams.

The first iteration of the Measurement Framework has been completed and shared with senior leaders, the Manager Toolkit has undergone full review with all feedback actioned, and the communications plan has been aligned to the revised Compass launch date in early May. T

rain-the-Trainer sessions for Try–Learn–Share have been delivered, with additional sessions scheduled to increase 'Experimenteer' capacity and ensure sufficient coverage across clinical and non-clinical areas. This progress strengthens leadership consistency, behavioural clarity and alignment with the Trust's operating model, while supporting the organisation's response to the Niche Well-Led Review and ICB culture expectations.

The next phase of work will focus on launching the Manager Toolkit and Values & Behaviours Vignettes, delivering further Train-the-Trainer sessions, and commencing the first wave of behavioural experiments. The "Know the V&Bs" narrative will be launched alongside development of the measurement dashboard prototype, ensuring the People & Culture Assurance Committee and Board gain clearer visibility of behavioural indicators and cultural progress.

3. Trust Operating Model (TOM)

Work to implement the Target Operating Model has continued at pace, with Phase 1 leadership arrangements now substantially in place and stabilisation activity underway across divisions and corporate services. Completion of Phase 1 senior recruitment has been a significant milestone. The process placed strong emphasis on leadership capability, values and behaviours, aligned with our new behavioural compass. This has enabled us to promote internal talent, attract new external expertise and support the development of emerging clinical leaders.

On 1 May, our four new divisional teams and the wider leadership structure went live. Recruitment to further key senior clinical leadership posts is progressing to strengthen capacity and embed the new arrangements.

The programme remains a central component of the Trust's response to the Well Led and NICHE recommendations, supporting clearer accountability, strengthened, diverse clinical leadership, and improved organisational effectiveness.

Work is now focused on shaping Phase 2 of the model, including the development of our 28 new directorates. These directorates will be the engines of our new clinical operating model and will ensure a broader and more diverse range of clinical voices is embedded in decision-making.

5. People systems – external review

Dearden HR were commissioned to review the Trust's HR service (November 2025-March 2026) and the outcome of their review has now been received and discussed at the People & Culture Assurance Committee.

The review evidenced numerous examples of good practice and the positivity amongst the HR team was a highlight. Key issues, opportunities and threats have been outlined in the report and set within context of both UHSx and the NHS as a whole.

The methodology in the review used a mix of qualitative feedback (interviews and focus groups) and quantitative data (model hospital data, Trust reports, external reports) to triangulate and conclude on key themes.

The review found that the service overall is under-resourced relative to the current requirements of the Trust, and in the context of the current delivery model. However, there are opportunities for structural change and change in roles and approach, including digital opportunities. A maturity of HR model was applied, and the review found the service operating at a functional level (beyond the 'essential foundation' level), but with the potential to be more strategic.

Thirteen recommendations are made in the report covering the HR operating model, resources, systems, recruitment, employee relations, workforce planning, leadership development, OD, EDI, automation and governance.

The interim CPO will be developing an implementation plan, with phased investment over the next 2 years. A key first step will be to strengthen aligned HR&OD support to the new Divisions with the development of 4 new senior HR business partners.

6. CQC WELL LED review.

The CQC undertook an announced trust level well led review of UHSx in July 2025.

The report from this inspection has now been received and is due to be published on the 8th May.

The findings in the report align closely with the developmental well-led review (NICHE) findings and recommendations.

The report notes one that the Trust continues to be in breach of Regulation 12 (Safety) and Regulation 17 (Good Governance). A formal notice has been issued in respect of Regulation 17, noting the following key concerns:

- Not all staff felt there was a culture based on transparency, equity, equality, human rights, diversity and inclusion. Not all staff felt respected, supported and valued.
- Work was still needed to consider of the Workforce Race Equality Standard and NHS staff survey to ensure staff from ethnic minority groups were not disproportionately disadvantaged by working in the organisation
- Governance arrangements lacked clarity and were not always effective at all levels. The systems and processes for managing risk were not always effective.
- Processes were in place to support learning from incidents and patient safety alerts, but these were not always leading to timely improvement.

The trust's well-led improvement plan already incorporates actions to address these concerns, and the updated BAF also captures the requirement for continued focus on culture and inclusivity, and to further strengthen our core quality governance processes.

A formal response / action plan to the CQC will be provided, with oversight of progress through established governance routes (P&C, P&Q, Audit Committee & Trust Board).

7. National Provider Improvement Programme (NPIP):

The Trust is participating in the NHS England National Provider Improvement Programme (NPIP). The purpose of NPIP is to determine whether challenged NHS providers have the conditions in place to deliver sustainable improvement, supported by a deliverable improvement plan. It has four key aims: assess key conditions of success, clarify issues and solutions, ensure deliverable improvement plans, and support sustainable improvement.

NPIP comprises five phases: mobilisation, assessment, plan, support, and transition. It focuses on conditions of success: board and organisational leadership, effective and insightful governance, staff engagement, and improvement approach.

The Trust entered NPIP on 4 March 2026 and the mobilisation phase, which consisted of a desk top review of key documentation, is nearing completion. A mobilisation report setting out both National and UHSx specific key lines of enquiry (KLOEs) following the desktop review is being finalised. The Trust will have an opportunity to comment on the report and help shape the KLOE for the assessment phase during May.

The assessment phase is expected to commence in late May and run for up to 12 weeks. As part of the assessment phase, NPIP team members will attend and observe key governance meetings (e.g. assurance committees, Executive Management Committee), meet with key

internal and external UHSx stakeholders to understand the range of views and run some targeted engagement sessions to explore KLOE in more depth with UHSx colleagues.

7. Strategy, Governance and Risk.

Board Assurance Framework: The Trust has been reviewing and updating its BAF for 2026/2027 to ensure it is fully aligned to the Trust Strategy 'Excellent Care Everywhere' and enables effective Board oversight of key risks to delivery. As a first step in this process, 12 Strategic Risks (SRs) were approved at the March Board. Each SR is aligned to a lead Board Assurance Committee, with a designated lead Executive Director. First draft updated 'templates' have been completed for each risk setting out current controls, assurances, key gaps in controls and assurance and priority actions for 2026/2027.

The BAF will continue to be developed throughout the year to ensure it effectively supports Board oversight of key risks to delivery of its Strategy.

Risk: Expert advisory support to work alongside the Trust's internal risk management team to deliver a 'risk improvement sprint' across the first six months of the next financial year has now been commissioned. Mobilisation will commence in May (delayed from April), with focused work across Q1 and Q2 to improve the quality of operational risk register entries and ensure risks are being actively managed and mitigated at all levels of the organisation.

Effective Board Writing skills training has been commissioned from NHS Providers for c. 90 senior leaders in May/June and September 2026. The first sessions are scheduled to take place in May, with follow up sessions in September to ensure all senior leaders have the opportunity to attend.

8. Next steps

Over the next two months, priorities are to:

- Formally launch the Behavioural Compass, building awareness, capability and confidence of staff in using the tools and actively building the Trust's values and behaviours into the Trust's core processes and approach to leadership.
- Stabilising and embedding the new TOM, supporting new leadership teams in the transition to the new structures and ensuring all underpinning and enabling activities are completed.
- Developing and communicating a clear 'roadmap' for the next phase of the TOM for Divisions and Corporate teams.
- Actively engaging with the NPIP team through the assessment phase of NPIP.
- Mobilising the 'risk improvement sprint' to strengthen operational risk management across the Trust.

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

Significant progress is being made in taking forward key priorities that respond to the well-led developmental review findings. This remains a priority focus for the year ahead, with an absolute recognition that there is significant work still to be done to further develop embed our new operating model, support and develop our leadership community, continue to strengthen governance and risk management and importantly, stay absolutely focused on building our culture in line with our values.

- **We are compassionate** – we communicate and act with kindness
- **We are inclusive** – our teams work collaboratively
- **We are respectful** – we behave professionally

Dr Andy Heeps
Chief Executive
May 2026

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	8.	**Meeting:**	Trust Board in Public	**Meeting Date:**	14 May 2026
Report Title:	Audit Committee Chair's Report				
Author(s):	Mike Driver – NED & Committee Chair				
Purpose of the report: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For Discussion**	**For Information only**	
	N/A	*Yes*	*Yes*	*N/A*	
Reason for not being taken in public *(indicate as appropriate)*	**Commercial confidentiality**	**Staff confidentiality**	**Patient confidentiality**	**Other exceptional circumstances (please detail)**	
	N/A	*N/A*	*N/A*	*N/A*	
Regulatory Reporting Requirement					

Summary of the report describing

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 Audit Committee on 28 April 2026.

The Committee meeting was quorate and received its scheduled business covering internal audit, including their draft annual report and positive opinion, counter fraud annual report and annual workplan, the external audit plan along with a draff of the Trust's annual governance statement, going concern opinion and assurance on the 2026/27 BAF processes.

The Committee also received reports detailing the Trust's management oversight for the use of single tender waivers and the mitigations for any losses or special payments along with the register of Board members interests.

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

The Board can take assurance from the oversight provided by this Committee over the systems and processes supporting the Trust's Board Assurance Framework.

Through the review by the Committee of the draft annual governance statement the Board can also take assurance that the statement is a balanced and fair reflection of the Trust's process and reflects within the opinion that there are control weaknesses for which there are improvement plans in place.

The Board can take assurance that Internal Audit delivered a positive audit opinion for the year based on their work and where internal control weaknesses were identified that management actions have been agreed and subject to Internal Audit monitoring.

The Committee agreed that the Trust's financial statements should be prepared on a going concern basis.

The Board should note the Committee approved that the Trust's financial statements should be completed on a going concern basis and that the Committee approved the counter fraud work plan and the external audit work plan.

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

The Trust will submit its Annual Report and Financial Statements for audit in line with the agreed timetable and these statements are being prepared on a going concern basis.

University Hospitals Sussex
NHS Foundation Trust

	The Committee agreed that it will undertake a complementary and additive deep dive of two of the three people BAF risks at its meeting in July 2026
Recommendation *(linked to What Next section)*	***The Board is asked to NOTE that:*** - ***The Committee was quorate and considered all the expected reports in line with its schedule of business.*** - ***The Committee's assurance over continuation of the underlying BAF processes.*** - ***The Committee agreed that the Trust's Financial Statements should be prepared on a going concern basis.*** - ***The Committee did not have any specific escalations to make to the Board and that the Trust's annual report and financial statements are being submitted for audit in line with the agreed timetable.*** - ***The Committee approved the counter fraud and external audit annual workplans.***
Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*	

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

Link to annual delivery plan	*The Audit Committee provides oversight of the Trust's systems of risk management and internal control which underpin the delivery of the Trust's annual plan.*
Link to BAF (explain which BAF risks this matter impacts on and what the impact is change in score/ change in assurance profile etc)	*The Committee has oversight of the application of the BAF process with each allocated Board Committee having responsibility for the scrutiny of the recorded assurances supporting the determined current quarterly scores.*

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

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

University Hospitals Sussex
NHS Foundation Trust

Audit Committee Chair's Report

The Audit Committee met on the 28 April and was quorate. It received all its planned business. In attendance were the Chief Financial Officer, the Interim Chief Corporate Affairs Officer, the Trust's Operational Finance Director, Deputy Director of Finance – Operational Finance, and Company Secretary along with the Trust's Internal and External Auditors and Local Counter Fraud team members. The Chief Information Officer and Head of Information Governance and Data Protection Officer also attended to support the discussion on the two internal audit reports of Digital Transformation and Data Security and Protection Toolkit report and the Trust's Chief Procurement Officer attended for the relevant report on tender waivers compliance along with the LCFS benchmarking paper on tender waivers.

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

Risk Management and BAF reports

The Committee considered, reviewed and discussed the underlying processes for the maintenance of the Trust's BAF and as a result were assured over these processes. The Committee noted the work undertaken to revise the format of the BAF document bringing into sharper focus the levels of assurance being provided and the impact of the mitigations.

The Committee discussed the format changes and agreed this would support the respective oversight committee oversight with a focus on the risk mitigations outcomes.

The Committee considered the risk management compliance report and noted the continued progress being made to improve the divisional risk literacy ahead of the planned risk improvement work which is to commence shortly.

The Committee agreed that it would continue with its complementary strategic risk deep dive at its July meeting and that would look at two of the people strategic risks.

The Committee discussed the value of undertaking a review of the Board's risk appetite assessments during the year as the BAF has been aligned to the Trust's strategy and the prior appetite statements were aligned to the categories of risk.

Internal Audit activity

The Committee noted the positive opinions provided in respect of digital transformation, establishment controls and the positive conclusion in respect to the Trust's data security and protection toolkit assessment.

The Committee noted the negative assurance opinion on capital project management recognising that this was an area identified by executive management as an area of concern and thus the scoping of this work was directed at support improvement activity. The Committee noted the assurance provided by the Chief Finance Officer on the actions developed to make these improvements. The Committee welcomed this but informed the Chief Financial Officer that there should be no delay in the delivery of these improvements.

The Committee noted the progress in delivering agreed management actions in the last quarter but recognised that in the main area, medical devices management, where delay in providing information to the auditors had occurred this was being subject to a re-audit in 2026/27.

Head of Internal Audit Opinion

The Committee received the draft Head of Internal Audit Opinion and noted that it provided a positive opinion on the Trust's overall systems of governance, risk management and internal control. The opinion reflected that whilst a small number of individual negative opinions had been provided within the year, these were in areas that Internal Audit had been asked to support the Trust with their planned improvements work and this was reflected positively by the Head of Internal Audit. The Committee noted that the report provided confirmation of Internal Audit's compliance with the required Public Sector Internal Auditing Standards.

Annual Accounts

External audit

The Committee noted that the external audit progress report confirmed that work is progressing well for the 2025/26 year end, with good liaison maintained with the Trust's finance team.

The Committee received the external plan, noting the work planned for each of the identified risks in respect of the production of the accounts and to the items within the accounts. The Committee noted that there were no elevated specific risks over and the routine work of the external auditors.

The Committee considered the non-audit work being undertaken in respect of to a national piece of NHS work on coding and agreed this did not pose a threat to their independence.

In approving the plan, the Committee agreed the fee proposed noting this was in line with the tender value for the work

Preparation of the financial statements

The Committee received an update that the Trust had submitted its draft financial statements in line with the national timetable. The Committee agreed that the Trust's financial statements should be prepared on a going concern basis.

The Committee considered the declaration to the Trust's external auditors in respect of information informing the audit risk assessment and confirmed it was consistent with their knowledge and reports received over the year.

Draft Annual Governance Statement

The Committee considered the draft AGS and discussed its content and agreed that it was consistent with their understanding and the reports received over the year. The Committee agreed that the statement should be incorporated into the Trust's annual report and be provided to External Audit for their formal review.

Declarations of Interest

The Committee noted the assurance the report provided over the Trust's continual compliance with its declaration of interest, gifts and hospitality policies. The Committee noted the high

level of returns with 99% of those expected to make a return and for those that had not done so by the year end, none had any budgetary responsibilities.

The Committee noted the review of the declared interests and that none posed any significant issues, and that process had been put in place to manage these interests in the areas of procurement decisions with the sharing of this information and the whole register with the procurement team. *[The register of Board Member declared interests is included as an appendix ahead of its placement on the Trust's website as part of the Trust's year end procedures]*

Referrals to other Committees

The Committee asked that the People and Culture Committee may wish to consider the work undertaken through the payroll improvement group to minimise payroll overpayments

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	28 April 2026	**Chair**	Mike Driver	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Item	Presenter	Purpose of the paper	Action Taken
Board Assurance Framework	Company Secretary	For assurance over the application of the Trust's process	The Committee considered the underlying processes for the maintenance of the Trust's BAF and as a result were **assured** over their continuation. The Committee **agreed** that at its future meetings it would continue to undertake a complementary and additive deep dives at its July meeting.
Risk Management Policy Compliance report	Interim Chief Corporate Affairs Officer	For assurance over the application of the Trust's process	The Committee **received** the risk management policy compliance report provided. The Committee discussed the improvement that has been made within the divisions in reviewing the highly scored risks. The Committee **endorsed** the work being undertaken to strengthen the risk management processes within the divisions and the establishment of a functioning corporate risk register.
Internal Audit Reports - Activity Progress Report - Recommendation Follow Up Report - Head of Internal Audit Opinion	BDO (Internal Auditors)	For assurance over respective areas of internal control	The Committee **noted** the work undertaken in the quarter and that internal audit had concluded work in areas where management anticipated they could add value through focused improvement recommendations. The Committee **noted** the positive opinions in respect of digital transformation and establishment controls along with positive conclusion in respect of the Trust's data security and protection toolkit.

			The Committee **noted** the negative assurance opinions in respect of the application of the systems of internal control within the areas of Estates Compliance and Capital Project Management. The Committee was assured over the actions being planned to address the improvement recommendations. The Committee **noted** the assured progress being made against the previous internal audit recommendations but raised with the executives the need to improve the timeliness of their overall delivery. The meeting **noted** the positive Head of Internal Audit Opinion noting the change in language used within the opinion along with the auditors quality assurance process and the self-attestation on their independence
Counter Fraud - 2025/26 Annual Report - Practive review recruitment - 2026/27 workplan	RSM (LCFS)	For assurance over respective areas of internal control and for information on the Trust's fraud profile	The Committee **noted** the work undertaken by the counter fraud team, that there were no elevated fraud concerns from the work in the last quarter of the year. The Committee **noted** the functional standards return which was assessed as green for each 12 requirements. The Committee **noted** the proactive review undertaken in relation to fraud prevention controls within the Trust's recruitment processes which provided a positive conclusion. The Committee **noted** that action had already been taken in respect of the improvement recommendation made. The Committee **approved** the workplan for 2026/27 noting that this includes the work carried over from 2025/26 and held a reasonable level of contingency to allow the team to react to emerging fraud risks.
External Audit Update - Progress report	GT (External Audit)	To note status of the External Audit work	The Committee **noted** that the 2025/26 external audit work has

- 2025/26 Plan			commenced and is progressing well and that this work has supported the developed work plan. The Committee **discussed** the plan noting that the audit risks were not exceptional for the Trust. The Committee **approved** the plan and fee and **agreed** that the non-audit work being undertaken does not impair their independence.
Annual Accounts preparation update	Chief Financial Officer	To note	The Committee **discussed** the content of the submission informing the audit risk assessment and **confirmed** it was consistent with their knowledge and reports received over the year. The Committee **noted** submission made of the Trust's group accounts.
Going Concern Assessment	Assistant Deputy Director of Finance - Operational Finance	To agree	The Committee **discussed** the respective assessments made for each of the constituent parts and the overall group and **agreed** the financial statements should be prepared on a going concern basis.
Draft Annual Governance Statement	Company Secretary	To review, comment and endorse progression to the Audit	The Committee considered the draft and **agreed** the statement was balanced and consistent with their knowledge and **agreed** this statement should be included within the Trust's annual report and passed to the external auditors for review
Losses, Special Payments	Assistant Deputy Director of Finance - Operational Finance	To note the report and the assurance it provides over the application of the Trust's processes.	The Committee **noted** that the quarter four update noting the analysis provided and discussed the work undertaken to recover outstanding amounts. The Committee **discussed** the actions being taken to minimise losses and the risk of wastage through better cross site working. The Committee took **assurance** from the continued comparably low value of losses and special payments.

Tender Waiver Report	Chief Procurement Officer	To note the report and the assurance it provides over the application of the Trust's processes.	The Committee **noted** the continuing relatively low level of these across the year and in the quarter and through discussion with the Chief Procurement Officer the Committee was **assured** over the processes being applied to support the review of Waivers.
Health and Safety Committee Chairs Report	Company Secretary	Provision of information on the activity of this Committee and that Committee's view of the Trust's Health and Safety risks.	The Committee **noted** that the gap in assurance in respect of a number of estates risks was provided by a report from the Estates Improvement Group direct to the Patient and Quality Assurance Committee. The Committee **noted** the revised meeting timetabling to allow the Estates Improvement Group to report more timely to the Health and Safety Committee.
Annual Declarations of Interest Report	Company Secretary	For assurance	The Committee **received** the report detailing the high level of compliance with the Trust's policy. The Committee **noted** the assurance this level of compliance provides.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	9.	**Meeting:**	Trust Board in Public	**Meeting Date:**	14 May 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)* **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 recommendations made)*	The report provides information over the business undertaken at the Research, Innovation and Digital Assurance Committee on 6 May 2026. The Committee meeting was quorate and received its scheduled business. The Board can take assurance from the oversight provided by this Committee over the domains of Research, Innovation and Digital 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 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 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. The Board can receive the BAF with confidence knowing that the content and scores for the new strategic risks 7 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 & innovation domains, in particular management of its cycle of business to oversee the governance of AI and to be assured of the Data Usage and Access Act 2025 (DUAA) Legislative Impact the Trust's compliance.** - **The Committee's recommendation that strategic risk 7 should open at 20 and risk 9 should open at 16 for Q1 2026/27.**
Assurance route already undertaken	

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 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	The Committee has oversight of the key assurances referred to within the BAF for new strategic risks 7 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**	**Environmental**	**Legal**	**External Registrations**
	N/A	N/A	Yes	Trusts are required to maintain effective systems of governance, risk management and internal control- FT Code of Governance)

University Hospitals Sussex
NHS Foundation Trust

Research, Innovation and Digital Assurance Committee Chair's Report

The Research, Innovation and Digital Assurance Committee met on 6 May 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 May meeting are listed below, noting the full breadth of the meeting's activity is included in a table at the end of this paper.

Research and Innovation

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

Research Delivery Plan for research and innovation

The Committee **received** the Research Delivery Plan Q4 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 (including multi-site studies), Principal Investigators and participant recruitment, and progress in set-up times. The Committee congratulated the team on continuing progress in the Trust's research ambitions.

Deep Dive into our Research partnerships

The Committee meeting was joined by system partner representatives including the ARC (Applied Research Collaborative) and the Committee heard from these partners about the collective planning and research work such that the Committee can be assured these are functional and deliver what is needed. Through coordinated and system-wide research embedding these have enabled activity that individual organisations would have been unable to deliver alone. The Committee heard that these had started to pivot from infrastructure setup to assuring impact. From the Surrey and Sussex ICB deputy Chair, the Committee welcomed appointments to the ICB's research team and reflected with thanks the strong foundations to the collaborative work through hard work of individuals in recent years.

Patient and public participation and involvement is a key area of the collective strategy in development. The Committee was given more details of the Health Innovation Network and the distinct skill sets that can be lent to benefit the Trust and leveraged to support the wider partnership. In line with the Trust's Communities strategy, the Committee discussed how acute care providers like UHSussex are part of a successful research system with the community and social care. The Committee recognised the virtuous circle for funding research capability that the partnership working can offer and asked for an update to come back

Innovation Update

The Committee had a discussion around how the Trust should approach innovation opportunities, acknowledging both upcoming digital developments and the limited current

level of maturity in innovation are important context for the Trust's innovation opportunities. The matrix approach presented and recognition of 'what good looks like' at a recent workshop had been helpful in offering focus and recognition how the HIN can support rapid advancement. The discussion referenced the importance of linking to the strategic intentions. The Committee acknowledged that the initial priority should be becoming a great adopter of proven innovations. The Committee acknowledged fast changing technology means there is a need to realism and invited work to enhance the Trust as an Adopter would **to come back** in 6 months' time

Clinical Research Development and the Commercial Research Development Centre

The Committee **noted** the strong performance of the Commercial Research Delivery Centre, which is in its second year and 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 remains **assured** that the growth in commercial research is being managed alongside, and not at the expense of, non-commercial and academic research activity, which have in fact been enhanced and supported. Eight domains had been set out in priorities going forward with key metrics identified and the Committee welcomed the good understanding of issues that these measures have helped to reveal and address.

Digital opportunities are being harnessed to look across organisations in Sussex to make the most of the digital infrastructure and how portfolio maps to disease prevalence. There had been identification of recognising research opportunities that extending use of Sussex private providers in research pathways (e.g. diagnostics) could bring while some barriers exist. The Committee heard about the ambition to better utilise the resources within Sussex and work with Participant Identification centres to improve readiness for studies. Synergies with the Digital work to move patients' communication digitally were discussed and the importance of synergy noted.

The opportunities of emerging academic clinical departments, the relationship with the medical school and other academic partners were noted. The new TOM structure with designated research teams will support the development of divisions with lower research maturity, while supporting those that are already further progressed. Embedded workforce capacity building has been positive and recognise there is some risk in medical and non-medical job planning to ensure time in research is embedded, particularly when return to Trust from outside projects.

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. Practical progress around pharmacy extending spokes and research activity across multiple sites had improved.

The Committee **noted** that this project was on track with an identified area within the Louisa Martindale building which had co-location opportunities with clinical support services, while noting there are considerable regulatory timescales. The work remains subject to ongoing scrutiny through the Strategy and Major Projects Committee, with this Committee focusing on the impact of delivery on research capability. However, with the progress made and detail of plans, the risk has been recommended to reduce.

Digital

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

Digital & Data Strategic Delivery Plan - Digital Workplan 2026/27

The Committee **received** the Digital Workplan 2026/27 as part of the Digital and Data Strategic Delivery Plan. The Committee **notes** the scale and complexity of the digital portfolio, with continuing growth in demand for digital support across the organisation, and the structured and active prioritisation mechanisms that are in use consideration to manage this demand. The Committee acknowledged the overlap between complex capital schemes and the need to consider digital implications of each with a strategic approach to manage demand.

The Committee noted the 2026/27 Workplan reflects a period of technical change freeze in the last 6 months to support a smooth path towards the go-live of the significant technical solutions, namely the EPR (Electronic Patient Record) and Sussex Pathology Network solutions (Laboratory Information Management and Order Communications Systems) early in 2027. The latter each have work underway to consolidate to single UHSussex systems. The Committee looks forward to a commissioned external report to come back for further assurance on the progression of these complex areas and noted the shared involvement from, and significance to, the Sussex Provider Collaborative.

The plan also recommends an Enterprise Architecture approach to assessing the requirement for digital investment for each new Division and Corporate Services as well as defining the future roadmaps across the next 3 – 5 years.

The Committee was assured that the majority of digital programmes are on track, with clear milestones, ownership and reporting. Artificial Intelligence (AI) governance oversight continues to focus on improved corporate business procedures with automation opportunities. The update received gave more detail on the framework for AI roll-out and the governance supporting it, with the AI governance group having met 3 times and developed a draft AI policy for approval.

The Committee heard about close control of rollout of ambient voice technology. In the meantime, dictation functionality had been enhanced through new licenses. The Committee acknowledged the tension between significant appetite for AI productivity and efficiency and the limited central bandwidth to enable their safe implementation. The importance of rapid progress was emphasised, which would require leveraging of learning from early adoption elsewhere where this can expedite. A report to support a discussion on risk appetite and the speed and scale of adoption has been asked to be brought back to the next meeting.

The Committee discussed the continued work to assess Data Usage and Access Act 2025 (DUAA) legislative impact and implement assurance activity. The Committee **noted** again how this provides aligned opportunities to use data more effectively for care, operational planning, research, and innovation, while also introducing clearer obligations on governance, transparency, and oversight. Cyber security and resilience remain a key focus.

Data Centre resilience has been enhanced and active directory work has commenced but this is recognised to be a complex exercise.

The Committee celebrated news that digital nurses have been recognised nationally and asked for information about this to be circulated to the Committee.

Patient-Facing Architecture

The Committee previously **noted** the paper that outlines the multiple ways in which the Trust interacts with its patients and how this could be improved to meet the Trust strategic ambitions.

A milestone was reached in March 2026 in the Synertec system where digital post exceeded physical post for the first time. Patient use of digital to read letters has gone from 20% at the start of the project to 68% at the time of meeting. The Committee welcomed this information and gave an **action** for receipt of regular metrics on key aspects of digital transformation such as this.

The report gave an update on the identified connectivity between the previously discussed recommendations and the activity underway to make improvement to multiple platforms. The Committee acknowledged the considerable organisational potential in this area and welcomed the capacity found within IT & Digital services to pursue these to streamline access while maintaining parallel arrangements for those patients who are not digital adopters or who require more support. The Committee noted the need to prioritise these developments for rapid progression.

Board Assurance Framework

The Committee noted the papers received aligned well to the strategic objectives looking back to the previous BAF risks as also the new principal risks for 2026/27 and how these are moving forward through the strategic delivery plans.

The Committee **scrutinised** its allocated element of the Board Assurance Framework relating to new strategic risks 7 and 9, these being:
- *Analogue to digital: harnessing technology and data to transform healthcare (**SR7**)*
- *Widening access to research and innovation (**SR9**)*

The Committee **considered** the triangulation enabled by the papers provided that helped the Committee to be assured that ambitions are realistic.
The Committee agreed that Risk 7 is correctly scored at 20 at the end of Quarter 1 2026/27.

The Committee heard about the challenges go further to reduce Risk 9 below a score of 16. The Committee acknowledged that strategic risk 9, relating to digital immaturity, cyber security and digital transformation may need particular Board discussion given the scale of transformation still underway, the wider risk environment and the priority for introduction of new technologies.

Referrals to other Committees

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

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	6 May 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 Work Plan - Programmes and Project Update 2025/6 Strategic Delivery Plan for 2026-27	Chief Information Officer	To Note: progress made to manage the demand and strategic alignment for digital transformation activity; major digital transformation programmes including EPR and EDMS; and the range of digital transformation activity last quarter that contribute towards improving the digital maturity of the Trust.	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. Internal audits recommendations around digital adoption were noted and will have associated actions. The Committee discussed the draft digital plan for 2026/7, noting the approach being proposed to the prioritisation of projects, and use of delivery partners to support delivery of digital transformation. An expression of interest for Frontline Productivity programme has been submitted to NHSE SE to support digital initiatives.
Data Usage and Access Act and Data Protection Act Implementation plan	Chief Information Officer	For assurance of maintained compliance with data protection legislation	**Noted** the progress being made on the key elements of the DUAA2025 and its phased implementation throughout 2026, including the implications for the Trust, required organisational actions, and associated strategic opportunities and risks.
Patient-Facing Infrastructure update	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, and monitoring of key metrics.

University Hospitals Sussex
NHS Foundation Trust

Item	Presenter	Purpose of the paper	Action Taken
Research & Innovation			
Research Delivery plan Q4 Highlight Report	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 2025-26 (inc Q4)	Director of Research & Innovation	To note a summary of research performance against agreed key indicators.	The Committee noted the KPI performance with positive growth in new commercial trials supported by the CRDC investment. The Committee noted that recruitment to non-commercial interventional studies had not worsened despite the progress being made on commercial studies, instead delivering mutual benefit.
Commercial Research Delivery Centre milestone report	Director of Research & Innovation	To provide information on this initiative	The Committee **noted** the delivery against the established KPIs for the Commercial Research Delivery Centre in quarter 4 with further improvement in commercial study set-up efficiency and improved time to recruit first patients to studies while also increasing the number of Trials running in the Trust and more widely across Sussex.
Clinical Research Facility Major Project update.	Director of Research & Innovation	To Note	The Committee **noted** progress on the Clinical Research Facility major project. In the meantime, the Committee noted examples of the hub-and-spoke model in practice broadening the reach of research participation across the Trust.
Funding Bid to My UHSussex Charity - Research Programme 2026-27	Director of Research & Innovation	To Note	The Committee **noted** and supports the bid to be made to the Charity Trustees seeking funding for year one of a proposed further three-year Research Fellowship programme. There was recognition of alignment to the trust's strategic ambitions. The opportunity to further raise the profile of MyUHSussex charity and the research it has made possible to benefit patients was discussed.

University Hospitals Sussex
NHS Foundation Trust

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 Noted the R&I risk register is maturing with additional risks to be added to reflect risks to delivery of the 5 year delivery plan. The Committee Noted the Digital Risk Register and that all risks are managed actively and reported through governance. Cyber security risks increased reflecting the geopolitical shifts observed by the technical industry and some challenges faced. 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. The risk of a 'Lack of fit for purpose Clinical Research Facility - has been reduced to 12 following April RIDSG meeting as the group are assured by the CRF Major Project.
Board Assurance Framework	Company Secretary	To review and recommend to the Board the scores for the new strategic risks 7 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 and 9 for Quarter 1 2026/27.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	10.	**Meeting:**	Trust Board in Public	**Meeting Date:**	14 May 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 May 2026.* *The Committee meeting was quorate and received its scheduled business, including the routine reporting on the strategy delivery plan report, the major project portfolio delivery report and the scheduled review of the RSCH Acute Floor Reconfiguration along with the respective element of the BAF. At this meeting the Committee received and reviewed the Trust 2026-2030 Green 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 rectification plans.* *The Board can review the Trust's Green Plan having confidence that the actions included within the plan have been considered by the Committee.*
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 receive the BAF with confidence that the content and opening score for Strategic Risk 6 and that there are mitigations identified with associated assurance reporting to support the achievement of the target score of 12.*
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***

University Hospitals Sussex
NHS Foundation Trust

	- ***The Committee's review of the Strategy Delivery plan and the Major Project Delivery report including the consideration of the Acute Floor Reconfiguration lessons learnt and being applied.*** - ***The Committee's recommendation of the score for their allocated elements of the BAF, strategic risk 6.*** ***The Board is asked to APPROVE the Trust's Green Plan noting that there remain a small number of presentational adjustments to be concluded (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 risk 6 and through their scrutiny of these recorded assurances consider and recommend to the Board their relevant current score.*					
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)*

University Hospitals Sussex
NHS Foundation Trust

Strategy and Major Projects Assurance Committee Chair's Report

The Strategy and Major Projects Assurance Committee met on the 7 May 2026 and was quorate with at four NEDs and four 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 Infrastructure, Director of Strategic Finance, Company Secretary and for the item on the Trust's Strategic Delivery Plan communication strategy the Director of Communications and Engagement.

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.

Trust Strategy Delivery Plan

The Committee **received** the Strategy Delivery Plan progress report showing progress over quarter four of 2025/26.

The Committee **discussed** the progress and projects at risk of delivery to their original timescales, and the correlation of these with the discussions at other Committee meetings aligned to the operational and performance challenges experienced in quarter 4 and noted that project resourcing remains a challenge into 2026/27. The Committee **noted** that the slippage within the projects was driven by a mix of internal capacity and resource challenges over the last quarter of 2025/26 and a small number of projects were awaiting external sign-off or engagement.

The Committee **reflected** on the successes delivered across Quarter 4 and its impact, and the work planned into Quarter 1, **noting** the rebasing of project SROs aligned to the launch of the Trust Operating Model. In respect of the delivered projects the Committee **noted** that benefits realisation phases will normally report to the Finance and Performance Committee.

The Committee **discussed** and **agreed** the development of impact KPIs for the projects and endorsed the need for a differential approach where for those that have a delivery over a longer multiyear will have at least annual metrics and those that are to deliver a tangible change in the year then in year 'real life' impact measures will be tracked. The Committee **asked** that within the annual metrics consideration be given to the establishment of measures that track cultural and experience change brought about by having a project for both patients and staff

Green Plan

The Committee **received** the Trust's 2026-2030 Green Plan and noted the plan builds from the original plan 2021 – 2025 and that the plan links to the NHS ICS green ambitions and the wider national NHS plan targets.

The Committee **discussed** the 63 core actions within the plan against 12 the workstreams and **noted** the deliverability assessment against the actions which recognises those that have interdependencies on others.

The Committee **discussed** the potential for the launch of this plan to act as a vehicle to secure staff and wider community engagement in supporting the Trust to achieve the plan.

The Committee **discussed** and **recommended** the development of a wider spectrum of measurable metrics as the delivery of the plan is reported over the five years.

The Committee **agreed** to recommend the Plan to the Board for approval noting the document has a final presentational change to be concluded.

Major Projects - Acute Floor Reconfiguration update

The Committee **noted** the Major Projects Portfolio report and **discussed** the Acute Floor Reconfiguration (AFR) project's lessons learnt report. The Committee **reflected** on the outcome of the review and the parallels to findings in a complementary review of overall capital project management undertaken by Internal Audit.

The Committee **noted** how the learning from this review being applied to other projects through the action plan aligned to the wider Internal Audit review.

The Committee **noted** the impact the weaknesses with the pre-construction services agreement determination and monitoring processes applied to the project to date and the work being undertaken now to manage the resources for the remaining elements of this project.

Board Assurance Framework

The Committee **scrutinised** its allocated element of the Board Assurance Framework relating to strategic risk 6 which is aligned to the strategic objective of Collaborating to improve the health and well-being of our communities.

Following the review of the BAF itself the reports received at the Committee in its meeting the Committee **agreed** with the recommendation that the opening scores for this risk at 16. The Committee reflected on the ambition built into the target score of 12 and **endorsed** this score noting this is supported by established mitigations which are reflected in the BAF.

Referrals to other Committees

The Committee **agreed** there were no matters from its May meeting it felt needed to be referred to another Committee for attention but did recognise that the benefits realisation of the delivered major project will flow to the Finance and Performance Committee as a matter of routine reporting.

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	7 May 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 for 2025/26 quarter 4 The Committee **noted** the delivery plan achievements, metric development and rebasing of project SRO aligned to the Trust Operating Model. The Committee **discussed** the themes within the off track projects and **endorsed** a review of the phasing of work to bring focus and support to those areas which bring the biggest patient or resourcing impact.
Trust Strategy Delivery Plan communications strategy	Director of Communications	For discussion and agreement	The Committee **noted** the levels of internal and external reach achieved at the launch of Strategy and endorsed the evolution of the ongoing communications plan about the delivery plan. The Committee **discussed** the approach and focus for the next 6 to 12 months recognising the work having a greater emphasis on engagement rather than message giving.
The Trust's Green Plan 2026-2030	Director of Infrastructure	For discussion and recommendation to the Board for approval	The Committee **received** and discussed the Trust 2026-2030 Green Plan noting that plan builds from the original plan 2021 – 2025 and that the plan links to the NHS ICS green ambitions and the wider NHS plan. The Committee **noted** the deliverability assessment against the

			actions which recognises those that have interdependencies on others. The Committee **agreed** to recommend the draft to the Board noting that presentational changes have yet to be concluded
Clinical Transformation Programme	Director of Strategy	For discussion	The Committee **noted** the work being undertaken and **endorsed** the approach as projects deliver then patient pathways be reviewed and revised to support the delivery of Excellent Care for our patients and staff deployed in the most effective way. The Committee **endorsed** that the Board be provided with an update on this work as it matures to enable a discussion to be held about priorities.
Major Project Portfolio Overview report	Director of Strategy	To note and be assured over the application of lessons learnt	The Committee **noted** the project progress the projects delivered in the year and the ongoing projects and their progress and actions being taken. The Committee **discussed** the reporting route for the delivered project realisation reporting.
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) and **reflected** on the outcome of the review of this project and their findings, and the complementary review of overall capital project management undertaken by Internal Audit. The Committee **noted** the learning from this review being applied. The Committee **noted** the work done to manage the resources for this project.
Board Assurance Framework	Company Secretary	To review and recommend to the Board the scores strategic risk 6	The Committee **considered** the relevant segments of the BAF and alongside the reports received at the meeting **agreed** with the executives view that the opening score for this risk should be 16 and the target of 12.

University Hospitals Sussex
NHS Foundation Trust

Strategy and Major Projects Programme Board Chair's report	Chief Strategy Officer	For information only	The Committee **noted** the update
Systems Developments	Director of Strategy	For information only	The Committee **noted** the update

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	11.	**Meeting:**	Trust Board in Public	**Meeting Date:**	14 May 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 May 2026. The Committee meeting was quorate and received its scheduled business. Quarterly reports for the main quality and patient safety domain areas were received at this meeting. The Board can take assurance through the work of the Committee that focus is being provided to the areas of patient safety, quality of services and patient experience including the processes supporting the reporting of patient, quality and safety KPIs.

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

The Board should note strengthening Quality Governance with full suite of quarterly reports received across all domains in Q3 and Q4 with the expectation that the implementation of the Target Operating Model will improve Quality Governance focus and capacity however Committee noted work required for update supporting IT systems. Quality governance processes are embedded and broadly functioning effectively and areas with partial or limited assurance are understood. Learnings are identified but there is variability in how these are translated into improvement actions and implemented across the Trust. Triangulating across quality domains key theme continues to be delay of follow-up appointments, test results, diagnostics and first appointments with greater prevalence in particular services and experience in the Emergency Department (ED) and communication

There was a theme of poor communication across multiple domains including complaints, incidents, medical examiners and peri-natal and the Committee has asked for deep dive into this area and to identify where improvement plans are in place and any gaps to come back to Committee.

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

Board should note gaps in assurance in Recognition and Response to Deteriorating Patient management (which triangulates to incidents, structured judgement reviews and inquests feedback) and the Committee has asked for the plan to address this to come back. There is an emerging theme and assurance gap in surgical site infections, with a reoccurrence in cardiac that had previously resolved and asked for assurance on monitoring and how oversight is being rolled out across other surgical domains.

The Committee noted the Mental Health update and that emergency attendances have risen across UHSussex but improvement achieved in inpatient length of stay resulting from system working, and the resulting patient experience and operational impact. There is an improvement programme led by Sussex Partnership NHS Foundation Trust (SPFT) across the ICB and the committee has sought assurance that this has the resourcing and oversight required to achieve impact.

To be able to provide assurance our F&E infrastructure is legally complaint, maintained to required standards and able to support service delivery the full extent of the issues in each area, the associated risk and their impact needs to be identified across the Trust. The Committee reflected on the risk in the Board

University Hospitals Sussex
NHS Foundation Trust

	Assurance Framework and has asked what support is needed to undertake this and over what timeframe to come back to committee. Progress should be recognised in 2025/26 standing up of the Estates Improvement Group to provide oversight/governance and 85% compliance to Statutory and mandatory testing and servicing. The committee received the full suite of Maternity reports was assured by compliance to reporting and continuing focus on the safety and experience of service users and babies. Committee noted the published external MBRRACE 2024 data (Mothers & Babies Reducing through Audits and Confidential Enquiries) in which UHSx was one of nine Trusts to have adjusted perinatal mortality rates 5-15% lower than average. In response to the communication theme the committee heard about promoting 'listen to me' initiatives and being an early adopter of Martha's rule in Maternity. Committee recognised the considerable number of standards, Birthrate+ workforce analysis, CNST Maternity Incentive Scheme (MIS), Saving Babies Lives, NHSE Maternity Care practice standards and the Homebirth Service Safety Review following a Prevention of Future Deaths Report in Manchester to be complied with (alongside and existing maternity improvement programme) and the gaps and actions identified. *Committee sought assurance of oversight, resourcing, and risks to achieving required compliance.* The Board can receive the BAF with confidence that the content and score for strategic risks 3 and 4 have 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 3 and 4 have their opening scores at 20 and 16 respectively.**
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/*	*N/A*	*N/A*

University Hospitals Sussex
NHS Foundation Trust

Patient and Quality Assurance Committee Chair's Report

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

Regulatory Compliance: The Board can take assurance that Q4 shows consistent Duty of Candour compliance of >90%, consistent good level incident reporting 62.2/bed day (benchmarked). The Patient Safety Incident Response Framework is embedded and there are no overdue Patient Safety Incident Investigations (most serious incidents) and the Trust meets requirements to engage with patients and complaints open >6 months reduced to 1%. The good level of reporting has coincided with a rise in overdue early learning reviews (ELRs).

.

Patient engagement: Over Q4 there were an increasing number of complaints which reflect upwards trajectory over last 2 years. Over 2025/26 the experience of care measured through Friends and Family has improved to 92% rating good or very good from 89.5% in 2024/25. PALs contacts are increasing in volume driven by concerns about poor communication especially appointments and cancellations. Noted a review complaints process is being undertaken with outcome in Q1 and an evaluation by Healthwatch on complaints letters which broadly found a good standard with areas for improvement. *Committee asked an analysis of the nature of the poor communication across domains and improvement work being undertaken to come back.*

Patient Safety: There had been nine never events in 2025/26, The Committee noted there is no common theme, and each have actions in place to embed learnings. There has been a rise in overdue incident closure which corresponds to increased level of reporting (with >90% no harm). Actions relating to the 1 Prevention of Future Deaths Reports received between January 2025/26 actions plans are in place. *The Committee confirmed oversight by QGSG.* The Medico-Legal report noted high volume of inquests in Q4 and themes within narrative verdicts.

Themes & Learning: Triangulating across incident reporting and patient experience the key theme continues to be delay of follow-up appointments, test results, diagnostics and first appointments with greater prevalence in particular services (ophthalmology and OMFS). Other themes are experience in ED and communication which are again consistent. Noted harm-free care factors (falls, pressure damage and surgical site infections) are a theme in incidents and are being addressed through the Fundamental Standard of Care and Infection Prevention Control.

Fundamental Standard of Care: The Committee acknowledged there has been partial but strengthening assurance through Fundamental Standard of Care with the Nursing Quality Group oversight and evidence it is now well embedded with Ward level leadership and clear targets set. Falls in Q4 showed sustained improvement with most Divisions tracking below mean averages. Martha's Rule had been fully implemented across all acute sites. Pressure damage had seen similar improvements with Trust new beds and mattresses. Board should note material gaps remain in documented Recognition and Response to Deteriorating Patient management (which triangulates to incidents), despite special cause improvement in NEWS (5+) and PEWS scores this is below the standard and shows variation. This is also a

Quality Account priority and will be reflected in this. *The Committee has asked for assurance of actions being taken to improve around this theme at its next meeting.*

Clinical Outcomes and Effectiveness:

Clinical Documentation**:** *Limited assurance:* Improvement in compliance noted (44% to 47%), however pace insufficient to meet 95% in date by end 2026. Pilot to review documents against national standards using AI to identify opportunities for consolidation. Out of date documentation acknowledged to represent considerable risk to the Trust. *Committee has asked for sought assurance of action plan and key risks to achieving compliance by December 2026.*

National Audits**:** *Partial Assurance* with number of non-compliant audits with 13 National audits at risk out of 75 and 3 outliers alerts received in Q4 due to gaps in data acquisition. Action plans being developed to reduce risk of audits at risk/outliers recognising the detrimental to the ability to benchmark and question variance.

GIRFT: Limited assurance: During 2025/26 UHSussex has participated in 6 reviews and engaged with Further Faster Meetings however compliance remains static. The Committee is looking to see refreshed use of GIRFT across the Trust but acknowledge this requires refreshed governance and oversight as the Trust Operating Model is rolled out.

Learning from Deaths**:** Assured with high scrutiny levels. Structured Judgement Reviews now ~28 days with 99% acute deaths scrutinised by medical examiners. Sustained SHMI improvement has been attributed in part to the improved fundamental standards of care including hydration.

NICE : Partial Assurance: Assured of NICE guidance process, that all guidance has a named lead and there is no longer a back-log. However, the Committee is alerted to the number of fully compliant guidance that started to reduce in Q4. Technical Appraisals are compliant.

Health Inequalities**:** Smoking Cessation assured, RTT inequalities widening for most-deprived cohorts. Data recording required improvement.

Quality Account**:** A first draft of the Quality Account 2025/26 was received and will be shared with the ICB. Four areas: patient falls outcome measures, VTEs, readmitted rates and ED performance had deteriorated. The committee discussed areas priority areas of focus with the triangulated issues described above while a limitation on data to assure improvement in readmission.

Infection Prevention and Control (IPC): The Committee received a report covering Infection Prevention and Control which containing the validated performance data across main infection types from Q4 2025/26. All surveillance metrics exceeded National thresholds, but benchmarks show the Trust compared favourably with South East and London Trusts. There was an improvement in staff influenza vaccination uptake to 52% in 2025/26, compared with 34% in the previous year. The Committee has a gap in assurance in Surgical site infection (SSI's) with variation in rates in areas which had been reduced previously; but noted the 'One Together" framework used for quality improvement. In the IPC Board Assurance Framework, the Trust is fully compliant against 40 of the 54 elements and no red areas. Norovirus outbreaks across sites in Q4 was noted and measures taken to action to surface decontamination. Plans in response to Anti-microbial Resistance NHSE 'Call to Action' are underway and include IV to oral switching.

Safeguarding: Assurance of statutory compliance and governance but noted an increase in referrals and Q4 safeguarding activity across children and young people and adults reflecting system pressures and complexity of need, particularly sustained pressure in ED,

flow issues, demand increased considerably (17% Adult Mental Health and 48% CAMHS). Training compliance on Level 3 training has reduced to 75% because of expanded training needs with adults safeguarding but a recovery trajectory was presented to address this to achieve 85% by the end of 2026. Oliver McGowan training Level 1 remains above target at ~97% and level 2 is being rolled out. Delayed discharges (CYP) have reduced since 2024/25 through system working in strengthened pathways and oversight but remains a significant concern. Noted focus on safeguarding in maternity. It is welcomed that Independent Domestic Violence Advocates have been recommissioned for 26/27.

Facilities and Estates: Limited Assurance as the Committee has been unable to understand the full extent of the issues across the Trust infrastructure, the associated risk and the impact that will support prioritisation of actions to ensure our estate is safe, legally complaint and maintained to required standards. *The Committee has asked what support is needed to undertake this and over what timeframe to come back to committee* The committee noted key areas of risk in Fire Safety, Ventilation and Water Management. Progress should be recognised in 2025/26 standing up of the Estates Improvement Group to provide oversight/governance with 85% compliance to Statutory and mandatory testing and servicing of the facilities and estate. There was welcome progress toward ensuring dashboards fully reflect the extent of compliance challenges, including Fire Safety actions and the committee heard about the plans to show clear trajectories of work programmes for improvement that will be essential given the scale of this agenda. An area of focus has been Medical Gases linked to CQC and internal audit and actions to address these are reported to the appropriate governance forums through Q1 2026/27.

Maternity: The Trust Perinatal Quality Oversight Model provided oversight across the service, and the committee was assured by compliance to reporting and outcomes and focus over the safety and experience of service users and babies. Committee noted the external MBRRACE 2024 data (Mothers & Babies Reducing through Audits and Confidential Enquiries) which UHSussex was one of nine Trusts to have adjusted perinatal mortality rates 5-15% lower than average and the Local Maternity and Neonatal System, 94% compliance with Saving Babies Lives. Committee received the Maternity patient safety incident response report and was assured incidents had been investigated and lessons learnt across the Trust and noted no-harm incidents reporting. It also noted the Q3 2025/26 Maternity Claims Scorecard recognising that some very historic cases are reflected 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 announcement of an Investigation Chaired by Donna Ockenden, the ongoing National Maternity and Neonatal Investigation and unannounced visit by the CQC to Worthing were noted and the negative media coverage received. The committee sought assurance on how those using our services and our staff are being supported at this time with concerns considering the coverage.

The meeting discussed low response rates on Friends and Family Test, heard about initiatives through Maternity and Neonatal Voices Partnership (MNVP) triangulating with Fundamental Standards Care walk arounds. The meeting also heard about promoting 'listen to me' initiatives and being an early adopter of Martha's rule in Maternity. The Committee recognised the considerable number of standards, Birthrate+ workforce analysis, CNST Maternity Incentive Scheme (MIS), Saving Babies Lives, NHSE Maternity Care practice standards and the Homebirth Service Safety Review following a Prevention of Future Deaths Report in Manchester to be complied with (alongside and existing maternity improvement

programme) and the gaps and actions identified. *Committee sought assurance of oversight, resourcing, and risks to achieving compliance by Dec 2026 at the next meeting.*

Care Quality Commission Inspection and Remedial Actions: The Committee were updated on inspection activity with further reports anticipated and the committee heard about the work to consolidate actions including those from reports to follow. A deep dive had been undertaken by NED members of the committee into the process of oversight of CQC actions by the CQC Improvement Steering Group and evidence of closure of actions and how actions are managed as Business As Usual when they are multi-year programmes of work.

Quality Scorecard: The Committee **noted** the number of formal complaints, number of open complaints were only special cause concern.

Other areas of note:

Antimicrobial Resistance: A presentation had been received in Q3 on NHSE's 'Call to Action' and an update on the plan was given at the May meeting.

Endoscopy Standards (JAG) accreditation: Risk to Trust compliance. *Committee has asked for sought assurance of progress and actions being taken to improve this at September 2026 meeting*

Ophthalmology: Following the December Committee presentation an update on the key risks in Ophthalmology was received and the learning and improvement initiatives including wait-list stratification and pathway work with GIRFT. *Committee has asked Ophthalmology to come back in 6 months to update on progress,*

Stroke and Mechanical Thrombectomy: The Committee reviewed Stroke Care standards and benchmarking (SSNAP) and noted that the revised standards have changed and for therapies onward to community rehabilitation there is work to do across Sussex with partners to meet requirements. Mechanical Thrombectomy has been expanded 8-8pm with a recent NHSE visit that led to agreed funding to support the Trust moving toward a 24/7 service.

Quality Impact Assessment: Committee awaits progress on wider use of QIA in the Trust. The assessments presented to the committee was limited given the considerable Cost Improvement Programmes. The Chief Finance officer described the close oversight and dynamic reviews on the pace and development of the improvement programme.

QGSG chairs report: The Committee **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. Focus was given to regulatory compliance and risks in areas across the Trust. CMO updated on medicines safety and work ongoing to improve access to aseptics. There was better grip on understanding where the issues are in the Estate and facilities with further work to do on identifying the implications for clinical compliance. EPMA in the Emergency Department remains a **noted** barrier.

Board Assurance Framework: The Committee scrutinised its allocated element of the Board Assurance Framework relating to strategic risks 3 and 4, this being *in relation to the following strategic objectives.*

Improving safety and experience ***SR3***
Improving equality of access and outcomes ***SR4***

Following the review of the BAF itself and the reports received at the Committee in May we agreed with the recommendation of the opening scores of 20 (SR3) and 16 (SR4) are appropriate with plans to reduce by the end of March 2027 to 16 and 12 respectively. The Committee seeks the health inequalities plans and mitigation measures at a future meeting.

The Committee also reflected on the Estate Improvement work and discussed the most suitable oversight of SR8 (*Better, more sustainable buildings and equipment*).

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**5 May 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			
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
Care Quality Commission (CQC) / Regulatory Update	**Presenter** Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted the update on CQC related activity and long awaited reports. CQC Steering Group continues to review actions moved to a BAU classification
Patient Safety & Experience			
Patient Safety and Engagement Q4 2025/26 Medico-legal Report Q4 2025/26	**Presenter** Director of Patient Experience for Director of Patient Safety & Learning	**Purpose** For Assurance	**Outcome /Action taken** Noted the report and positive repo discussed the triangulation of themes from complaints and inquests identifying Communication issues as an area for future deep-dive
Mental Health Update Q4- stocktake across attendances and length of stay for patients	**Presenter** Deputy Chief Nurse (Quality)	**Purpose** For information	**Outcome /Action taken** Noted update and executive escalation of considerable increased demand at ED & environment safety implications for MH care; also MHA data visibility. Discussed changes to the Mental Health Act and implications for acute trusts. Urgent gaps to be addressed by Q2.
Infection Prevention and Control Q4 2025/26	**Presenter** Chief Nurse	**Purpose** For assurance	**Outcome /Action taken** Noted. Seeking further clarification to come back after sternum surgical site infections investigation to determine if these were due to patient comorbidities or issues the Trust had sought to learn from.

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 (Feb 2026)	**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. Informed the discussion toward the infrastructure Board Assurance Framework risk oversight.
Safeguarding (Adults, Children and Maternity) Q4 2025/26	**Presenter** Director of Safeguarding	**Purpose** For assurance	**Outcome/Action taken** Noted the update on work taking place and apparent progress.
Clinical Outcomes & Effectiveness & Health Inequalities Q4 2025/26 Report Mortality & Learning from Deaths Q4 2025/26 DRAFT Quality Account 2025/26	**Presenter** 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. Noted the Draft Quality Account
Maternity			
Perinatal Quality Surveillance Report and Dashboards to February 2026	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted and assured over the performance
Maternity Claims Scorecard Q3 2025/26	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted
Perinatal Mortality Review Tool (PMRT) Q4 2025/26	**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted and assured over the performance
Maternity PSIRF Q4 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 Q3 2025/26	**Presenter** CNO/ Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted and assured over the performance
Homebirth Service Assurance Report	**Presenter** CNO/ Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted and assured over the performance
Bi-annual Perinatal Workforce Report	**Presenter** CNO/ Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted and assured over the performance
Maternity Care Bundle Gap Analysis	**Presenter** Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted the current position

University Hospitals Sussex
NHS Foundation Trust

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 SR3 and SR4 to the Board

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	12.	**Meeting:**	Trust Board in Public	**Meeting Date:**	14 May 2026
Report Title:	People & Culture Assurance Committee Chair's Report				
Author(s):	Professor 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 Assurance Committee in May 2026.

The Committee meeting was quorate at each of these meetings and received its scheduled business and had a positive 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 agreed to provide feedback on the People scorecard to enable this to be iteratively improved for 2026/27.

The Committee took the following actions:-

- *Considered the Trust's Workforce Standards submissions and recommended them to the Board for final approval*
- *Considered the Guardian of Safe Working Hours annual report and recommend this be presented to the Board for information*
- *Reviewed the allocated segments of the Board Assurance Statements to make a recommendation to the Board.*

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

The Board can receive the BAF with confidence that the content and opening score for the three strategic risks SR5, SR11 and SR12 having been scrutinised by the Committee.

The Board can approve the submission of the mandated data sets relating to WRES, WDES and Gender Pay gap based on the assurance provided to and through this Committee.

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 5, 11 and 12, noting that there remains work to*

University Hospitals Sussex
NHS Foundation Trust

	be completed on populating fully certain elements of the BAF itself for the next Committee meeting - *the guardian of safe working hours annual report* *The Board is asked to **APPROVE** the formal submission of the Trust's Workforce Race Equality Standards submission and the Workforce Disability Equality Standards submissions.*
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.* *The BAF had been considered by the Executive Management Committee and the underlying process at the Audit Committee.*

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 8, 10 and 11*

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)*

University Hospitals Sussex
NHS Foundation Trust

People and Culture Committee Chair's Report

The People and Culture Assurance Committee met on 5 May 2026. The Committee was quorate at both meetings as was attended by at least two Non-Executive Directors and two Executives Directors. In attendance at these meetings were the respective report presenters including the Director of Human Resources, the Associate Director of Leadership, Culture and Development, Head of Medical HR and for the Guardian of Safe Working Hours for her annual report and the Chief Information Officer and Head of Libraries for their item on digital literacy.

At its meeting the Committee received its planned items including a report on the delivery of the Excellent Care Everywhere people ambition delivery plan for quarter 4 of 2026/26 and the people plan priorities for quarter 1 of 2026/27, the cultural programme delivery plan, the NHS staff survey, the workforce equality standards submissions, a health and wellbeing programme update, the resident doctors 10 point plan, the guardian of safe working annual report and an update on digital literacy. The meeting also considered the 2026/27 opening BAF and corresponding opening risk scores for those risks to which the Committee has allocated lead oversight.

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. Through this report the Committee **noted** the continuing improvement in performance reported across the various workforce KPIs noting the significant improvement in the job planning work led by the Chief Medical Officer.

The Committee **discussed** the overall level of staff employed and noted that through the most recent round of recruitment the period of supernumerary delivery has just completed, and this will now see a consequent reduction in bank staffing. The meeting **noted** that a workforce transformation plan is being developed which is incorporating new ways of working, digitisation, changes to pathways. The Committee also **discussed** the levels of staff employed within the Trust and reflected on the digital immaturity, levels of bed occupancy in quarter 4 and recognised the developing work to look at UEC flow and improvement which will support an overall reduction in bed occupancy. The Committee in considering the Trust's sickness levels **noted** that, whilst relatively low, a project has commenced to support staff back into work after periods of sickness, including through enhancements in the occupational health service.

<u>Culture Programme</u>

The Committee **received** an update on the launch of the behavioural compass into the Trust. The Committee was **assured** through the updates provided by the Chief Strategy Officer and Director of Communications on the breadth of approach to communicate the behavioural compass across the Trust. The Committee noted that the Trust's annual Star Awards have been aligned to behavioural compass to allow a process to recognise and celebrate how these behaviours are being lived. The Committee **discussed** the ways the messages were being cascaded to ensure that those will less access to the Trust intranet are not left behind.

The meeting **noted** that post the launch the next stage will be creating space and support to enable meaningful conversations are being held on living our values and noted the developing information to be provided to managers within the refreshed manager toolkit.

Excellent Care Everywhere people promise strategic delivery plan

The Committee **received** its scheduled report providing an update on the improvement projects aligned to the Trust's Strategic People Ambition.

The Committee **noted** that there was just one element of the plan that was off track, this being the Trust workforce inclusion plan. Whilst work is progressing in this area the Committee noted that there is work to be concluded to ensure that the actions align to the inclusion values work to ensure there is not a duplication of reporting effort. The Committee **agreed and endorsed** the need to ensure there is clear outcome reporting to track the impact of the actions on the inclusion value rather than a reporting of plan delivery.

10 – point plan improving resident doctors working lives

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

The Committee **noted** the expanded membership for the implementation group overseeing the delivery of this group as agreed at the last Committee meeting has delivered positive impact on progressing work.

The Committee **noted** the continued progress from the last Committee report through the delivery of the action plan and was **assured** over the oversight of the action plan delivery.

The Committee **thanked** Naiomi Hartley who was steeping down from the role of resident doctor representative.

Workforce Equality Standards

The Committee **received** and considered the three data set reports noting that a wider annual equality report will follow providing more information on the actions planned.

The meeting **discussed** the areas of improvement and the areas where change is slower. It recognised that gender pay gap reporting is driven by a level of longer serving staff with CEAs that remain in place until retirement and which, in the past, were skewed to males.

The Committee **discussed** the new programmes of work to support career progression for under-represented staff groups into senior roles. The Committee **noted** the workforce inclusion plan is the lead intervention to improve these metrics.

The Committee **endorsed** these data sets be referred to the Board for their agreement to make the required submission to NHS England.

Guardian of Safe Working Hours Annual 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 **endorsed** the planned action to support the Guardian with a deputy or another guardian to enable the work to be expanded to the Locally Employed Doctors.

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 8, 10 and 11 aligned to the objectives of ensuring our workforce is happy, healthy and supported, we are living our values in everything we do, and we have the right people, right skills working towards a common goal.

Following the review of the BAF itself the reports received at the Committee in its meeting the Committee **agreed** with the recommendation that the opening scores for these risks are 16, 16 and 20 respectively. The Committee reflected on the ambition built into the target scores and **endorsed** these noting that the reduction to the cultural risk to be achieved by the year end was supported by clear reports at the meeting.

The Committee **endorsed** the work being undertaken to improve the risk management processes and the benefits this will bring to clarity of actions being taken to mitigate operational people linked risks.

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.

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	5 May 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 a focus on the people metrics and **noted** the continuing improvement in performance reported across the various workforce KPIs noting the significant improvement in the job planning work led by the Chief Medical Officer. The Committee **discussed** the overall level of staff employed and noted the actions being taken to monitor this work. The Committee **noted** a review of the people function and processes has been undertaken and an action plan is in development.
Culture Programme Update	**Presenter** Chief Strategy Officer and Director of Communications and Engagement	**Purpose** For information	**Outcome /Action taken** The Committee was **assured** through the updates provided by the Chief Strategy Officer and Director of Communications on the breadth of approach to communicate the behavioural compass across the Trust. The Committee **noted** that the Trust's annual star awards have been aligned to behavioural compass to allow a process to recognise and celebrate how these behaviours are being lived.

University Hospitals Sussex
NHS Foundation Trust

			The meeting **noted** that post the launch the next stage will be creating space and support to enable meaningful conversations are being held on living our values and noted the developing information to be provided to managers within the refreshed manager toolkit
NHS Staff Survey	**Presenter** Associate Director, Leadership, OD & Engagement	**Purpose** For information	**Outcome /Action taken** The Committee **received** the update and reflected on the improvement actions being taken to close the gap further to the national average score. The Committee **noted** that the respective divisional teams are supported to develop detailed actions and that through the divisional oversight the tracking of these improvements is embedded into the divisional governance processes.
Workforce Equality Standards - WRES - WDES - Gender pay gap	**Presenter** Associate Director, Leadership, OD & Engagement	**Purpose** For information	**Outcome /Action taken** The Committee **received** the three data set reports and **discussed** the areas of change and the areas where change is slower recognsing that for gender pay the gap is driven by a level of longer serving staff with CEAs that remain in place until retirement and in the past these were skewed to males. The Committee **discussed** the new programmes of work to support career progression for underrepresented staff groups into senior roles. The Committee **endorsed** these data sets be agreed by the Board for submission.

Health and Wellbeing update having a focus on the cost of living support offered	**Presenter** Associate Director, Leadership, OD & Engagement	**Purpose** For information	**Outcome /Action taken** The Committee **noted** that the overall health and well-being plan is incorporated in the Strategy Delivery plan and reporting. The Committee **reflected** on the cost of living support offer to staff and endorsed that this supports workforce stability. The Committee **discussed** the benefit of the processes currently on offer and **endorsed** that a further request be made to the Trust Charity to continue this level of support for a further period.
10-point plan improving resident doctors	**Presenter** Director of Medical HR	**Purpose** For assurance	**Outcome** The Committee **received** the report and update on the delivery of the 10 point plan. The Committee **noted** the expanded membership for the implementation group overseeing the delivery of this group as agreed at the last Committee meeting has delivered positive impact on progressing work. The Committee **noted** the continued progress from the last Committee report through the delivery of the action plan and was **assured** over the oversight of the action plan delivery. The Committee **thanked** Naiomi Hartley as the resident doctor representative.
Guardian of safe working hours Annual report	**Presenter** Chief People Officer	**Purpose** For assurance	**Outcome /Action taken** The Committee **received** the report and noted the Guardian's assurance over the established processes for exception reporting. The

			Committee **noted** that the report provided **assurance** over the action being taken in respect of issues raised. The Committee in recognition of the expansion of the exception reporting to Locally Employed Doctors **endorsed** enhancing the level of support through a second or deputy guardian
Internal Communications – update	**Presenter** Director of Communications	**Purpose** For information	**Outcome /Action taken** The Committee **received** the update on the delivery against the agreed recommendations. The Committee **discussed** the launch of a UHSussex voices channel for extended internal communications to aid the cascade of messages into and across the Trust. The meeting **noted** the focus on the measurement of the effectiveness of the launch of excellent care everywhere strategy was a key focus of the last quarter. The Committee **noted** the extended staff panel membership and its use of this panel to sense check recognition of the Strategy launch communication. The Committee **noted** the plan priorities for the launch of values and behaviours and the support for STARs. We need to promote this access route
Excellent Care Everywhere – Patient Promise strategic delivery plan for quarter 4 and priorities for quarter 1 on 2026/27	**Presenter** Director of workforce	**Purpose** For discussion and assurance	**Outcome** The Committee **received** its scheduled report providing an update on the improvement delivery and how these align to the Trust's Strategic Ambitions.

			The Committee **noted** that the progress and that one element of the plan that was off track, this being the Trust workforce inclusion plan. The Committee **discussed** this area and **noted** the work to be concluded was to ensure that the actions align to the inclusion values work. The Committee **agreed** and endorsed the need to ensure there is clear outcome reporting to track their impact rather than reporting of plan delivery. The Committee in considering the frequency of receiving this report and **agreed** that this report should move to six monthly.
Digital Literacy & Confidence	**Presenter** Chief Information Officer and Head of Library Services	**Purpose** For discussion	**Outcome /Action taken** The Committee **received** the report noting how this work is looking to mitigate the current relatively low levels of digital maturity. The Committee **discussed** the work planned to enhance literacy as new systems are rolled out and that this will assist in enhancing digital maturing within the workforce. The Committee **reflected** on the role of the Trust and the expectations it should have of new employees whilst supporting those already employed to become more digitally proficient.
Committee reporting group reports	**Presenter** Taken for information without wider discussion	**Purpose** For information	**Outcome /Action taken** The Committee **received** these and discussed the report in relation to apprenticeships. In this area the Committee **noted** the

			positive take up of this route and the high levels of such staff retention and career progression.
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 risks.
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 the scores of the three allocated strategic risks, SR5, scoring 16, SR11, scoring 16 and SR 12 scoring 20. The Committee **discussed** the ambitious target scores set and endorsed these. The Committee **noted** this planned work to improve the clarity of mitigations to ensure the metrics to show their impact are clear.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	13.	**Meeting:**	Trust Board in Public	**Meeting Date:**	14 May 2026
Report Title:	Finance & Performance Assurance Committee Chair's Report				
Author(s):	Philip Hogan, NED and Committee Chair				

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)*

This report presents the business of the Finance and Performance Assurance Committee (FPAC) meetings in February, March and May 2026.

FPAC received, reviewed and noted the Financial and Performance reports for months 10, 11 and 12 of 2025/26 including forecasts for the full year, undertook extensive review and discussion of the plans for 2026/27.

The Committee was quorate at each meeting and received all its scheduled business by the end of the quarter.

In accordance with its Terms of Reference and Trust Standing Financial Instructions, FPAC approved two investment decisions:

- In March, the contract award for the supply of Security Services; and
- In May, a business case to replace a CT scanner in Worthing with cardiac capability.

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)*

In May FPAC commended two recommendations for Board approval that exceed the Committee's delegated authority:

- The Capital works contract for the reconfiguration of the Trust's Stroke Service, with an expectation that the Income and Revenue business case will be finalised and approved in June; and
- An additional funding request for the ongoing ventilation and cooling works at Worthing for an additional MRI Scanner.

In March, the FPAC also confirmed that it had reviewed the changes to the Electronic Patient Record (EPR) Project Business Case from version 2.6 to version 2.8, the changes being minor in nature.

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 FPAC on the Trust's:

- Financial and operational performance and the plans to address any risks to the achievement of the annual delivery and Break-Even plans;
- Efficiency and Cost Improvement initiatives;
- Cash management process;
- Capital Expenditure programme;
- Commercial and Procurement operations; and
- Environmental and Sustainability reports and the Green Plan.

The Board can receive the BAF with confidence that the content and score for strategic risks assigned to the Committee. The new strategic risks for have been scrutinised and the current and target assessment scores are presented for Q1 2026/27.

University Hospitals Sussex
NHS Foundation Trust

Recommendation *(linked to What Next section)*	The Board is asked to note that the Trust: • Met and exceeded its Financial Break even target for 2025/26; • Met it's 65-week RTT targets and has generally maintained operational performance metrics against its delivery plan, although has not yet delivered the transformational change to significantly move the Trust up the national performance metrics. • Is managing within very tight cash limits; • Fully spent its allocated Capital Budget; and • Agreed a break-even plan and performance delivery targets for 2026/27. The Board is asked to approve: • The Capital works Contract for the Stroke Reconfiguration initiative; and • The additional funding for the Ventilation and cooling works for the additional MRI Scanner at Worthing Hospital. These approvals will be brought to a subsequent meeting. • The opening and target scores for BAF strategic risks 1, 2, 8 and 10.
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 1,2, 8 and 10 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)*

University Hospitals Sussex
NHS Foundation Trust

Finance and Performance Assurance Committee Chair's Report

The Finance and Performance Assurance Committee met in February, March and May 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 deferrals in month of Environmental & Sustainability Report (Q3), the Green Plan and the update on CQC Actions oversight, and Non-RTT Waits (overdue follow up) analysis but all had been received by the May 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 4 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** at the end of Month 12, subject to audit, the Trust achieved the planned break-even position and having received a National allocation of deficit support funding, reports a £4.9m surplus. The committee acknowledged the non-recurrent funding through 2025/26 that the Trust would not have been entitled to had break-even not been achieved.

The Committee recognised contributions from finance and operational teams, in particular through the H2 process. The Committee heard of the wider benefits gained from the process and how the quality impact assessment (QIA) process supported decision making. Although in aggregated, operating divisions were adverse to plan in month 12 and year to date, the Committee has been sighted on Division performance through H2 and recognised the strong leadership to recover adverse positions by year-end in the Surgery divisions and Clinical Support Services.

The Committee recognise that support received from system partners is testament to the positive relationships that have been maintained. The Committee discussed the implications for forecasting focus for 2026/27 and for the future and noted that external support had conducted work to explore composition of the outturn position to see if the risk profile has changed.

The Committee recognise that non-recurrent mitigations been applied to deliver the planned position and have questioned through its meetings the implications or risks these pose for 2026/27. The Committee also heard about the lessons learned to inform the budget setting for 2026/27 that included how budgeted whole time equivalents were handled for how efficiency targets are transacted. The Committee sought to understand how estate valuation can have a positive impact on public dividend capital.

The Committee has **discussed** through 2025/26 the constrained cash position. 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. The cash position had not materially changed and remains a challenge into 2026/27 and these controls will need to be maintained. Additionally, it will be important that efficiency programmes deliver the identified cash-releasing savings.

Grip and Control reports have been received and the committee heard about some improved metrics including insights to the cash position. While discretionary non-pay expenditure have remained below thresholds some upward trend following a change in process that will be further examined. The Committee praised nursing leadership for the close control of agency expenditure. However, the Committee has cautioned against taking undue

assurance from this positive performance and will look forward to workforce plans to ensure they consider future needs as part of maturing approach to efficiency planning. Delivery of efficiencies in bank and substantive staffing had not delivered in previous years and the Trust remains an outlier on overall temporary working spend and without transformation work the workforce may be mis-calibrated.

Efficiency and Productivity

The Committee **received** the scheduled efficiency and productivity reports at each of its meetings in the quarter. At month 12, the Committee noted that Efficiency programme full-year delivery was £96.84m, £16.12m adverse to plan. The key drivers of the underperformance had been the under-delivery in the schemes identified later in the year.

Capital

The Committee **noted** that the Trust at month 12 finished the year ahead of plan with any plan reprofiling having had NHSE and Sussex system partner agreement.
The Committee acknowledged delivery had included some reprofiling and sought further clarification on what this means for future years across specific major projects so the Trust can be assured of continued appropriateness of spend and has made recommendations for improved report clarity. The Committee heard about the Capital Investment Group scrutiny applied to the plan and individual schemes.

The Committee asked for a risk stratified medical equipment replacement programme plan to **be brought back** to the next meeting.

The Committee expressed concerns with the revised MRI Ventilation and Cooling business cases that had required considerable additional funding above the original budget agreed that included scope creep and associated cost increases. A recent internal audit identified fragmentation in the programme that had brought considerable growth in costs and led to a decision to consolidate to a single Infrastructure directorate in the new Trust Operating Model. The Committee acknowledged the lessons for capital plan profiling and associated contracting and looks forward to the action plan addressing these issues **to be brought back** in future capital updates.

2026/27 financial planning and budget setting

The Trust agreed a breakeven financial plan for 2026/27 following extensive engagement with NHS England and ICB colleagues and discussion at Trust Board. While the plan has been accepted, several core components continue to be refined as the Trust moves from plan submission to delivery. The Committee has acknowledged at each meeting the risks to delivery of the plan.

An update was received that will be discussed at Board. The Committee **received** reports on the planning process and recognises there is zero additional funding without a clear delivery saving plan. The Committee received NHS England's feedback to the non-compliant plan submission and the Committee heard there were actions to respond to these assurance challenges.

The Committee reviewed the new budget setting for 2026/27 and acknowledged implications for cost improvement plans due to changes in director leadership. The Committee heard project initiation documentation has been outlined for £110m of the £140m efficiency plan for 2026/27 and was informed of identified mitigation plans and leadership arrangements reflecting the multi-year nature of plans necessitating in-house capability building but with specialist external support where appropriate.

The 2026/27 plan has not changed since the discussion at Board in March. The Committee recognised some associated details were being worked through and papers that outlined the process were **noted**. The Committee acknowledged lessons from 2025/26 reflecting on the deliverability of the CIP programme, particularly the difficulty of reliance on delivery of late additions to the plan.

The Committee has discussed the framework of the programme by which it should be provided with the necessary confidence that the year-on-year delivery of efficiencies will continue to increase to meet the challenging 2026/27 target. The Committee looks forward to the further confidence that should be gained from enhanced detail in targeted areas of the plan delivery.

Commercial Report

The Committee received wide ranging updates including work on the technology implementation roadmap and an inventory management system progress including its rollout and next phase expected to have considerable benefits realisation. Details of Sussex system-wide procurement collaboration projects were shared together with the pipeline for 2026/27 that leveraged aggregated buying power.

The Committee continues to recognise that food concessions are key areas of partnership working vital to staff wellbeing and feeling valued. The Committee received assurance of these concessions reaching the highest food safety ratings and heard and about work to enhance vending machine and out of hours offerings.

The Committee received a procurement and supplies report that showed how the Trust had recognised and worked to mitigate volatility caused by global events that increase energy and manufacturing costs and may extend lead times from suppliers. These include work with national NHS supply chain and work with suppliers on contingent high risk product ordering. The report reflected improvement in the contract management function and particular focus post-contract award. Partnership working with contract analysts had enabled positive savings. The Committee recognised that contract management and procurement is a contributor to the Trust's CIP and seeks assurance on how opportunities are recognised to be realistic with more detail **to come back**.

Investment decisions

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

• A contract award for the supply of Security Services (March 2026); and
• A business case for a replacement CT scanner for Worthing with cardiac capability (including draw-down and expenditure of NHSE Return to Constitutional Standards capital funding and the investment of capital funds). (May 2026)

In May the Committee commended other **recommendations** for Board approval that exceed the Committee's delegated authority:
- Stroke Service Reconfiguration Full Business Case
- Additional funding requests for ventilation and cooling works at Worthing Hospital for an additional MRI Scanner.

In March, the Committee also confirmed that it had reviewed the changes to the Electronic Patient Record (EPR) Project Business Case from version 2.6 to version 2.8, the changes being minor in nature as this Trust agreed business case proceeds through NHS governance.

Quarter 4 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 had deteriorated month on month since December through February and although there was improvement in March, overall, the Trust performance remained lower than national average and did not meet the 78% 4-hour target at year end but has maintained ambulance handovers While this performance has been static it was against a context of increased attendances, but also of likely greater acuity.
- The Committee acknowledged considerable site variation and discussed the factors. While the concerted work to improve long standing corridor care challenges in RSCH were evident, there were worsened positions in other sites. Changes to the Trust Operating Model implemented from May 2026 had been designed to ensure the necessary division focus and revised reports were discussed.
- Referral to treatment performance saw improvement at month 12 to 55.1% which is below the national performance level but met the Trust's improvement trajectory. The Committee **noted** significant progress in reducing the cohort of patients at risk of waiting over 65 weeks. There were 52 65-week waits in March 2026, a decrease of 342 compared to February 2026.
- The Committee praised teams for having delivered all metrics that the Trust had said they would with the exception of the overall waiting list size and recognised the considerable effort to address what had been one of the largest RTT recovery challenges in England.
- Cancer treatment targets were not met in starting treatment within 62 days and missed the local recovery trajectory target with a performance of 62.9% in February 2026. The faster diagnostic standard performance improved to 80.9% at month 11, exceeding the national average. The Committee heard the expected position is to improve in March 2026 to achieve the commitments in the plan i.e. achieving 62-day and FDS 28-day standards.

The Committee had previously widened its scope to non-RTT wait performance and discussed the requested analysis at its May meeting. The Committee **noted** oversight had been strengthened through Trust-wide processes, pathway level visibility via business intelligence, and weekly Waiting List review of overdue volumes, wait duration and recovery progress. The overdue backlog had reduced considerably through April 2026 following targeted interventions in OMFS, Ophthalmology and Gastroenterology alongside the strengthened trust-wide oversight.

The Committee heard that key enablers underway included administrative validation at scale, supported by a planned technological solution to deliver in H1 2026/27 and expansion of patient initiated follow-up (PIFU) supported via Netcall, funded by NHSE, with patient access via the NHS App; rolled out to first specialties in March 2026 and all specialties by March 2027. The Committee recognise the importance of oversight of this cohort and will confirm a suitable reporting frequency to provide the necessary assurance on managing it.

Environmental Sustainability Report

At the March meeting the Committee **received** the quarter 4 report on the Trust's delivery against its Green Plan. The Trust had continued to deliver against its original *Patient First, Planet First* Green Plan, which targeted a 57% reduction in direct carbon emissions from the 2009/10 baseline by 2025/26. It was estimated that at the end of 2025/26, Trust's direct

footprint will be ~ 36,000 tonnes CO_2e. This is a 6% reduction from the 2019/20 baseline (or ~ 15% reduction excluding the Louisa Martindale Building).

While this represents meaningful progress, the variance to the 57% reduction target relates to estate growth, clinical expansion and the national grid not meeting its decarbonisation projected plans.

The Committee heard the focus over the last quarter has been the development of the green plan refresh for 2026 – 2030, and included stakeholder events and engagement and should be aligned with the *Together to Zero* ICS Green Plan and updated Greener NHS guidance. The refreshed plan will adopt a 2019/20 baseline and establish interim milestones to 2032 in line with NHS England's net zero trajectory. The Committee **noted** the revised draft Green Plan 2026 -2030 would be considered by the Strategy & Major Projects Committee and work would progress to develop climate resilience plans for all major sites and a Sustainable Travel and Transport Strategy by 2026.

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 the new strategic risks assigned to the Committee by the Board at their meeting in March.

Strategic Risks 1, 2, 8 and 10, relate to the following strategic objectives:
- SR1 Delivering timely care for planned treatment and cancer care
- SR2 Urgent and Emergency Care - improving access, quality, safety and environments
- SR8 Better, more sustainable buildings and equipment
- SR10 Improving value and financial sustainability

Through the information recorded in the BAF and the reports received at the May meeting the Committee **agreed** their quarter 1 scores.

The Committee discussed SR8 and acknowledged that the target risk for 2026/27 should be reset once the work to confirm the realistic impact on the risk from major actions taken is complete and **brought back** to the Committee, in light of the considerable backlog maintenance and estate condition challenge. The Committee noted that the Patient & Quality Assurance committee have proposed a change to the lead assuring committee oversight for this risk for which the Committee is supportive and will continue to oversee the closely linked capital plan, mindful of this risk.

The Committee noted a typographical error in SR1 and **noted** that the paper to Board confirms that if the associated transformation activity goes ahead, the target risk should reduce to 12.

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.

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**26 February 2026**	**Chair**	Philip Hogan	**Quorate**	Yes
Meeting Date	**26 March 2026**	**Chair**	Philip Hogan	**Quorate**	Yes
Meeting Date	**7 May 2026**	**Chair**	Philip Hogan	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

2025/26 Quarter 4 Financial Performance Report - monthly position - cash reporting - grip and control reports	**Feb**	**Mar**	**May**	**Presenter** Chief Finance Officer / Director of Operational Finance	**Purpose** For assurance	**Outcome /Action taken** **Noted** M12 position and delivery that was in line with the submitted plan despite in month deficits reported at M10 and M11. Progress on recovery activities were noted.
2025/26 Quarter 4 Efficiency & Productivity Reporting - monthly position and assurance process	**Feb**	**Mar**	**May**	**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 Months 10 (Feb), 11 (Mar) and Quarter 4 (May)	**Feb**	**Mar**	**May**	**Presenter** Director of Strategic Finance	**Purpose** To update on the implementation of the 2025/26 capital plan & set out actual position at Q4	**Outcome /Action taken** **Noted** the delivery of the was ahead of plan in quarter 4 but included some plan re-profiling agreed with system partners. The Committee asked for changes to future reporting and reports to come back including a risk stratified medical equipment replacement programme and actions to address contracting lessons learned
Commercial Progress Report Q4 2025/26 including Procurement Update			**May**	**Presenter** Chief Procurement Officer	**Purpose** To Note	**Outcome /Action taken** Noted activity undertaken by the commercial directorate

University Hospitals Sussex
NHS Foundation Trust

Operational Performance Reporting ▪ Performance Scorecard ▪ Constitutional Standards Performance Report	**Feb**	**Mar**	**May**	**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 but targets at Feb 2026 were not met. The level of improvement in urgent & emergency care remained insufficient. The Committee noted identified growth in UEC demand is unsustainable. Previously reported elective Demand led to growth in waiting list size that risks achievement of targets. The Committee received analysis of non-RTT waits to understand risk and actions taken to mitigate it
Planning Approach 2026/27 – 2028/29	**Feb**	**Mar**	**May**	**Presenters** Chief Finance Officer/ Director of Strategic Finance	**Purpose** For approval	**Outcome /Action taken** **noted** the full submission of the Financial Plan in February 2026 and subsequent submission of a revised plan in March 2026. The committee **noted** the current status at Q4 and progress to develop and implement the 2026/27 financial plan. Discussions informed further refinement ahead of the Q1 Board review
ICS System Update	**Feb**			**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 took place in late January 2026 to be replaced by new meeting arrangements.
Drivers of the Deficit and UEC Diagnostic and Support for Efficiency Delivery Discussion Paper	**Feb**	**Mar**	**May**	**Presenter** Chief Finance Officer/	**Purpose** Discussion and proposal to Board	**Outcome /Action taken** Noted the analytical work undertaken here and the links to the delivery plans for 2026/27 and future years. Discussed in March May a proposal for external support, local readiness and realisable benefit. No contract award recommendation made
Investment Decisions & Contract Recommendations - Contract Award for Security Services		**Mar**		**Presenter** Chief Finance Officer / Chief Commercial 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 Security

						Services subject to further work to reduce the mitigation costs and to reported to a future meeting. And **noted** the compliance with Procurement regulations and the Trust SFIs.
Investment Decisions & Contract Recommendations - MRI replacement (Worthing) Ventilation & Cooling works			**May**	**Presenter** Chief Finance Officer	**Purpose** To Agree and recommend for Board approval	**Outcome /Action taken** The Committee **commended to Board** use of additional funds to address the variance caused by expanded scope of works that brings the total scheme cost above FPAC's authorised limit. Asked to bring back lessons learnt re Capital plan.
Investment Decisions & Contract Recommendations - CT scanner replacement (Worthing)			**May**	**Presenter** Divisional Operations Director (Cancer Division)	**Purpose** To Approve	**Outcome /Action taken** The Committee **approved** option to procure a like-for-like scanner with cardiac capability and approved draw-down and expenditure of NHSE Return to Constitutional Standards capital funding Approve the investment of £1,907k of capital funds (excl Maintenance Contract)
Investment Decisions & Contract Recommendations - Electronic Patient Record (EPR) Programme and Full Business Case (change)		**Mar**		**Presenter** Chief Operating Officer	**Purpose** To Note	**Outcome /Action taken** The Committee **noted** the changes from V2.6 to V2.8 and confirms with NHSe that the Board are aware of the iterations to the FBC and approves version 2.8 of the FBC by NHSE issued deadline 31/3/2026.
Risk and Board Assurance Framework	**Feb**		**May**	**Presenter** Chief Finance Officer / Company Secretary	**Purpose** To agree whether risks for Q1 are fairly stated.	**Outcome /Action taken** The Committee **reviewed** their allocated risks and **agreed** with recommended risk scoring for Q1 2026/27. The Committee noted a proposal to change the Committee lead for SR8 (infrastructure) and that the target risk score would be re-set following assessing of expected action impact.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	14.	**Meeting:**	Trust Board in Public	**Meeting Date:**	14 May 2026
Report Title:	Maternity Assurance Reports – Public Board				
Sponsoring Executive Director:	Dr Maggie Davies – Chief Nursing Officer				
Author(s):	Stephanie White – Divisional Head of Quality & Safety for Women & Children				
Purpose of the report: *(indicate as appropriate)*	**For Decision**	**For Assurance**	**For discussion**	**For Information only**	
	N/A	*Yes*	*Yes*	*N/A*	
Reason for not being taken in public *(indicate as appropriate)*	**Commercial confidentiality**	**Staff confidentiality**	**Patient confidentiality**	**Other exceptional circumstances (please detail)**	
	Yes / N/A	*Yes / N/A*	*Yes / N/A*	*Yes / N/A*	
Regulatory Reporting Requirement					

Summary of the report describing

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

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

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

PQOM (formerly PQS) and Maternity Dashboard – February 2026

What

Following the Ockenden review recommendation for strengthened Board oversight of maternity services, NHS England developed a national maternity dashboard. This has been locally adapted at University Hospitals Sussex, tested through Quality Board, and is now embedded as the **Perinatal Quality Oversight Meeting (PQOM)** to provide structured assurance and escalation to the Board.

So What

Key escalations:

- In February, UHSussex maternity services have been subject to **significant media attention**, which has the potential to impact both public confidence in the service and staff morale.
- A national investigation has been announced, **chaired by Donna Ockenden**, with scope yet to be confirmed.
- Sustained external scrutiny continues, including:
  - visits by the **National Maternity and Neonatal Investigation (NMNI)** to SRH and Worthing, with ongoing senior leadership engagement,
  - an anticipated **Human Tissue Authority (HTA)** inspection across all four sites in April 2026, requiring estates and regulatory remediation.
- Mitigations are in place, including public communications highlighting strong national safety benchmarking (MBRRACE), staff engagement forums to support wellbeing, and active estates remediation led by maternity and quality leadership teams.
- **Estates challenges** remain across all sites and continue to be a constraint and risk factor.

Key positives:

- HTA-related remedial actions completed at RSCH and PRH, with residual infrastructure works underway.
- Investment in quality and safety improvements, including:
  - commencement of the Bereavement Suite at PRH,
  - delivery of ROTEM devices to support PPH management,
  - improved maternity wayfinding and signage across all sites.

What Next

- **Perinatal services remain under enhanced oversight** MNIST targeted support and national investigations. Trust-wide Perinatal mortality remains below national benchmarks.

- **Workforce pressures remain** - despite recent successes in recruitment - particularly in midwifery and neonatal nursing, although further recruitment continues and use of agencies has ceased. Skill-mix and capacity pressures continue to affect TMBU access.
- **High-scoring risks** remain under Board review, including:
  - homebirth service assurance,
  - theatre capacity for emergency and elective caesarean section,
  - merged guidance implementation,
  - estates compliance, temperature control, and security access at Sussex House,
  - access constraints in early pregnancy and surgical miscarriage services.
- Maintaining high standards of **service and support**, **staff morale,** and **public confidence** during the Ockenden investigation and ongoing MNIST engagement remains a priority, supported through PQOM and Board escalations.

Perinatal Workforce Report (Biannual)

What

This biannual report provides Board-level assurance on the perinatal workforce across all contributing specialties, in response to the **First Ockenden report** and **CNST requirements**. It outlines workforce capacity, recruitment, retention and staff experience across maternity, neonatal and associated services.

So What

- **Workforce fill rates** have improved since the previous report but remain below recommended levels, reflecting vacancies, sickness absence and parental leave.
- **Midwifery recruitment** against current establishment has been achieved, with all funded posts filled.
- **Agency usage has ceased**, reducing workforce instability and cost.
- Recruitment of **third-year students** is paused pending Board approval of updated **Birth Rate Plus (BR+) recommendations**, alongside the implementation of the **NHSE Graduate Guarantee Scheme**.
- **Neonatal nursing vacancies** have reduced to below **5–10%** across sites, with a clear pipeline to improve **Qualified in Specialty (QIS)** coverage from **42% to 51%**.
- **Staff engagement and morale** remain variable, influenced by sustained national scrutiny and short-term absence rates. Targeted mitigations are in place, including Professional Midwifery Advocate (PMA) leadership, restorative culture programmes, listening events and increased senior visibility.

What Next

- Workforce planning for **Maternity Incentive Scheme (MIS) Year 7** has been evidenced as compliant.
- A **BR+ assessment** was completed in summer/autumn 2025, with the final report received in January 2026. Current staffing models reflect the 2023 recommendations; confirmation of updated recommendations is expected in May **2026**.
- The perinatal workforce remains on a **positive trajectory**, with sustained recruitment, falling vacancy rates and continued absence of agency usage.

University Hospitals Sussex
NHS Foundation Trust

	• **Recruitment and retention strategies** are demonstrating impact, including:
	  ○ **98% retention** of the 2024 preceptorship cohort,
	  ○ **100% retention** of the 2025 cohort,
	  ○ achievement of the **National Preceptorship Quality Mark** Trust-wide.
	• Further improvements are anticipated as recruitment pipelines mature and new staffing models, including the **homebirth hybrid model** and enhanced **PMA leadership**, embed across services.

Recommendation *(linked to What Next section)*	For the Trust Board to **NOTE** the contents of the assurance report.
Assurance / Scrutiny route already undertaken (***please explain where matter previously considered, and assurance provided)***	

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*

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	15.	**Meeting:**	Trust Board in Public	**Meeting Date:**	14 May 2026
Report Title:	Integrated Performance Report				
Sponsoring Executive Director:	Dr. 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 March 2026 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 Q3 in Mar-26) 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*

NHS
University Hospitals Sussex
NHS Foundation Trust

Integrated Performance Report

March 2026 *(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

NHS
University Hospitals Sussex
NHS Foundation Trust

Please see enclosed the integrated performance report for University Hospitals Sussex. It shows our performance to March 2026 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 Q3 in Mar-26) 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

NHS
University Hospitals Sussex
NHS Foundation Trust

Chief Executive Summary page 2

Overall Trust performance during March was challenging, with continued winter pressures but material improvement in planned care recovery longest waits which were better than plan, whilst cancer and diagnostic access targets continue to improve. 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 December 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 and met the Trust aim for >60 incidents per 1000 beddays in February-26. Key themes from incidents, include falls and pressure ulcers as key contributors. The Falls Rate per 1,000 bed days March 2026, was 4.68, with an average rolling year 4.5 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 below the mean average March-25 and has reduced since March 2025 from 185 to 139 March-26. 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.

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 almost eliminated Mar-26, and 18 week performance exceeded the target agreed nationally as part of our annual plan. The waiting list is higher than planned due to increases in demand, and some constraints in certain specialties. Long waits impact patient experience, and have 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 Trust into 2026/7.

Trust constitutional access standard performance for diagnostics saw an improvement in Q4 of 2.7% and performance 8.6% better than National position, and is focussing on mitigating endoscopic modality backlogs.

Cancer performance for 62 day performance was below Trust planned recovery target in February but did improve by 2.3% relative to the same time the previous year. Faster diagnosis performance was above target of 80.9% Feb-26 and above the national average for February (80.5%). Skin and colorectal anatomical sites are most challenging and have largest backlogs. Focus is being dedicated to these anatomical sites.

University Hospitals Sussex
NHS Foundation Trust

Chief Exec Summary page 3

ED performance at the Trust has remained challenging in quarter 4. In March, the Trust saw 68.9% of patients within four hours. 12 hour performance and corridor care saw a worsened position in Q4 but remained materially better than 2024/5 corridor care, and was in the context of a 5% increase in attendances via ambulance in 2025/6. There has been a 41% reduction in 60 minute handovers. 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 fell slightly in quarter 4, and was below the mean average at the Trust over the past 17 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.

Vacancy rates have reduced to 6.9% Mar-26. 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 quarter, with sustained compliance (above 90%) for STAM and a marginal deterioration in appraisal rates to 88.2% but 5% higher than 2024/5

Our Communities

Patient experience reduced marginally to 91.7% in March, but remained above the 90% target and 2% points higher than March-25. A&E FFT remains most challenged for the Trust (and nationally) with 82.4% Feb-26, compared to 79.2% Nationally (February) 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.

NHS
University Hospitals Sussex
NHS Foundation Trust

Chief Exec Summary page 4

Our Future

The Trust submitted a revised breakeven financial plan for 2025/26. The initial position at M12 was delivery of the breakeven position which meant the Trust became eligible to receive £4.92m of additional deficit support funding bringing the final position to £4.92m surplus. The plan to achieve the breakeven position included the delivery of a £112.96m efficiency programme. For the year to M12 efficiency delivery is £96.84m, £16.12m adverse to plan but still reflecting the greatest annual efficiency achieved since the formation of UHSussex.

Plans to reduce bank and agency spend fell behind the challenging 22% agency spend reduction plan this financial year. Overspend significantly reduced to March-26 and is partly impacted by industrial action. 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 and their latest status across key project milestones. 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 (6.7 versus 6.85 National Survey results 2024). However other indicators, such as declining turnover, sickness absence and vacancies suggest a stable or improving position, reflected too in early staff survey results.

National performance assessment framework

UHSx remains Segment 4 overall rating with a provider capability assessment of red, and the Trust Overall ranking has reduced from 113 in Q2, to 121 (of 134).
The most notable drivers are performance against access constitutional standards (both planned care and UEC) and two key metrics from NHS national staff survey (raising concerns and engagement sub-scores). Relative UEC performance deteriorated in Q3, resulting in a lower score and ranking.
Implied Productivity score reduced from top quartile towards median.
The Trust continues to engage with NHS England and the ICB through their formal oversight processes in respect of all aspects of our performance, which through these quarterly meetings provide assurance on the delivery of Trust's annual plan.

Summaries

Excellent
Care
Everywhere

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

NHS
University Hospitals Sussex
NHS Foundation Trust

Metric Summary

Strategic Ambition	Performance Measure	Latest	Month	Previous	Direction	24/25 Month	Target	Plan	National
Patients	A&E and Emergency flow - % treated and admitted/discharged within 4 hours	Mar-26	68.9%	66.1%	Increase	71.50%	78%	78.00%	77.1%
	A&E and Emergency flow - Ambulance Handovers > 60 minutes	Mar-26	2.50%	2.8%	Decrease	2.4%	< 2024/5	2.30%	5.40%
	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	Mar-26	7.93%	8.72%	Decrease	7.03%	< 2024/5	7.48%	11.70%
	Cancer - 28 day faster diagnosis standard	Feb-26	80.9%	74.4%	Increase	80.0%	80.0%	80.0%	80.5%
	Cancer - To achieve the 62 day standard	Feb-26	62.9%	63.3%	Decrease	68.9%	75.0%	72.8%	68.64%
	Diagnostics - % Breaching 6 week target (DM01 modalities)	Mar-26	11.6%	11.4%	Increase	13.60%	<5%	8%	20.2%
	RTT 52 Weeks	Mar-26	3580 (3.18%)	4753	Decrease	6923	3301	3.23%	1.70%
	RTT Elective care - >=65 Weeks	Mar-26	52	394	Decrease	377	0	0	
	RTT Elective care - 18 Week Performance	Mar-26	55.1%	52.2%	Increase	48.9%	55%	55%	62.6%
	Safer Staffing - Average fill rate - registered nurses/ midwives (day shifts)	Mar-26	93.4%	93.4%	Same	89.6%	95%		
	Safer Staffing - Average fill rate - registered nurses/ midwives (night shifts)	Mar-26	96.4%	96.1%	Increase	93.4%	95%		
	Safer Staffing - Average fill rate - care staff (day shifts)	Mar-26	86.6%	84.3%	Increase	81.0%	95%		
	Safer Staffing - Average fill rate - care staff (night shifts)	Mar-26	95.4%	93.1%	Increase	91.1%	95%		
	Care Hours Per Patient Day	Mar-26	7.8	7.8	Same	7.8			
	Incidents/1000 beddays	Feb-26	62.20	59.94	Increase	54.69			
	Falls	Mar-26	4.68	4.66	Increase	4.64			
	Pressure Ulcers	Mar-26	2.19	2.89	Increase	3.01			
	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	Dec-25	100.8	101.3	Decrease	104.8	100 (as expected range)		100
People	Training & development - Appraisals completed	Mar-26	88.2%	89.3%	Decrease	83.30%	>90%		
	Training & development - STAM Weighted Average	Mar-26	93.6%	93.8%	Decrease	91.20%	>90%		
	Workforce capacity - Vacancy Factor (Substantive contracted FTE) - monthly	Mar-26	6.9%	7.2%	Decrease	7.40%	10%		
	Workforce efficiency - Absence Sickness in month	Mar-26	4.6%	4.5%	Increase	4.90%	<4%		
Communities	Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good	Mar-26	91.7%	91.50%	Increase	89.70%	>=90%		91.60%
Future	Financial Stability - Variance from breakeven plan YTD	Mar-26	-4.92	4.45	Decrease		£0		
	Bank and Agency Spend against planned trajectory	Mar-26	32.27	27.15	Increase		£0		
	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	Mar-26	30	30	Same		<27th		
One UHSX	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	Mar-26	6.7	6.7	Same	6.4	>6.9		

Statistical Process Control

University Hospitals Sussex
NHS Foundation Trust

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.

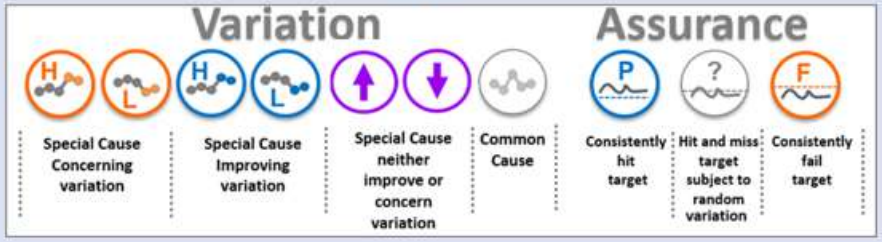
The rules (please note the rules are ordered to priortised in the order trend, shift, 2 out of 3, single point)

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



Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

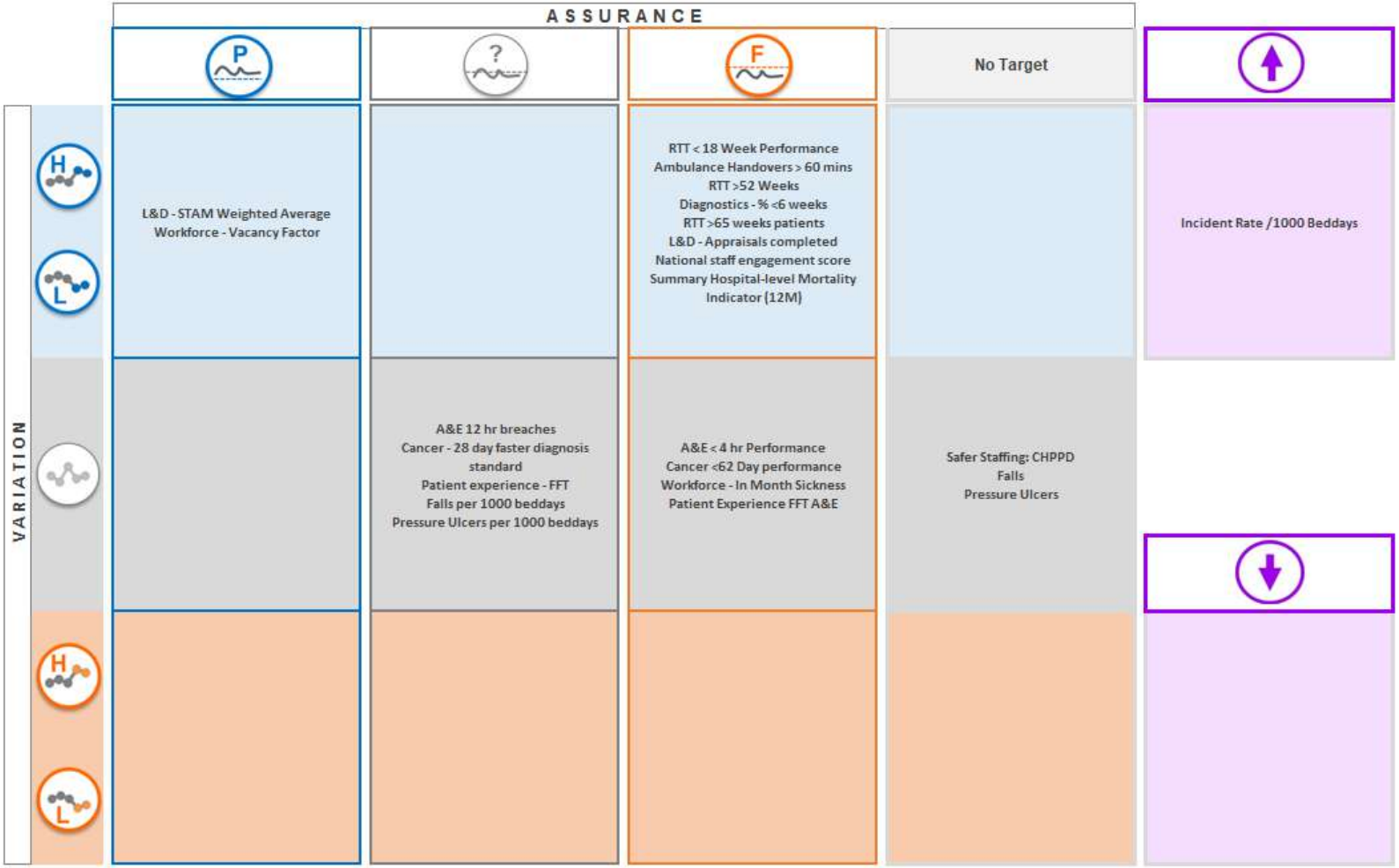
IPR SPC Summaries

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT < 18 Week Performance	Mar 26	55.1%	55.0%	H	F	49.7%	47.4%	52.1%
A&E < 4 hr Performance	Mar 26	68.9%	78.0%		F	70.2%	67.1%	73.2%
A&E 12 hr breaches	Mar 26	3052	2498		?	2777	1902	3651
Ambulance Handovers > 60 mins	Mar 26	2.5%	0.0%	L	F	3.6%	1.2%	5.9%
Cancer - 28 day faster diagnosis standard	Feb 26	80.9%	77.0%		?	74.3%	66.3%	82.3%
Cancer <62 Day performance	Feb 26	62.9%	75.0%		F	62.1%	52.9%	71.3%
RTT >52 Weeks	Mar 26	3580	3301	L	F	6939	5376	8502
Diagnostics - % <6 weeks	Mar 26	11.6%	5.0%	L	F	16.7%	11.9%	21.4%
RTT >65 weeks patients	Mar 26	52	0	L	F	1170	265	2075
L&D - Appraisals completed	Mar 26	88.2%	90.0%	H	F	86.1%	83.9%	88.3%
L&D - STAM Weighted Average	Mar 26	93.6%	90.0%	H	P	92.0%	91.0%	93.1%
Workforce - Vacancy Factor	Mar 26	6.9%	10.0%	L	P	8.6%	7.3%	10.0%
Workforce - In Month Sickness	Mar 26	4.6%	4.0%		F	4.8%	4.2%	5.5%
National staff engagement score	Mar 26	6.68	6.90	H	F	6.40	6.08	6.71
Summary Hospital-level Mortality Indicator (12M)	Dec 25	100.80	100.00	L	F	103.10	101.78	104.42
Patient experience - FFT	Mar 26	91.7%	90.0%		?	90.8%	89.0%	92.6%
Incident Rate /1000 Beddays	Feb 26	62.20	-			57.32	51.17	63.47
Patient Experience FFT A&E	Mar 26	82.2%	90.0%		F	82.5%	77.7%	87.2%
Safer Staffing: CHPPD	Mar 26	7.90	-			7.98	7.30	8.66
Falls	Mar 26	289	-			262	219	305
Pressure Ulcers	Mar 26	139	-			155	105	205
Falls per 1000 beddays	Mar 26	4.68	4.20		?	4.44	3.70	5.18
Pressure Ulcers per 1000 beddays	Mar 26	2.19	2.00		?	2.62	1.81	3.44

Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

IPR SPC Summaries



Excellent Care Everywhere

Patients

Excellent
Care
Everywhere

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

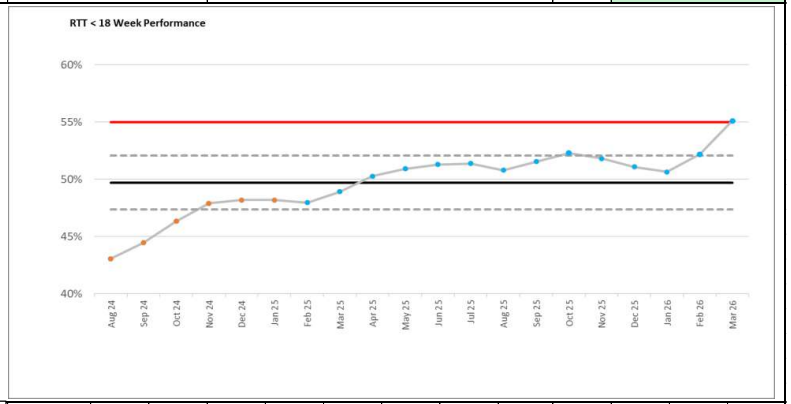
University Hospitals Sussex
NHS Foundation Trust

	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**	136/139		
	Latest Month Actual	55.10%	**National Performance**	62.6% February		
	Latest Month Trend	Decreased (worsened)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- RTT <18 Week performance was 55.1% for UHSX Trust Mar-26, 0.1 percentage points better than the improvement trajectory.
- This was an improvement of 2.9% from Feb-26, and 6.2% from Mar-25.
- This was the Trust's best performance since 2022; however, performance remains challenged compared to national average, which was 62.6% for Feb-26.

- The waiting list size reduced following additional activity including outsourcing (delivered through Q4 Elective Sprint) to 112,535 in Mar-26 compared to 114,132 in Mar-25 and 114,061 in Feb-26. This is 10,782 behind the operational plan for Mar-26, due to higher-than-expected demand.



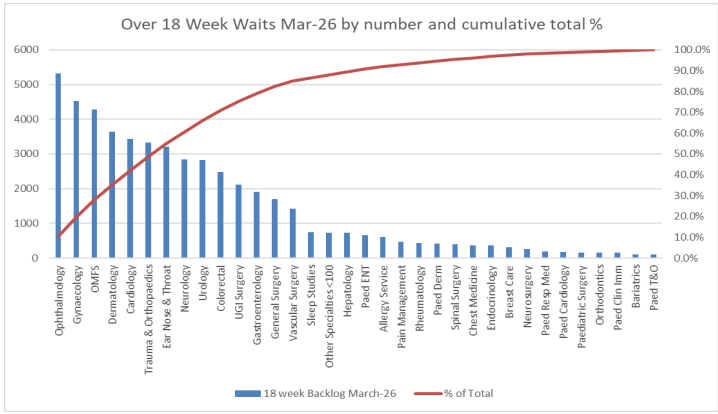
Key Actions

- 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-27.
- 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.

	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%	50.7%	52.2%	55.1%
Variance	0.1%	1.1%	0.6%	0.2%	-0.3%	0.1%	0.0%	-1.3%	-1.9%	-3.1%	-2.2%	0.1%

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

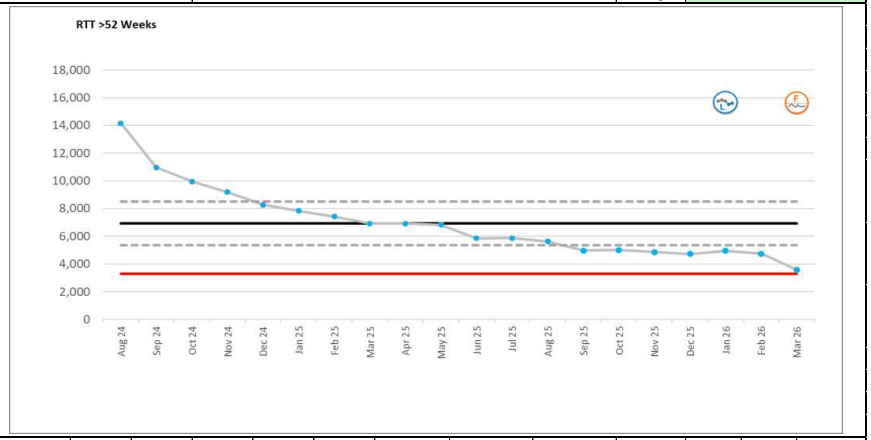
Excellent Care Everywhere

University Hospitals Sussex
NHS Foundation Trust

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**	Feb-25 132/135		
Latest Month Actual	3580 (3.18%)	**National Performance**	1.7% February-25		
Latest Month Trend	Reduced (improved)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

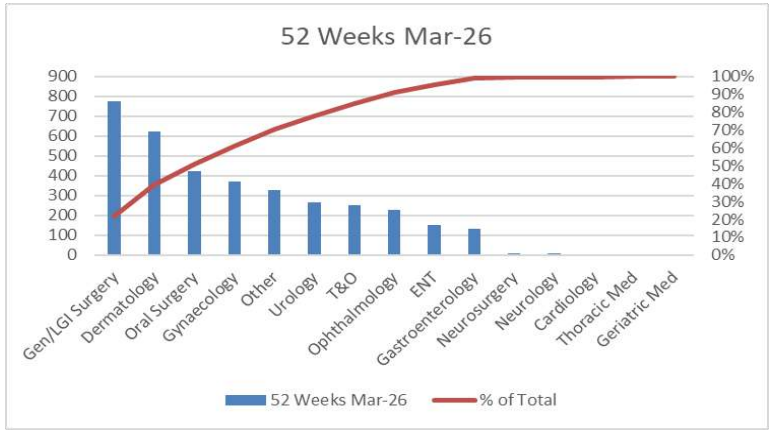
- 52 Week breaches reduced by 1173 patients at Mar-26 month end – to 3,580 patients. This is 3,343 fewer than Mar-25, but 279 more (worse) than the planned recovery trajectory.
- 52-week waits comprised 3.18% of WL, better than but in line with improvement trajectory (3.2%). However, this was supported by waiting list being higher than plan.
- Specialties with most 52 week waits Mar-26 are colorectal/Upper GI/General Surgery (777 patients), dermatology (622 patients), oral surgery (424 patients) and gynaecology (370 patients). These four specialties collectively make up 61% of the total 52 week backlog
- There were 52 65-week waits in Mar-26, a decrease of 342 compared to Feb-26. This is in line with the level agreed with NHS England through Tier 1 process.



Key Actions

- Divisions have created recovery plans to mitigate Mar-26 52-week risks with detailed weekly and daily monitoring to track progress. This follows successful reductions of 61ww by June, 58ww by Septemeber, 55ww by Dec-25 as the Trust shifted 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 Q4, 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	4961	4753	3580
Variance	-305	-372	-1040	-544	-421	-804	-425	-265	-170	-34	540	279



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**

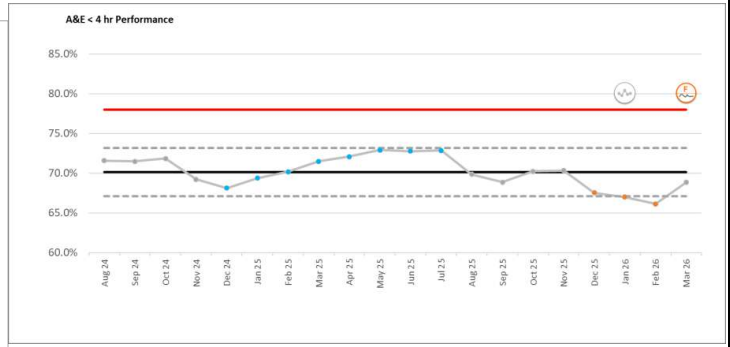
Excellent Care Everywhere

University Hospitals Sussex NHS Foundation Trust

Our Ambition: Patients: Better urgent and emergency care					
A&E <4Hour % Performance	**Target**	78% by March-26			
Latest Month Plan	78.00%	**National Rank**	105th of 121 Trusts (Mar-25)		
Latest Month Actual	68.87%	**National Performance**	77.1% (Mar-26)		
Latest Month Trend	Reduced (worsened)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- A&E <4-hour performance was 68.9% in Mar-26. This is 2.8% higher than Feb-26, and 2.6% lower than Mar-25. National performance was 77.1% in March. It is below the Trust planned improvement trajectory of 78.0% for Mar-26.
- RSCH saw improvement in performance from 59.3% Feb-26 to 63.4% Mar-26, 2.8% higher than Mar-25. PRH improved to 58.8% from 57.3% but below 66.8% Mar-25. Worthing improved to 59.6% from 54.1% Feb-26 but below 61.9% Mar-25. SRH saw an improvement to 57.6% from 54.9% Feb-26 but below 65.1% Mar-25. RACH reduced to 90% from 91.3% Mar-26 and 90.6% Mar-25.
- Patients in A&E for 12 hours increased to 3052 compared to 2890 in Feb-26 (but marginally better per calendar day) , but higher than Mar-25 (2662)
- 60-minute handovers reduced to 2.5% from 2.8% in Mar-26 and 0.1% higher than Mar-25. 45-Minute handovers increased to 8.8% from 8.4% last month (and compared to 8.3% in Mar-25).
- A&E attendances were 1.5% higher in Mar-26 compared to Mar-25 with ambulance handovers being 5.6% higher between years, and walk ins being 0.6% higher, hence not only an overall increase in attendances, but also of likely greater acuity.
- There was 1 fewer 21-day patients on average in Mar-26 (477) compared to Feb-26 , and 1 more than Mar-25. Discharged Ready (DRD) patients on average per day increased by 12 patients from last month to 403, and was 57 more than Mar-25



	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%	67.0%	66.1%	68.9%
Variance	0.9%	2.3%	-0.4%	-1.3%	-4.9%	-5.8%	-5.8%	-2.8%	-4.3%	-4.0%	-7.9%	-9.1%

Key Actions

- Programme of work with designated UHSx SRO in place and working with the ICB re the model and provision of the UTC. National specification has been used as the basis for the local specification. Implementation plan by July 2025 - achieved. Ongoing productivity metrics now receiving focus in order to improve performance, increase speed, and ultimately reduce high spend intrinsic in the initial programme delivery.
- Full review of UEC programme in terms of focus and governance.
- Revised UEC Improvement programme has been agreed with 3 programme 'Buckets' 1) Front Door 2) Wards & Departments 3) Discharge. Each has an executive SRO. Delivery Leads for each discrete piece of work within the buckets have been identified, all lead names now agreed.
- Capacity and configuration group established to support Hospital flow
- RSCH Sprint Continues

Interdependencies with other performance indicators

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

A&E4hr	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Trend
UHS<4hr %	70.3%	70.4%	67.6%	67.0%	66.1%	68.9%	
RSCH	63.2%	59.9%	56.1%	57.5%	59.3%	63.4%	
PRH	65.6%	67.0%	60.9%	60.3%	57.3%	58.8%	
RACH	90.4%	86.8%	83.6%	89.3%	91.3%	90.0%	
Worthing	59.1%	60.2%	54.6%	56.1%	54.1%	59.6%	
SRH	62.1%	64.9%	67.1%	59.6%	54.9%	57.6%	
National	74.1%	74.2%	73.8%	72.5%	74.1%	77.1%	
A&E 12 hours in department	3,007	2,641	2,793	3,560	2,890	3,052	
A&E Attendances	38,471	37,096	36,827	37,241	33,159	38,471	
Time to Triage	19	18	19	20	21	23	
Time to Treatment	141	133	140	141	142	146	
Mean Waiting Time	327	316	329	370	362	345	
Ambulance Handovers	7,576	7,350	7,583	7,717	6,697	7,407	
Ambulance Handover <15 minutes	52.5%	55.6%	53.3%	45.7%	52.6%	50.1%	
Ambulance Handover >45 minutes	9.0%	7.4%	8.9%	11.4%	8.4%	8.8%	
Ambulance Handovers > 60 minutes	3.5%	2.1%	2.8%	3.6%	2.8%	2.5%	
Emergency Admissions > 1 LOS	5941	5565	6055	5847	5155	5765	
Bed Occupancy	94.5%	94.5%	94.7%	95.8%	95.4%	95.1%	
Average LOS (Excl LOS 0)	9.70	9.90	9.60	11.90	10.80	10.50	
>= 7 day LOS Patients	959	995	951	1,050	1,068	1,063	
>=21 day LOS Patients	459	434	401	437	478	477	
Ave. DRD per day	353	354	306	375	391	403	

Exec Owner Nigel Kee **SRO** David Coyle

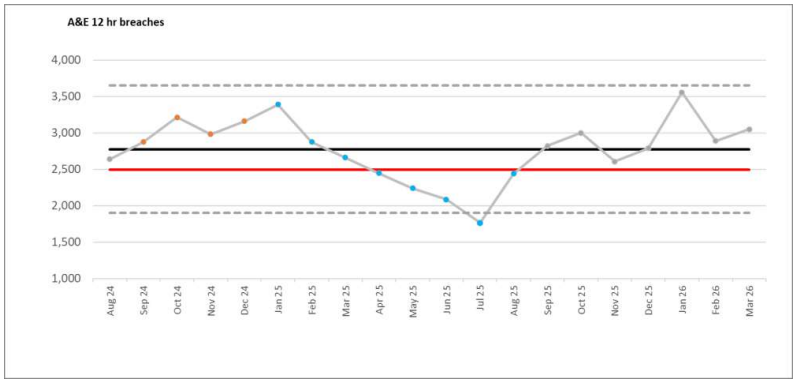
Excellent Care Everywhere

University Hospitals Sussex
NHS Foundation Trust

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	2498	**National Rank**	69/123 week of 17th April		
Latest Month Actual	3052 (7.93%)	**National Performance**	11.70%		
Latest Month Trend	Increased (worsened)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- The Trust has seen a 0.6% increase in 12 hour delays in 2025/26. This in the context of growth in attendances of 1.5% overall, and a 4.8% increase in ambulance handovers.
- However, there was a slight improvement March-26 when compared to February allowing for working days (98 per day compared to 103 per day Feb)
- Of 3052 patients who waited over 12 hrs in A&E, prior to leaving the department, 979 were at the Royal Sussex County due to extended flow constraints in month. This was approximately the same per working day as February-26, but 22% higher than Mar-25.
- Worthing site also had a challenging month with 931 over 12 hr waits, 68% higher than March-25.
- As A&E attendances were higher in 25/26 the %12 hours was 7.12% compared to 8.24% 24/25.



	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	3560	2890	3052
Variance	-401	-476	-468	-936	264	328	275	81	40	614	316	554

Key Actions

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

A&E >12 hours in Department:	2025/26						Last Year		Last Month	
Site:	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Var.	% Var.	Var.	% Var.
RSCH	1,050	978	1,011	1,075	884	979	-109	-10.0%	95	10.7%
PRH	333	363	395	481	433	454	-21	-4.4%	21	4.8%
RACH	0	4	7	4	6	0	-2	-100%	-6	-100.0%
SRH	964	482	502	882	802	688	145	26.7%	-114	-14.2%
WSH	660	814	878	1,118	765	931	377	68.1%	166	21.7%
UH Sussex ALL	**3,007**	**2,641**	**2,793**	**3,560**	**2,890**	**3,052**	**390**	**14.7%**	**162**	**5.6%**

As % of all Attendances	2025/26						Last Year		Last Month	
Site:	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Var.	% Var.	Var.	% Var.
RSCH	12.62%	12.68%	13.41%	13.94%	13.13%	12.47%		-2.2%		-0.7%
PRH	7.15%	8.06%	8.80%	10.46%	11.07%	9.79%		-0.5%		-1.3%
RACH	0.00%	0.13%	0.24%	0.15%	0.26%	0.00%		-0.1%		-0.3%
SRH	13.04%	6.81%	7.29%	12.42%	12.51%	9.28%		1.6%		-3.2%
WSH	7.52%	9.45%	9.87%	12.36%	9.59%	10.29%		4.2%		0.7%
UH Sussex ALL	**7.82%**	**7.12%**	**7.58%**	**9.56%**	**8.72%**	**7.93%**		**0.9%**		**-0.8%**

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.

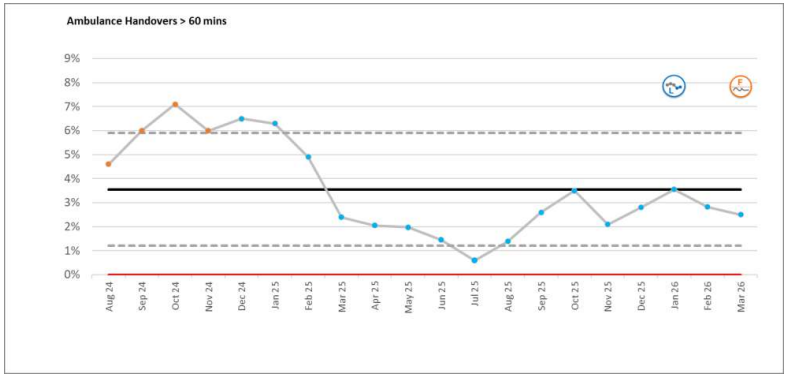
Exec Owner Nigel Kee **SRO** David Coyle

Excellent Care Everywhere

University Hospitals Sussex
NHS Foundation Trust

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	2.40%	**National Rank**	Second Best Performing Region		
Latest Month Actual	2.50%	**National Performance**	5.4% National -1.2% South East Coast		
Latest Month Trend	Reduced (improved)	**NPAF Area: Access to Services**		**DQ**	Amber

- The Trust has seen significant improvement in extended ambulance handover delays in 2025/6 to date. This was a 41% improvement in 60 minute handovers in 25/6 compared to 24/5.
- There was a reduction to 184 >60 min handovers in Mar-2026 compared to Feb (189) but slightly higher than Mar-25 (169)
- Of the 184 delays in March, 88 of these were at the Royal Sussex County, whilst 41 were at Worthing Hospital , 29 at Princess Royal Hospital and 26 at SRH.
- As a % of all handovers, March-26 saw 2.5% of 7407 handovers over 60 mins, compared to 2.8% February-26, and 2.4% Mar-25.



Key Actions

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

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.

	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	274	189	184
Variance	-446	-333	-229	-363	-216	-233	-252	-277	-259	-186	-126	15

Handovers:	2024/25			2025/26			Last Year	
Site	**Jan-25**	**Feb-25**	**Mar-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Var.**	**% Var.**
RSCH	2,311	2,099	2,358	2,502	2,239	2,500	142	6.0%
PRH	885	687	799	940	771	840	41	5.1%
SRH	1,899	1,665	1,742	1,973	1,724	1,930	188	10.8%
WSH	2,177	1,932	2,118	2,302	1,963	2,137	19	0.9%
UH Sussex ALL	**7,272**	**6,383**	**7,017**	**7,717**	**6,697**	**7,407**	**390**	**5.6%**

>60 Minute Handovers:	2024/25			2025/26			Last Year	
Site	**Jan-25**	**Feb-25**	**Mar-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Var.**	**% Var.**
RSCH	225	184	100	128	64	88	-12	-12.0%
PRH	65	20	13	49	73	29	16	123.1%
SRH	87	83	24	32	42	26	2	8.3%
WSH	83	28	32	65	10	41	9	28.1%
UH Sussex ALL	**460**	**315**	**169**	**274**	**189**	**184**	**15**	**8.9%**

% >60 Mins Handover:	2024/25			2025/26			Last Year	
Site	**Jan-25**	**Feb-25**	**Mar-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Var.**	**% Var.**
RSCH	9.7%	8.8%	4.2%	5.1%	2.9%	3.5%		-0.7%
PRH	7.3%	2.9%	1.6%	5.2%	9.5%	3.5%		1.8%
SRH	4.6%	5.0%	1.4%	1.6%	2.4%	1.3%		0.0%
WSH	3.8%	1.4%	1.5%	2.8%	0.5%	1.9%		0.4%
UH Sussex ALL	**6.3%**	**4.9%**	**2.4%**	**3.6%**	**2.8%**	**2.5%**		**0.1%**

Exec Owner Nigel Kee **SRO** David Coyle

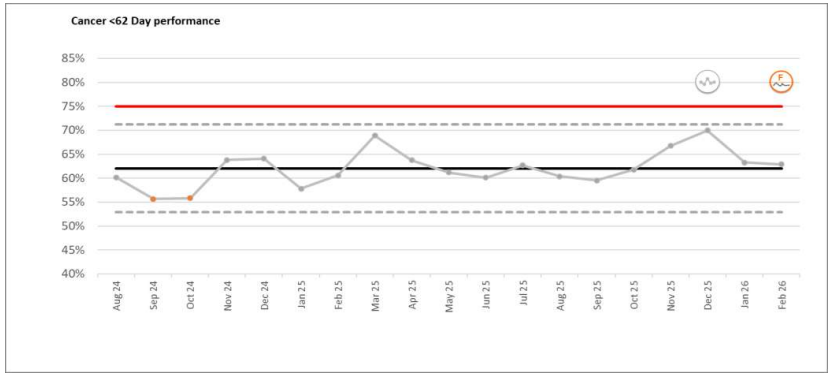
Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Faster Access to planned treatment and cancer care					
Cancer Care : 62 Day Performance	**Target**	75% by March-26			
Latest Month Plan	72.80%	**National Rank**	116 of 146 Feb-26 (with Type 1 A&Es)		
Latest Month Actual	62.90%	**National Performance**	68.64%		
Latest Month Trend	Increased (Better)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- Cancer 62-day cancer treatment targets were not met in Feb-26 with 62.9% starting treatment in under 62 days. This was a 0.4% deterioration from Jan-26, but a 2.3% improvement from Feb-25. It was lower than the National average of 68.6% for Feb-26 and behind the Trust recovery trajectory plan for February (72.8%). The national position improved marginally to 68.6% Feb-26 from 68.4%. The trust was ranked 116 of 146 Feb-26. Recovery to above 70% performance is forecast for march 62D performance.
- The number of over 62-day patient backlog at the end March was 338 (EB32 version), the same as Feb-26 reduction in 104-day prospective waits in March to 88 patients from 102 March. Skin is 28.4% of this backlog and increased by 3 over the past month from 93 end Feb-26 to 96 end Mar-26. To reduce the backlog requires a reduction in retrospective performance (ie more treatment of backlog patients).
- The anatomical sites with most over 62 day patients at the end of Mar-26 were skin (96 patients , 3 more than Feb-26 , colorectal (75 patients, 7 fewer than Feb-26), and urology (46 patients, 16 fewer than Feb-26). The total backlog is the same size to Feb-25.

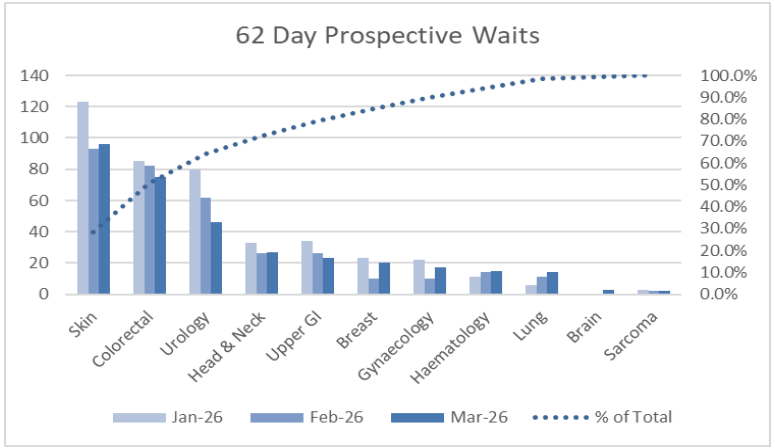


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	61.4%	61.5%	61.5%	61.2%	60.4%	65.7%	68.9%	69.7%	71.0%	67.8%	72.8%	75.2%
Actual	63.8%	61.2%	60.1%	62.7%	60.4%	59.6%	61.8%	66.8%	70.0%	63.3%	62.9%	
Variance	2.4%	-0.3%	-1.4%	1.5%	0.0%	-6.1%	-7.1%	-2.9%	-1.0%	-4.5%	-9.9%	

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**

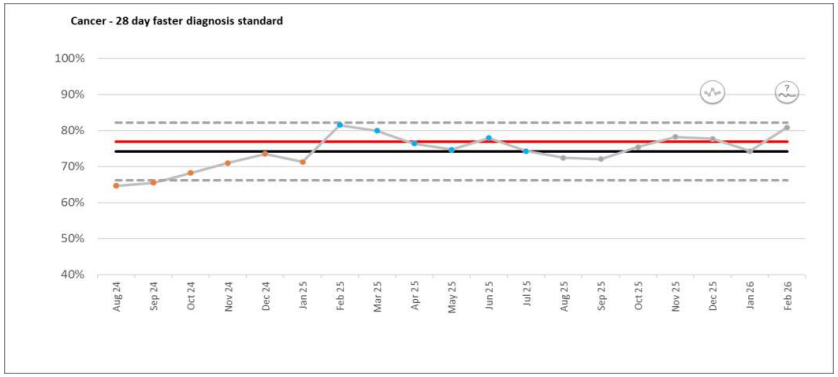
Excellent Care Everywhere

University Hospitals Sussex
NHS Foundation Trust

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	79.6%	**National Rank**	89 of 141 -Feb-26		
Latest Month Actual	80.9%	**National Performance**	80.5%		
Latest Month Trend	Increased (improved)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

- FDS improved to 80.9% Feb-26 from 72.8% in January and was 81.6% in Feb-25. Trust performance was better than the national average of 80.5%. UHSx ranked 89/141 in Feb 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.



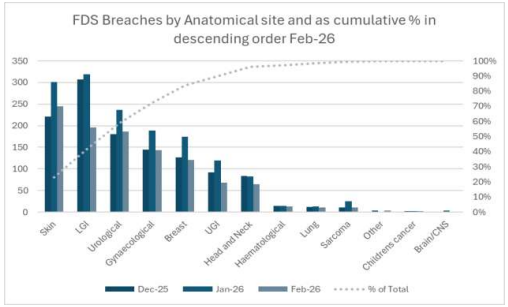
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	77.9%	78.0%	77.9%	76.3%	76.7%	78.7%	78.7%	79.6%	80.4%	78.6%	81.6%	80.0%
Actual	76.4%	74.7%	78.0%	74.3%	72.5%	72.1%	75.5%	78.3%	77.8%	74.3%	80.9%	
Variance	-1.5%	-3.2%	0.1%	-2.0%	-4.2%	-6.6%	-3.3%	-1.3%	-2.7%	-4.2%	-0.7%	

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	Dec-25	Jan-26	Feb-26
Brain/CNS	96.6%	86.2%	96.9%
Breast	89.3%	87.1%	91.0%
Gynaecological	70.1%	66.0%	71.3%
Haematological	36.4%	31.8%	38.1%
Head and Neck	86.3%	84.7%	88.4%
LGI	68.4%	66.6%	78.2%
Lung	85.0%	75.9%	81.7%
Other	50.0%	66.7%	20.0%
Sarcoma	81.7%	67.9%	80.4%
Skin	78.9%	76.3%	79.4%
UGI	73.4%	68.0%	81.0%
Urological	66.8%	55.7%	65.7%
Childrens	87.5%	88.2%	87.5%



Interdependencies with other performance indicators

- Delays to cancer treatment can impact patient experience and outcomes

Exec Owner Nigel Kee **SRO** Huw Edwards

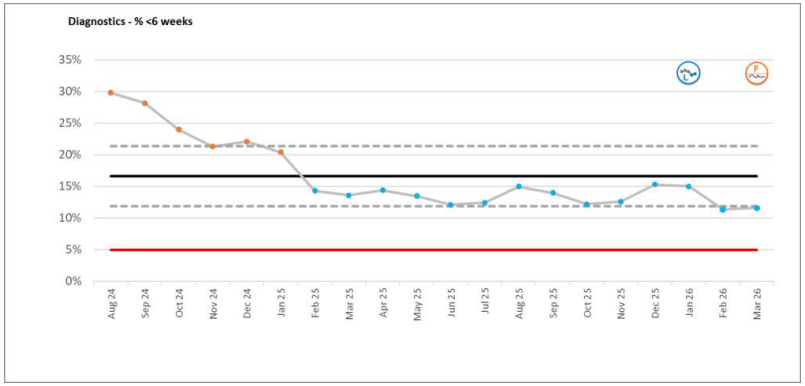
Excellent Care Everywhere

University Hospitals Sussex
NHS Foundation Trust

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	5.00%	**National Rank**	40th of 116 (NHSproviders >5000 WL size) Feb-26		
Latest Month Actual	11.60%	**National Performance**		20.2% (Feb-26)	
Latest Month Trend	Increased (worsened)	**NPAF Area: Access to Services**		**DQ**	Green

Key Messages

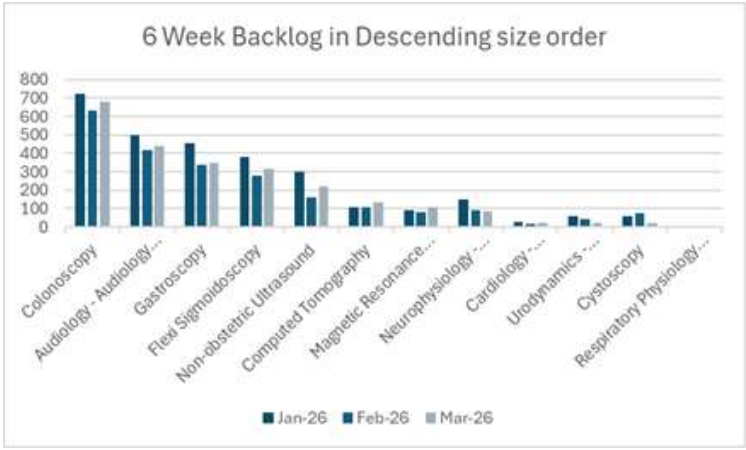
- Diagnostic Performance increased by -0.2% to 11.6% in Mar-26 from 11.4% in Feb-26, and 2.0% better than Mar-25. This is 8.6% lower than National average Feb-26 (20.2%). This is however 6.6% adverse against the planned trajectory for the month of 5%.
- The waiting list size increased by 1092 patients in March. The 6 week backlog increased by 168 patients.
- Highest backlog numbers in Mar-26 are endoscopic modalities 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%	15.0%	11.4%	11.6%
Variance	0.4%	-0.5%	0.1%	1.4%	3.0%	4.0%	4.2%	6.6%	7.3%	7.0%	4.9%	6.6%

Key Actions

- The Trust is refreshing recovery plans to target improvement to the 5% Operational Standard March-27 with additional scrutiny at modality level.



Interdependencies with other performance indicators

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

Exec Owner Nigel Kee **SRO** Huw Edwards

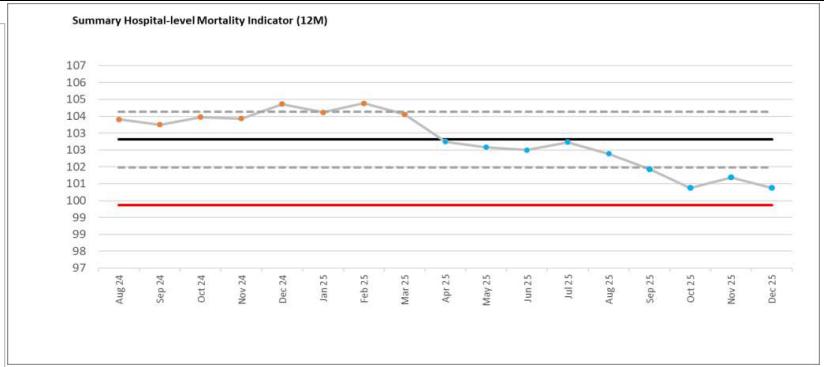
Excellent Care Everywhere

University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Patients: Fairness in access, experiences and outcomes					
Standardised Hospital Mortality Indicator	**Target**	In Expected Range			
24/25 Actual	104.80	**National Rank**	In expected range		
25/26 Actual	100.80	**National Performance**	100		
Latest Month Trend	Reduced (improved)	**NPAF Area : Patient Experience**		**DQ**	Green

Key Messages

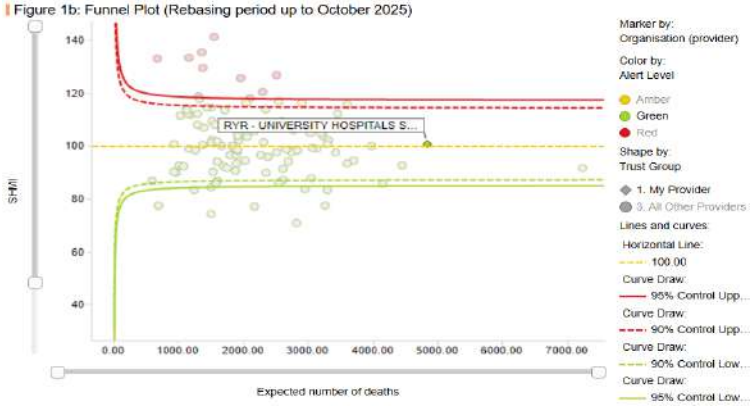
- The SHMI (Summary Hospital-level Mortality Indicator) is a measure used in to monitor mortality. The SHMI gives an indication of whether the number of deaths in a hospital is higher or lower than expected, based on the types of patients they treat. It does this by comparing the actual number of patients who die following hospital treatment (either during their stay or within 30 days of discharge) with the number expected to die. The expected number of deaths is calculated using a statistical model that predicts the number of deaths we would expect for a given group of patients, the case mix model used to calculate the expected number of deaths is based on the patients age, gender, primary diagnosis, comorbidities, admission method and socioeconomic factors (like deprivation index)
- The SHMI for UHSx is 100.8 (January 2025 - December 2025). This result is 'as expected' and is not an outlier.



	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	100.8	101.3	100.8			
Variance	-1.2	-0.4	-1.0	-1.3	-1.5	-2.1	-3.4	-2.8	-4.0			

Key Actions

- Continued montioring and investigation of SHIMI diagnostic code outlier status



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

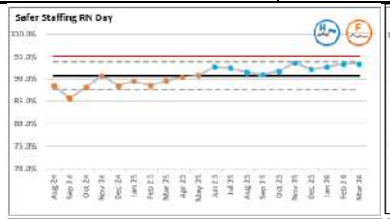
Excellent Care Everywhere

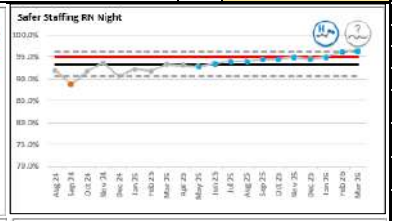
NHS
University Hospitals Sussex
NHS Foundation Trust

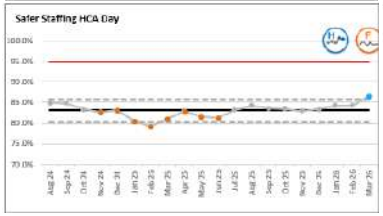
Our Ambition: Patients: Fairness in access, experiences and outcomes					
Safer Staffing % Staffing against planned rota	Target	>95%			
Latest Month Plan		National Rank			
Latest Month Actual	Table below	National Performance			
Latest Month Trend	Variable per staff group/shift as below	NPAF Area: Patient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

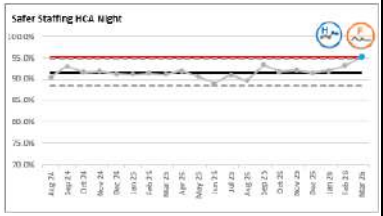
Key Messages

- 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 April 24. The current position is sustained at 7.8. Please note there is a drop in CHPPD from 9.2 to 8.2 in August 25 this is a result of removing ITU, paediatrics and neonates due to over inflating the CHPPD and masking lower levels of staffing in other areas. Benchmarking with peers is underway to review inclusion criteria.
- The charts shows the fill rate % for Day and Night shifts for Registered Nurses/midwives and Health Care Assistants. Whilst there is some fluctuation, there has been a statisitically significant improvement in RN day and night fill rates in November .
- Day HCA fill rates are lowest with 86.6% 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%	92.6%	93.4%	93.4%
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%	95.0%	96.1%	96.4%
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%	84.3%	84.3%	86.6%
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%	91.9%	93.1%	95.4%
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	7.6	7.8	7.8

Key Actions

- The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce with the skill and experience to deliver quality care.
- There are subgroups focusing on agency/bank reduction, recruitment, targeted retention, roster optimising, enhanced care, workforce diversification and sickness management. The Deputy Chief Nurse (DCN) for Workforce along with the clinical workforce team undertook establishment reviews using the safer nursing care tool (SNCT) for all inpatient areas in the November 25 .
- Due to robust recruitment and onboarding there is a direct correlation with the gradual improvement in fill-rate, resulting in a significant reduction in RN and RMN agency. Agency use has been exited in midwifery and RN agency exited non specilist areas, where agency is required this as a last resort with Director of Nursing or Deputy Chief nurse approval.
- Band 5 vacancy is at 7.3% and HCA band 2/3 vacancy is 10.8%.
- Changes to the Health and Care Visa in 2025 which is a subtype of the skilled worker visa has increased the salary to 25k. The increased salary threshold for visa sponsorship had 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. In April 26 due to the pay award, band 3 are not restricted due the salary threshold, resulting in the ability to recruit to band 3 where sponsership is required.

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 Gerricke

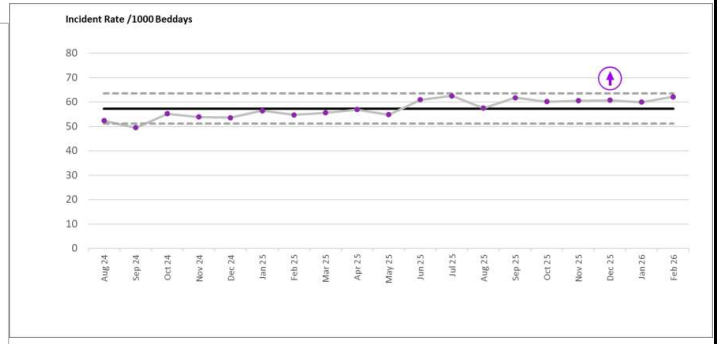
Excellent Care Everywhere

University Hospitals Sussex
NHS Foundation Trust

	Our Ambition: Patients: Fairness in access, experiences and outcomes				
	Incidents per 1000 beddays	**Target**			
	2024/25	54.69	**National Rank**		
	25/26 Latest Month Actual	62.20	**National Performance**		
	Latest Month Trend	Reduced	**NPAF Area: Patient Safety**	**DQ**	Green

Key Messages

- Local targets are based on national Benchmarking
- The NHS England Learning from Patient Safety Incidents (LfPSE) which demonstrates the reporting rate per 1000 bed days within Trusts. Recording rates (per 1,000 bed days) ranged from 7 to 130 incidents in acute trusts.
- UHSussex has increased the reporting rate per thousand bed days from 52 in August 2024 to 62 in February 2026, thus meeting the Trust target of >60. 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.
- For actual harms (approved) graded as low, moderate, severe and death the numbers reported for the highest percentage of reported patient safety incidents are graded as no/low harm (97%). Pressure damage and falls, medication incidents and hospital acquired thrombosis are the most common themes within the low harm categories.
- However delays to appointments, diagnosis and lost to follow-up, along with harm free driver such as falls and pressure damage 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	60.72	59.94	62.20	
Variance	7.7	2.1	10.3	11.6	5.2	12.3	4.9	6.7	7.2	3.5	7.5	

Key Actions

- Collaboration with clinical simulation and learning and development with regard to human factors training in patient safety incidents.
- A review of higher risk specialties is underway, including Ophthalmology and OMFS, including with GIRFT and using risk stratification of waiting patients to reduce harms from waits for follow ups.
- Actions to address falls and pressure damage are included in the fundamental standards of care and professional standards programmes of work.
- 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, and an audit of DoC letters is supporting quality improvement.
- A new RLDatix (DCIQ) training video is now available on Iris to support the understanding of the incident reporting and handling processes.
- The UHSussex Patient Safety Partners open each PSG with a presentation on shared learning from incident themes.

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.

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

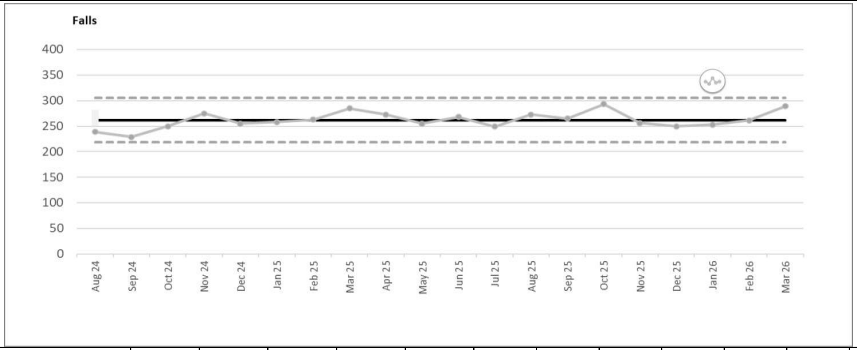
Excellent Care Everywhere

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	285	**National Rank**			
2025/6 latest month	289	**National Performance**			
Latest Month Trend		**NPAF Area: Patient Safety**	**DQ**	Green	

Key Messages

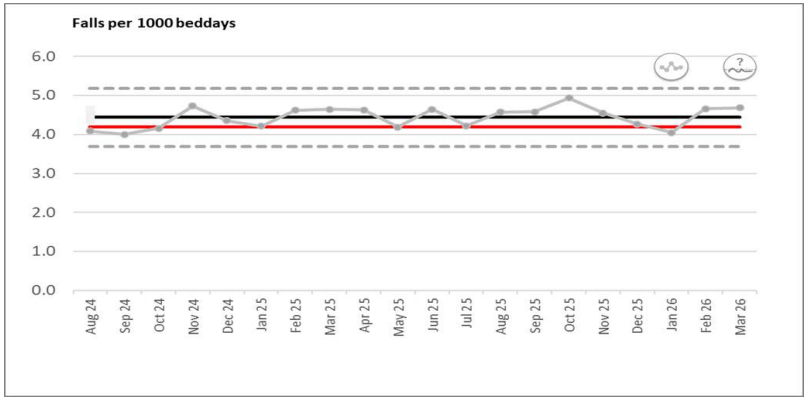
- Falls without harm continue to contribute to a proportion of harm across UHSussex, and are part of a area to minimise them.
- From April 2025 - March 2026 the number of falls has remained broadly the same 273 - 289 has been a decrease in falls since March 2025, 285 to September, 265.
- 69.81% of falls (185 patients) in September 2025 reporting no harm.
- Falls Rate per 1,000 bed days September 2025, 4.58. Average rolling year 4.46. Target 4.2. Overall, Trust data is tracking along the mean average and within the upper control limit, for both the number of falls and the number of falls per 1,000 bed days.
- Moderate harm and above falls since April 2024 have not identified pattern or trend currently.



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	253	261	289
Variance	17.00	-55.00	30.00	22.00	34.00	36.00	43.00	-19.00	-5.00	-5.00	-2.00	4.00
/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	4.05	4.66	4.68
Variance	0.28	-0.96	0.49	0.36	0.48	0.58	0.77	-0.18	-0.08	-0.16	0.04	0.04

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.
- The divisions have been driving up improvement opportunities by focussing on the top themes such as completing falls and bedrail risk assessments and undertaking lying/standing blood pressures. This has enabled the identification of actual or potential issues earlier so that mitigations can be put in place.
- Rate of falls will continue to be monitored via the weekly Harm Free Care Group, monthly QGSG and two monthly FSoC patient safety group.



Interdependencies with other performance indicators

- Harms contribute significantly to poor patient experience outcomes and staff experience.

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

Excellent Care Everywhere

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	185	**National Rank**		
	25/26 Latest Month Actual	139	**National Performance**		
	Latest Month Trend		**NPAF Area: Patient Safety**	**DQ**	Green

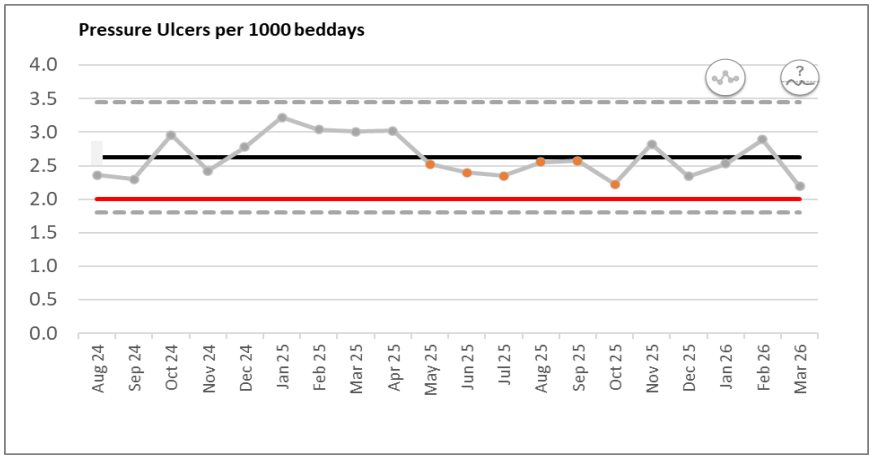
Key Messages

- Risk factors for developing a hospital-acquired pressure injury include older age, immobility, altered mental condition, urinary or faecal incontinence, hospitalisation for fracture, surgical intervention, reduced appetite and nasogastric tube or intravenous nutrition. Research has shown that pressure injuries are preventable. The strategy for preventing pressure injuries relies on two interdependent domains: pressure injury risk identification and pressure injury risk mitigation.
- HAPD –The number of category two HAPU has reducing since March 2025 from 185 to 139 in month March-26.
- The 12 month rolling rate of category two HAPU per 1000 bed days is 2.53 (target 2.0).
- A thematic review for HAPU category two and above has been undertaken which has not identified any patterns or trends at this time.

Key Actions

- Purpose T risk assessment being completed on time September 2025 at 71% across the Trust. This is a decline from March 2025 at 79.12%. This is attributed to several areas going live with Patient Track which has increased the denominator.
- There has been a decrease in category two HAPU since March 2025, 185 to September, 139. With HAPU Category 2 pressure being the most prevalent category.
- PU rate per 1,000 bed days March 2.19 , with average rolling year 2.53. Target 2. Overall, Trust data is tracking along the mean average and within the upper control limit, for both the number of presure ulcers and the number of pressure ulcers per 1,000 bed days.
- A mattress audit has taken place. Critical Care beds across all sites will be replaced in May, as will fractured neck of femur beds. Ward based mattress's will be replaced via rolling replacement programme. There are quarterly mattress audits scheduled throughout 2026.
- The TVN team have introduced a new product selection guide and wound care formulary in April 2026.
- The TVN team in-person teaching and education sessions across UHSussex continue to be well attended and evaluated.

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	158	162	139
Variance	21.00	6.00	-10.00	-2.00	14.00	17.00	-46.00	18.00	-26.00	-39.00	-11.00	-46.00
/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	2.53	2.89	2.19
Variance	0.35	0.08	-0.20	-0.03	0.19	0.27	-0.74	0.40	-0.44	-0.69	-0.15	-0.82



Interdependencies with other performance indicators

- This is a key indicator of patient care, and links with outcomes, length of stay, patient experience.

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

Excellent Care Everywhere

Our People

Excellent
Care
Everywhere

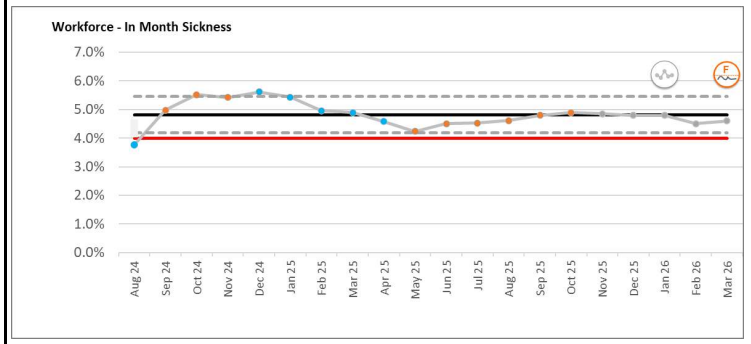
We are compassionate. We are inclusive. We are respectful.

University Hospitals Sussex NHS Foundation Trust

Our Ambition: Our People					
Sickness Absence Rates	**Target**	<4% sickness			
24/25 Month Actual	4.90%	**Regional Rank**			
25/26 Month Actual	4.60%	**National Performance**	4.7% (May-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. There are in month and rolling average measures, below focuses on Q4.
- Sickness rates have continued to decline on the previous year with all Q4 in month rates showing a reduction compared to 24/25, most noticeably in January 26 where the rate has dropped from 5.4% the previous year to 4.8%. For comparison UHSx is below both the national rate of 5.9% the SE Regional rate of 5.1% and Sussex ICB position of 5.4%.
- In M12 of Q4 of 2025-26 several clinical Divisions were in that month at or below the Trust target of 4%, this included both Surgery Divisions and Specialist Division. This reflects the strong divisional focus on sickness.
- Of particular note is Facilities and Estates which in Q4 has recorded its lowest quarterly rates for sickness for several years with in month rates of 6.5%, 5.7% and 5.0%.
- Ancillary staff have seen a sustained decrease over this quarter and were at 5.8% in March 26.

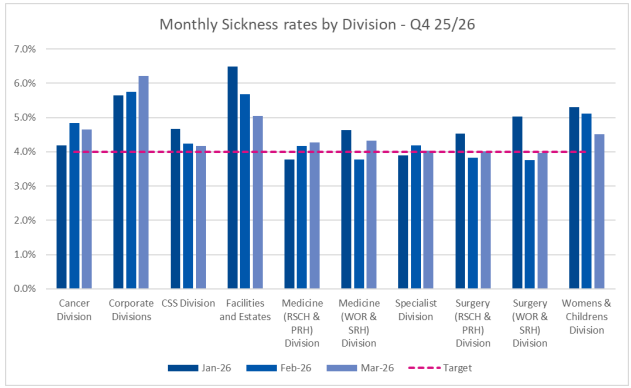


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	4.9%	4.9%	4.9%	5.4%	3.8%	5.0%	5.5%	5.4%	5.6%	5.4%	5.0%	4.9%
25/26	4.6%	4.2%	4.5%	4.5%	4.6%	4.8%	4.9%	4.9%	4.8%	4.8%	4.5%	4.6%
Variance	-0.4%	-0.6%	-0.4%	-0.8%	0.8%	-0.2%	-0.6%	-0.5%	-0.8%	-0.6%	-0.5%	-0.3%

Key Actions

- **Nursing and Midwifery** - workstream with a focus on 72 hotspot areas for sickness. Hotspots have been updated to ensure focus is in the right areas.
- **Systems** - the 'Other' category has now been removed from healthroster w.e.f. 1/4/26, this was accounting for up to 10% of absences in some months. This will improve the recording of absence reasons moving forward.
- **Governance** - The focus is now on driving further improvements in the new Trust structure to achieve the new Trust sickness target for 2026/7 of 4.5%.
- **Mental Health Action Plan** – MH Action plan has been produced and continues in phase one of implementation with the intention of reconvening the stakeholder group shortly.
- **Medical Workforce** - a workstream to improve the recording and management of doctors' absence is underway with a range of actions. Further work is needed in this area.
- **Staff Group** - tailored action plans in place for HCAs and Ancillary staff.
- **Assurance** - The People & Culture Assurance committee has had a 'deep-dive' into

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

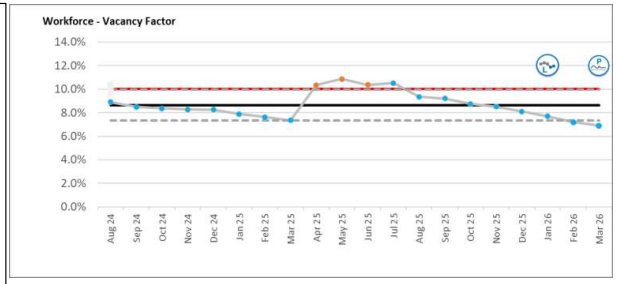
Exec Owner David Grantham **SRO** Helen Weatherill

Excellent Care Everywhere

Our Ambition: Our People			
Vacancy Factor	**Target**	**<10%**	
24/25 Month Actual	7.40%	**National Rank**	**Not available**
25/26 Month Actual	6.90%	**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 18,150 (increase of 881 from prior year). There are 16,903 wte staff in post (increase of 921 wte from prior year and an increase of 227 between Q3-Q4). The Trust currently has 1,246 wte vacancies resulting in a vacancy rate of 6.9% for M12.
- There has been a significant investment in substantive budgeted establishment (including the N&M workforce to reflect safer staffing tool outputs) and a very successful recruitment drive to fill these newly created posts and to keep vacancy levels with target.
- Vacancy rates by staff group are Additional Clinical Services (11.1%), Healthcare Science (8.9%), Registered Nursing (6.1%) and AHPs (4.3%).
- Band 5 RN vacancy factor is at 7.3%, the lowest this financial year. Positive progress has been made to reduce HCA vacancies to 10.9%. The Trust has the lowest overall vacancy rate this year.
- The Trust has increased its substantive registered nurse workforce by 326 wte staff in the previously 12 months as part of a coordinated approach to reduce agency spend and further improve the continuity of care for our patients

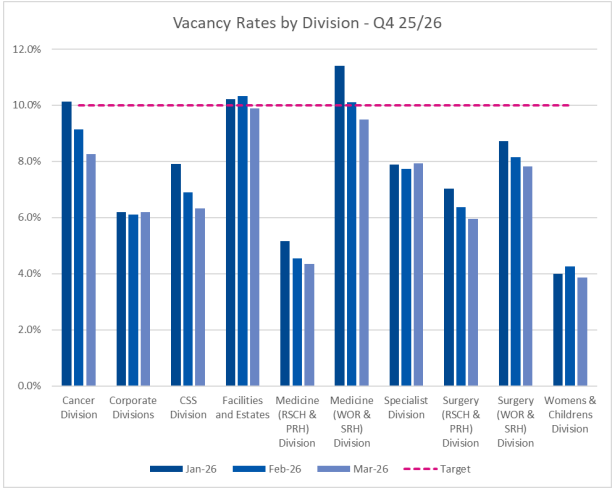


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	8.3%	8.7%	8.7%	9.0%	8.9%	8.5%	8.4%	8.3%	8.3%	7.9%	7.6%	7.4%
25/26	10.3%	10.9%	10.4%	10.5%	9.3%	9.2%	8.8%	8.5%	8.1%	7.7%	7.2%	6.9%
Variance	2.0%	2.2%	1.7%	1.5%	0.4%	0.7%	0.4%	0.2%	-0.2%	-0.2%	-0.4%	-0.5%

Key Actions

- Head of Resourcing has worked closely with the Communications team to develop a comprehensive campaign brief for the new UHSussex employer brand campaign, **"Excellent Care Starts with You."** The campaign is designed to raise local awareness of UHSussex as an employer of choice by showcasing the breadth of careers behind excellent care through authentic staff-led videos and digital content across paid social media channels. The campaign will launch across key social media platforms in June 2026, with activity focused on local audiences across Brighton, Haywards Heath, Worthing and Chichester. This work had previously been paused due to budget constraints.
- Resourcing is also re-engaging with Facilities and Estates, now that new budgets are in place, to progress plans for wrapping a number of Trust lorries and vans with the new employer branding and imagery. This will help promote UHSussex as an employer of choice across the local area, particularly during peak traffic times.
- In addition, Resourcing is working with Communications to explore maximising the use of new staff attraction materials, including stills and short videos, that showcase authentic staff stories about how colleagues contribute to delivering excellent care. We are scoping using these assets on digital screens across our hospital sites.

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.

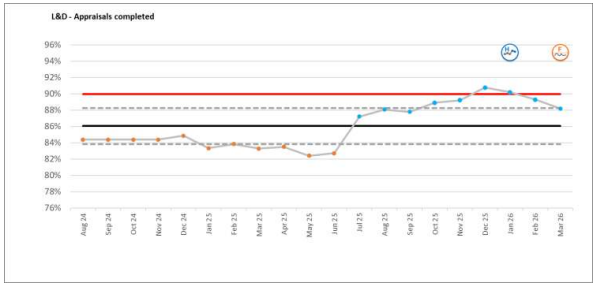
Exec Owner	David Grantham	**SRO**	David Vincent

University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Our People					
Annual Appraisal %Compliance	**Target**	>90%			
24/25 Month Actual	83.30%	**National Rank**	Not available		
25/26 Month Actual	88.20%	**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 a Appraisal recorded as complete within the previous 12 months.
- Compliance **fell slightly** from 88.5% in February to 87.3% in March, and represents a **continuing fall** since December 2025 (90.8%), although this was the highest level achieved since recording began in 2021. The March 2026 figure is nevertheless **significantly improved on March 2025** (87.3% vs 83.0%).
- the patters is seen **across-the-board**, with **12/17 Divisions falling** (from -5.2% points in DCEO to -0.3% points in Medicine (WOR&SRH)). Similarly **8/8 Staff Groups declined** (from -5.4% points in Healthcare Scientists to -0.6% points in Nursing & Midwifery, and -0.4% points in Students).
- Notably, the four largest % point **falls were in Corporate Divisions** (DCEO, CSO, CFO, CPO), although these are relatively smaller by headcount. The only **notable increases** were CEO (by +7.0% points) and CN (+1.4% points).
- **Operational pressures** and **organisational change** following the TOM implementation are both likely factors in the reduced compliance (vs 90.0% target).

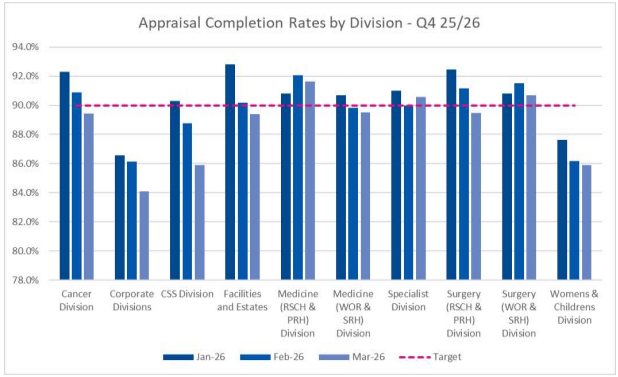


Incl Medics	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	80.6%	81.8%	82.2%	82.4%	82.4%	84.3%	83.3%	83.9%	84.9%	83.4%	83.8%	83.3%
25/26	83.5%	82.4%	82.7%	87.2%	88.1%	87.8%	88.9%	89.2%	90.8%	90.2%	89.3%	88.2%
Variance	2.9%	0.7%	0.6%	4.8%	5.7%	3.5%	5.6%	5.3%	5.9%	6.8%	5.5%	4.9%
Non-medics	Apr	May	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%	89.7%	88.5%	87.3%
Variance						2.6%	5.0%	4.7%	5.5%	6.6%	4.8%	4.3%

Key Actions

- **New Non-Medical Appraisal documentation** has been introduced to streamline the process, following piloting in Facilities & Estates.
- The **quality of appraisals remains positive**. Latest data from the rolling appraisee feedback survey: 91.9% felt it was a positive experience overall, 90.8% agreed they could discuss all the topics they wanted to, 90.2% agreed they felt safe talking about health and well being.
- Continuing work via **Divisional Meetings** and **with HRBPs** to target support to teams with lowest scores or notably falling rates.

Breakdown of Latest Month



Interdependencies with other performance indicators

- Appraisal is linked to staff satisfaction and development being an oportunity to recognise contribution and acheivements and any development needs. It does require time and focus and prioritising appraisal can be a challenge for managers and supervisors against operational and other immediate pressures.

Exec Owner David Grantham **SRO** Nick Groves

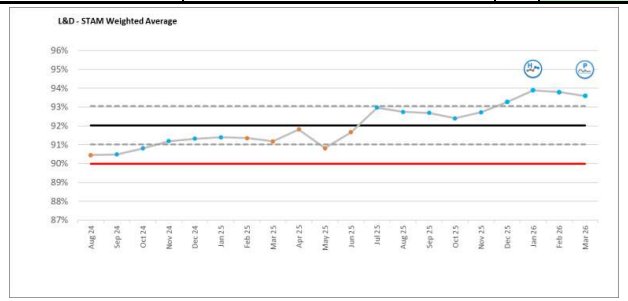
Excellent Care Everywhere

University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Our People				
Statutory and Mandatory Training Compliance %	Target	>90%		
24/25 Month Actual	91.20%	National Rank	Not available	
25/26 Month Actual	93.60%	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 93.6% in M12 (March), 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 86.9% (a full 12 months in a row within the 80% range), all other groups are compliant above 90%.
- Divisionally, the picture has improved and no single division is an outlier for M12. This is an improvement on M9 where there were two divisional outliers.

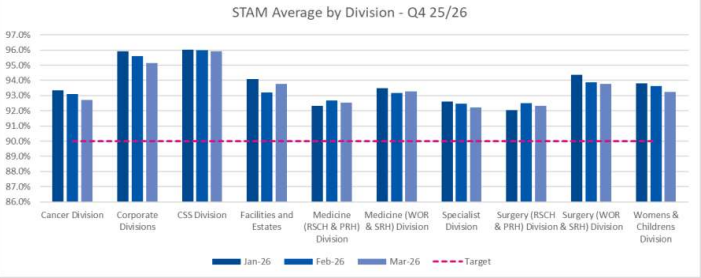


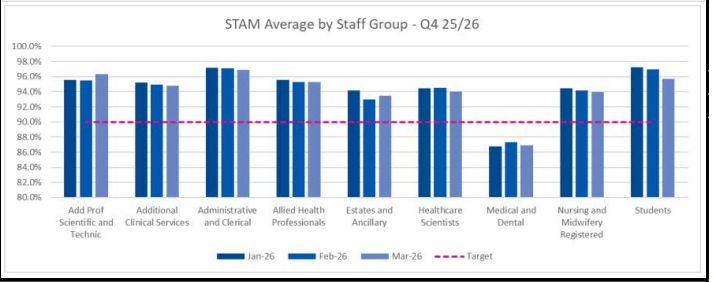
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	90.5%	90.7%	90.6%	90.7%	90.5%	90.5%	90.8%	91.2%	91.3%	91.4%	91.4%	91.2%
25/26	91.82%	90.82%	91.67%	92.97%	92.75%	92.70%	92.4%	92.7%	93.3%	93.9%	93.8%	93.6%
Variance	1.3%	0.1%	1.1%	2.3%	2.3%	2.2%	1.6%	1.5%	1.9%	2.5%	2.4%	2.4%

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 although compliance has risen (86.7%). The updated approach has addressed the issue 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

Excellent Care Everywhere

Communities

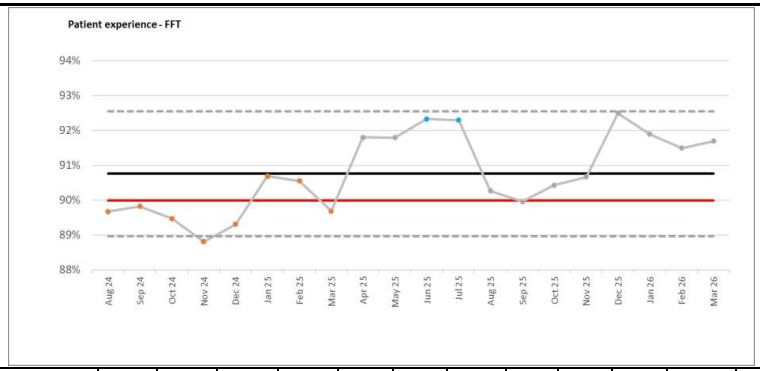
Excellent
Care
Everywhere

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

University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Communities			
Patient Experience: FFT	**Target**	>90%	
24/25 actual	89.7%	**National Rank**	37th of 123 A&E, 113 of 131 Inpatients, 21st of 130 outpatients
Latest Month Actual	91.7%	**National Performance**	91.6% (Feb-26)
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 91% at the end of Q4 2025/26) are satisfied that they have a good or very good experience of care, based on more than 30,000 responses.
- Patient reported experience of ED closely aligns to 4-hour performance
- The positive experience of care episodes identified through FFT is in contrast to trajectories for volumes of complaints and concerns, which are steeply upward. Triangulated data across complaints, PALS and other patient feedback identifies that the most prevalent causes of poor patient experience are delays to treatment, follow up, referral onward, results and tests, and the communication with the patient (including responsiveness by phone and email). Increases continue to be noted in complaints about the behaviour of



Key Actions

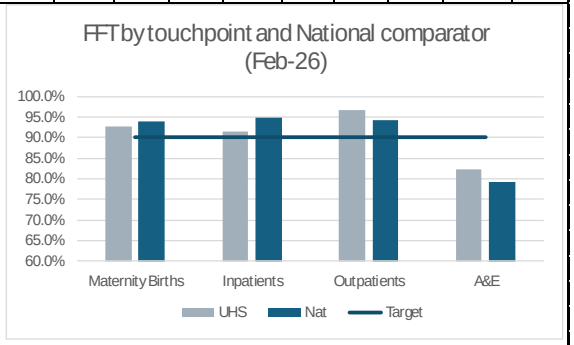
- Emergency department improvements and waits are integrated within the new strategy, and drivers such as 4-hour performance and RTT targets are integrated within the IPR. Patient reported experience via FFT will improve with reducing 4 hour and 12 hour waits, and ambulance handover times.
- To improve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

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
24/25	88.9%	89.4%	88.8%	89.0%	89.7%	89.8%	89.5%	88.8%	89.3%	90.7%	90.5%	89.7%
25/26	91.8%	91.8%	92.3%	92.3%	91.7%	90.0%	90.4%	90.7%	92.5%	91.9%	91.5%	91.7%
Variance	2.9%	2.4%	3.6%	3.3%	2.0%	0.1%	1.0%	1.9%	3.2%	1.2%	1.0%	2.0%

Breakdown Latest Month

Feb-26

FFT Scores	UHS	Nat
Maternity Births	92.8%	93.9%
Inpatients	91.5%	94.8%
Outpatients	96.6%	94.3%
A&E	82.4%	79.2%



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

Excellent Care Everywhere

Future

Excellent
Care
Everywhere

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

University Hospitals Sussex
NHS Foundation Trust

Our Ambition: Excellent Care for the Future					
Financial Stablility/variance from Breakeven Plan	**Target**	£0			
25/26 Plan YTD (£m)	£15.54m deficit	**National Ranl**			
25/26 Actual YTD (£m)	£4.92m surplus	**National Performance**			
Latest Month Trend	Decreased (improved)	**NPAF: Finance and Productivity**		**DQ**	Green
Key Messages					

- The Trust submitted a revised breakeven financial plan for 2025/26. The intial position at M12 was delivery of the breakeven position which meant the Trust became eligible to receive £4.92m of additional deficit support funding bringing the final position to £4.92m surplus.
- The plan to achieve the breakeven position included the delivery of a £112.96m efficiency programme. For the year to M12 efficiency delivery is £96.84m, £16.12m adverse to plan but still reflecting the greatest annual efficiency achieved since the formation of UHSussex.
- The cash position is £3.05m which is £0.63m favourable to plan.
- The capital expenditure plan is adjusted through the year to recognise additional capital funding that has been granted to the Trust for new schemes; as at M12 the plan total is £142.05m. Actual capital expenditure to M12 is £142.14m which is £0.09m greater than planned. This overspend was agreed with NHSSussex ICB in order for the system to fully utilise its capital expenditure limit.

2025/26 M12 £m	**Annual Plan**	**YTD**		
		Plan	**Actual**	**Variance Fav/(Adv)**
I&E (Surplus) / Deficit	0.00	0.00	(4.92)	4.92
Efficiency	112.96	112.96	96.84	(16.12)
Cash	2.42	2.42	3.05	0.63
Capital	142.05	142.05	142.14	(0.09)

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	16.60	2.43	0.00
Actual	4.67	9.29	12.62	13.79	14.96	15.16	15.16	15.30	16.51	18.59	4.45	-4.92
Variance	0.27	0.49	0.48	0.49	0.02	0.02	-0.97	-0.97	-0.97	-1.99	-2.02	4.92

Key Actions

- The Trust M12 position is subject to audit. Trust staff are working to provide appropriate evidence to the auditors to support the recognition of income and expenditure in the position, incuding the basis of any necessary estimates and rationale for judgements made.
- Where delivery of 2025/26 efficiencies was through non-recurrent means, these savings need to be recurrent. This is encompassed in the Trust's efficiency plan for 2026/27.

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.

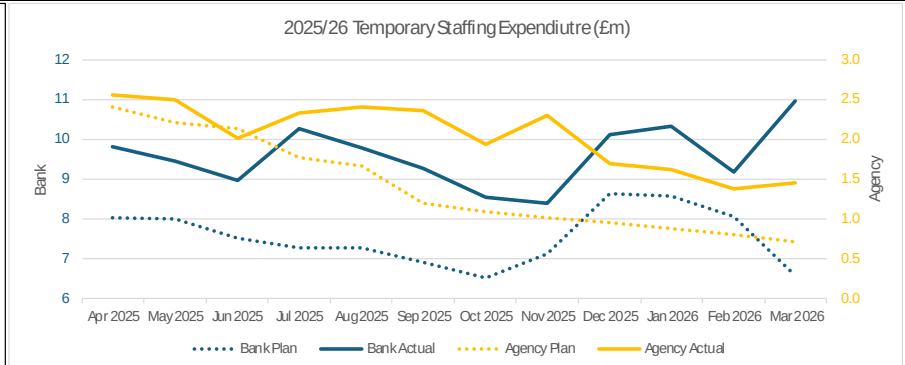
Exec Owner Jonathan Reid **SRO** Naeem Uddin

Excellent Care Everywhere

University Hospitals Sussex NHS Foundation Trust

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)	107.35	**National Rank**			
25/26 Actual YTD (£m)	139.62	**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 M12 is in excess of plan each month and by a cumulative full-year total of £24.6m. 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 M12 is in excess of plan in all months apart from M3 giving a cumulative total overspend of £7.7m.



£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	90.51	90.51
Bank Actual	9.80	9.46	8.97	10.25	9.79	9.26	8.55	8.38	10.13	10.34	9.19	10.95	115.07	
Variance	(1.76)	(1.47)	(1.46)	(2.97)	(2.51)	(2.36)	(2.01)	(1.25)	(1.49)	(1.77)	(1.12)	(4.37)	(24.56)	
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	16.84	16.84
Agency Actual	2.55	2.49	2.01	2.33	2.41	2.37	1.94	2.30	1.70	1.62	1.38	1.46	24.55	
Variance	(0.14)	(0.29)	0.13	(0.57)	(0.74)	(1.17)	(0.85)	(1.28)	(0.75)	(0.74)	(0.58)	(0.74)	(7.72)	
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	107.35	107.35
Combined Actual	12.35	11.96	10.98	12.59	12.20	11.62	10.49	10.68	11.83	11.96	10.57	12.41	139.62	
Variance	(1.90)	(1.76)	(1.33)	(3.54)	(3.25)	(3.53)	(2.86)	(2.53)	(2.24)	(2.51)	(1.69)	(5.12)	(32.27)	

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 need for temporary staff backfill

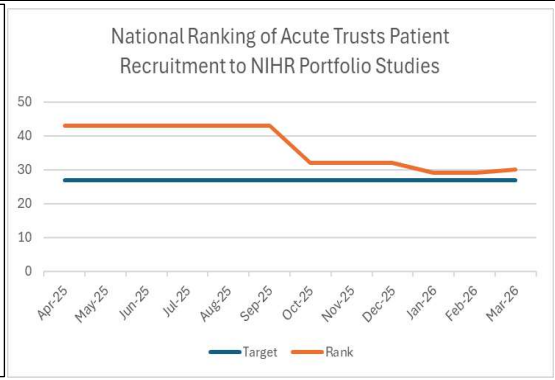
Exec Owner Jonathan Reid **SRO** Naeem Uddin

Excellent Care Everywhere

University Hospitals Sussex
NHS Foundation Trust

Our Ambition: One UHSx					
Recruitment to studies national ranking	**Target**	27th or less			
24/25 Actual	55th	**National Rank**	55/134		
25/26 Actual	30th	**National Performance**	0.22		
Latest Month Trend	Increased (improved)	**NPAF Area: Access to Services**		**DQ**	Green
Key Messages	Opportunities for patients to benefit from participating in research have widened, recruitment ranking has impro				

- Research and innovation are central to high-quality, sustainable healthcare, ensuring patients benefit from the latest advances. Beyond individual studies, a strong research culture improves care quality, strengthens community engagement, and supports system resilience. It also enhances staff development and helps attract and retain talent. For these reasons, the Trust has placed research and innovation at the heart of its strategy.
- This year opportunities for patients to benefit from participating in research have widened. This chart shows shows the 12-month rolling Acute Trust ranking in terms of total recruitment to studies on the NIHR portfolio. At year end the Trust was ranked 30th putting it just outside the top 20% of recruiting Acute Trusts. Recruitment stood 7141 against the 27th placed of 7244. This indicator is subect to our hospital sites being selected for high recruiting studies, this is dependent on factors such as having the relevant population required to answer the reserach question. The Trust consistently perfoms well in respect of the number of studies it has open to recruitment. This year the Trust ranked 25th out 134.



Portfolio development - Our research delivery teams, working with specialty research leads, continually review available studies that offer potential benefit and are feasible to run across the Trust. In addition, our new NIHR Commercial Research Delivery Centre (CRDC) for Sussex 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.
Strategic development of R&I - Sitting under our new Trust strategy for 2025-30 *Excellent Care Everywhere* - the R&I delivery plan focuses on a number of key work areas:
Major Capital Project to develop UHSx 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) A centre of excellence, part of a national network to accelerate commercial clinical research. The CRDC aims to expand patient access to cutting-edge treatments, reduce health inequalities through more inclusive research participation, strengthen local research infrastructure, and drive inward investment into Sussex and the wider UK.
Research delivery workforce model Transformation of workforce models for research delivery - alignment to new ToM, hub and spoke research delivery and agile workforce.
Streamlining study set up and delivery Improving the efficiency of clinical trial set up and delivery in line with DHSC performance expectations.
Developing divisional embedded workforce research capacity Increasing job planned 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 Directorates (JCADs) Over the following year, five initial JCADs will be established in Cardiology, Critical Care & Peri Operative Medicine, Cancer, Infection and Paediatrics. These build on existing areas of research strength in partnership with Brighton and Sussex Medical School and align with the Trust's operating model, ensuring each clinical division has a dedicated research focus. The JCADs will act as flagship centres for research within each division, uniting clinicians, researchers and patients to strengthen clinical academic partnerships.
Development of our Research Leaders Maximising research career development through the *MyCharity UHSussex* Fellowship programme, NIHR and other fellowship opportunities. **Further development of the Health & Care Research Partnership** Supporting regional research growth and opportunity through shared research infrastructure, capacity building and collaboration with regional partner organisations.
Further development of Sussex Patient and Community Involvement and Engagement in Research – supporting the sustainability and development of the Sussex Research Engagement Network (REN) - widening participation and inclusion in research.

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

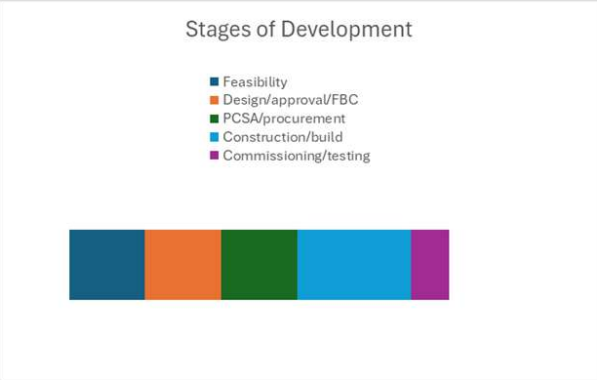
Excellent Care Everywhere

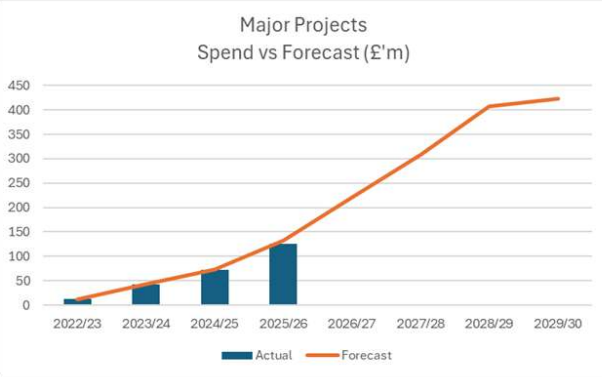
NHS
University Hospitals Sussex
NHS Foundation Trust

Major Projects Portfolio Overview

Across the Major Projects Portfolio key milestones have been achieved in the last period however challenges and issues have also been identified with plans are being worked through to mitigate. and minimise impact to the programmes. Across the portfolio the **financial spend almost met forecast**, the externally funded schemes were on track, but we finished the period behind on RSCH AFR and Stroke. The **helipad became CAA certified and opened at the beginning of March** achieving a significant milestone for the Trust, at time of writing we had received 12 patient transfers by helicopter and are recommending that this project be closed out as an MP and pass to BAU for ongoing monitoring. The **ventilation project saw all 4 planned mobile theatres delivered on site by the end of March** providing a highly visible signal to staff and patients of investment in improving quality of the surgical facilities. Work is now progressing to commission the theatres and tender the work needed to start refurbishments. Emergence of potential revenue cost pressures is being discussed and work ongoing to avoid this transpiring. The capital development for the **Southlands Theatre project** is proving challenging to finalise within the budget. The clinical accommodation has been modified to reduce costs and discussions are ongoing to determine what should be within scope of the project, this challenge is represented. The RSCH AFR project has **secured supplemental funding over 2 years of £11mill** which will help to cover the capital costs, there are still wider ventilation and IT hub issues that require confirmation of funding before moving forward. The **Stroke FBC** has yet to be approved **requiring further analysis of the project financial risk** to provide assurance to the Board. The **SRH RAAC** remediation project moves into the next period with a **recommended set of options to take to SOC and OBC stages** which will be presented today. A recommendation to add a major project to the portfolio is tabled today for the Ophthalmology Service transformation which meets all criteria and is both complex and contentious.

Portfolio Health						
Project Programme	Prog	Cost			Overall	
	Time	£R	£C	Qlty	Total	Move
Stages 2&3	●	●	●	●	●	=
Helideck	●	●	●	●	●	=
EPR	●	●	●	●	●	=
Stroke Reconfiguration	●	●	●	●	●	↓
RSCH AFR	●	●	●	●	●	↑
CRF	●	●	●	●	●	=
Southlands Theatres	●	●	●	●	●	↓
SRH RAAC Remediation	●	●	●	●	●	=
Theatre Ventilation	●	●	●	●	●	↓
Property Rationalisation	●	●	●	●	●	=





Excellent Care Everywhere

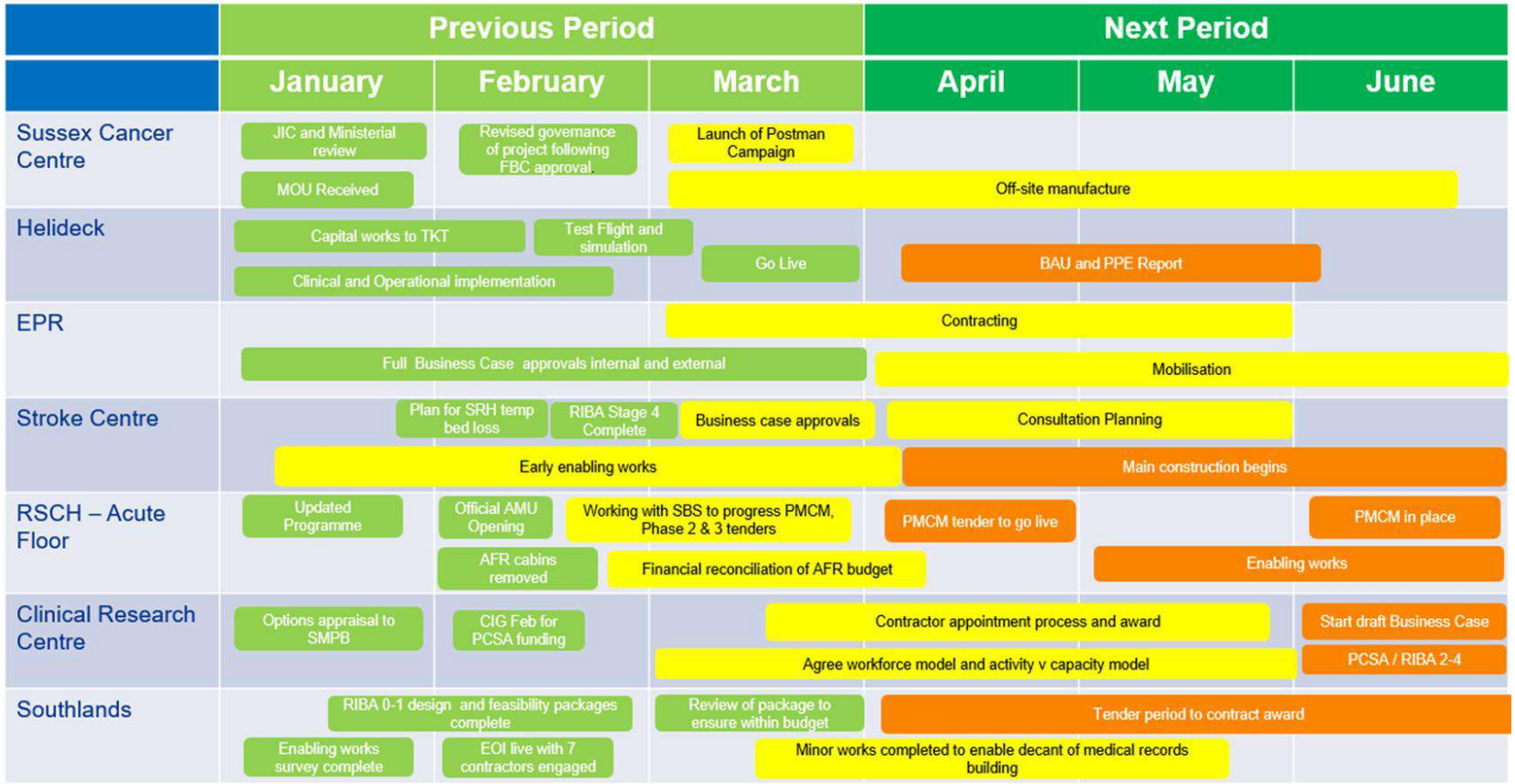
Anticipated Challenges and focus in the next period

NHS
University Hospitals Sussex
NHS Foundation Trust

Major project	Challenges and Actions in Next Period
Stroke	• Pursuit of ICB commitment to £3.7 million revenue and development of a mitigation plan if this is not forthcoming • FBC discussed at Board on 31/03/2026 – not approved pending surety on GMP and understanding of impact of application of 2023 guidance • Award of construction contract delayed pending provision of further assurance on risk • Paper to May FPC to address Board concerns re risk on capital delivery to budget and revenue • Completion of Estates design review and estates costs
RSCH AFR	• Confirmation of additional funding from NHSE to cover capital cost gap subject to submission and approval of business case via NHSE constitutional standards process • Medicine division need to develop plan for reduced corridor care capacity and elimination of MH ward • Refresh design to accommodate agreed CT room and IT hub solutions • Review unit ventilation requirement and develop costed design as existing ventilation is end of life and not fit for purpose
Southlands Theatres	• Cost report continues to show a project overspend of £3.2M despite clinical approval for design modifications to reduce the overall clinical accommodation – mitigation plan in development • Compliance with Waste Management policy and mitigation of additional imposed costs (estimated at £0.75M- £1.1M) • Property team seek approval to issue notice to vacate to charity radio station (Seaside radio) based at Southlands Hospital • Confirming support by NHSE for extended programme due to procurement framework changes • Compliance with BREEAM regulation and mitigation of imposed costs • Tender award
SRH RAAC Remediation	• Present financial options to F&P Committee • Trust approval of SOC • Continue NHSE engagement to secure support for preferred option with NHSE RAAC remediation fund • Progress SOC to OBC
Theatre Ventilation	• Theatres have arrived on site, focus will be on connection, set up and commissioning. • Decant options for RSCH need to come to CTPB workshop • Review of programme to reduce timelines to be instigated • Plan for short term approach to SEH theatre 2 requires decision through new steering group and CTPB • WGH and non-theatre ventilation will progress post procurement of decant theatres and initial survey works

NHS
University Hospitals Sussex
NHS Foundation Trust

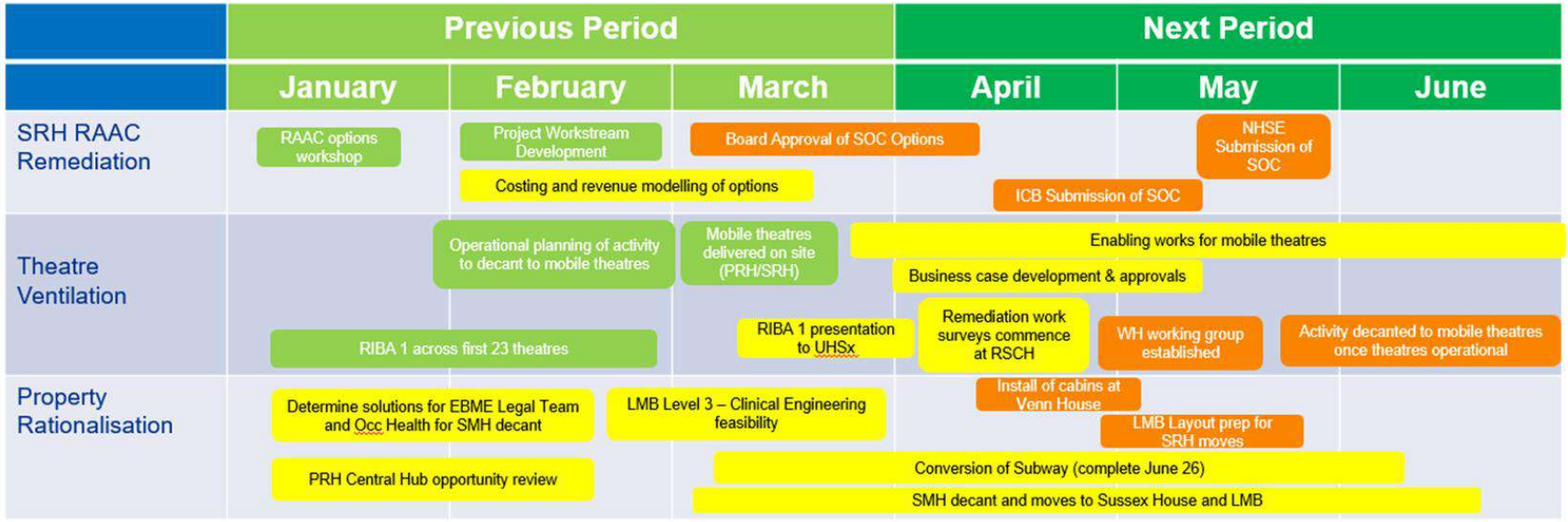
Key Milestones in previous and next period



Excellent Care Everywhere

NHS
University Hospitals Sussex
NHS Foundation Trust

Key Milestones in previous and next period cont.



Completed

WIP

Not started

Excellent Care Everywhere

One UHSussex

Excellent
Care
Everywhere

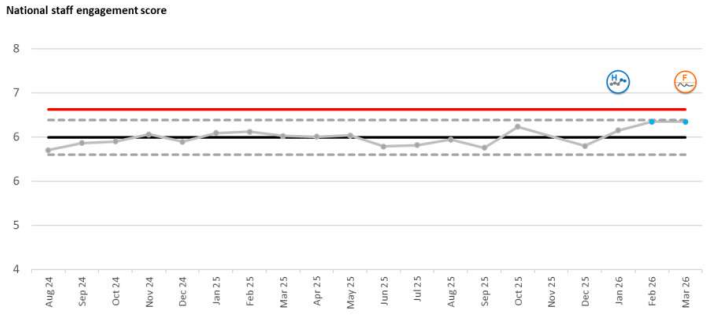
We are compassionate. We are inclusive. We are respectful.

University Hospitals Sussex
NHS Foundation Trust

Our Ambition: One UHSx					
Staff Engagement Scores	**Target**	>6.9			
24/25 Actual	6.42	**National Rank**			
25/26 Actual	6.68	**National Performance**	6.85 - Annual 2024 National NHS Staff Survey		
Latest Month Trend	Same (Stable)	**NPAF Area: People and Workforce**		**DQ**	Green

Key Messages

- Staff engagement is measured nationally through the annual NHS Staff Survey and quarterly People Pulse survey, and locally through the monthly UHSussex Pulse Survey.
- The fourth quarter of the 2025-26 year has remained below the national average staff engagement score in the monthly UHSussex Pulse Survey, ending with a score of 6.68 (out of 10) in March 2026 (Q4 score range: 6.52 to 6.68). This is compared to our 6.42 score in March 2025. 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 6.68 (out of 10) in the 2025 national NHS Staff Survey, representing a statistically significant improvement from 2024 (6.59). Following a period of decline in earlier years, the 2025 results demonstrate a clear positive upward trend, with engagement levels now broadly in line with the national position for Acute Trusts. Staff engagement and overall experience improved across the Trust, with all NHS People Promise elements and Themes showing year-on-year progress.

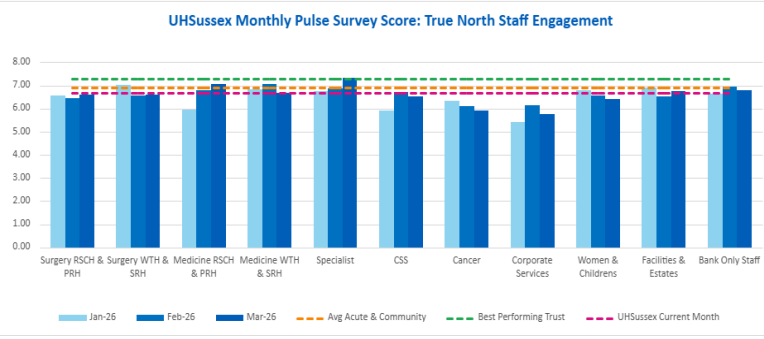


Key Actions

- Trust-wide and local 2025 NHS Staff Survey results have been shared, with leaders supported to engage teams in structured discussions, recognise strengths and agree locally owned improvement actions aligned to divisional priorities.
- People and Culture programmes are fully aligned to the Trust Strategy's Ambitions and Priorities and the NHS People Promise, ensuring improvement activity directly supports strategic delivery and a continued focus on improving staff experience and engagement.
- Progress is monitored through established governance, with 12 of 13 programmes on track at the end of Q4 2025–26. Delivery during the quarter has demonstrated tangible impact across three strategic Ambitions of excellent care for our people, our communities and together, including strengthened staff voice, improved health and wellbeing support, progress on inclusion, leadership development, values-based recruitment, education and workforce planning, and further steps towards embedding a shared One UHSussex culture.

	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	6.5	6.7	6.7
Variance	-0.9	-0.7	-1.0	-0.8	-0.6	-0.1	0.3		-0.1	0.0	0.2	0.3

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 (4.6% and 5.7% respectively and our stability rate is 92.3%.

Exec Owner Sarah-Jane Taylor, Interim CPO **SRO** Helen Weatherill, Director of HRM

Excellent Care Everywhere

National Performance Assessment Framework and League Tables

Excellent
Care
Everywhere

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

National Performance Assessment Framework Analysis

University Hospitals Sussex NHS Foundation Trust

SCORE	SEGMENT	No. metrics	Q1	Q2	Q3	Q4		
Access to services	4	8	3.1	3.2	3.2		↓	marginal
Finance & Productivity	3	3	1.7	1.8	2.5		↓	moderate
Effectiveness & Experience	4	3	2.6	2.6	2.5		↑	marginal
Patient Safety	4	4	3.4	3.2	3.2		→	
People & Workforce	3	3	2.9	2.7	2.7		→	
Average / total score	4	21	2.8	2.8	3			

RANKING	SEGMENT	No. metrics	Q1	Q2	Q3	Q4		vs Q1
Access to services	4	8	113	116	120		↓	-7
Finance & Productivity	3	3	19	28	60		↓	-41
Effectiveness & Experience	4	3	119	113	106		↑	13
Patient Safety	4	4	129	121	127		→	2
People & Workforce	3	3	89	82	83		→	6
Average / total	4	21	117	113	121			-4

- Latest NOF ratings published 18 March 26.
- UHSx remains Segment 4 overall rating with a provider capability assessment of red
- Overall ranking has reduced from 113 in Q2, to 121 (of 134).
- Summary of key drivers for the UHSx rating & changes between Q2 and Q3 provided on the next slide but the most notable drivers are performance against access constitutional standards (both planned care and UEC) and two key metrics from NHS national staff survey (raising concerns and engagement sub-scores).
- Relative UEC performance deteriorated in Q3, resulting in a lower score and ranking.
- Implied Productivity score reduced from top quartile towards median.
- Marginal changes only in other scores.
- Note – latest staff survey scores not reflected in Q3, but expect to see in Q4 (with relative improvement in our score).

Summary of Q3 segmentation key drivers and actions

	Key drivers for the 25/26 score	key changes between Q2 and Q3	Actions being taken	BAF
Access to services	RTT performance (total wait list & total > 52 ww), UEC performance (4 hours).	Relative UEC performance dropped.	Proposal for major UEC & Flow programme within 2026/2027 plan, with specialist improvement support from external advisory partner. Strengthened Planned Care programme to address overall waiting list size & transform pathways.	SR1 SR2
Finance & Productivity	Deficit plan = max score of 3. Actual score aggregates at 2.5.	Implied Productivity score dropped in Q3 last year & due to the way this metric is calculated this is now impacting the current year NOF rating.	Substantial cost improvement & productivity programme within 2026/2027 plan, with expert advisory support.	SR10
Effectiveness & Experience	discharge ready to discharge date.	Marginal improvement.	Links to UEC & Flow, and ongoing partnership work to address NCTR outside the Trust's control.	SR1 SR6
Patient Safety	staff survey - raising concerns sub-score.	(latest staff survey results expected to have positive impact in Q4)	Being addressed via Q&S programme and values and behaviour compass roll out. CPO assessing additional actions to build confidence of staff.	SR3 SR11
People & Workforce	staff survey - engagement theme sub-score	(latest staff survey results expected to have positive impact in Q4)	Values and Behaviours compass, new operating model (TOM) and ongoing engagement work (e.g. staff conference), improvement.	SR11 SR12

Detailed scores provided on the next slide. Not all metrics are ranked - denoted by 0 / Green (due to auto-formatting).

Metric detail

NHS
University Hospitals Sussex
NHS Foundation Trust

Quarter	Domain	Sub-domain	Metric_description	Reporting_date	Units	Value	Ranl
Q3 2025	Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatmer	Dec-25	%	51.1	
Q3 2025	Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatmer	Dec-25	score	3.93	
Q3 2025	Access to services	Elective care	Percentage of patients waiting over 52 weeks for elective treatment	Dec-25	%	4.07	
Q3 2025	Access to services	Elective care	Percentage of patients waiting over 52 weeks for elective treatment	Dec-25	score	3.83	
Q3 2025	Access to services	UEC	Percentage of emergency department attendances admitted, transferred or dischar	Q3 2025/26	%	69.41	
Q3 2025	Access to services	UEC	Percentage of emergency department attendances admitted, transferred or dischar	Q3 2025/26	score	3.42	
Q3 2025	Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	Q3 2025/26	%	66.08	
Q3 2025	Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	Q3 2025/26	score	3.14	
Q3 2025	Access to services	Elective care	Difference between planned and actual 18 week performance	Dec-25	percenta	-1.87	
Q3 2025	Access to services	Elective care	Difference between planned and actual 18 week performance	Dec-25	score	2.65	
Q3 2025	Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Dec-25	%	19.66	
Q3 2025	Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Dec-25	score	3.64	
Q3 2025	Access to services	Cancer care	Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgen	Q3 2025/26	%	77.09	
Q3 2025	Access to services	Cancer care	Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgen	Q3 2025/26	score	2.6	
Q3 2025	Access to services	UEC	Percentage of emergency department attendances spending over 12 hours in the de	Q3 2025/26	%	8.23	
Q3 2025	Access to services	UEC	Percentage of emergency department attendances spending over 12 hours in the de	Q3 2025/26	score	2.52	
Q3 2025	Finance and productivity	Finance	Planned surplus/deficit	2025/26	%	-1.62	
Q3 2025	Finance and productivity	Finance	Planned surplus/deficit	2025/26	score	3	
Q3 2025	Finance and productivity	Finance	Variance year-to-date to financial plan	Month 9 2025	%	-0.08	
Q3 2025	Finance and productivity	Finance	Variance year-to-date to financial plan	Month 9 2025	score	2	

Metric detail

NHS
University Hospitals Sussex
NHS Foundation Trust

Q3 2025	Finance and productivity	Productivity	Implied productivity level	2 2025/26 vs Q2 2024/2	%	3.8	45
Q3 2025	Finance and productivity	Productivity	Implied productivity level	2 2025/26 vs Q2 2024/2	score	1.99	45
Q3 2025	Effectiveness and experien	Effective flow and discharg	Average number of days from discharge ready date to actual discharge date (includi	Dec-25	days	1.48	109
Q3 2025	Effectiveness and experien	Effective flow and discharg	Average number of days from discharge ready date to actual discharge date (includi	Dec-25	score	3.57	109
Q3 2025	Effectiveness and experien	Patient experience	Summary Hospital-level Mortality Indicator	Oct 24 - Sep 25	score	2	0
Q3 2025	Effectiveness and experien	Patient experience	CQC inpatient survey satisfaction rate	2024	score	2	0
Q3 2025	Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	out of 10	6.03	123
Q3 2025	Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	score	3.75	123
Q3 2025	Patient safety	Patient safety	Number of MRSA bacteraemia cases (12 months)	Jan 25 - Dec 25	count	4	0
Q3 2025	Patient safety	Patient safety	Proportion of E. coli bacteraemia	Jan 25 - Dec 25	rate	1.14	0
Q3 2025	Patient safety	Patient safety	Proportion of C. difficile infections	Jan 25 - Dec 25	rate	1.16	0
Q3 2025	Patient safety	Patient safety	Number of MRSA bacteraemia cases (12 months)	Jan 25 - Dec 25	score	3.01	0
Q3 2025	Patient safety	Patient safety	Proportion of E. coli bacteraemia	Jan 25 - Dec 25	score	2.5	0
Q3 2025	Patient safety	Patient safety	Proportion of C. difficile infections	Jan 25 - Dec 25	score	2.63	0
Q3 2025	People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	out of 10	6.59	114
Q3 2025	People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	score	3.55	114
Q3 2025	People and workforce	Retention and culture	Sickness absence rate	Q2 2025/26	%	4.66	46
Q3 2025	People and workforce	Retention and culture	Sickness absence rate	Q2 2025/26	score	1.76	46

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16.	**Meeting:**	Trust Board in Public		**Meeting Date:**	14 May 2026	
Report Title:	Board Assurance Framework report						
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 March agreed the opening 12 Strategic Risks that make up the BAF, noting their alignment to the Trust's strategic ambitions.

The underlying process for the BAF oversight remains the same, this being that each Strategic Risk is assigned an Executive who supported by relevant Directors maintain the information contained in the BAF and provide a judgement as to the current risk score as the year progresses, each Strategic Risk has a lead oversight Board Committee who are responsible for triangulating and challenging the BAF segments with the information they receive and make a recommendation to the Board. The Audit Committee retains a role in undertaking a complementary review on a cyclical basis of one or two segments.

The structure of the BAF has been adjusted to provide greater specificity as to the type of assurance being reflected on when forming a judgement on the efficacy of the control environment, bringing clarity to which assurances are provided externally to the Trust (3rd Line assurance).

Each board committee reviewed the elements for which they have allocated oversight at their meetings in May and provided a recommendation to the Board on the respective strategic risk scores.

The Audit Committee received a report on the overall process supporting the BAF and a report on the underpinning risk management processes.

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 content of the BAF itself continues to be refined following feedback from the Committees on the mitigation timescales and the link to the Trust's developing Trust Risk Register will be enhanced through the centrally driven risk improvement sprint work.

The opening risk profile shows 7 of the 12 strategic risks significantly scored and by the year end through the delivery of the developed mitigations only one risk at this time is planned to remain scored significantly.

University Hospitals Sussex
NHS Foundation Trust

	The aggregate risk profile across the 12 strategic risks shows the impact of the current controls mitigates this by some 25% but to achieve the stated appetite levels a further 55% improvement from the 31 March 2027 target scores will be required. *The current Board risk appetite statements need to be realigned to the Trust's strategic ambitions and therefore a review is being planned to review these to ensure they remain realistic.*
What Next ***(summary of intended action and benefits supporting the choices and recommendation(s)being made)***	*The Board can take assurance over the underpinning BAF oversight processes.* *The Board is asked to note the recommendations of the respective committees which is reflected in the scores recorded for each Strategic Risk which shows seven of these significantly scored with the agreed target scores moving for all but one of these risks to a moderate score by the year end.*
Recommendation *(linked to What Next section)*	*The Board should **NOTE** the assurance provided by the respective lead oversight committee review of their BAF segments.* *The Board is asked **AGREE** the opening scores and target year end scores, supported by the relevant oversight committees' recommendations.* *The Board is asked to **NOTE** the level of aggregate strategic risk held by the Trust and the actions in place to achieve the target score* *The Board is asked to **NOTE** the planned risk appetite workshop being arranged to ensure that the current risk appetite statements remain realistic and that should any changes be recommended that these will come to the Board for review and agreement.*
Assurance / Scrutiny route already undertaken (*please explain where matter previously considered, and assurance provided)*	*The Audit Committee considered the BAF at its meeting in April 2026 and each of the respective oversight Committees considered their element of the BAF at their meetings at the start of May 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 cover all BAF risks*

University Hospitals Sussex
NHS Foundation Trust

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

2026/27 Board Assurance Framework Report

1 Introduction

1.1 The Board agreed 12 Strategic Risks at its March meeting, aligned to the strategic ambitions set out within the Trust's 5-year strategy 'Excellent Care Everywhere'.

1.2 The BAF for 2026/27 is aligned to assess key risks to the delivery of the strategy, with a new format to the BAF and a shift towards a 'positive assurance' model, setting out the key actions planned for the year to reduce the overall risk profile and support delivery of the strategy. .

2 BAF processes

2.1 The underpinning Board Assurance Framework (BAF) processes remain in place, these being

- assigned executive leads to each BAF risk, to provide oversight of the maintenance of the document, the review of action delivery and utilising the assurances received when determining the current risk scores;
- the Executive Management Committee will receive the BAF and triangulate the respective individual executive judgements prior to the document being presented to the Board Committees;
- assigned Board Committees to each BAF risk, to enable triangulation of the assurances and reports they receive with the judgements recorded in the BAF to enable a recommendation to be made to the Board on the risk scores; and
- the Audit Committee retains its role to undertake complementary reviews on a cyclical basis of one or two strategic risks to enable wider triangulation to be undertaken given that the audit committee membership is the chairs of all Board Committees and that the strategic risks themselves in reality cut across many Committee domains.

2.2 The BAF itself will continue to be presented on a quarterly basis to the Board Committees, with the first reporting taking place to the Committee meetings in May 2026.

3 BAF Structure

3.1 The Trust has revised the format of its BAF for 2026/27, there are now three pages for each Strategic Risk,

- the first page shows at a glance the current risk score relative to its annual target score and the Board's stated appetite along with an assessment of the assurance strength. This page also records the delivery of agreed actions to further mange the risk and to bring a focus to the actions taken and being taken in respect of each of its identified strategic risks.
- the third page shows a mapping of the assurances received to their respective key controls and for each assurance whether this provided by operational management (1st line), corporate service led assurance activities (e.g. peer review or ward accreditation), executive, group or committee oversight (2nd line) or by an independent source (3rd line).
- the second page which will be completed as the risk improvement work is concluded will show the link to the Trust's Risk Register and identified key 'risk metrics' that will be chosen as proxy measures for the impact of improved controls and / or measures to reduce risk (e.g. corridor care hours / utilisation of temporary escalation spaces).

3.2 This updated format brings into sharper focus the strength of assurance being relied upon to make judgements on the risk score and the effectiveness of the delivered actions on the mitigation of the risk.

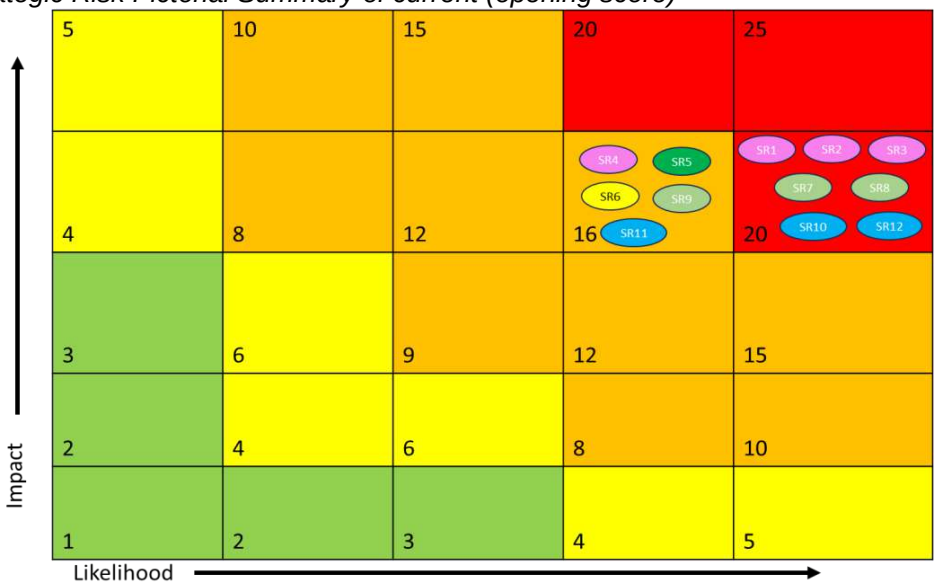
3.3 The BAF retains an explicit link to a Board Committee allocated for initial / primary oversight, which will focus on the seeking of and then understanding of the assurances listed against the key controls. The BAF also retains a nominated executive lead for each risk.

4 BAF summary

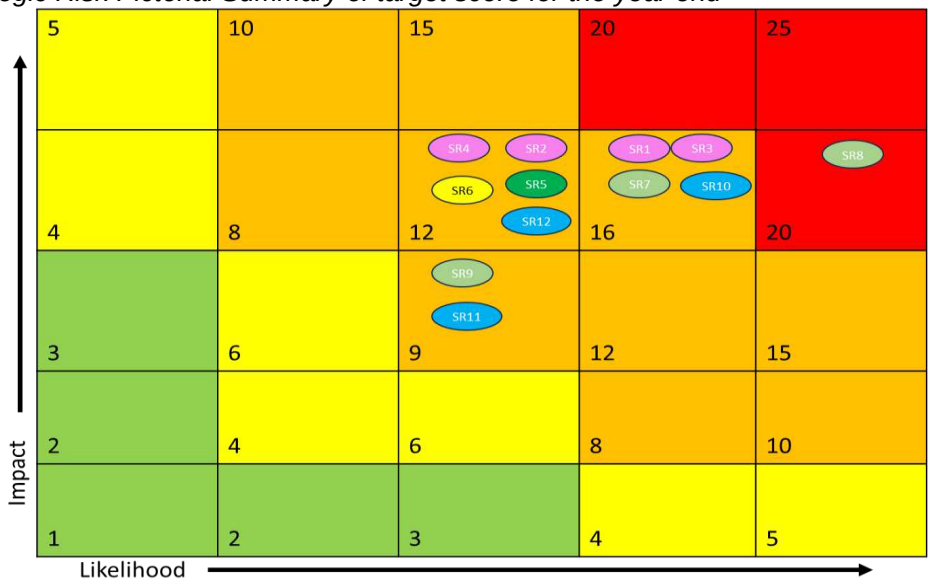
4.1 The overall risk profile for the Trust remains high. At the start of the year 7 of the 12 Strategic risks are significantly scored, these cover the ambitions of Excellent Care for our patients (coloured pink), Excellent Care for the Future (coloured light green) and Excellent Care Together (One UHSx) (coloured blue)

4.2 Risks to two ambitions Excellent Care for Communities (coloured yellow) and Excellent Care for our people (coloured dark green) are scoring 16.

Strategic Risk Pictorial Summary of current (opening score)



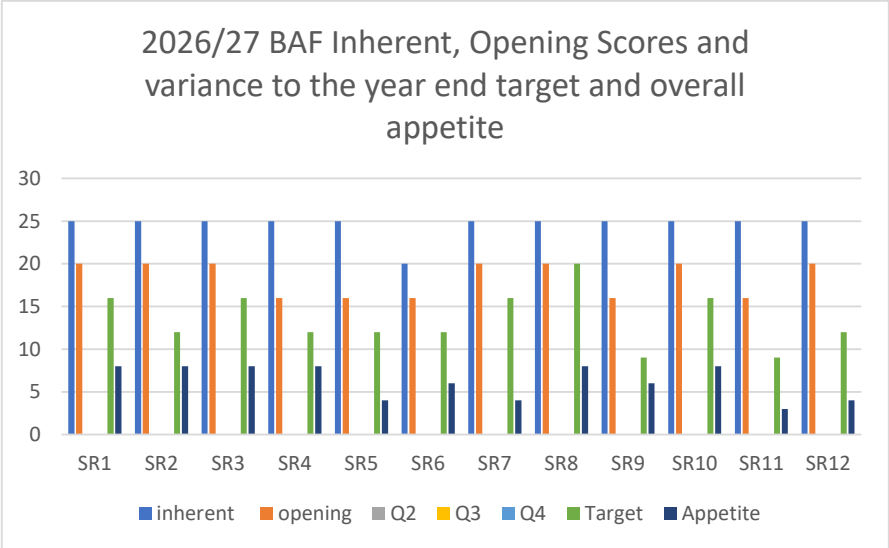
Strategic Risk Pictorial Summary of target score for the year end



4.3 SR8 aligned to the objective of better, more sustainable buildings and equipment has a year end target score of 20 which is the same as its current score at the start of 2026/27 and is the only strategic risk not planning to reduce during the year. Note that the review of this risk by both the Patient and Quality and Finance and Performance Committees recognised that the reason for this target score is that work is still to be completed to determine the impact of the planned actions, and once this is concluded it is expected that a realistic target score will be determined.

4.4 SR12 aligned to the objective of right people, right skills working towards common goals has the largest reduction from a score of 20 to a score of 12.

4.5 Below is a summary chart showing for the 12 Strategic Risks their opening scores and the distance from their respective year-end target score.



4.6 Below is an analysis of the Trust's overall risk profile, showing the aggregate total of the 12 strategic risks inherent scores, opening (current score for the year), the target score for the 31 March 2027 and then comparing that to the overall appetite scores.

	Inherent score	Current (opening) score	Target score	Appetite score
Total	295	220	162	75
% reduction against the inherent		25%	45%	75%
% reduction against opening score			26%	

This shows an overall reduction of some 25% from the inherent score to the opening (current) score and then a further 26% reduction from the current score is needed to achieve the aggregate targets scores. A further 54% from the 31 March 2027 target scores is required to achieve the current stated appetite scores.

4.7 The current Board risk appetite statements need to be realigned to the Trust's strategic ambitions and therefore a review is being planned to review these to ensure they remain realistic.

5 Committee Review of the BAF

5.1 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.

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

5.2.1 Patient and Quality Assurance Committee

The Committee agreed that for the patient and quality strategic risks, SR3 and SR4 the current risk scores recommend by the executives were reasonable as were the target risk scores.

The Committee in considering the flow of assurance it receives it noted that the oversight of Strategic Risk 8, aligned to the objective of better, more sustainable buildings and equipment would be better placed moving to them. This was discussed at the Finance and Performance Committee who agreed that the Patient and Quality committee will take the overall lead on this risk, with the Finance and Performance committee also playing a key role in tracking key risk mitigations. The Patient and Quality committee asked for a number of revisions to the BAF entry for this risk to ensure that the actions set out clearly articulate required risk and governance improvement work to strengthen assurance.

At this meeting it was recognised that the reason for the target score of SR8 showing no change to the current score is that work is still to be completed to determine the impact of the planned actions, and once this is concluded it is expected that a realistic target score will be determined.

5.2.2 People and Culture Assurance Committee

The Committee agreed that for the people and culture strategic risks, the current risk scores recommend by the executives were reasonable and that the ambition for these risks was reflected in their target scores.

5.2.3 Research, Innovation and Digital Assurance Committee

The Committee agreed that for both the research and innovation strategic risk and the digital strategic risk the current risk scores recommend by the executives were reasonable and that the mitigation plans and proposed assurance reporting supported the improvement ambition reflected in their target scores.

5.2.4 Finance and Performance Assurance Committee

The Committee agreed that for the Strategic Risks 1 and 2 relating to performance and the Strategic Risk 10 relating for finance the recommended current and target scores were reasonable.

The Committee noted that the ambition for SR2 had been adjusted from the original draft to a score of 12 and asked that the revised target score be reflected in future reports.

The Committee reflected on the flow of assurance in relation to SR8 and agreed with the view of the Patient and Quality Committee that they should assume the lead for oversight of this risk as it was recognised that the Finance and Performance Committee would continue to play a significant assurance oversight role.

5.2.5 Strategy and Major Projects Assurance Committee

The Committee agreed that for the partnership strategic risk SR6, the current risk score recommend by the executives was reasonable as is the target score.

5.2.6 Audit Committee

The Audit Committee continued to receive a report providing information in respect of the underpinning processes for the oversight and update to the BAF along with a report on the Trust's level of compliance with its risk management policy.

6 Conclusion

6.1 The Board should **NOTE** the assurance provided by the respective lead oversight committee review of their BAF segments.

6.2 The Board is asked **AGREE** the opening scores and target year end scores, supported by the relevant oversight committees' recommendations.

6.3 The Board is asked to **NOTE** the level of aggregate strategic risk held by the Trust and the actions in place to achieve the target score

6.4 The Board is asked to **NOTE** the planned risk appetite workshop being arranged to ensure that the current risk appetite statements remain realistic and that should any changes be recommended that these will come to the Board for review and agreement.

NHS
University Hospitals Sussex
NHS Foundation Trust

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)

Strategic Objectives	Strategic Risks	Risk Scores (Key: I = Impact L = Likelihood T = Total																	
		Inherent (uncontrolled)			2026/27 Q1			2026/27 Q2			2026/27 Q3			2026/27 Q4			2026/27 Target		
		I	L	T	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
Oversight provided by the Finance and Performance Assurance Committee																			
SR 1 Delivering timely care for planned treatment and cancer care	*If we do not transform our diagnostic and planned care pathways and improve utilisation of our key assets (e.g. theatres) then we will not be able to provide timely care and treatment for our patients resulting in poor patient experience and potential harm to our patients, under delivery of our activity & finance plan, reputational damage and regulatory intervention.*	5	5	**25**	4	5	**20**										4	4	**16**
	Assessed strength of mitigations				***Some weaknesses***														
SR2 Urgent and Emergency Care - improving access, quality, safety and environments	*If we do not transform urgent and emergency care pathways, reduce avoidable admissions and improve flow through our hospitals then patients needing inpatient care will wait too long for a bed, leading to overcrowding in our emergency departments and very high bed occupancy levels resulting in poor patient experience, avoidable harm to our patients, excess costs and poor value care, reputational damage and regulatory action.*	5	5	**25**	4	5	**20**										4	4	**12****
	Assessed strength of mitigations				***Some weaknesses***														
SR10 Improving value and financial sustainability	*If we do not manage costs effectively, optimise productivity, and ensure our activities are effective then we will not return to financial balance resulting in lower value care / the poor use of public funds and unsustainable services for patients.*	5	5	**25**	4	5	**20**										4	4	**16**
	Assessed strength of mitigations				***Some weaknesses***														

NHS
University Hospitals Sussex
NHS Foundation Trust

Strategic Objectives	Strategic Risks	Risk Scores (Key: I = Impact L = Likelihood T = Total																	
		Inherent (uncontrolled)			2026/27 Q1			2026/27 Q2			2026/27 Q3			2026/27 Q4			2026/27 Target		
		I	L	T	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
Oversight provided by the Patient and Quality Assurance Committee																			
SR3 Improving safety and experience	*If we fail to have robust quality governance systems and processes, use our data intelligently, and develop a strong safety culture that supports learning then we will not know how safe, effective and high quality care our care is or fail to identify and address key risks and issues resulting in potential avoidable harm, adverse outcomes, poor patient experience, excess costs, reputational damage and regulatory action.*	5	5	**25**	4	5	**20**										4	4	**16**
	Assessed strength of mitigations				***Some weaknesses***														
SR4 Improving equality of access and outcomes	*If we do not actively and systematically approach tackling health inequalities in collaboration with our local partners then we will fail to play our part in improving the health and well-being of our local population resulting in less equitable access to care, poorer outcomes and contractual/regulatory noncompliance.*	5	5	**25**	4	4	**16**										4	3	**12**
	Assessed strength of mitigations				***Some weaknesses***														
SR8 *** Better, more sustainable buildings and equipment	*If we do not effectively maintain and improve our estate infrastructure and medical equipment, then we may experience increased disruption to service delivery and be unable to provide the capacity needed to deliver clinical services resulting in increased risk to patient and staff safety and to the safe and sustainable delivery of clinical services.*	5	5	**25**	4	5	**20**										4	5	**20**
	Assessed strength of mitigations				***Some weaknesses***														
Oversight provided by the People and Culture Committee																			
SR5 Ensuring our workforce is happy, healthy and supported	*If we do not retain, support, develop, engage and transform our workforce for the future then our staff will not thrive and we will encounter workforce shortages, increase our reliance on temporary staff and / or have skills and capability gaps in our teams resulting in lower staff engagement and experience, lower quality and less efficient services for patients, and higher staffing costs.*	5	5	**25**	4	4	**16**										4	3	**12**
	Assessed strength of mitigations				***Some weaknesses***														

NHS
University Hospitals Sussex
NHS Foundation Trust

Strategic Objectives	Strategic Risks	Risk Scores (Key: I = Impact L = Likelihood T = Total																	
		Inherent (uncontrolled)			2026/27 Q1			2026/27 Q2			2026/27 Q3			2026/27 Q4			2026/27 Target		
		I	L	T	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
SR11 Living our values in everything we do	*If we do not develop our organisational culture to make UHS a more inclusive place to work that celebrates our diversity and tackles discrimination then our staff will not feel valued, empowered or psychologically secure resulting in lower staff engagement, poorer staff wellbeing, challenges with recruitment and retention, and lower quality of care to patients.*	5	5	**25**	4	4	**16**										3	3	**9**
	Assessed strength of mitigations				***Some weaknesses***														
SR12 Right people, right skills working towards common goals	*If we do not implement an effective operating model, with excellent leaders who are empowered and supported to drive improvement, with devolved decision making and accountability then we will not be able to deliver our OneUHS vision of consistent, high quality, efficient care across all our hospitals and services resulting in poorer quality of care for patients, poorer staff experience and engagement and lower value care.*	5	5	**25**	4	5	**20**										4	3	**12**
	Assessed strength of control				***Some weaknesses***														
Oversight provided by the Research, Innovation & Digital Assurance Committee																			
SR7 Analogue to digital: harnessing technology and data to transform healthcare	*If we do not build a robust digital infrastructure, supporting digitally skilled staff that adopt transformational digital solutions then we will not deliver new and innovative models of care, research or support staff to work more efficiently, nor deliver cyber resilience resulting in poorer patient outcomes, less efficient services, risk for patient data and staff disengagement.*	5	5	**25**	4	5	**20**										4	4	**16**
	Assessed strength of mitigations				***Some weaknesses***														
SR9 Widening access to research and innovation	*If we do not create the right culture, infrastructure and partnerships then we will not become a thriving centre for research and innovation and not attract sufficient research funding resulting in poorer health outcomes for patients, and challenges in attracting and retaining high calibre staff.*	5	5	**25**	4	4	**16**										3	3	**9**
	Assessed strength of mitigations				***Some weaknesses***														

NHS
University Hospitals Sussex
NHS Foundation Trust

Strategic Objectives	Strategic Risks	Risk Scores (Key: I = Impact L = Likelihood T = Total																	
		Inherent (uncontrolled)			2026/27 Q1			2026/27 Q2			2026/27 Q3			2026/27 Q4			2026/27 Target		
		I	L	T	I	L	T	I	L	T	I	L	T	I	L	T	I	L	T
Oversight provided by the Strategy & Major Projects Assurance Committee																			
SR6 Collaborating to improve the health and well-being of our communities	*If we do not work build stronger partnerships with primary, community, mental health, social care and other partners and fail to develop new care pathways with system partners then we will continue to over rely on hospital based and specialist care resulting in less equitable access to care and poorer outcomes.*	4	5	**20**	4	4	**16**										4	3	**12**
	Assessed strength of mitigations				***Some weaknesses***														

**** reflects the revised and agreed target score**
***** shows move of oversight to Patient and Quality Committee**

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	17.	**Meeting:**	Trust Board in Public		**Meeting Date:**	14 May 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 or other reports

Governor Elections

Nominations have been received in respect of the governor elections, for the public constituencies of Chichester and Worthing and the Staff Constituency of Princess Royal there was only one nomination so those candidates will be elected unopposed. For the public constituencies Brighton and Hove and Mid Sussex these received more than one nomination and elections for these positions commenced on the 6 May and will close on 1 June 2026.

We will once all five positions are filled commence with their induction and with the support of the Lead Governor provide a "buddy" for each new governor.

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

NED recruitment

We have completed the NED recruitment process and a recommendation from the interview panel was made to the Governors who agreed to appoint Mr Jin Sahota and Mr Andy Hobart subject to the completion of the required pre appointment checks.

The pre appointment checks have commenced with the aim to have these concluded to enable the new NEDs to commence in June.

Recommendation *(linked to What Next section)*

The Board is asked to NOTE

- ***The progress with the Governor elections***
- ***The positive conclusion of the NED recruitment process with the decision taken by the Governors to appoint to both vacant positions***

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*

University Hospitals Sussex
NHS Foundation Trust

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 enable the Council of Governors to operate effectively.*	

Trust Board in Public

Thursday 14 May 2026

APPENDICES

University Hospitals Sussex NHS Foundation Trust

BOARD REGISTER OF DECLARATIONS OF INTERESTS AND FIT & PROPER PERSONS DECLARATIONS 2025

Name	Job Title	Interests Declared	Period	Fit and Proper Persons Self-Assessment Form	Gifts and Hospitality Declaration
Philippa Slinger	Chair	Interests: - Son and daughter-in-law are both Consultants in University Hospitals Dorset Consultancies/Direct Employment: - Clinical Partners Ltd, 12 days per year from November 2025	1 April 2025 – 31 March 2026	Completed	Dinner at NHS Providers Conference
Bindesh Shah	Non-Executive Director	- None	1 April 2025 – 31 March 2026	Completed	None
David Curley	*Non-Executive Director*	- *None*	*1 April 2025 – 30 June 2025*	*Completed*	*None*
Professor Gordon Ferns	Non-Executive Director	Consultancies/Direct Employment: - University of Sussex Consultant - NHS England 1 day per week secondment, South Wales University Affiliations: - Member HEART UK Medical, Scientific and Research Committee Interests: - Write scientific publications / Supervise a PhD student	1 April 2025 – 31 March 2026	Completed	Sponsorship to European Cardiac Society meeting in Madrid- registration, flights and accommodation
Professor Jackie Cassell	Non-Executive Director	Consultancies/Direct Employment: - National Lead for Adult Social Care, UK Health Security Agency - Chair - Quality Standards Committee Affiliations: - Society of Apothecaries London - Member, British Association Sexual Health & HIV - Fellow - Faculty of Public Health Interests: - Daughter works in Invited Inspections team, Royal College of Surgeons London	1 April 2025 – 31 March 2026	Completed	None
Kate Steadman	*Non-Executive Director*	*Shareholdings:* - *Share options in Serco plc* Affiliations*:* - *Chair of a small charity focusing on education and training for disadvantaged children - The Spencer Steadman Trust*	*1 April 2025 – 31 January 2026*	*Completed*	*None*

Lucy Bloem	Non-Executive Director	Consultancies/Direct Employment: - Deloitte - Arbuthnot's Portfolio	1 April 2025 – 31 March 2026	Completed	None
Mike Driver CB	Non-Executive Director	Consultancies/Direct Employment: - Sopra Steria (0.5 days) - Maximus UK (1.5 days) - RICS (3 days) - Newton Impact (1day) - KPMG Saudi Arabia (1day) Shareholdings: - MBD and Associates: Strategy, Design and Delivery Ltd – Shareholdings	1 April 2025 – 31 March 2026	Completed	None
Professor Paul Layzell	Non-Executive Director	Consultancies/Direct Employment: - Vice-Chair, Plumpton College - Chair, Herts for Learning Ltd - Chair, Qualification Board, ACCA Affiliations: - Member, Regulatory Board, ACCA - Member, Board of Governors, University of Hertfordshire	1 April 2025 – 31 March 2026	Completed	None
Philip Hogan	Non-Executive Director	Consultancies/Direct Employment: - Chair of Trustees Goldfinch Trust	1 April 2025 – 31 March 2026	Completed	None
Wayne Orr	*Non-Executive Director*	- *None*	*1 April 2025 – 31 January 2026*	*Completed*	*None*
Dr Andy Heeps	Chief Executive (from 15 December 2025) *(Interim Chief Executive 1 September – 15 December 2025)* *(Chief Operating Officer/Deputy Chief Executive – 31 August 2025)*	Affiliations: - Member of the Royal College of Obstetricians and Gynecologists (by examination) - Member of the British Medical Association - Member of the British Medical Association	1 April 2025 – 31 March 2026	Completed	1) Vascular Society of Great Britain / Accommodation and dinner / I was invited to speak at the Vascular Society ASPIRE new clinical leaders event 2) Dinner at NHS Providers Conference
Professor Catherine Katie Urch	Chief Medical Officer	Consultancies/Direct Employment: - Human Research Authority (Fee Paid work) Interests: - Declaration of Husband's roles in NHS: chair of Oxleas NHSFT	1 April 2025 – 31 March 2026	Completed	None

		chair of SE HIN NED NHSE workforce and development department			
David Grantham	*Chief People Officer*	Affiliations*:* - *Healthcare People Management Association, member and participant* *National Association of Medical Personnel - past president and life member*	*1 April 2025 – 15 February 2026*	*Completed*	*None*
Dr George Findlay	*Chief Executive*	Interests*:* - *Wife is a salaried GP in Brighton*	*1 April 2025 – 31 August 2025*	*Completed*	*None*
Helen Brown	Interim Chief Corporate Affairs Officer	- None	12 January 2026 – 31 March 2026	Completed	None
Jonathan Reid	Chief Financial Officer	Affiliations: - Member, Royal Society for Public Health Member, British Accounting Association - Incoming Chair, HFMA Kent Surrey and Sussex Branch (subject to AGM confirmation) - Ad Hoc Accountancy Exam Marking for Kaplan UK - Partner works in East Sussex Healthcare NHS Trust	1 April 2025 – 31 March 2026	Completed	None
Dr Maggie Davies	Chief Nurse	- None	1 April 2025 – 31 March 2026	Completed	None
Michelle Arrowsmith	*Interim Chief Corporate Affairs Officer*	Interests*:* - *Director of husband's company – Woodford Woodworking Tooling Ltd*	*08 October 2025 – 9 January 2026*	*Completed*	*None*
Nigel Kee	Chief Operating Officer	Interests: - Fellowship of the Royal College of Nursing	1 April 2025 – 31 March 2026	Completed	None
Roxanne Smith	Chief Strategy Officer	- None	1 April 2025 – 31 March 2026	Completed	None
Sandi Drewett	*Chief Culture & Organisational Development Officer*	Interests*:* - *Life member of the British deaf association* - *Fellow of CIPD*	*01 April 2025 – 30 May 2025*	*Completed*	*None*
Sarah Jane-Taylor	Interim Chief People Officer	- None	16 February 2026 – 31 March 2026	Completed	None

NHS
University Hospitals Sussex
NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust

Green Plan 2026 - 2030

TO BE GRAPHIC DESIGNED

We are compassionate
We are inclusive
We are respectful

Contents

University Hospitals Sussex
NHS Foundation Trust

Section	Item	Page number
1	Introduction	
2	Our Last Green Plan	
3	Context – NHS Core Carbon Footprint & Footprint Plus	
4	Our Trust Strategy	
5	Our New Green Plan	
6	Net Zero Clinical Transformation	
7	Medicines	
8	Food & Nutrition	
9	Workforce & Leadership	
10	Reduce & Reuse	
11	Travel & Transport	
12	Adaption	
13	Digital Transformation	
14	Estates & Facilities	
15	Waste Management	
16	Procurement	
17	Research & Innovation	
18	Governance	
19	Risk	

Introduction

University Hospitals Sussex
NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust (UHSussex) provides acute and specialist care to more than 1.8 million people across Brighton & Hove, West Sussex and the wider region. As one of Sussex's largest employers, our estate, operations and procurement choices carry a significant environmental footprint. Equally, they represent a powerful opportunity to support our wider Trust Strategy by improving health outcomes and contributing to a sustainable, resilient health and care system.

Our strategy *Excellent Care Everywhere* sets out our commitment to Being Green. It articulates our ambition to become one of the greenest trusts in the country. It recognises the importance of this to our development as an organisation, our communities, our patients and our staff.

This green plan is shaped around our five strategic ambitions, ensuring that sustainability is not a standalone agenda but a core enabler of high quality, equitable and financially responsible care.

Our new plan builds on the progress achieved through our previous *Patient First, Planet First Green Plan (2022–2025),* as well as the priorities identified by our Buildings & Utilities Working Group, Sustainable Travel Group and Green Ambassador network.

Our 2026 – 2030 plan focuses on the areas where the Trust has the greatest ability to reduce emissions we directly control (the NHS Carbon Footprint) and to influence emissions across the wider system and supply chain (the NHS Carbon Footprint Plus), recognising the role of leadership, partnership and system working in achieving lasting change.

The delivery of this plan is fully aligned with the NHS Sussex *Together to Zero Green Plan* and national *Greener NHS* guidance. This ensures a coherent, system wide approach to Net Zero and climate resilience, while reinforcing the Trust Strategy's focus on integration, accountability and delivering excellent care for our population now and in the future.

As the NHS evolves, following the establishment of NHS Surrey and Sussex Integrated Care Board, we will continue to review and align our approach to reflect any emerging system level sustainability plans and priorities.

Together, these commitments provide a clear and practical framework to embed sustainability into how we plan, deliver and improve care over the coming years.

Our last Green Plan

NHS
University Hospitals Sussex
NHS Foundation Trust

Since our last plan, we have successfully completed 95 Key Actions, with a further 60 currently in progress - including ongoing improvement initiatives that are continuous by nature. 9 actions have not been started, as they depend on other workstreams to be completed.

The NHS landscape in sustainability has evolved significantly since our last plan. As a result, 8 actions are now being addressed at a national level or have been superseded by updated guidance, including using in house carbon reporting to identify hotspots for reduction.

The NHS carbon footprint for 2024/25 is due to be published by NHS England in April 2026. Based on NHSE's published data, our reported emissions for 2023/24 were 39,958 tonnes CO_2e, against a 2032 target of 20,553 tonnes CO_2e. We estimate that our 2024/25 footprint will reduce to approximately 37,600 tonnes CO_2e.

This Green Plan Refresh has been developed with input from colleagues across clinical, operational, corporate, and support services, whose expertise, insight, and commitment have been essential in shaping a practical and deliverable approach to sustainable healthcare at UHSussex.

Context

University Hospitals Sussex
NHS Foundation Trust

NHS Core Carbon Footprint and Footprint Plus

University Hospitals Sussex NHS Foundation Trust's carbon footprint reflects the scale and complexity of the services we provide across a large and diverse estate. In line with national NHS methodology, our emissions are reported across two categories: the NHS Carbon Footprint, covering emissions we directly control, and the NHS Carbon Footprint Plus, covering emissions we can influence but do not directly control.

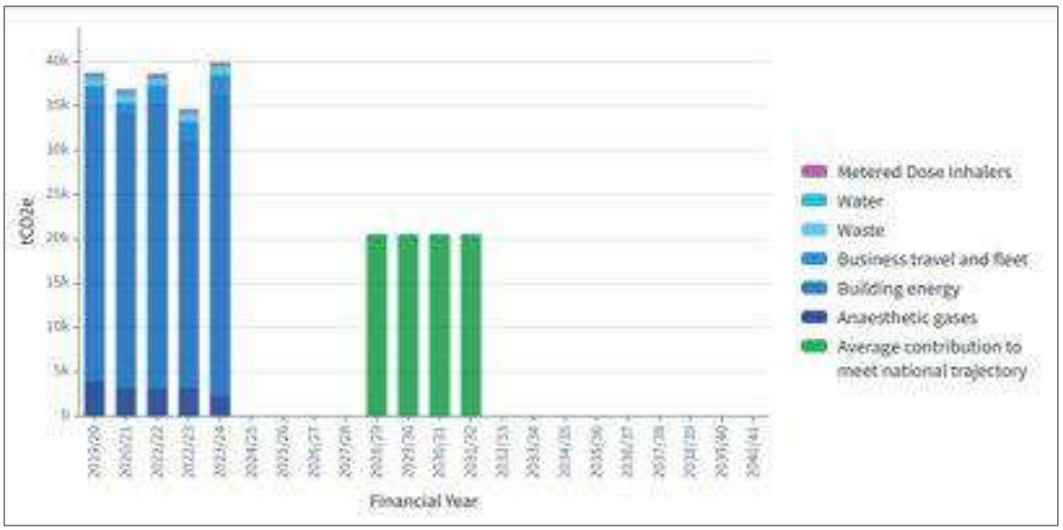
The national NHS targets are defined against 1990 levels to allow comparison with the UK Climate Change Act (2008):

- Reach net zero by 2040 for the emissions we control directly (the NHS Carbon Footprint), with an 80% reduction by 2028-2032 against 1990 levels;
- Reach net zero by 2045 for the emissions we can influence but don't directly control (the NHS Carbon Footprint Plus), with an 80% reduction by 2036-2039 against 1990 levels

Those national targets defined against the 2019/20 emissions footprint calculated in line with the Delivering a Net Zero NHS report are equivalent to:

- Reach net zero NHS Carbon Footprint by 2040, reducing emissions by at least 47% by 2028-2032;
- Reach net zero NHS Carbon Footprint Plus by 2045, reducing emissions by at least 73% by 2036-2038.

The graph below illustrates our current carbon footprint trajectory, with emissions for 2023/24 at 39,958 tCO_2e and a 2032 target of 20,553 tCO_2e.



Our Carbon Footprint Plus baseline is 191,000 tCO_2e, with 128,895 tCO_2e attributed to our supply chain. We expect this to decrease as our suppliers progress on their journeys toward Net Zero. To support this, our procurement team has implemented a sustainable procurement policy aimed at meeting the reduction targets outlined above. Further details are provided in the Procurement section of this plan.

University Hospitals Sussex
NHS Foundation Trust

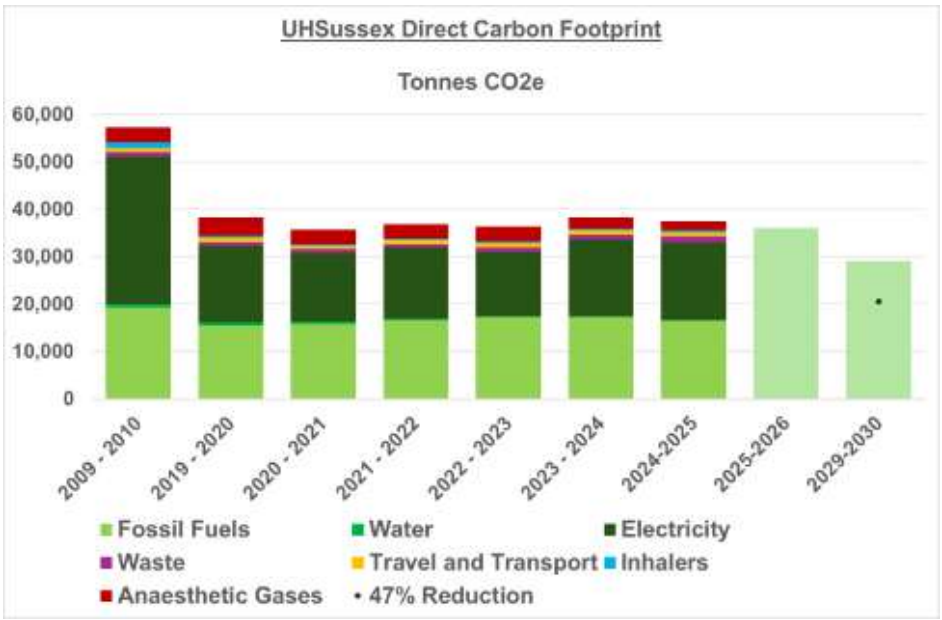
NHS Core Carbon Footprint and Footprint Plus

Our NHS Carbon Footprint (Direct Emissions)

The NHS Carbon Footprint covers emissions from energy use in our buildings (electricity and fossil fuels for heating and hot water), anaesthetic gases, metered dose inhalers, fleet vehicles, business travel, water use, and waste management. These are the areas where the Trust has the greatest direct control and where national targets require the fastest reductions.

Our original Green Plan used a baseline year of 2009/10, but this has been updated to 2019/20 in line with NHS England reporting. Since then, the Trust has made significant progress in reducing emissions across the estate, particularly through energy efficiency measures and reductions in anaesthetic gases. However, absolute emissions have been partially masked by increased activity, the opening of new energy-intensive buildings, site and service expansion, and continued reliance on gas-fired heating systems for example the addition of the LMB building increased emissions by approximately 3,500 tonnes CO_2e.

We estimate that our carbon footprint for 2025/26 will be around 36,000 tonnes CO_2e. With ongoing grid decarbonisation and the actions modelled in this Green Plan, we predict emissions could reduce to approximately 29,000 tonnes CO_2e by 2030, delivering nearly 5,000 tonnes of savings over this period. Despite this progress, achieving the 2032 target of a 47% reduction equivalent to 20,533 tonnes CO_2e will require continued large-scale heat decarbonisation, estate transformation, and targeted operational reductions.



University Hospitals Sussex
NHS Foundation Trust

NHS Core Carbon Footprint and Footprint Plus

Our NHS Carbon Footprint Plus (Indirect Emissions)

The NHS Carbon Footprint Plus captures emissions associated with the manufacture and transport of medicines, medical equipment, and supplies, IT, digital services, and other outsourced activities as well as patient, visitor, and staff commuting

For UHSussex, the Carbon Footprint Plus is significantly larger than our direct footprint, with the majority of emissions embedded within our supply chain. This reflects national patterns across the NHS, where procurement and clinical consumption account for the largest share of emissions.

While these emissions are harder to control directly, they are strongly influenced by clinical decision-making, procurement choices, and service models, making them a critical focus for clinical transformation and sustainable procurement.

What this means for our road to Net Zero

To meet the NHS Net Zero target of a 47% reduction in direct emissions by 2028/32, the Trust must prioritise:

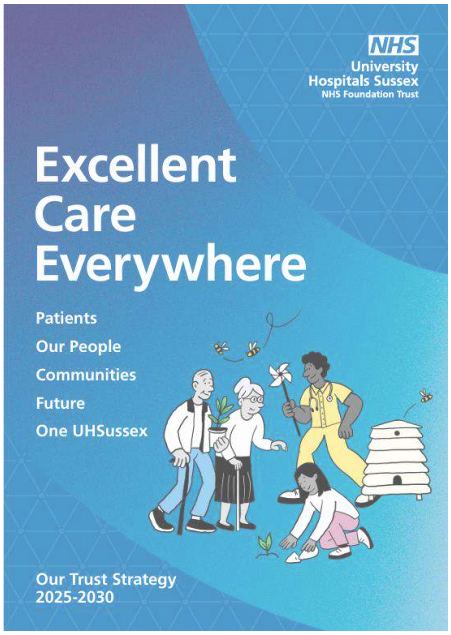
- Phasing out fossil fuel heating systems
- Reducing unnecessary energy demand
- Supporting low-carbon clinical pathways
- Embedding sustainability into procurement and service design

At the same time, reducing our Carbon Footprint Plus will require system-wide collaboration, alignment with the NHS Sussex *Together to Zero* plan, and sustained engagement with clinicians, suppliers, and partners.

This Green Plan therefore focuses not only on technical carbon reduction measures, but on transforming how care is delivered, ensuring that emissions reduction goes hand in hand with improved patient outcomes, financial sustainability, and service resilience.

University Hospitals Sussex
NHS Foundation Trust

Our Trust Strategy



Being Green is one of the key priorities within our Trust Strategy, under **Excellent Care for Our Communities.**

In this, we state our intention to be one of the greenest NHS trusts in the country.

Trust Strategy → Being Green Priority → Green Actions

ON-SITE RENEWABLE ENERGY	Solar panel installations and connection of Worthing Hospital to the town's new heat network.
REUSE BY DEFAULT	Minimising waste as a top priority
LOW-CARBON TRANSPORT	Transition to an electrified transport fleet
GREEN INNOVATION TEST BED	Launch a Green Test Bed in partnership with universities and industry

Our New Green Plan

NHS
University Hospitals Sussex
NHS Foundation Trust

This Green Plan is for 2026 – 2030 and has 12 specific areas of focus shaped around our 5 Trust Strategy ambitions

Excellent care for our patients

Medicines
Food and Nutrition

Excellent care for our people

Workforce and Leadership

New Green Plan

Excellent care for our communities

Reducing and reusing
Travel and Transport
Adaptation

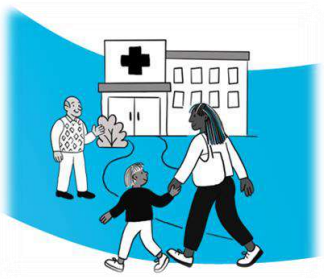
Excellent care for the future

Digital Transformation
Estates and Facilities
Waste Management
Supply Chain and Procurement
Research and Innovation

Excellent care together

Net Zero Clinical Transformation

9



Excellent care together

NHS
University Hospitals Sussex
NHS Foundation Trust

Net Zero Clinical Transformation

Clinical activity is the single largest contributor to the Trust's carbon footprint, influencing medicines use, travel, estate utilisation and procurement. Delivering Net Zero therefore depends on transforming how care is designed and delivered while continuing to improve quality, safety and patient outcomes.

During this Green Plan period, the Trust will prioritise clinical transformation in high-impact pathways. This will focus on reducing unwarranted variation, preventing avoidable admissions and supporting care closer to home where clinically appropriate.

The Trust will formalise and expand its clinical sustainability capability over the lifetime of the plan through workforce development and structured leadership roles. This reflects the central role of clinical leadership in delivering safe, high-quality and low-carbon healthcare.

By 2030, the Trust aims to have carbon hotspot analysis embedded within selected priority pathways, aligned with national and ICS clinical sustainability priorities.

The Trust has established a clinical sustainability leadership structure which has already enabled measurable progress and provides a strong foundation for further development:

- A Green Clinical Lead and Deputy Green Clinical Lead with dedicated programmed time
- Specialty leadership within Anaesthetics and Respiratory Medicine
- A multidisciplinary Green Clinical Working Group providing oversight, coordination and peer support

Through charitable funding, the Trust recruited two Sustainability Fellows (Anaesthetics and Respiratory), demonstrating the value of dedicated clinical leadership time in delivering measurable improvements in sustainable healthcare.

The Green Clinical Lead has also raised the regional and national profile of UHSussex, contributing to shared learning and collaboration, including as a founding member of the Circular Economy Healthcare Alliance focused on reducing reliance on single-use medical products.

This work has directly informed the UHSussex Trust Strategy to 2030, embedding commitments to circular economy principles and sustainable healthcare delivery.

Over the course of this Green Plan, the Trust will continue to strengthen workforce capability and establish clear executive and clinical accountability for delivery through existing governance structures.

Excellent care together

NHS
University Hospitals Sussex
NHS Foundation Trust

Net Zero Clinical Transformation

Commitment	Timescale
Implement NHS Sussex Sustainable Healthcare Impact Assessments (SHIAs) for all business cases, service developments, and major clinical change proposals	2026
We will adopt and scale the Green Theatres Programme across our sites, building on existing initiatives and achievements	2027
Conduct a sustainability impact assessment of clinical pathways and reduce emissions initially in one area with a wish to go further. Focusing on high-impact areas such as critical and perioperative care, respiratory, renal and maternity.	2028
Re-establish the Sustainability Fellows model with an aspiration to recruit at least one fellow per year.	2027
Appoint clinical sustainability leads and relaunch a multidisciplinary green clinical working group to coordinate clinical decarbonisation initiatives.	2026
Establish a formal process to support and evaluate clinician-led sustainability and QI projects with measured carbon, cost and patient outcome impacts.	BAU
Work collaboratively across NHS Sussex to share learning, avoid duplication, and deliver system-level carbon reductions	BAU
Implement circular economy initiatives through the Circular Economy Healthcare Alliance to reduce single-use clinical products.	BAU

Excellent care for our patients

NHS
University Hospitals Sussex
NHS Foundation Trust

Medicines

The Trust has continued to reduce medicines related emissions beyond the previous Green Plan period. Desflurane has been fully removed from all sites, and nitrous oxide is now supplied via cylinders, with all but one manifold decommissioned. The remaining manifold serves another Trust at one site, and options for its removal are being actively explored.

The Anaesthesia Fellow delivered significant reductions in anaesthetic gas emissions, supporting the desflurane phase out and leading work on nitrous oxide, which previously accounted for 27% of emissions. This enabled the planned decommissioning of manifolds in 2024, with an estimated saving of over 1,500 tonnes CO_2e. The fellow also developed proposals for Entonox destruction units across obstetric services and delivered further improvements, including reducing unnecessary intravenous paracetamol use, piloting reusable anaesthetic devices, and reducing inappropriate use of anti-embolism stockings.

The Inhalers Fellow refreshed the Trust's inhaler emissions baseline and identified metered dose inhalers as a key priority. Interventions were developed for emergency and inpatient settings, including discharge pathways promoting lower carbon dry powder inhalers and improved prescribing processes. While large scale reductions were not yet realised, the fellowship established critical foundations, including an inhaler sustainability subgroup, trained 'inhaler champions', and a Trust-wide inhaler strategy.

Together, these fellowships demonstrate the value of clinician led sustainability in delivering high-impact change and building long-term capability.

The Pharmacy team has also been central to progress through its long established cross-site sustainability group. Over the past eight years, this has driven operational improvements including a DPI first approach to inhalers, waste reduction initiatives, and the replacement of inefficient medicines refrigeration with a new energy-efficient cold room. Further prescribing improvements include batch production of chemotherapy to reduce waste, cost and clinical time, and optimising pack sizes for oral medicines to streamline dispensing. Pharmacy sustainability activity and forward plans are reported regularly to the Trust Sustainability Team. As part of this Green Plan, the team will explore alternatives to cooling sprays, such as reusable cooling devices, and continue using the Royal Pharmaceutical Society's Green Toolkit to support a sustainable pharmacy service.

Excellent care for our patients

NHS
University Hospitals Sussex
NHS Foundation Trust

Medicines

Commitment	Timescale
Complete decommissioning of our final nitrous oxide manifold.	2027
Assess current Entonox use in maternity units and creating a targeted plan to implement appropriate reduction solutions.	2027
Complete the roll out of our DPI-first inhaler protocol.	2028
Further improve our regular audit and feedback loops for clinical gas usage.	BAU
Eliminate desflurane.	Complete
Reduce nitrous oxide waste.	BAU
Optimise prescribing practices.	BAU
Identify, quantify and report sustainability benefits for projects	BAU

Excellent care for our patients

NHS
University Hospitals Sussex
NHS Foundation Trust

Food and Nutrition

At our Trust, we have made lots of improvements over the last Green Plan, contributing sustainability to our Nutritional Steering Group. We have done this by adjusting our menu to lower carbon alternatives such as chicken and turkey and the addition of plant based meals, as well as rolling out our “Too good to Throw” project, which now passes food nearing expiration from our on site partners to our wards and to staff.

We have worked with new and existing partners, such as Apetito and Peabodys, to promote more sustainable practises such as Veganuary and reducing single use items.

Even before our last Green Plan, one of our kitchens was refurbished an all-electric to reduce our fossil fuel usage.

Our food waste is segregated and collected at ward level, with our next challenge being ensuring the segregation continues throughout the hospital, given the lack of space at some of our sites.

We also have fruit and vegetable stalls at some of our sites weekly, encouraging all who visit and work here to eat healthily. As a trial, this has been very well received and we plan to extend the project. In Q1 of 2026, we are removing single-use juice pots from our catering.

Over this Green Plan, we will investigate how to reduce the single use plastics we use for our ward meals, with several possible solutions already being reviewed. We’ll be looking at not only the effect this has on the carbon footprint of delivering our food, but also how it will impact our waste streams.

We’ll also be investigating standardising our food offering across all the sites, and the possibility of introducing seasonal menus. We already use local produce where we can, but we will continue to assess this with our catering partners.

Commitment	Timescale
Increase plant-based and locally sourced menu options.	BAU
Eliminate single-use plastics and reduce food waste to near-zero.	2030
Work with suppliers to measure and report the carbon footprint of food services	2028
Support staff and patient education on healthy sustainable diets.	BAU
Remove single-use juice pots from catering services.	2026

Excellent care for our people

NHS
University Hospitals Sussex
NHS Foundation Trust

Workforce and Leadership

Embedding sustainability across the workforce is vital for long-term change. Our people are our greatest asset; their engagement determines the success of our Green Plan. Our ICS's Green Plan emphasises sustainability literacy and leadership as essential enablers.

Embedding sustainability within leadership, decision-making and professional development ensures that environmental responsibility becomes everyone's business. For UHSussex, this means building capability and confidence among leaders, clinicians and support staff to act on carbon reduction and resource efficiency in their day to day roles.

We have developed a Green Ambassador network and intend to refresh and strengthen this over the course of this plan. Our communications team provide regular sustainability updates Trust-wide and colleagues have participated in regional events such as the smart conference.

Over the course of this Green Plan (2026 - 2030), UHSussex will strengthen board-level and senior leadership accountability for Net Zero delivery, ensuring sustainability is embedded within governance, decision-making, and organisational culture.

We will continue to build sustainability capability across all staff groups, supporting leaders, clinicians, and operational teams to understand how their roles contribute to carbon reduction, resource efficiency, and climate resilience.

By 2030, sustainability considerations will be embedded into key organisational processes, including business case development, service redesign, procurement, and capital prioritisation.

This approach aligns with the NHS Sussex emphasis on sustainability literacy and leadership as critical enablers of system-wide Net Zero delivery.

Commitment	Timescale
Appoint a Board-level Net Zero Lead with formal accountability for oversight, assurance and reporting of Green Plan delivery.	Complete
Appoint named divisional sustainability leads with defined responsibilities for implementing Green Plan actions and reporting progress through governance structures	2026
Assess workforce capacity and skill requirements for delivering the green plan, considering good practice examples such as hybrid roles, apprenticeships, fellowships and NHS estates sustainability career pathways, appraisals and job descriptions.	2026
Promote and signpost the Greener NHS sustainability training modules to all staff groups and monitor uptake	2026
Develop and implement a Trust-specific Green Plan awareness training package for all staff groups	2027
Expand the Green Ambassador Network to include representation in every division and operate quarterly engagement and reporting sessions	Complete - BAU
Embed sustainability responsibilities and awareness within corporate and clinical staff induction programmes..	Complete
Develop communications and engagement campaigns updating workforce on Green Plan progress and sustainable healthcare.	Complete - BAU

University Hospitals Sussex
NHS Foundation Trust

Excellent care for our communities

Reduce and Reuse

The Trust will actively reduce and minimise the use of single use products across both clinical and non-clinical settings.

Progress will require tangible changes in ways of working, with sustainability considerations routinely embedded alongside safety, quality and clinical effectiveness. This will include supporting staff to review current practice, challenge unnecessary use of single use items and implement agreed changes in a safe and consistent way. Workforce engagement will be a key enabler, ensuring that frontline insight informs priorities and that staff are supported to contribute to delivery.

There are opportunities to reduce waste and deliver financial savings through more consistent product use, reduction of unwarranted variation, and standardisation where this can be achieved safely. The Womble Project demonstrates what can be achieved through a structured approach to reuse and recycling. This Trust wide initiative has established clear processes for reclaiming and reusing materials that would previously have been disposed of, delivering a sustained reduction in waste and recurrent cost savings. It provides a practical model for scaling action through clear governance, defined processes and staff participation.

To provide oversight and assurance, the Trust will establish a multidisciplinary Expert Committee, with representation from clinical teams, Infection Prevention and Control, Procurement, Sterile Services, Waste Management and Finance. The committee will oversee a time limited, Trust wide review of single use products to identify and agree priority areas for action. The review will focus on analysing procurement data to understand product volume and spend, identifying high volume single use items where there is the greatest opportunity for impact. From this analysis, the Trust will prioritise up to three opportunities for early delivery, focusing on actions that can be implemented within existing resources and without significant changes to clinical practice or extensive additional training.

All proposed changes will be subject to appropriate clinical, infection prevention and patient safety assurance. Delivery will be supported through aligned procurement processes, clear communication, and proportionate training where required, alongside wider workforce awareness activity to support consistent adoption.

Commitment	Timescale
Establish a multidisciplinary Expert Committee to review single use products	2026
Complete review of high-volume single use items	2026
Embed sustainability considerations into procurement processes	2026–2027
Support workforce engagement, communication, and training for agreed product changes	BAU

Excellent care for our communities

NHS
University Hospitals Sussex
NHS Foundation Trust

Travel and Transport

At UH Sussex, we have worked over the last Green Plan cycle to offer our staff and visitors lots of different ways to travel. Our Green travel team have fitted police recommended cycle storage, as well as offering bicycle maintenance sessions for all our staff, across all of our sites.

We offer salary sacrifice for bicycles and e-bikes, as well as having received a stock of e-bikes from a charity, which we have used as prizes for our staff to further encourage active travel.

Our Chichester to Worthing minibuses reduce the load on our car parking, along with a full staff scheme for bus use, allowing users to benefit from reduced fares across the region, not just on hospital routes.

Where a car is necessary, our salary sacrifice scheme allows for zero emission vehicles, and coupled with Park and Rides for our sites, we are actively working to reduce the single car travel at the trust.

All of this has led to our most comprehensive staff travel survey result yet, which allows us to understand the carbon footprint of our travel, and set KPIs for reduction.

All of the information is regularly updated on our Trust intranet and signposted as new schemes become available.

In the next cycle, we plan to continue moving our fleet to zero emission vehicles and working alongside our capital projects team to identify how EV charging across our sites can be rolled out. This will keep us aligned to the NHS's Net Zero Travel and Transport Roadmap, and our 2025-2030 Trust Strategy.

By 2030, the Trust will have delivered a fully embedded Sustainable Travel Strategy aligned with NHS England requirements, supporting reduced reliance on single-occupancy car travel, increased uptake of active and public transport, and a transition to zero-emission fleet vehicles where operationally feasible.

Commitment	Timescale
Update and implement the Trust Sustainable Travel Plan prioritising active travel, public transport and zero-emission transport.	2026
Offer only zero-emission vehicles through vehicle salary sacrifice schemes.	Complete
Transition fleet procurement and leasing to zero-emission vehicles only	2028
Maintain formal partnerships with local authorities and transport providers to deliver transport decarbonisation measures.	Complete
Undertake electrical capacity assessments and develop business cases for EV charging infrastructure installation.	2027
Undertake and analyse a regular staff travel survey to monitor modal shift.	2026/28/30
Operate a Green Travel Bureau to promote and support sustainable commuting options	BAU

University Hospitals Sussex
NHS Foundation Trust

Excellent care for our communities

Adaption

The changing climate poses increasing risks to the Trust's infrastructure and service delivery, patient safety and staff well being. Particularly through flooding, overheating and disruptions to supplies and infrastructure.

For UHSussex, we are working through our current adverse weather risks to compile a new climate change risk register for our sites, which will be complete in 2026.

Alongside this, we are working to assess where we can develop biodiversity on our sites and mitigate against weather with changes on site.

The goal is to produce and implement a Trust-wide Climate Resilience Plan, protecting critical infrastructure, and working with local authorities on community resilience.

By investing in adaptation now, the Trust safeguards its services, reduces operational disruption, and protects patients, staff, and assets against future climate shocks.

Commitment	Timescale
Undertake climate change risk assessments for all hospital sites	2027
Embed adaptation measures into estates strategy, master planning, capital projects and estate design standards.	BAU
Integrate heatwave and flood resilience into emergency planning.	BAU
Collaborate with local authorities on place-based climate resilience planning.	2030
Undertake air quality assessments across Trust sites in line with the NHS Clean Air Hospital framework and implement a prioritised improvement plan to address identified risks.	2028

Excellent care for the future

NHS
University Hospitals Sussex
NHS Foundation Trust

Digital Transformation

Digital transformation plays a dual role in the Trust's Net Zero journey. While digital services introduce their own carbon footprint through devices, data storage, and supply chains, they also offer significant opportunities to reduce emissions by avoiding travel, reducing paper use, and improving operational efficiency.

Over this Green Plan period, the Trust will focus on ensuring digital solutions are deployed where they demonstrably reduce carbon, improve patient experience, or support more efficient use of estate and clinical time. Digital sustainability considerations will increasingly form part of procurement and system design decisions. We have already made progress towards this. Our EDMS rollout is due to complete in 2026, which, coupled with our hybrid-mail solution and EPR progress, has already shown a significant reduction in paper and printing.

We are working Trust-wide to roll out digital tools that reduce the need for travel, streamline clinical pathways, and enhance access to care, all while cutting waste and emissions. This is a key aim in our 2025-2030 Trust Strategy, aligned to the national aim to move from treatment to prevention.

We are working towards removing printed leaflets and booklets where possible, with a recent 36-page patient safety booklet being completely digitised, in conjunction with our nursing teams.

In this plan, we will be investigating moving our on-site data centres and servers to the cloud, which will not only reduce maintenance, but also directly impact our electricity usage.

We will also be investigating the digitalisation of our legacy paper records, which will reduce the need for on and off-site archiving, as well as improve retrieval for our patients.

We still have some areas with high paper and printer usage, and plan to work with teams on site to discuss how to limit these, especially as we move our main practises to digital.

Commitment	Timescale
Maximise the benefits of digital transformation to reduce emissions and improve patient care, through EPR, Synertec and the EDMS roll out	BAU
Supported by the Digital Maturity Assessment, consider opportunities to embed sustainability in digital services, such as by: •using circular and low-carbon approaches to IT hardware management	BAU
Investigate moving data centres and servers to the cloud	2027
Promote digital inclusion to ensure equitable access to services	2026
Identify, quantify and report sustainability benefits for major IT projects.	BAU

Excellent care for the future

NHS
University Hospitals Sussex
NHS Foundation Trust

Estates and Facilities

The Trust's estate is the largest single source of controllable carbon emissions, including building heating and cooling, water, as well as waste management. The ICS Green Plan emphasises heat decarbonisation, energy efficiency, and renewable generation.

Delivering the Trust's Heat Decarbonisation Plans, expanding solar generation, improving insulation and building management systems, and embedding net zero design principles in all refurbishments are all key steps to reduce our emissions.

Throughout the last Green Plan, we have developed Heat Decarbonisation Plans for our sites and are already underway with decarbonising buildings. Our new buildings are not being connected to our fossil fuel energy centres but are being designed with heat pumps to limit the additional emissions we create.

We are underway with a major solar project across several buildings and are currently connecting to the new Worthing Heat Network, which will be complete in 2026. This project will yield a 60% reduction on emissions on the site, as well as allowing us to remove boilers, keeping one as short term back up.

We will continue to engage and explore local opportunities with our partners such as Sussex Energy, universities and Local Authorities for delivery of low carbon heating solutions and other partnership opportunities

We have been rolling out LED installations from our capital programme and expect to complete the switch during this Plan.

We already include sustainability impacts on all our business cases, including those not specifically for emissions reducing schemes.

The Trust have opened the new Louisa Martindale Building in Brighton, that whilst being more than double the footprint of our old site, has yielded significant emissions reductions.

We have planned to overhaul our critical ventilation systems over the next five years, including AHU replacements and upgrade of fans to direct drive or VSD versions.

Effective use of the Trust's estate is central to both financial sustainability and carbon reduction. The energy and emissions associated with healthcare buildings are largely driven by the amount of space in operation, regardless of occupancy. Optimising utilisation in line with Carter efficiency metrics will ensure space is used only where it adds clinical value, supporting modern models of care including outpatient, digital and community provision. Aligned with the Estates Masterplan, improved utilisation will allow activity to be concentrated in the most efficient buildings, enabling rationalisation or repurposing of older, higher-carbon areas. This is expected to reduce emissions by approximately 600 tonnes of CO_2, alongside reducing energy demand, backlog maintenance and operational cost while improving environments for patients and staff.

This programme of work directly supports the NHS Sussex Together to Zero priorities on heat decarbonisation, energy efficiency, and place-based infrastructure solutions, contributing to system wide emissions reduction and resilience.

Excellent care for the future

NHS
University Hospitals Sussex
NHS Foundation Trust

Estates and Facilities

Commitment	Timescale
Update Heat Decarbonisation Plans to include phased removal of fossil-fuel heating, aligned with Local Area Energy Plans and supported by grid capacity assessments.	2028
Connect Worthing Hospital to the local heat network	2026
Remove remaining oil-fired primary heating system from operation.	2030
Complete LED lighting conversion across the estate and secure funding to achieve full coverage by 2030	2030
Expand our solar PV provision across our estate with installations in St Richard's, Southlands and Princess Royal Hospitals.	2026
Ensure all applicable new building and major refurbishment projects are compliant with the NHS Net Zero Building Standard	BAU
Maintain energy management monitoring and implement corrective actions from anomaly detection and performance reviews	BAU
Deliver an ongoing staff behavioural energy reduction campaign.	BAU
Optimise estate utilisation through the delivery of our Estates Masterplan in line with Carter efficiency requirements.	BAU

Excellent care for the future

NHS
University Hospitals Sussex
NHS Foundation Trust

Waste Management

On waste, many of our sites have restrictive waste compounds, which makes segregation a challenge. Where we have suitable space, we have domestic waste compactors and carboard baling, reducing the pick ups required to remove waste from site.

We have no waste going to landfill, with all going to recycling or other treatment.

We have been segregating food waste including oils for over ten years, and more niche streams like printer toner cartridges are fully recycled.

Our Dry Mixed Recycling has increased over the last 3 years, reducing other streams, but we plan to assess the levels of waste to reduce over the next 3 years.

Our waste teams undertake training with some of our clinical teams, and this will be rolled out to more areas in the is plan.

Our sharps bins are currently single use, and the team are actively investigating suitable alternatives, including assessing for whole life costing and carbon emissions. Many reusable alternatives are sourced globally, so whilst we would see a local reduction in waste, the emissions from manufacture, delivery and processing may offset this.

We are underway with a project to recycle our patient curtains, and are investigating more areas we can make the clinical environment more sustainable.

Waste is heavily dependent on what is procured by the Trust. Over this Green Plan, we will work with procurement to understand which supplies can be switched for “waste-friendly” versions, at regular new meetings of a Product Selection Group.

Commitment	Timescale
Complete waste baseline assessments across all waste streams and set reduction targets and KPIs.	2026
Implement ongoing clinical waste segregation training aligned to the 20/20/60 waste model	2026

Excellent care for the future

NHS
University Hospitals Sussex
NHS Foundation Trust

Procurement

Approximately two-thirds of our total emissions come from purchased goods and services. The ICS Green Plan commits all organisations to implement the NHS Net Zero Supplier Roadmap and embed social value in all contracts.

At our Trust, we are actively managing the inclusion of the Carbon Reduction Plan (CRP) and Net Zero Commitment (NZC) requirements for new procurements and new frameworks in a twofold manner. Firstly, we meet our obligations via our new procurement policy, which went live in 2025. Secondly, we also ensure that all our on-boarding procedures are dictated by the Net Zero Supplier Roadmap.

We are already ensuring that for all contracts above £5 million per annum, our suppliers publish a carbon reduction plan (CRP) for their UK Scope 1 and 2 emissions and a subset of scope 3 emissions as a minimum (aligning with PPN 06/21). We built upon this in April 2024, where we extended this monitoring to all new procurement, including the Net Zero Commitment requirement for all supplier contracts below £5 million per annum and above £10k (exc. VAT).

Finally, building up on our current success we are confidently looking to ensure that all of our suppliers will have to provide a CRP from April 2027 onwards.

Over the last plan, we have worked with IPC and our internal procurement teams to reduce our PPE usage, including our successful "Gloves Off" campaign, which garnered global attention. We have also switched to reusable torniquets, suture packs and holloware bowl and reduced our use of couch roll.

University Hospitals Sussex is also one of five healthcare trusts across England that have come together to form the Circular Economy Healthcare Alliance, demonstrating their commitment to a greener and more sustainable NHS.

Excellent care for the future

NHS
University Hospitals Sussex
NHS Foundation Trust

Procurement

Commitment	Timescale
Apply a minimum 10 % social value weighting in all procurements.	Complete
Require suppliers with contracts >£5 m to publish a Carbon Reduction Plan.	Complete
We will embed circular-economy principles expanding our SSD capacity to allow for making reusable, low-carbon clinical consumables the default option wherever clinically appropriate	2030
Work with local suppliers and SMEs to shorten supply chains	BAU
Implement the NHS Net Zero Supplier Roadmap requirements within procurement processes.	BAU
Require supplier participation in the Evergreen Sustainable Supplier Assessment and support emission reduction actions.	BAU

Excellent care for the future

NHS
University Hospitals Sussex
NHS Foundation Trust

Research and Innovation

Sustainable Research Delivery

The Trust is committed to delivering research in a way that supports the ambitions of the Trust's Green Plan by reducing the environmental impact of how studies are designed, conducted, and supported. We are embedding sustainability principles into every stage of the research pathway, ensuring that innovation and environmental responsibility progress hand in hand.

Building Sustainability into Research Design

To empower our research leaders to design low-carbon, patient-centred studies, all Trust research fellowships will incorporate training in sustainable research design. This will include approaches such as reducing equipment and consumable use, reducing waste, minimising unnecessary patient visits, and expanding the use of remote and digital monitoring.

Reducing Travel and Improving Access

In line with the NHS ambition to reduce emissions from patient and staff travel, we are reshaping how people access research. Our teams are:

- Delivering research across all Trust hospital sites
- Aligning research appointments with routine clinical care
- Expanding community-based research clinics and diagnostic services

These changes reduce travel-related carbon emissions while improving convenience and widening access to research opportunities.

Digitising Research Processes

To reduce waste, streamline workflows, and lower the carbon footprint of research operations, we will digitise key research processes, including the transition to electronic trial master files and digital regulatory archiving.

Innovation Driving Sustainable Care

Across the Trust, clinical teams continue to explore how innovation can enhance the quality, efficiency, and sustainability of services. Research is increasingly embedded as a driver of improvement, supporting the Trust's wider sustainability goals and contributing to greener, more resilient clinical pathways. Alignment with the wider Green Plan will be further strengthened through collaboration with the Sustainability Fellows as they are appointed.

Commitment	Timescale
Sustainability training embedded in all research fellowships	2027
Full digitisation of trial master files and regulatory archiving	2028

Governance

University Hospitals Sussex
NHS Foundation Trust

The Green Plan is overseen by the Environmental Sustainability Steering Group (ESSG), chaired by the Executive Lead for Net Zero, with the Director of Infrastructure acting as Senior Responsible Officer (SRO). Membership includes leads for each Green Plan focus area and key operational stakeholders.

Each focus area has a named lead accountable for delivery of actions and performance reporting through the ESSG. Workstream leads maintain delivery plans aligned to the Green Plan structure to enable consistent monitoring and assurance.

During 2026 the Trust will establish baselines, KPIs, resource requirements and anticipated carbon and financial impacts for each action. This will support prioritisation of delivery and ensure alignment with organisational planning and capital processes.

Progress is monitored through existing Trust governance arrangements, with six monthly reporting against agreed milestones and KPI's. The Net Zero Board Lead provides regular updates to the Board via the Finance and Performance Committee, and key progress is reported in the Trust Annual Report.

The Trust also contributes to system-wide reporting through the NHS Sussex Net Zero Programme, sharing data on energy, waste, travel and supply chain emissions to support ICS-level planning and delivery.

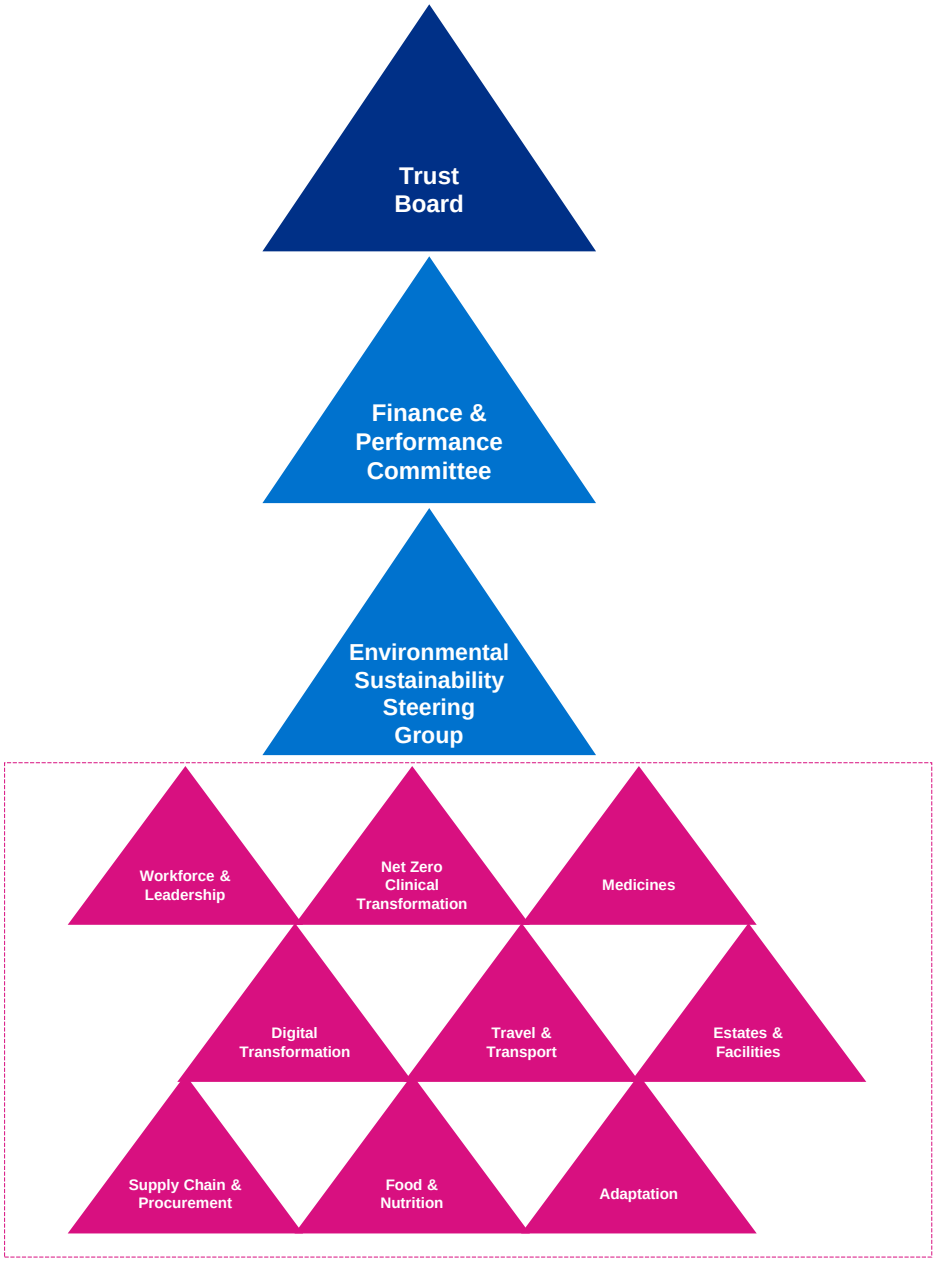
Where risks to delivery are identified they are managed through the Trust's corporate risk framework to ensure executive oversight and timely intervention.

The Green Plan is reviewed annually to confirm that objectives, priorities and delivery trajectories remain appropriate.

Actions	When
We will embed our Green Plan within established governance processes, ensuring that delivery risks, controls and assurances are reflected through our Board Assurance Framework and reporting	2026
Review Green Plan progress with the board annually for new actions and targets	BAU
Identify and agree on KPIs for all areas, including NHS metrics and carbon emissions, that can be reported and monitored through ESSG governance.	2026

Governance

University Hospitals Sussex
NHS Foundation Trust



Risks

University Hospitals Sussex
NHS Foundation Trust

The main risks with regard to the Green Plan are:

- Human Resource
  - Within our plan, many of the actions need to be rolled out to teams that are nearing capacity.
  - Specialist teams, such as our Digital Transformation, Clinical and Procurement divisions, may need extra resource before 2030 to continue to align the NHSE guidance and our action plans.
  - Some actions require the “goodwill” of staff to complete, as they are not currently part of their job role. As these staff are most suited to help, the Trust need to identify where resource can be added.
- Funding
  - Our teams will need to access funding outside of our Trust’s capital and revenue streams to ensure that our plans can be implemented effectively.
  - This will involve getting suitable projects ready for future funding, including design where necessary.

As with all actions to become a sustainable healthcare organisation, we need to pull all our staff, patients and visitors into our actions over this Green Plan.

This will need planning and resource for our sustainability team, including external support, to ensure that a sustainable culture can be built and sustained.

Actions	When
Development of an invest-to-save decarbonisation pipeline with defined payback and risk assessment, funding-ready projects.	2027
Integrate our plan with internal capital planning and lifecycle replacement plans.	2027
Identify gaps in our resourcing to determine our route to achieve this plan.	2026

NHS
University Hospitals Sussex
NHS Foundation Trust

NHS
University Hospitals Sussex
NHS Foundation Trust

Mortality and Learning from Deaths 2025/26 Q4 Report

Caroline Wiggs - Learning from Deaths Lead

April 2026

Learning from Death Mortality Overview - 2025/26 Q4

*Data source SHMI Module HEDS and includes of out of hospital deaths. Latest data available.

NHS University Hospitals Sussex NHS Foundation Trust

		Total Adult Deaths	Total Inpatient Deaths	Total A&E/ED Deaths	Deaths within 72 hours	Crude Mortality*
Jan-26	**WGH**	132	115	17	35	3.08
	SRH	112	103	9	22	2.50
	RSCH	114	95	19	25	2.15
	PRH	39	32	7	12	1.48
		397	**345**	**52**	**94**	**2.36**
Feb-26	**WGH**	90	81	9	23	3.05
	SRH	59	52	7	12	2.42
	RSCH	86	78	8	24	2.11
	PRH	27	24	3	3	1.45
		262	**235**	**27**	**62**	**2.31**
Mar-26	**WGH**	114	105	9	30	3.04
	SRH	87	81	6	28	2.43
	RSCH	116	100	16	26	2.09
	PRH	36	31	5	10	1.46
2025/26		**353**	**317**	**36**	**94**	**2.30**
Q4	**UHSx**	**1012**	**897**	**115**	**250**	

Key Observations

- **1012** **acute** adult deaths; decrease from **1118** in 2024/25 Q4.
- **897 (89%)** inpatient adult deaths; marginal % decrease from **1004 (90%)** in 2024/25 Q4.
- **115 (11%)** adult deaths in A&E/ED; marginal % increase from **114 (10%)** in 2024/25 Q4.
- **24.7%** of all **acute** adult deaths occurred within 72 hours.
- Latest (2025/26 Q3) data for **Total adult deaths within 30 days of discharge; HSMR** and **SHMI** opposite.
- UHSx monthly Crude Mortality **between 2.30** and **2.36**.
- Highest number of **acute** adult inpatients deaths in Jan-26, lowest in Feb-26.
- **WGH** and **SRH** serve an older patient population, reflected by higher deaths per 1,000 bed days in relation to total bed days. See slide 3 for overview.

		Deaths within 72 hours	Total Adult Deaths within 30 days of discharge*	Crude Mortality*	HSMR (12 Month Rolling)*	SHMI (12 Month Rolling)*
Oct-25	**WGH**	25	33	2.96	93.72	95.92
	SRH	12	27	2.63	98.90	98.85
	RSCH	21	31	2.26	97.90	111.16
	PRH	9	19	1.60	79.91	96.8
		67	**110**	**2.43**	**94.54**	**100.77**
Nov-25	**WGH**	19	32	2.99	92.89	96.32
	SRH	18	43	2.57	95.66	99.12
	RSCH	33	29	2.23	98.51	111.06
	PRH	6	18	1.64	82.00	99.70
		76	**122**	**2.41**	**93.84**	**101.32**
Dec-25	**WGH**	24	49	3.06	95.18	98.13
	SRH	27	36	2.52	94.73	97.31
	RSCH	28	37	2.17	97.72	110.65
	PRH	7	23	1.56	77.09	96.53
2025/26		**86**	**145**	**2.38**	**93.33**	**100.83**
Q3	**UHSx**	**229**	**377**			

The reduction in **acute** adult deaths, with corresponding increase in **community** deaths, suggests improved access to palliative care support enabling end-of-life care outside the acute setting.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at UHSx and the number that would be expected to die on the basis of average England figures.

Learning from Death Mortality Overview - 2025/26 Q4

Adult deaths per 1000 bed days in relation to total bed days.

NHS
University Hospitals Sussex
NHS Foundation Trust

2025/26 Q4 Deaths per 1000 Bed Days				
	WGH	SRH	RSCH	PRH
Jan-26	2.70	3.63	0.75	0.97
Feb-26	1.62	2.29	0.99	1.20
Mar-26	2.06	2.68	1.02	1.05
Q4 Total	**2.10**	**2.89**	**0.89**	**1.06**

Note: Bed days data taken from dashboard PB004 - Length of stay insights

2025/26 Q3 Deaths per 1000 Bed Days				
	WGH	SRH	RSCH	PRH
Oct-25	2.13	2.39	1.06	1.21
Nov-25	1.82	2.64	1.07	1.14
Dec-25	2.46	2.58	1.12	1.14
Q3 Total	**2.14**	**2.53**	**1.08**	**1.16**

Note: Bed days data taken from dashboard PB004 - Length of stay insights

2025/26 Q3 data included for comparative purposes. Higher ratio observed at **SRH** in **Nov-25** attributed to lower discharge numbers, reflecting shorter lengths of stay and/or increased bed availability during the period

Key Observations

- Deaths per 1000 bed days higher at **WGH** and **SRH** compared with other sites, reflecting the older patient populations served at these hospitals.
- **SRH** recorded a notably high number of deaths in Jan-26, visible as a clear monthly peak.
- When interpreted alongside total bed days, variation in death counts appears to be influenced by case mix, age profile, and seasonal pressures, rather than indicating an unexpected deterioration in quality of care.
- Month-to-month fluctuations evident, highlighting the need for cautious interpretation of single-month spikes, particularly at site level where numbers are smaller and volatility is greater.
- These trends are consistent with wider mortality indicators, which show **overall Trust mortality within expected limits.**

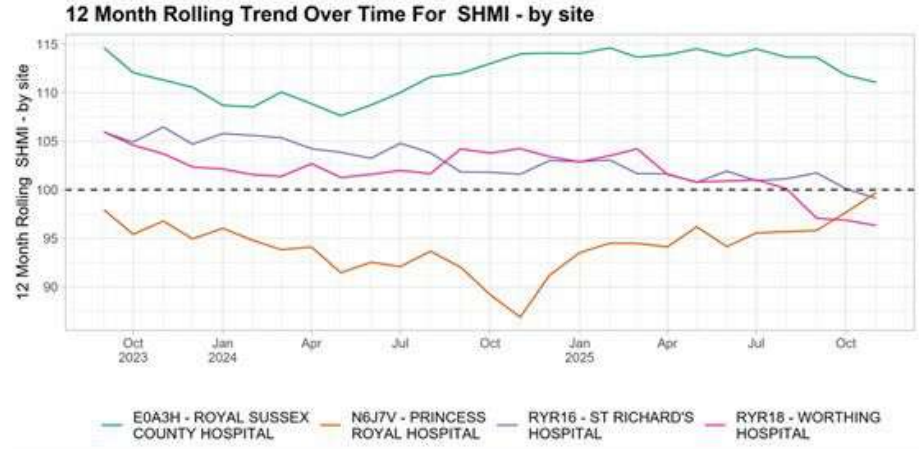
Learning from Death Mortality SHMI HSMR Overall Position - 2025/26 Q4

*Data source SHMI Module HEDS. Latest data available.

NHS University Hospitals Sussex NHS Foundation Trust

Key Observations

- Overall, mortality indicators **remain within expected limits, with evidence of gradual improvement** over time.
- **Trust-level SHMI** ranges from **101.32** to **101.35**, remaining within the expected range and demonstrating a slow downward (improving) trend in recent rolling periods.
- **HSMR** between **92.76** and **93.84**, representing a statistically **significant low outlier**, driven by **lower-than-expected in-hospital deaths** across the standard 56 diagnosis groups. This provides additional reassurance regarding Trust mortality performance.
- **Variation is observed across sites:**
  - **RSCH** consistently recording the **highest SHMI**
  - **PRH** demonstrating **very low HSMR** and **below-expected SHMI**
  - **WGH** and **SRH** showing broadly **stable or improving** trends.
- **Weekend SHMI remains statistically significantly high** at Trust level despite improvement over time, and continues to be monitored alongside service and pathway factors.
- Recent **coding quality changes** include:
  - Reduced coding depth
  - Lower recorded comorbidity
  - Increased R-coded primary diagnoses
  - Reduced supportive care coding



Based on latest HEDs report (19/03/2026.)

Learning from Death Mortality Outliers - 2025/26 Q4

*Data source SHMI Module HEDS. Latest data available.

NHS
University Hospitals Sussex
NHS Foundation Trust

Key diagnostic groups with higher than expected mortality rate over 12 month period.

There are 144 SHMI diagnosis groups used within the SHMI definition, some of which are single CCS groups and others are aggregates of CCS groups. For more details, please refer to the official SHMI definition (https://digital.nhs.uk/data-and-information/publications/ci-hub/summary-hospital-level-mortality-indicator-shmi) .

The table below shows SHMI diagnosis groups that fall outside an over-dispersed 95% Poisson funnel plot using data from the last 12 months.

SHMI - Key Diagnosis Groups
excluding groups with < 7 observed deaths or < 7.5 expected deaths

SHMI Diagnosis Group	Observed Deaths	Expected Deaths	SHMI
113 :: Other connective tissue disease	91	55.24	164.73
128 :: Complication of device; implant or graft	72	49.73	144.80

- SHMI diagnosis group 113 :: Other connective tissue disease continues to have the largest difference between observed and expected deaths across all SHMI diagnosis groups.

Key Observations

- **113 (Other connective tissue disease)** continues to represent the Trust's most significant mortality outlier, with the **largest observed-expected death gap across all SHMI groups**. There have been four VLAD deterioration alerts in the last 12 months, with observed deaths rising against stable expected deaths. Site-level analysis indicates the **highest SHMI values at WGH and SRH**, supporting the need for further focused review.

- **128 (Complication of device, implant or graft)** remains a statistically significant SHMI outlier, with **72 observed deaths versus 49.73 expected (SHMI 144.8).** The group has triggered two VLAD deterioration alerts in the last 12 months, supporting ongoing focused review despite overall Trust mortality remaining within expected limits.

Based on latest HEDs report (19/03/2026.)

Learning from Death Mortality Outliers - 2025/26 Q4

*Data source SHMI Module HEDS. Latest data available.

NHS
University Hospitals Sussex
NHS Foundation Trust

VLAD alerts help detect changes in mortality rates over time.

SHMI Diagnosis Group	Group Description	Deterioration Triggers (latest 3 months)
13	Cancer of pancreas	1
37	Fluid and electrolyte disorders	1
68	Peripheral and visceral atherosclerosis	1
73	Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	1
75	Chronic obstructive pulmonary disease and bronchiectasis	1
79	Respiratory failure; insufficiency; arrest (adult)	1
92	Biliary tract disease	1
101	Urinary tract infections	1
107	Skin and subcutaneous tissue infections	1
113	Other connective tissue disease	1

SHMI Diagnosis Group	Group Description	Improvement Triggers (latest 3 months)
2	Septicemia (except in labor), Shock	1
57	Acute myocardial infarction	1
70	Aortic and peripheral arterial embolism or thrombosis	1
96	Gastrointestinal hemorrhage	1

Key Observations

- **68 (Peripheral and visceral atherosclerosis)** has had recurrent VLAD alerts - flagged with relevant teams to investigate.
- Multiple recent VLAD deterioration alerts, including for **37 (Fluid and electrolyte disorders)**, which is a recognised area for clinical coding training and ongoing quality improvement.
- There have been **4** Improvement VLAD alerts over the last three months for **2 (Septicemia/shock)**, **57 (Acute myocardial infarction), 70 (Aortic and peripheral arterial embolism or thrombosis)**, and **96 (gastrointestinal haemorrhage)**, indicating short-term periods of lower-than-expected mortality.

Based on latest HEDs report (19/03/2026.)

Learning from Death Mortality Demographics - 2025/26 Q4

University Hospitals Sussex NHS Foundation Trust

Deaths by IMD Decile (1 = most deprived, 10 = least deprived) Breakdown of acute adult deaths by ethnicity and underlying population as well as SJR referrals during the period.

Demographics for Adult Deaths					
	Jan-26	Feb-26	Mar-26	UHSx Q4 Total	% of total adult deaths
1	9	9	14	**32**	**3.2%**
2	21	12	16	**49**	**4.8%**
3	35	19	37	**91**	**9.0%**
4	30	24	19	**73**	**7.2%**
5	41	30	42	**113**	**11.2%**
6	70	41	52	**163**	**16.1%**
7	59	33	46	**138**	**13.6%**
8	52	30	45	**127**	**12.5%**
9	41	36	50	**127**	**12.5%**
10	39	28	31	**98**	**9.7%**
Missing	0	0	1	**1**	**0.4%**
UHSx Q4 Total	**397**	**262**	**353**	**1012**	
No. in most deprived postcodes (D1-4)	**95**	**64**	**86**	**245**	
% in most deprived postcodes (D1-4)	**23.9%**	**24.4%**	**24.4%**	**24.2%**	

Adult Deaths by Ethnicity	UHSx Q4 Total	% of total adult deaths
White:English, Welsh, Scottish, Northern Irish or British	**476**	**47.0%**
White: Any other White background	**15**	1.5%
White:Irish	**8**	0.8%
Asian or Asian British: Indian	**2**	0.2%
Mixed or multiple ethnic groups: White and Black Caribbean	**1**	0.1%
Other ethnic group: Any other ethnic group	**1**	0.1%
Other ethnic group: Arab	**3**	0.3%
Not known	**116**	11.5%
Please Select	**390**	38.5%
Q4 Total	**1012**	

Key Observations

Of **801** acute adult deaths within Adur, Arun, Brighton & Hove, Chichester, Mid Sussex and Worthing Local Authorities:

- **26.3% (211)** within most deprived postcodes (D1-4) equal to **23.5%** of underlying population, increase from **25.5% (196)** in 2025/26 Q3.
- Highest number of deaths in **D6 (16.2%, 130)** with **1.06** deaths per 1000, increase from **(124, 1.02)** in 2025/26 Q3.
- However, highest deaths per 1000 related to **D3 (1.14),** slight increase from **(1.13)** in 2025/26 Q3.

Of all **1012** acute adult deaths:

- **24.2% (245)** within most deprived postcodes (D1-4); slight increase from **21.3% (238)** in 2024/25 Q4.
- Highest related to **D6 16.1% (163)**; slight % increase from **15.5% (173)** in 2024/25 Q4.
- **50% (506)** did not have an ethnicity recorded in Careflow - targeted training being rolled out to address this gap.
- Of those with recorded data, **47% (476)** identified as **White (English, Welsh, Scottish, Northern Irish or British).**

Demographics for SJR Referrals					
	Jan-26	Feb-26	Mar-26	UHSx Q4 Total	% of all SJR referrals
1	2	0	0	**2**	**1.9%**
2	4	4	1	**9**	**8.4%**
3	3	2	8	**13**	**12.1%**
4	3	4	1	**8**	**7.5%**
5	2	3	3	**8**	**7.5%**
6	7	3	5	**15**	**14.0%**
7	9	4	6	**19**	**17.8%**
8	7	2	2	**11**	**10.3%**
9	3	3	6	**12**	**11.2%**
10	1	4	5	**10**	**9.3%**
Missing	0	0	0	**0**	**0.0%**
UHSx Q4 Total	**41**	**29**	**37**	**107**	
No. in most deprived postcodes (D1-4)	**12**	**10**	**10**	**32**	
% in most deprived postcodes (D1-4)	**29.3%**	**34.5%**	**27.0%**	**29.9%**	

- **29.9% (32)** of SJR referrals within most deprived postcodes; increase from **25.2% (37)** in 2024/25 Q4.
- Highest number of SJR referrals related to **D7** at **17.8% (19)**; shift from **D8 (21.1%, 31)** in 2024/25 Q4.

Learning from Death Mortality Demographics - 2025/26 Q4

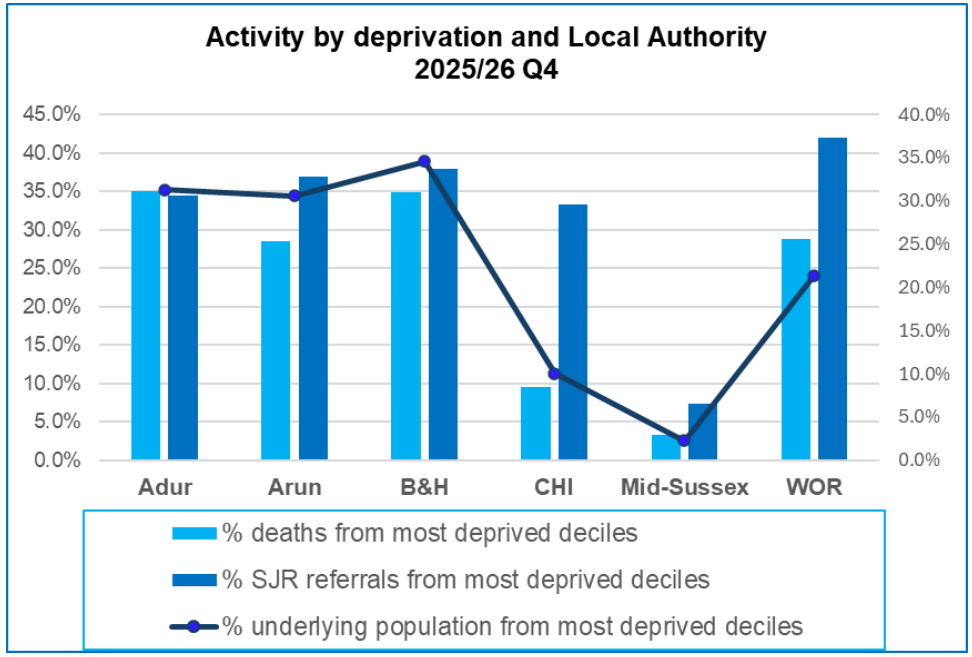
Deaths by IMD Decile (1 = most deprived, 10 = least deprived) Local Authority overview

NHS
University Hospitals Sussex
NHS Foundation Trust

Activity by deprivation and Local Authority	Adur	Arun	B&H	CHI	Mid-Sussex	WOR
% underlying population from most deprived deciles	31.3%	30.6%	34.5%	10.0%	2.2%	21.4%
% deaths from most deprived deciles	34.9%	28.5%	34.9%	9.6%	3.3%	28.8%
% SJR referrals from most deprived deciles	34.5%	36.8%	37.9%	33.3%	7.3%	41.9%

Note: Data provided over 12 month period (Apr-25 to Mar-26) to minimise seasonal disruption

% SJR referrals includes ALL SJR referrals, including those subsequently Not Required.



Key Observations

- The Trust's mortality review process appropriately over-selects cases involving the most deprived populations, indicating heightened scrutiny rather than barriers to access, while not providing a direct measure of access to care.
- **Adur: 3.7%** more deaths in most deprived than expected based on underlying population and **3.2%** more SJR referrals.
- **Arun: 2%** fewer deaths in most deprived than expected based on underlying population but **6.3%** more SJR referrals.
- **Brighton:** Marginally more deaths **(0.3%)** in most deprived than expected based on underlying population and **3.4%** more SJR referrals.
- **Chichester: 0.5%** fewer deaths in most deprived than expected based on underlying population but significantly more **(23.3%)** SJR referrals. Consistent findings across previous reporting periods.
- **Mid-Sussex: 1.1%** more deaths in most deprived than expected based on underlying population and **5.1%** more SJR referrals. Represents a significant increase in % SJR referrals from previous reporting period **(Jan-25 to Dec-25)**
- **Worthing: 7.5%** more deaths in most deprived than expected based on underlying population and even more **(20.6%)** SJR referrals.

Learning from Death Child Deaths Overview - 2025/26 Q4

Deaths by IMD Decile (1 = most deprived, 10 = least deprived)

Breakdown of acute child deaths by hospital site, ethnicity and underlying population.

University Hospitals Sussex NHS Foundation Trust

Total Child Deaths					
	WGH	SRH	RACH	RSCH	UHSx Q4 Total
Jan-26	1	0	1	2	4
Feb-26	0	1	0	0	1
Mar-26	0	0	0	0	0
Q4 Total	**1**	**1**	**1**	**2**	**5**
Note: no child deaths recorded at PRH					

Child Deaths by Ethnicity		
Adult Deaths by Ethnicity	**UHSx Q4 Total**	**% of total**
White:English, Welsh, Scottish, Northern Irish or British	**5**	**100.0%**
White: Any other White background	**0**	0.0%
White:Irish	**0**	0.0%
Asian or Asian British: Indian	**0**	0.0%
Mixed or multiple ethnic groups: White and Black Caribbean	**0**	0.0%
Other ethnic group: Any other ethnic group	**0**	0.0%
Other ethnic group: Arab	**0**	0.0%
Not known	**0**	0.0%
Please Select	**0**	0.0%
Q4 Total	**5**	

Key Observations

- **5 acute** child deaths during 2025/26 Q4.
- **100%** identified as **White (English, Welsh, Scottish, Northern Irish or British).**
- **20% (1) acute** child death within most deprived postcodes (D1-4).
- Highest number of deaths in **D5 (40%, 2)**
- Due to the low number of deaths, caution should be taken when interpreting trends, as small numerical changes may result in disproportionate percentage variation.

Demographics for Child Deaths					
	Jan-26	Feb-26	Mar-26	UHSx	% of total
1	0	0	0	**0**	**0.0%**
2	0	0	0	**0**	**0.0%**
3	0	0	0	**0**	**0.0%**
4	1	0	0	**1**	**20.0%**
5	1	1	0	**2**	**40.0%**
6	0	0	0	**0**	**0.0%**
7	0	0	0	**0**	**0.0%**
8	1	0	0	**1**	**20.0%**
9	1	0	0	**1**	**20.0%**
10	0	0	0	**0**	**0.0%**
Missing	0	0	0	**0**	**0.0%**
UHSx Q4	**4**	**1**	**0**	**5**	
No. in most deprived postcodes (D1-4)	**1**	**0**	**0**	**1**	
% in most deprived postcodes (D1-4)	**25.0%**	**0.0%**	**0.0%**	**20.0%**	

Learning from Death Fractured Neck of Femur (#NOF) Mortality - 2025/26 Q4

NHS University Hospitals Sussex NHS Foundation Trust

Overall performance/mortality related to fractured of neck of femur (#NOF) during the quarter.
Breakdown by hospital site. *Data sources National Hip Fracture Database/SHMI module. Latest data available.

		No. of patients	Hours to operation (annual)	30 day mortality % (annual)
Jan-26	WGH	34	35.2	4.1
	SRH	33	33.3	6.3
	RSCH	49	27.7	3.7
	National		39.1	5.0
		116	**32.1**	**4.7**
Feb-26	WGH	39	35.8	
	SRH	30	33.0	
	RSCH	55	27.9	
	National		38.8	
		124	**0**	**0**
Mar-26	WGH	33	35.2	
	SRH	41	33.3	
	RSCH	58	28.2	
	National		38.6	
2025/26		**132**	**32.2**	
Q4	**UHSx**	**372**	**21.4**	

*Data source National Hip Fracture Database. Latest data available.

#NOF listed on MCCD 2025/26 Q4					
WGH	SRH	RSCH	PRH	UHSx Q4 Total	% of all Adult Deaths
2	1	0	0	3	0.3%

Key Observations

- **372** patients treated for #NOF across **WGH, SRH** and **RSCH** in 2025/26 Q4; slight increase from **356** in 2025/26 Q3. Activity remains consistent with earlier quarters, when compared with 2025/26 Q2 **(371)** and 2025/26 Q1 **(372)**, indicating overall stability in #NOF caseload.
- **% 30 day mortality** for 2025/26 Q4 awaited. Available 2025/26 Q4 and 2025/26 Q3 data provided.
- **Hours taken to operate** remains consistently **less than national average**.
- **SRH** remains an outlier for **% 30 day mortality**; with **WGH** and **RSCH** consistently below national average.
- **RSCH** consistently **below national annualised crude mortality.**
- **WGH below national annualised crude mortality** in 2025/26 Q3 - reflective of improved outcomes following clinical transformation work.
- **SRH** has been **above national annualised crude mortality** across 2025/26 Q1-Q3. The reduction from **8.3** in Q2 to **8.1** in Q3 provides reassurance of early improvement but warrants continued monitoring.
- **3 (0.3%) acute** adult death MCCDs recorded #NOF in 2025/26 Q4 (**Nil** in Q3, **2** in Q2 and **2** in Q1). Consistently low numbers, with **as expected SHMI.**

Crude Mortality (annualised)	2024/25 Q3	2024/25 Q4	2025/26 Q1	2025/26 Q2	2025/26 Q3
WGH	8.8	6.5	5.0	5.3	3.8
SRH	5.0	5.1	6.7	8.3	8.1
RSCH	3.2	2.4	3.0	3.3	3.4
National	5.3	5.3	5.1	5.1	5.0

		No. of patients	Hours to operation (annual)	30 day mortality % (annual)
Oct-25	WGH	42	36.8	3.9
	SRH	39	35.3	8.7
	RSCH	55	27.4	4.1
	National		39.5	5.1
		136	**33.2**	**5.6**
Nov-25	WGH	33	36.0	4.2
	SRH	29	35.1	8.2
	RSCH	46	27.2	4.5
	National		39.4	5.7
		108	**34.4**	**5.7**
Dec-25	WGH	37	37.5	4.5
	SRH	25	35.3	8.3
	RSCH	50	27.2	4.2
	National		39.3	5.6
2025/26		**112**	**33.3**	**5.7**
Q3	**UHSx**	**356**	**33.6**	**5.6**

*Data source National Hip Fracture Database.

PRH activity not captured as part of National Falls and Fragility Fracture Audit Programme

Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
Fracture of neck of femur (hip)	120	1,575	120	120	0.9966	As expected SHMI

*Data Source SHMI deaths associated with hospitalisation (Dec-24 to Dec-25)

Learning from Death Mortality Deaths by Age Group - 2025/26 Q4

Breakdown of adult deaths by age group

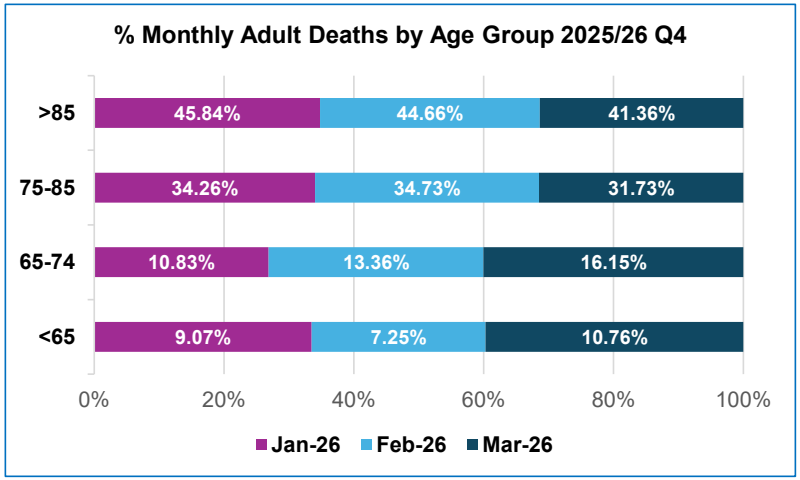
NHS Hospitals Sussex NHS Foundation Trust

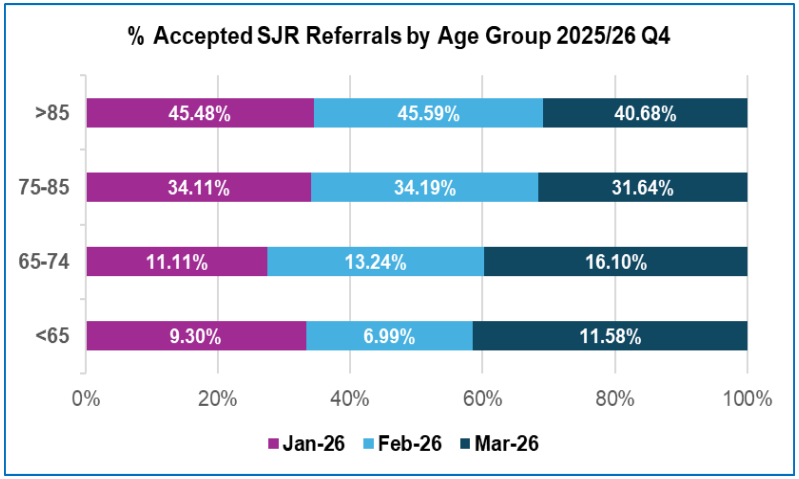
Key Observations

- Minimal variance between the proportion of adult deaths and accepted SJR referrals, indicating proportionate, appropriate scrutiny.
- Highest proportion of **acute** adult deaths in **over 85 age group** - reflective of the older patient population served by **WGH** and **SRH**.
- Most adult deaths in **over 85 age group** occurred in the month of January 2026 **(45.84%)** - expected seasonal pattern during winter period.
- Consistently fewer deaths in **under 65 age group**, with majority of SJR referrals accepted.

% Adult Deaths by Age Group			
Age	**Jan-26**	**Feb-26**	**Mar-26**
<65	9.07%	7.25%	10.76%
65-74	10.83%	13.36%	16.15%
75-85	34.26%	34.73%	31.73%
>85	45.84%	44.66%	41.36%

% Accepted SJR Referrals by Age Group			
Age	**Jan-26**	**Feb-26**	**Mar-26**
<65	9.30%	6.99%	11.58%
65-74	11.11%	13.24%	16.10%
75-85	34.11%	34.19%	31.64%
>85	45.48%	45.59%	40.68%





Learning from Death Mortality Deaths by Length of Stay (LoS) - 2025/26 Q4

Hospitals Sussex NHS Foundation Trust

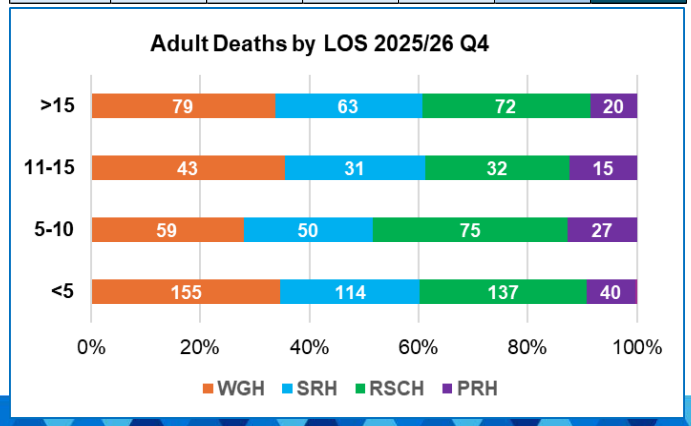
Breakdown of adult deaths by Length of Stay (LoS)

Key Observations

- **44.1% (446)** acute adult deaths with **LoS less than 5 days**; increase from 42% (412) in 2025/26 Q3.
- Slight decrease in number of adult deaths with **LoS greater than 15 days** from 24.8% in 2025/26 Q3 to **23.1%** this quarter (Q4.)
- Highest proportion of accepted SJR referrals in 2025/26 Q4 related to patients with **LoS greater than 15 days (37.1.%, 14)**, **shift from LoS less than 5 days** in 2025/26 Q3 **(48.3%, 14).** However, variance between accepted referrals for LoS less than 5 days and greater than 15 days equates to a difference of only 1 additional accepted SJR, indicating broadly consistent scrutiny across LoS categories.

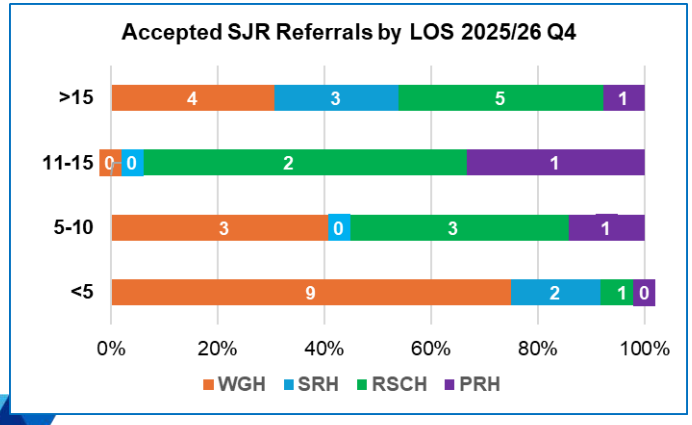
Adult Deaths by LOS

No. of Days	WGH	SRH	RSCH	PRH	UHSx Q4 Total	% of total adult deaths
<5	155	114	137	40	**446**	**44.1%**
5-10	59	50	75	27	**211**	**20.8%**
11-15	43	31	32	15	**121**	**12.0%**
>15	79	63	72	20	**234**	**23.1%**
Q4 Total	**336**	**258**	**316**	**102**	**1012**	



Accepted SJR Referrals by LOS

No. of Days	WGH	SRH	RSCH	PRH	UHSx Q4 Total	% of accepted SJR referrals
<5	9	2	1	0	**12**	**34.3%**
5-10	3	0	3	1	**7**	**20.0%**
11-15	0	0	2	1	**3**	**8.6%**
>15	4	3	5	1	**13**	**37.1%**
Q4 Total	**16**	**5**	**11**	**3**	**35**	



Learning from Death Mortality Deaths by Ward - 2025/26 Q4

Breakdown of adult deaths by ward (by highest number of deaths and deaths per 1000 bed days.)

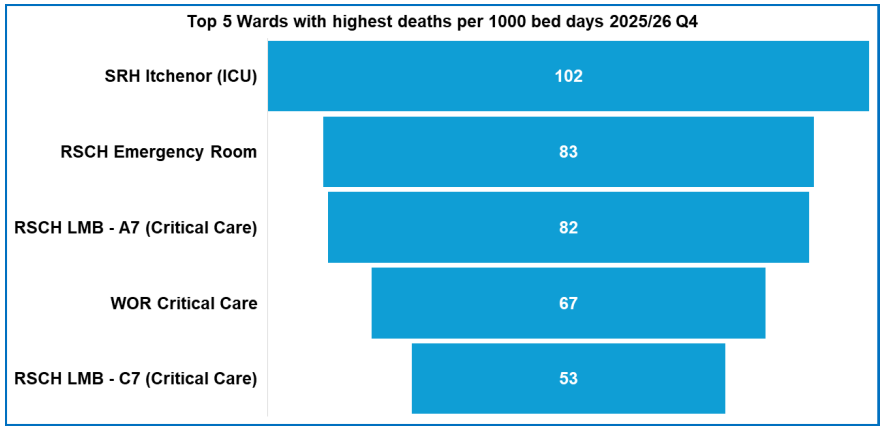
NHS
University Hospitals Sussex
NHS Foundation Trust

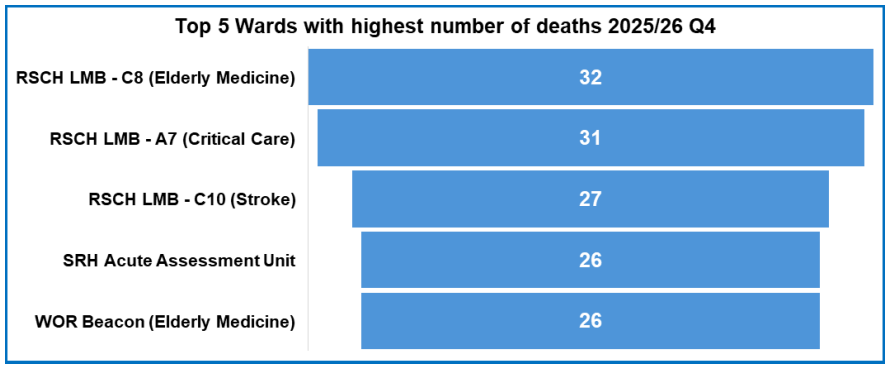
Adult Deaths on Ward 2025/26 Q4				
Adult Deaths on Ward (order of incidence for no. of deaths)	**No. of deaths**	**No. of deaths per 1000 bed days**	**% of site specific deaths**	**% of all adult deaths**
RSCH LMB - C8 (Elderly Medicine)	32	18.5	10.1%	**3.2%**
RSCH LMB - A7 (Critical Care)	31	81.8	9.8%	**3.1%**
RSCH LMB - C10 (Stroke)	27	17.1	8.5%	**2.7%**
SRH Acute Assessment Unit	26	13.4	10.1%	**2.6%**
WOR Beacon (Elderly Medicine)	26	8.8	7.7%	**2.6%**
SRH Petworth (Respiratory Medicine)	25	15.1	9.7%	**2.5%**
SRH Itchenor (ICU)	24	102.1	9.3%	**2.4%**
WOR EF Zone B	24	44.0	7.1%	**2.4%**
WOR Botolphs (Stroke)	24	19.4	7.1%	**2.4%**
SRH Ashling (General Medicine)	24	11.6	9.3%	**2.4%**
PRH Balcombe (Acute Medicine)	22	23.3	21.6%	**2.2%**
RSCH LMB - B8 (Elderly Medicine)	22	13.3	7.0%	**2.2%**
WOR Critical Care	21	66.9	6.3%	**2.1%**
WOR Byworth (Respiratory Medicine)	21	14.4	6.3%	**2.1%**
WOR Durrington (Elderly Medicine)	21	10.2	6.3%	**2.1%**
WOR Buckingham (Elderly Medicine)	21	7.7	6.3%	**2.1%**
RSCH Acute Medical Unit	20	18.7	6.3%	**2.0%**
SRH Bosham (Acute Medicine)	20	10.7	7.8%	**2.0%**
SRH Lavant (Stroke)	19	10.2	7.4%	**1.9%**
SRH Ford (Elderly Medicine)	18	9.7	7.0%	**1.8%**

Note: Bed days data taken from dashboard PB050 - LOS Programme dashboard

Key Observations

- Majority of inpatient adult deaths across **ICU/Acute, General/Elderly Medicine, Respiratory and Stroke**, with top 20 ward areas having **between 18 and 32** deaths within 2025/26 Q4.
- **32** adult deaths on **RSCH LMB C8 (Elderly Medicine)**; **10.1%** at RSCH; **3.2%** across UHSx; with **18.5** deaths per 1000 bed days.
- **22** deaths on **PRH Balcombe**; **21.6%** at PRH; **2.2%** across UHSx, with **23.3** deaths per 1000 bed days. Expected finding, reflecting care of acutely unwell General Medicine patients.
- **SRH Itchenor (ICU)** had highest number of deaths per 1000 bed days at **102.1, 24** deaths.
- Highest deaths per 1000 bed days were seen in **ITU** and **Critical/Emergency Care.** Expected finding reflecting patient acuity and severity.

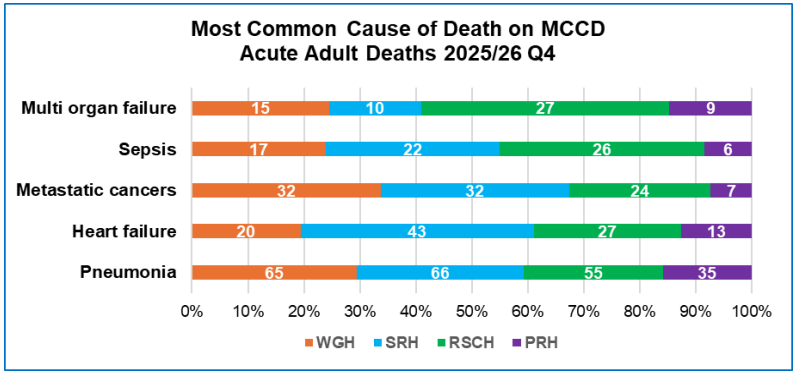




Learning from Death Mortality Cause of Death - 2025/26 Q4

Most common causes of acute adult deaths listed on MCCD (1a, 1b, 1c, 1d and 2.) Breakdown by hospital site.

NHS Hospitals Sussex NHS Foundation Trust



Note: A CoD may be missing from the ME referral if referred to the Coroner. Multiple CoD may be listed on the MCCD.

Common Cause of Death on MCCD Acute Adult Deaths 2025/26 Q4						
Cause of Death (order of incidence)	**WGH**	**SRH**	**RSCH**	**PRH**	**UHSx Q4 Total**	**% of all Adult Deaths**
Pneumonia	65	66	55	35	221	**21.8%**
Heart failure	20	43	27	13	103	**10.2%**
Sepsis	32	32	24	7	95	**9.4%**
Metastatic cancers	17	22	26	6	71	**7.0%**
Multi organ failure	15	10	27	9	61	**6.0%**
Top 5 CoD Q4 UHSx Subtotal	**149**	**173**	**159**	**70**	**551**	**54.4%**
Brain injury/subdural haemorrhage	10	14	25	3	52	**5.1%**
Frailty of old age	12	12	16	5	45	**4.4%**
Missing	10	10	18	6	44	**4.3%**
Stroke	18	10	12	1	41	**4.1%**
Respiratory failure	11	2	9	0	22	**2.2%**
Renal disease/failure	3	5	10	3	21	**2.1%**
Liver disease/failure	4	6	3	0	13	**1.3%**
Fractured neck of femur (#NOF)	2	1	0	0	3	**0.3%**

Key Observations

- **21.8% (221)** of all **acute** adult deaths had **pneumonia** listed on the death certificate - reduction from **24.2% (237)** in 2025/26 Q3.
- The top 5 common causes of deaths on MCCDs were **pneumonia, heart failure, metastatic cancers, multi organ failure** and **sepsis**. These remain the same top five causes as in 2025/26 Q3, although there was a change in ranking between sepsis and multi-organ failure. Collectively, these causes accounted for **54.4% (551)** of all acute adult deaths, representing a slight reduction from **55.9% (548)** in 2025/26 Q3.
- **4.3% (44)** cases had no given cause(s) of death on the ME referral form; % decrease from **4.9% (48)** in 2025/26 Q3. Attributed to cause of death not being agreed and/or referral to the Coroner.
- **Frailty of old age** was listed on MCCDs for **4.4% (45)** of all **acute** adult deaths; % increase from **3.1% (30)** in 2025/26 Q3.
- **3 (0.3%)** death certificates noted a recent **fractured neck of femur (#NOF)**; **0 (0%)** in 2025/26 Q3. Finding reflective of frailty within the older patient population served by **WGH** and **SRH**.

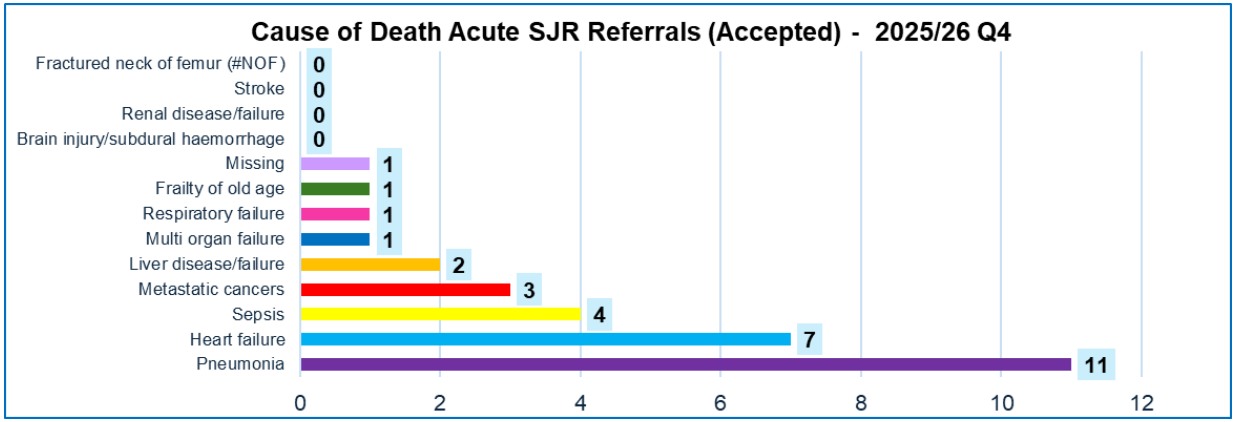
Learning from Death Mortality Cause of Death - 2025/26 Q4

University Hospitals Sussex NHS Foundation Trust

Most common causes of acute adult deaths listed on MCCD (1a, 1b, 1c, 1d and 2) in cases referred (**and accepted**) for SJR. Breakdown by hospital site.

Most Common Cause of Death on MCCD Acute SJR Referrals (Accepted) 2025/26 Q4						
	WGH	SRH	RSCH	PRH	UHSx	% of accepted SJR referrals
Pneumonia	3	3	3	2	11	**31.4%**
Heart failure	4	0	3	0	7	**20.0%**
Sepsis	3	0	1	0	4	**11.4%**
Metastatic cancers	1	1	0	1	3	**8.6%**
Liver disease/failure	2	0	0	0	2	**5.7%**
Q4 UHSx Total	**13**	**4**	**7**	**3**	**27**	**77.1%**

Note: Table details accepted SJR referrals only.



Key Observations

- **31.4% (11)** of **acute** adult deaths with **accepted** SJR referrals had **pneumonia** listed on the death certificate. **13.8% (4)** in 2025/26 Q3.
- The top 5 common causes of deaths on MCCDs in cases referred for SJR were **pneumonia, heart failure, sepsis, metastatic cancers** and **liver disease/failure**. These accounted for **77.1% (27)** of **acute** adult deaths referred and **accepted** for SJR.
- **2.9% (1)** cases had no given cause(s) of death on the ME referral form; decrease from **6.9% (2)** in 2025/26 Q3. Attributed to cause of death not being agreed and/or referral to the Coroner.
- Relatively high % values due to low number of accepted SJR referrals (**35**.)
- Note: Fractured neck of femur (#NOF} no longer mandated reason for SJR (SHMI as expected.)

Learning from Death Structured Judgement Review (SJR) Referrals - 2025/26 Q4

SJRs referrals received, accepted and completed during quarter.

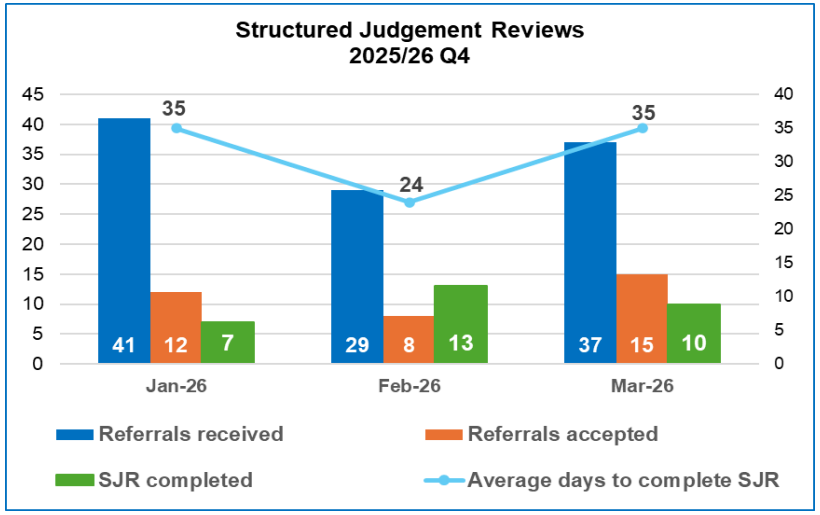
University Hospitals Sussex NHS Foundation Trust

Adult Deaths Referred for SJR	WGH	SRH	RSCH	PRH	25/26 Q4	% of all Deaths referred for SJR	24/25 Q4
Jan-26	16	2	20	3	41	**10.3%**	50
Feb-26	10	5	11	3	29	**11.1%**	50
Mar-26	18	5	10	4	37	**10.5%**	47
Q4 Total	**44**	**12**	**41**	**10**	**107**		**147**
% of all adult deaths referred for SJR	**13.1%**	**4.7%**	**13.0%**	**9.8%**	**10.6%**		**13.1%**

SJR acceptance rate by site	WGH	SRH	RSCH	PRH
Jan-26	31.3%	50.0%	25.0%	33.3%
Feb-26	20.0%	20.0%	36.4%	33.3%
Mar-26	50.0%	60.0%	20.0%	25.0%

A Panel of senior SJR Reviewers and the LfD Clinical Lead review referrals to determine whether to progress to a comprehensive SJR. National Mortality Case Record Review (NMCRR) guidance is to review 10% of deaths and the Panel will look to increase SJR progression rate in 2026/27 Q1.

Reason not progressed to comprehensive SJR	Jan-26	Feb-26	Mar-26	UHSx
Referred to Coroner	11	10	14	**35**
Referred to local M&M	8	5	6	**19**
Other	10	6	2	**18**
Q4 Total	**29**	**21**	**22**	**72**



Key Observations

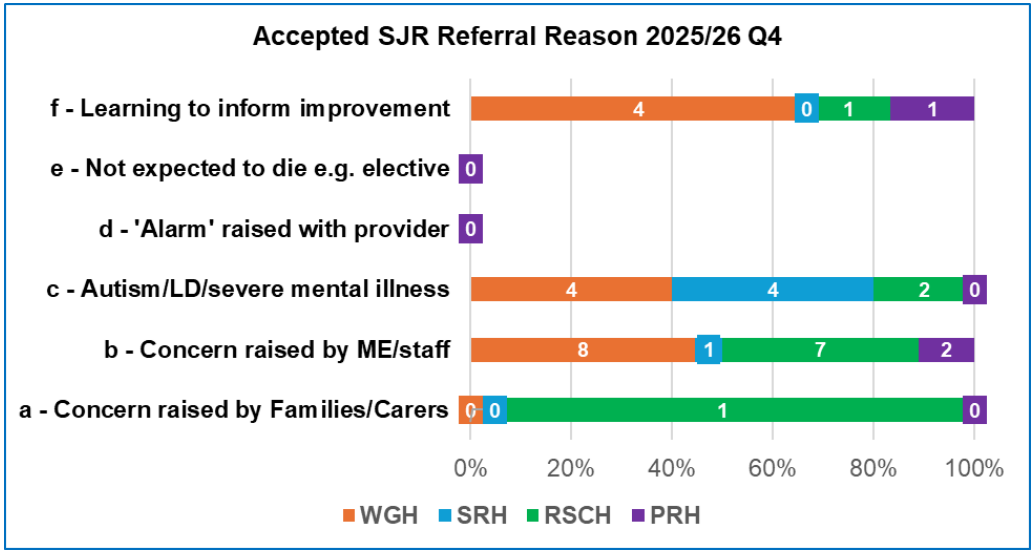
- **10.6% (107) acute** adult deaths referred for SJR; decrease from **13.1% (147)** in 2024/25 Q4. Of those**, 33% (35)** were **referred to the Coroner**; **18% (19)** to **M&M Review** and **17% (18)** categorised as **'Other**'. 'Other' is recorded where the Panel determines that an SJR is not indicated due to the absence of new learning, or where concerns relate to specific aspects of pre-admission care and are therefore directed to relevant teams rather than M&M Review.
- At site level, **WGH** accounted for the highest proportion of SJR referrals linked to adult deaths, representing **13.1%** of referrals (**44** cases). **RSCH 13%, 41.** This compares to **10% (38)** at **WGH** and **22.1% (76)** at **RSCH** in 2024/25 Q4. Reduction in **RSCH** SJR referral rate attributed to review of SJR 'alert' triggers.
- Lower number of SJR referrals in Feb-26 consistent with number of adult deaths recorded. Proportion referred for SJR each month stable, ranging **between 10.3% and 11.1%**.
- **30** SJRs completed; decrease from **64** in 2024/25 Q4, attributed to implementation of weekly SJR Screening Panel.
- SJR referral acceptance rate was **33%** for the quarter, consistent with **32%** in 2025/26 Q3, and higher than **24%** in 2024/25 Q4.
- Sustained improvement in average time taken to complete SJR - **31 days** in 2025/26 Q4, compared to **53 days** in 2024/25 Q4. However, average days to complete SJR in Mar-26 impacted by delay in obtaining relevant health records.

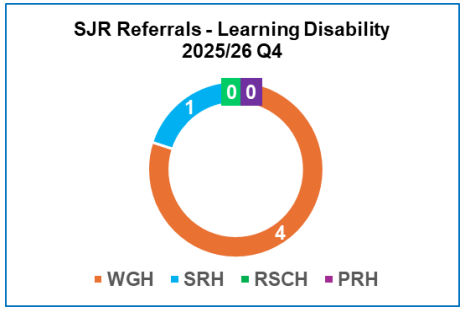
Structured Judgement Reviews	Jan-26	Feb-26	Mar-26	25/26 Q4	24/25 Q4
Referrals received	41	29	37	**107**	**147**
Referrals accepted	12	8	15	**35**	**36**
SJR completed	7	13	10	**30**	**64**
Average days to complete SJR	35	24	35	**31**	**53**
Note: 24/25 Q4 totals include previous backlog project.					

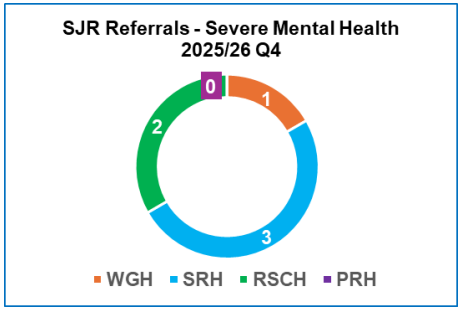
Learning from Death Structured Judgement Review Referrals - 2025/26 Q4

SJR referrals may be received from the ME office, DQSM, Medico-Legal and/or Patient Safety

University Hospitals Sussex NHS Foundation Trust







Accepted SJR Referral Reason	WGH	SRH	RSCH	PRH	25/26 Q4	% accepted SJR referrals	24/25 Q4
a - Concern raised by Families/Carers	0	0	1	0	1	2.9%	9
b - Concern raised by ME/staff	8	1	7	2	18	51.4%	8
c - Autism/LD/severe mental illness	4	4	2	0	10	28.6%	11
d - 'Alarm' raised with provider	0	0	0	0	0	0.0%	4
e - Not expected to die e.g. elective	0	0	0	0	0	0.0%	1
f - Learning to inform improvement	4	0	1	1	6	17.1%	3
Q4 UHSx Total	**16**	**5**	**11**	**3**	**35**		**36**

Note: Table includes accepted referrals only. 1 x WGH case in Mar-26 with known LD and SMH.

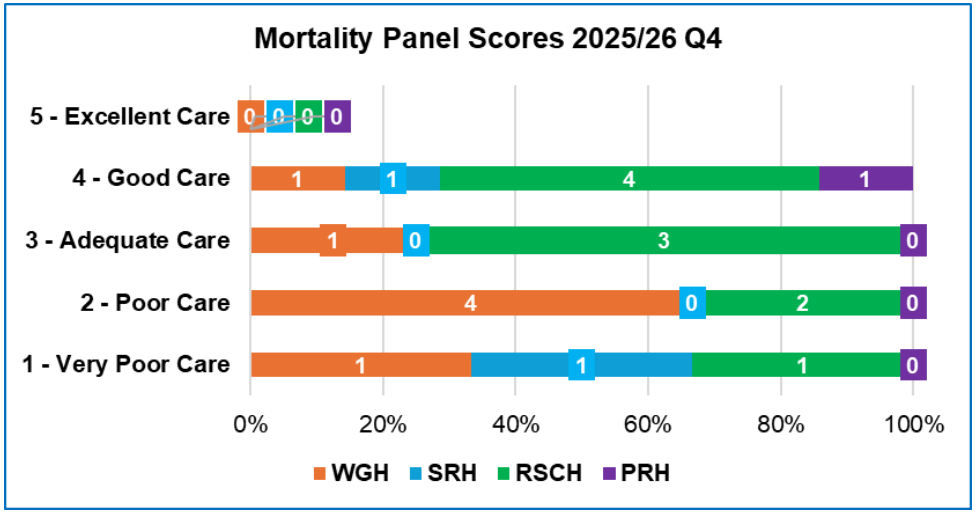
Key Observations

- **Concern raised by ME/staff** was the highest reason for **accepted** SJR referrals related to **acute** adult deaths at **51.4% (18)**, significant increase from **22% (8)** in 2024/25 Q4. Reflective of appropriate ME referral practice.
- **28.6% (11) accepted** SJR referrals related to **Autism/LD/severe mental illness** compared to **31% (11)** in 2024/25 Q4.
- **2.9% (9) accepted** SJRs referred due to **Concern raised by Families/Carers**; decrease from **25% (9)** 2024/25 Q4. Attributed to referrals being appropriately redirected to M&M processes or the treating team to resolve next-of-kin concerns locally.
- **Nil** SJR referrals related to **'Alarm' raised with provider** during the quarter. This has been a consistent finding across all quarters of 2025/26.
- **4.7% (5) known Learning Disability** referrals; decrease from **6.8% (10)** 2024/25 Q3. **5.6% (6) known Severe Mental Health** referrals; decrease from **9.5% (14)** in 2024/25 Q4. All cases meeting mandated SJR criteria continue to be appropriately referred, with alternative statutory review pathways used where applicable.

Learning from Death SJR Mortality Panel Outcome Scores - 2025/26 Q4

Mortality Panel scores following completion of SJRs by SJR Reviewers.

University Hospitals Sussex NHS Foundation Trust



SJRs Reviewed at Mortality Panel (Scores) 2025/26 Q4							
	WGH	SRH	RSCH	PRH	25/26 Q4	% SJR Reviewed	24/25 Q4
1 - Very Poor Care	1	1	1	0	3	15.0%	4
2 - Poor Care	4	0	2	0	6	30.0%	13
3 - Adequate Care	1	0	3	0	4	20.0%	11
4 - Good Care	1	1	4	1	7	35.0%	1
5 - Excellent Care	0	0	0	0	0	0.0%	0
Q4 UHSx Total					**20**		**29**

Key Observations

- A combination of long-term sickness and annual leave within LfD team led to fewer Mortality Panels within the quarter.
- **20** SJRs reviewed at Mortality Panel; decrease from **29** in 2024/25 Q4.
- **45% (9)** of SJRs reviewed at Mortality Panel scored **1 (Very Poor Care)** or **2 (Poor Care)**; decrease from **58.9% (17)** in 2024/25 Q4.
- **30% (6)** of SJRs reviewed at Mortality Panel scored **2 (Poor Care)**; decrease from **44.8% (13)** in 2024/25 Q4.
- **65% (13)** of all SJRs reviewed at Mortality Panel **scored between 1 and 3**; significant decrease from **96.6% (28)** in 2024/25 Q4. Attributed to random selection of cases scoring **4** (**Good Care)** being discussed at Mortality Panel.
- **20% (4)** scored **3 (Adequate Care)**; decrease from **37.9% (11)** in 2024/25 Q4. Attributed to new processes and lower number of cases discussed at Mortality Panel.
- **35% (7)** scored **4 (Good Care)**; **3.4% (1)** in 2024/25 Q4 but at time when only cases scoring 1, 2 or 3 by SJR Reviewer were listed for Mortality Panel discussion.
- **Nil** cases scored **5 (Excellent Care)**; **equal to** 2024/25 Q4.

A Panel of SJR Reviewers and the Mortality & Learning from Deaths Lead review completed SJRs with a score of 1 (Very Poor Care), 2 (Poor Care) or 3 (Adequate Care.) 2025/26 Q4 included random selection of cases scoring 4 (Good Care).

Learning from Death SJR Mortality Panel M&M Referrals - 2025/26 Q4

Cases where Mortality Panel identifies requirement for M&M Review.

NHS
University Hospitals Sussex
NHS Foundation Trust

Requirement for M&M Review identified at Mortality Panel						
	WGH	SRH	RSCH	PRH	25/26 Q4	% Reviewed
Jan-26	1	0	2	0	3	**75.0%**
Feb-26	2	0	0	0	2	**25.0%**
Mar-26	2	0	3	0	5	**62.5%**
Q4 Total	**5**	**0**	**5**	**0**	**10**	
%Reviewed					**50.0%**	

Key Observations

- **50% (10)** cases discussed at Mortality Panel referred for M&M Review.
- Significant monthly variation in the proportion of cases discussed at Mortality Panel and referred for M&M Review, ranging **from 25% to 75%**. Attributed to variance in number of Mortality Panels held within each month.
- Note: Benchmarking data is not available for 2024/25 as this was not previously recorded; however, this will be included in future quarterly reports.

Mortality Panel, SJR and Panel discussion outputs routinely shared with the relevant DQSM to disseminate learning.

Learning from Death SJR Mortality Panel Identification of Potentially Avoidable Deaths - 2025/26 Q4

University Hospitals Sussex NHS Foundation Trust

Cases where the Mortality Panel identifies that the death may have been avoidable, for which a Datix will be raised.

1 **Adult death identified as 'may have been avoidable' by Mortality Panel in 2025/26 Q4**

Potentially Avoidable Deaths Identified by Mortality Panel							
	WGH	SRH	RSCH	PRH	25/26 Q4	% Reviewed	24/25 Q4
Jan-26	0	0	0	0	0	0.0%	0
Feb-26	1	0	0	0	1	12.5%	0
Mar-26	0	0	0	0	0	0.0%	0
Q4 Total	**1**	**0**	**0**	**0**	**1**		**0**
%Reviewed					**5.0%**		**0.0%**

Case No.	Site	DoD	Mortality Panel Date	Update
1	WGH	17/12/2025	03/02/2026	Datix is under review with the Division.

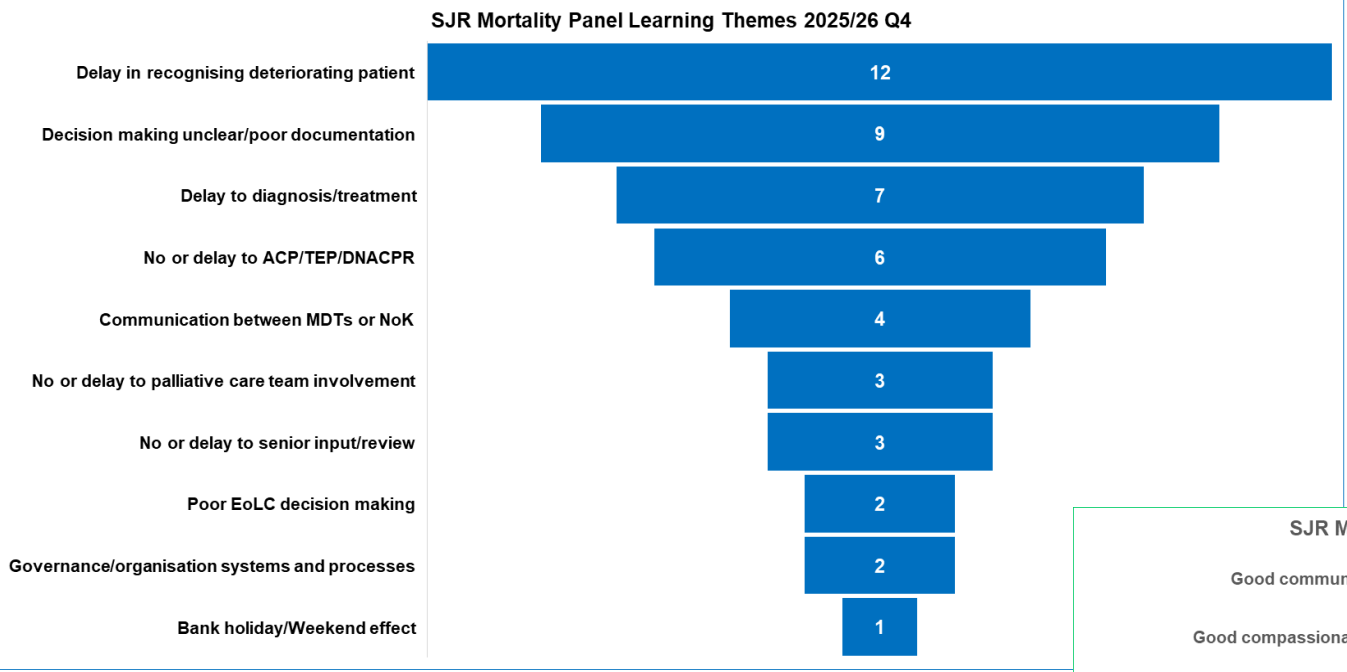
Key Observations

- **1** case identified by the Mortality Panel as '**may have been avoidable**'; increase from **Nil** in 2024/25 Q4. Datix raised by the LfD team and currently under review by Division.
- The sustained low or absence of cases across 2025/26 is attributed to the change in practice whereby SJRs are no longer routinely undertaken for cases referred to the Coroner.
- The Mortality Panel no longer routinely grades harm; decisions on harm grading will now be made at Divisional level or through the PSIRG process.
- Problems in care continue to most commonly occur during the **ongoing** and **end-of-life** phases of care, which remains a longstanding and consistent finding.

Learning from Death SJR Mortality Panel Learning Themes - 2025/26 Q4

Recurrent and emergent learning themes identified during the reporting period.

University Hospitals Sussex NHS Foundation Trust



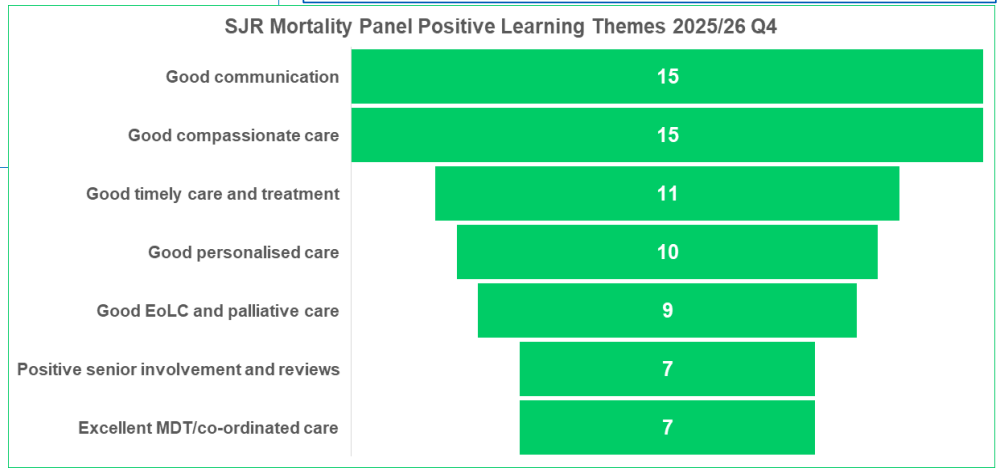
Note: More than one theme may be identified on case discussion

Key Observations - learning

- **Delay recognising deteriorating patient (12, 24.5%)** was the top learning theme in 2025/26 Q4. This remains a high incidence theme.
- **Unclear decision making (9, 18.4%)** was the next highest learning theme in 2025/26 Q4.
- The top three learning themes accounted for **57.1%** of learning themes identified at Mortality Panel.
- **No or delay to ACP/TEP/DNACPR** equated to **12.2% (6)** of learning themes identified at Mortality Panel.

Key Observations - positive learning

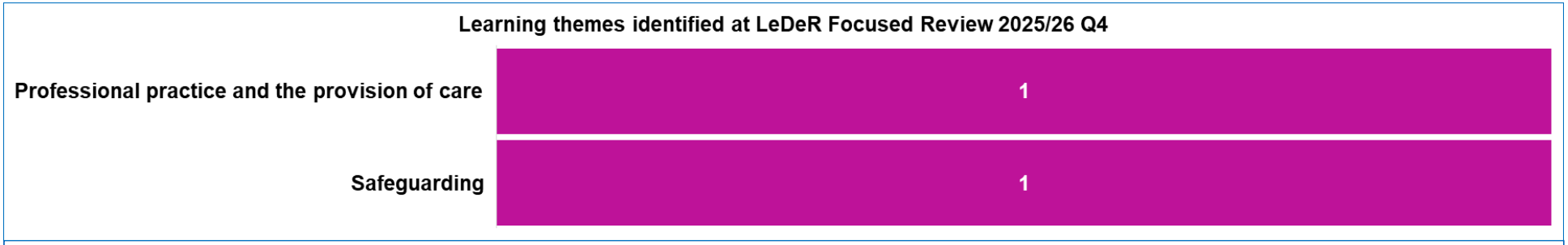
- **Good communication** and **compassionate care (15)** were the joint highest positive learning themes identified in Q4 2025/26, together accounting for **40.5%** of themes discussed at Mortality Panel and showing consistently high incidence across quarters.
- **Timely, personalised care** were the next highest categories.
- **Excellent MDT/co-ordinated care** was also recognised.



Learning from Death LeDeR Focused Review Learning Themes - 2025/26 Q4

University Hospitals Sussex NHS Foundation Trust

Learning from lives and deaths - People with a learning disability and autistic people (LeDeR.)
Learning themes identified at LeDeR Focused Review where UHSx was the main stakeholder during the reporting period.



Key Observations

- The frequency of LeDeR Focused Reviews decreased in 2025/26 Q4, with continued uncertainty regarding future service provision.
- **1 (50%)** UHSx cases discussed at LeDeR Focused Review identified learning related to **Professional practice and provision of care** which is a recurrent theme. This represents a decrease from **2 (50%)** in 2025/26 Q3; **7 (58.3%)** in 2025/26 Q2; **2 (40%)** in 2025/26 Q1.
- **1 (50%)** UHSx cases discussed at LeDeR Focused Review identified learning related to **Safeguarding**; comparable to **none** in 2025/26 Q3; **2 (17%)** in 2025/26 Q2; **none** in 2025/26 Q1.
- **Key take aways - Discharge planning should incorporate consideration of the support required to transition from hospital care to the patient's local community, with a review of current policies required to ensure alignment with latest NICE guidance.**
- **Actions** - Review of multi-disciplinary team learning disability surgical pathway to inform service improvement.
  Develop service improvement plan regarding time frame and quality of S42 expectations.

A Panel of system stakeholders led by LeDeR meet to discuss adult deaths reviewed by LeDeR Reviewers, to identify care issues, propose actions and disseminate learning to relevant teams/organisations. The Mortality & Learning from Deaths Lead and Safeguarding Lead attend on behalf of UHSx. Copies of UHSx SJRs and assurance regarding learning/actions taken routinely shared with LeDeR. Note: More than one theme may be identified on case discussion.

Medical Examiner Office Update - 2025/26 Q4

University Hospitals Sussex NHS Foundation Trust

ME Service overview during reporting period, including general update, observations and concerns, challenges and celebrations.

Updates:

- **2026/27** Medical Examiner Office income (part of Sussex ICB contract) under review - proposed reduction in funding for Brighton & Mid-Sussex ME Office based on number of deaths.
- Review of Brighton & Mid-Sussex community deaths catchment area to include all GP practices in Haywards Heath, which are currently split with SASH ME Office.
- Consideration of single ME Office serving West Sussex, Brighton & Mid-Sussex.
- **2026/27** Planned reduction in community palliative care provision likely to lead to higher number of adult deaths in acute setting.

Escalations:

- Protracted delay with PAS integration impacting move to Datix IQ - flagged with UHSx IT Network team, work on required server due to start in Apr-26. This has hampering ability to deliver Mortality & LfD Dashboard for Divisions to access real-time data.

Challenges:

- Significant staffing pressures across teams, arising from long-term sickness absence and maternity leave and compounded by planned annual leave, have resulted in challenging workflows and delays in the completion of MCCDs.
- Lack of access to Plexus (GP records) - ongoing issue.
- Limited space in the ME Office at SRH, but new desk reconfiguration now in place to maximise available space and improve ergonomics.
- Currently no viable option for co-location of ME and Bereavement teams at SRH due to large desk requirement - Property Management Team advise expected to take >12 months.

Celebrations:

- Sustained positive feedback from bereaved families regarding ME Service provision.

Data limitations:

- Available benchmarking data across ME Offices in England and Wales remains limited. This has been flagged with the Regional Medical Examiner team by Lead Medical Examiners and Lead Medical Examiner Officers.

Medical Examiner Office Update - ME Office Overview - 2025/26 Q4

Information provided by Lead MEOs, on behalf of independent ME Service.

NHS
University Hospitals Sussex
NHS Foundation Trust

	2025/26 Funded ME FTE for Expected Deaths	2025/26 Funded MEO FTE for Expected Deaths
West Sussex	2.3	6.8
Brighton & Mid Sussex	1.7	5.0

Medical Examiner Scrutiny - Adult deaths		Adult Deaths (No.)	Average time taken to complete MCCD (Days from referral	Average time taken to complete MCCD (Days from death to	Positive NoK feedback on MEO contact	Concerns raised by NoK regarding MEO contact
West Sussex	Acute inpatient deaths	594	1.8	4.4	41	0
	Community deaths	968	1.5	4.3	57	1
		1562	**1.6**	**4.3**	**98**	**1**
Brighton & Mid Sussex	Acute inpatient deaths	418	2.9	4.3	12	1
	Community deaths	371	3.1	6.5	8	0
		789	**3.0**	**5.4**	**20**	**1**
Q4 Total		**2351**	**2.3**	**4.9**	**118**	**2**

Medical Examiner Office Benchmarking

Available benchmarking data across England and Wales remains limited. The 2024 National Medical Examiner Report indicates that between October and December 2024, the median time from death to completion of the MCCD was 5 days or fewer for nearly three-quarters of Medical Examiner Offices in England (73%), 3 days or fewer for over a third (36%), and 8 days in Wales.

Key Observations

- **2351** adult (**acute** and **community**) deaths were reviewed in 2025/26 Q4, with activity higher in **West Sussex (1562**) than **Brighton & Mid Sussex (789).**
- Overall timeliness of MCCD completion remains strong, averaging **2.3 days** from referral and **4.9 days** from death.
- **West Sussex** demonstrates consistently quicker MCCD completion, averaging **1.6 days** from referral and **4.3 days** from death across adult **acute** and **community** deaths.
- **Brighton & Mid Sussex** shows longer timescales, particularly for adult **community** deaths (**6.5 days** from death), influencing the higher overall average for the area.
- Next of kin experience is overwhelmingly positive, with **118** positive feedback responses relating to **Medical Examiner Officer (MEO) contact.**
- Very few concerns were raised - only **2** across the entire system, indicating high-quality communication and engagement.
- No correlation is evident between longer MCCD timescales and family dissatisfaction, providing assurance that compassionate engagement is maintained.
- Overall, strong assurance on the effectiveness, quality, and compassion of the **Medical Examiner Service**, with targeted opportunities to improve timeliness in **community** settings.

Medical Examiner Office Update - Acute Inpatient Data - 2025/26 Q4

Information provided by Lead MEOs, on behalf of independent ME Service.

University Hospitals Sussex NHS Foundation Trust

Adult Deaths (Acute)		Scrutinised (No.)	Scrutinised (%)	Average time taken to complete MCCD (Days from referral to sending)	Average time taken to complete MCCD (Days from death to sending)	Referred to Coroner (No.)	Referred to Coroner (% of total adult deaths)	Investigated by Coroner (No.)	Investigated by Coroner (% of total adult deaths)	Investigated by Coroner (% of referred to Coroner)
Jan-26	**WGH**	132	100.00%	2.1	4.8	13	9.85%	7	5.30%	53.85%
	SRH	112	100.00%	1.6	4.6	18	16.07%	10	8.93%	55.56%
	RSCH	113	99.12%	2.2	4.1	20	17.54%	17	14.91%	85.00%
	PRH	39	100.00%	2.0	4.0	2	5.13%	2	5.13%	100.00%
		396	**99.78%**	**2.0**	**4.4**	**53**	**13.35%**	**36**	**9.07%**	**67.92%**
Feb-26	**WGH**	90	100.00%	1.8	3.9	11	12.22%	8	8.89%	72.73%
	SRH	59	100.00%	1.6	4.0	11	18.64%	7	11.86%	63.64%
	RSCH	86	100.00%	3.0	5.0	23	26.74%	10	11.63%	43.48%
	PRH	27	100.00%	1.9	3.8	4	14.81%	4	14.81%	100.00%
		262	**100.00%**	**2.1**	**4.2**	**49**	**18.70%**	**29**	**11.07%**	**59.18%**
Mar-26	**WGH**	114	100.00%	2.2	4.3	16	14.04%	10	8.77%	62.50%
	SRH	87	100.00%	1.4	4.5	9	10.34%	4	4.60%	44.44%
	RSCH	113	97.41%	6.1	4.6	29	25.00%	14	12.07%	48.28%
	PRH	36	100.00%	2.1	4.5	3	8.33%	3	8.33%	100.00%
		350	**99.35%**	**2.9**	**4.5**	**57**	**16.15%**	**31**	**8.78%**	**54.39%**
Q4 Total UHSx		**1008**	**99.71%**	**2.3**	**4.3**	**159**	**15.77%**	**96**	**9.49%**	**60.38%**

Key Observations

- Significant staffing pressures across teams, arising from long-term sickness absence and maternity leave and compounded by planned annual leave.
- **99.35%** **acute** adult deaths scrutinised; **99.6%** in 2024/25 Q4. **Note**: There were **4** cases with police/coroner involvement sent without scrutiny to avoid delay.
- Average time taken from referral to issuing MCCD **2.3 days**; decrease from **2.9 days** in 2024/25 Q4.
- Average time taken from death to issuing MCCD **4.3** days; decrease from **5.2 days** in 2024/25 Q4.
- **15.77% (159)** **acute** adult deaths referred to Coroner; decrease from **19% (212)** in 2024/25 Q4.
- Of those referred, **60.38% (96)** investigated; **61.3% (130)** in 2024/25 Q4.
- **9.49%** of **acute** adult deaths investigated by Coroner; decrease from **11.6%** in 2024/25 Q4.

Medical Examiner Office Update - Community Deaths Data - 2025/26 Q4

Information provided by Lead MEOs, on behalf of independent ME Service.

NHS University Hospitals Sussex NHS Foundation Trust

Adult Deaths (Community)		Scrutinised (No.)	Scrutinised (%)	Average time taken to complete MCCD (Days from referral to sending)	Average time taken to complete MCCD (Days from death to sending)	Referred to Coroner (No.)	Referred to Coroner (% of total adult deaths)	Investigated by Coroner (No.)	Investigated by Coroner (% of total adult deaths)	Investigated by Coroner (% of referred to Coroner)
Jan-26	West Sussex	381	100.00%	1.3	4.2	30	7.87%	8	2.10%	26.67%
	Brighton & Mid Sussex	143	100.00%	2.8	6.2	9	6.29%	0	0.00%	0.00%
		524	**100.00%**	**2.0**	**5.2**	**39**	**7.44%**	**8**	**1.53%**	**20.51%**
Feb-26	West Sussex	284	100.00%	1.5	4.4	9	3.17%	7	2.46%	77.78%
	Brighton & Mid Sussex	101	100.00%	2.8	6.2	13	12.87%	4	3.96%	30.77%
		385	**100.00%**	**2.1**	**5.3**	**22**	**5.71%**	**11**	**2.86%**	**50.00%**
Mar-26	West Sussex	303	100.00%	1.6	4.3	21	6.93%	6	1.98%	28.57%
	Brighton & Mid Sussex	127	100.00%	3.7	7.1	10	7.87%	2	1.57%	20.00%
		430	**100.00%**	**2.7**	**5.7**	**31**	**2.32%**	**8**	**1.86%**	**25.81%**
Q4 Total		**1339**	**100.00%**	**2.3**	**5.4**	**92**	**6.87%**	**27**	**2.02%**	**29.35%**

Key Observations

- **1339 community** adult deaths; **968** occurred in West Sussex and **371** in Brighton & Mid Sussex; increase from **1047** in 2024/25 Q4.
- **100% community** adult deaths scrutinised, **same** as in 2024/25 Q4.
- Average time taken from referral to issuing MCCD **2.3 days**. (West Sussex **1.5 days**; Brighton & Mid Sussex **3.1 days**.) **3.3 days** in 2024/25 Q4.
- Average time taken from death to issuing MCCD **5.4** days; **6.3 days** in 2025/26 Q4.
- **6.87% (92) community** adult deaths referred to Coroner; significant reduction from **12.1% (127)** in 2024/25 Q4.
- Of those referred, **29.3% (27)** investigated; significant increase from **17.3% (22)** in 2024/25 Q4.
- **2.02%** of adult deaths investigated by Coroner; similar to **2.1%** in 2024/25 Q4.

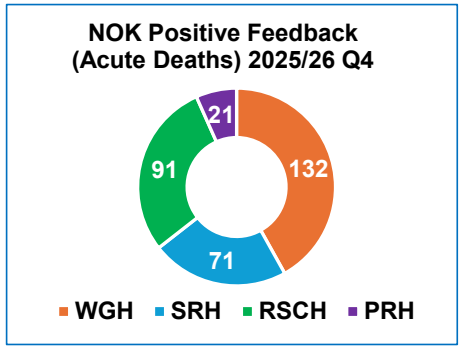
Medical Examiner Office Update - Acute NOK Feedback - 2025/26 Q4

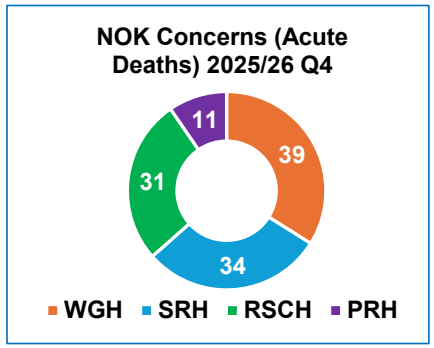
Key concerns raised by families/Next of Kin (NOK) calls are referred for SJR and learning is identified through the SJR outputs.

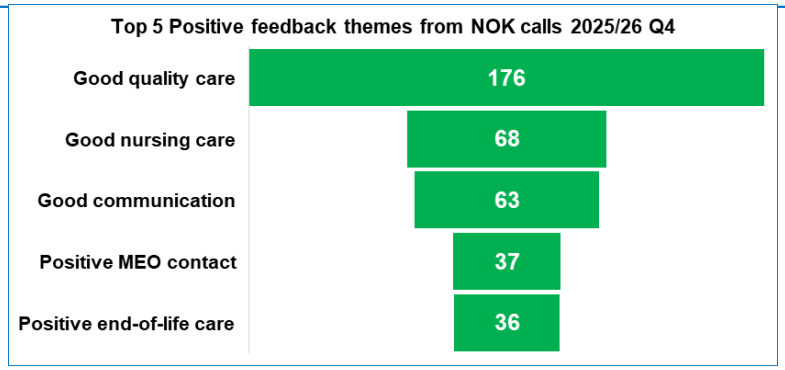
University Hospitals Sussex NHS Foundation Trust

Key Observations

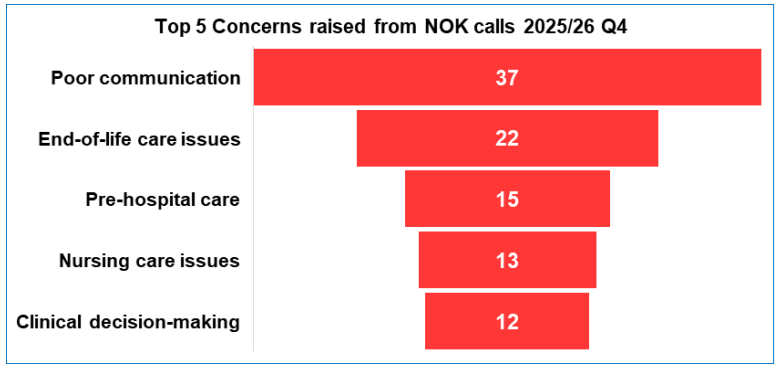
- **73.3% (315)** positive feedback responses; consistent with 2025/26 Q4 and representing an increase from **69% (257)** in 2024/25 Q4.
- **26.7% (115)** negative feedback responses, unchanged compared to 2025/26 Q4 and decrease from **31% (114)** in 2024/25 Q4.
- The highest volume of positive feedback continues to relate to **Good quality care**, with consistently strong feedback regarding interactions **with Medical Examiner Officers (MEOs)**. This indicates sustained confidence in both the standard of care delivered and the manner in which families are engaged by the ME Service.
- **Poor communication** remains highest proportion of negative feedback themes. **Pre-hospital care** and **Clinical decision-making** were identified as growing areas of concern and will require ongoing monitoring.







Note: NOK may indicate more than one theme when giving feedback



Positive Feedback Received from NOK Calls (Acute Deaths)					
	WGH	SRH	RSCH	PRH	UHSx
Jan-26	41	31	31	9	**112**
Feb-26	54	23	37	8	**122**
Mar-26	37	17	23	4	**81**
Q4 Total	**132**	**71**	**91**	**21**	**315**

Negative Feedback Received/Concerns Raised from NOK Calls (Acute Deaths)					
	WGH	SRH	RSCH	PRH	UHSx
Jan-26	14	7	12	3	**36**
Feb-26	13	10	8	3	**34**
Mar-26	12	17	11	5	**45**
Q4 Total	**39**	**34**	**31**	**11**	**115**

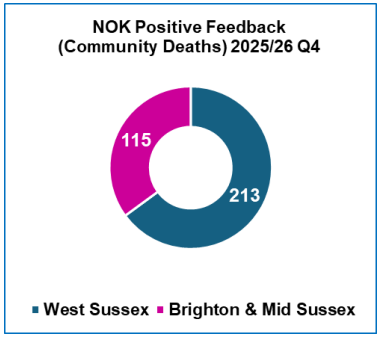
Medical Examiner Office Update - Community NOK Feedback - 2025/26 Q4

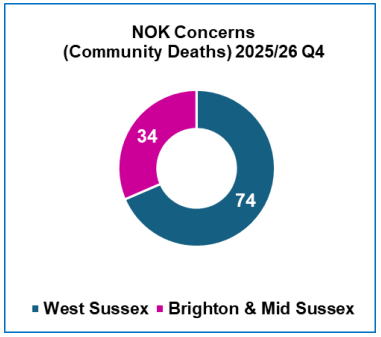
NHS University Hospitals Sussex NHS Foundation Trust

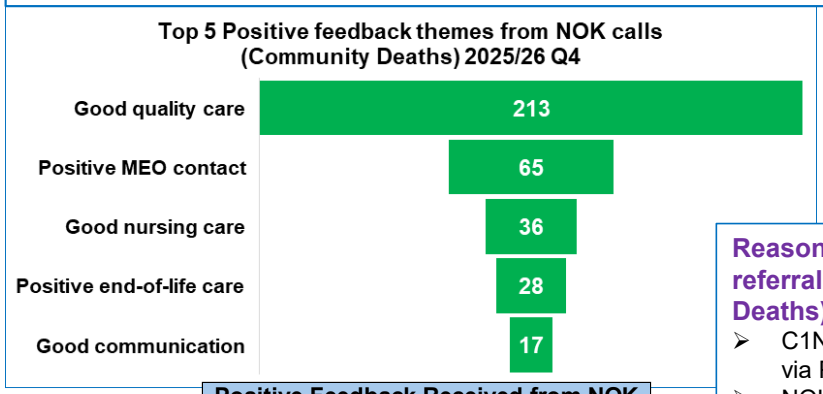
Key concerns raised by families/Next of Kin calls where deaths have occurred in the community.

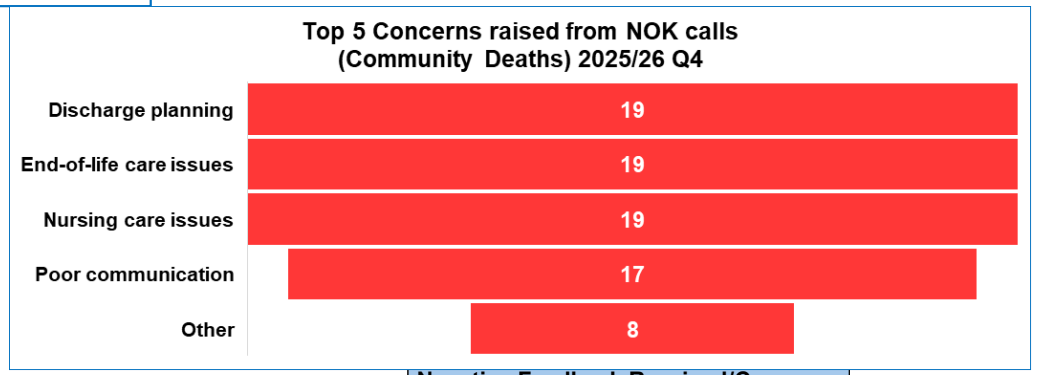
Key Observations

- **75.2% (328)** positive feedback responses; **74.7% (215)** in 2024/25 Q4.
- **24.8% (108)** negative feedback responses; **25.3% (73)** in 2024/25 Q4
- Consistent balance between positive and negative feedback, with no significant change in sentiment compared with the previous quarter.
- Consistently high volume of positive feedback for **Good quality care,** with a notable increase in feedback relating to interactions with **Medical Examiner Officers (MEOs)**, rising from **46** responses in 2024/25 Q3.
- Highest number of concerns related to **Discharge planning, End-of-life care** and **Nursing care. Discharge planning** was identified as growing area of concern and will require ongoing monitoring.









Positive Feedback Received from NOK Calls (Community Deaths)

	West Sussex	Brighton & Mid Sussex	Total
Jan-26	80	42	**122**
Feb-26	78	44	**122**
Mar-26	55	29	**84**
Q4 Total	**213**	**115**	**328**

Reasons for Coroner referral (Community Deaths):

- C1NA (often referred via Police)/C1NB
- NOK concern regarding cause of death
- Missed diagnosis
- Previous trauma
- Previous procedure
- Unknown cause

Note: NOK may indicate more than one theme when giving feedback

Negative Feedback Received/Concerns Raised from NOK Calls (Community Deaths)

	West Sussex	Brighton & Mid Sussex	UHSx
Jan-26	29	11	**40**
Feb-26	12	13	**25**
Mar-26	33	10	**43**
Q4 Total	**74**	**34**	**108**

Mortality & Learning from Deaths 2025/26 Q4 Report Highlights

NHS
University Hospitals Sussex
NHS Foundation Trust

- **106** fewer **acute** adult deaths in 2025/26 Q4 **(1012)** compared to 2024/25 Q4 **(1118.)** **24.2% (245) acute** adult deaths and **29.9% (32)** SJR referrals within most deprived postcodes (D1-4.) Corresponding increase in **community** deaths.
- Average time taken from referral to issuing MCCD **2.3 days** in 2025/26 Q4 compared to **2.9 days** in 2024/25 Q4.
- **15.77% (159) acute** adult deaths referred to Coroner and **9.49% (96)** investigated. Of those cases referred, **60.38%** investigated. Compares to **19% (212)** cases referred and **11.6% (130)** investigated in 2024/25 Q4**.**
- **21.8% (221)** of all **acute** adult deaths and **31.4% (11) accepted** SJR referrals had **pneumonia** listed on MCCD. Pneumonia has remained the highest cause of death on MCCD throughout 2025/26.
- Majority of inpatient adult deaths across ICU/Acute, General/Elderly Medicine, Respiratory and Stroke, with top 20 ward areas having **between 18 and 32** deaths within 2025/26 Q4. **RSCH LMB C8 (Stroke)** had highest number of deaths **(32)** in 2025/26 Q4.
- Sustained improvement in average time taken to complete SJR - **31 days** in 2025/26 Q4, compared to **53 days** in 2024/25 Q4. However, average time taken in Mar-26 impacted by delay in obtaining relevant health records.
- **40** more SJR referrals in 2024/25 Q4 **(147, 13.1%)** compared to 2025/26 Q4 **(107, 10.6%)** 2025/26 Q4 SJR acceptance rate **33%** with weekly SJR Screening Panel reviewing referrals, to decide on whether to proceed to comprehensive SJR. (Reasons recorded for 2025/26 Q4 - **35** referred to Coroner, **19** referred to local M&M and **18** Other.)

UHSussex Guardian of Safe Working (GoSW) Annual report 25/26

Author (GoSW) **Dr Charlotte Ford Consultant Gastroenterologist and Guardian of safe working**

Contributors **Nicola Taylor (Band 4 Medical Workforce officer), Melanie Clay (Medical Workforce manager), Jane Berry (Band 4 Workforce compliance officer), Nick Wilson (Finance officer), LFG /RDF fora**

2006 ERs (exception reports) have been submitted in 25/26 by resident doctors (RDs). This is an 11% increase overall compared to the 1785 ERs submitted in 24/25. The largest increase in ERs has been seen at RSCH and PRH sites.

552 ERs have been submitted at Worthing (WGH*) in 25/26 compared to 461 in 24/25 (16% increase).

380 at St Richards Hospital (SRH) in 25/26 compared to 460 in 24/25 (21% decrease).

1003 at Royal Sussex County Hospital (RSCH**) in 25/26 compared to 795 in 24/25 **(21% increase)**.

131 at PRH in 25/26 compared to 69 in this period 24/25 **(47% increase)**.

The majority of ERs at UHSussex (UHSx) were submitted by RDs in medical specialties; 83% WGH, 68% Medicine SRH, 59% RSCH and 99% Medicine at PRH.

The highest numbers of ER at WGH have been submitted by Acute medicine (19%) and Elderly Medicine (15%)

At SRH the highest numbers of ER have been submitted by Acute Medicine (21%) and Respiratory (14%)

At RSCH site RDs submitted the highest number of ER in Elderly medicine (13%) and Emergency Medicine (11%)

At PRH the majority were submitted by doctors working in Elderly Medicine (53%).

ER reforms have been implemented at UHSussex from 4.2.26, early indicators suggest an increase in overall ER, with more RDs requesting payment over time-off-in-lieu (TOIL) for additional hours worked. Other early trends include an increase in exception reporting among HST (higher specialty trainees) and those on NROC (non-resident on call) rotas. A higher number of RDs have submitted ERs on the theme of emergency events taking place at the end of the shift including patients becoming unwell, complex discharge planning or handover completing tasks for their ‘last case seen’.

24 immediate safety concerns (ISCs) have been upheld during 25/26 at UHSx. 187 Guardian fines have been levied for 25/26 (WGH;49, SRH;29, RSCH;100 PRH;9).

Resident doctors fora (RDF) have taken place monthly with changes to offer a face-to-face meeting, senior leadership engagement and catering. The Trust has approved a new process for RDs declaring themselves ‘Too tired to drive’ after a long shift which ensures they are provided with rest space or travel home.

(*WGH; refers to trainees at WGH and Southlands Hospital) **RSCH; includes trainees at RSCH Royal Sussex County Hospital and RACH (Royal Alexandra Children’s Hospital), BGH (Brighton General Hospital) and SEH Sussex Eye Hospital sites)

Introduction

This report has been standardised to the National template produced in guidance to allow central data processing (NHS Employers April 2026).

Table 1: High level data UHSussex

Number of Resident doctors (RDs) in training posts: 1167

Grade	Site	Number of RDs 2025/26
F1	RSCH/PRH	103
F1	SRH	33
F1	WTG	31
F2	RSCH/PRH	84
F2	SRH	33
F2	WTG	34
GP	Bri/Mid-Sussex	114
GP	Coastal	93
Core	RSCH/PRH	124
Core	SRH	37
Core	WTG	51
Higher	RSCH/PRH	239
Higher	SRH	79
Higher	WTG	112

1.0 Exception reporting (ER)

1.1 Number of exception reports submitted:

Number of exception reports submitted in 25/26	**2006**

2006 ERs (exception reports) have been submitted in 25/26 by RDs at UHSx. This is an 11% increase overall compared to the 1785 ERs submitted in 24/25. The largest increase in ERs has been seen at RSCH and PRH sites.

- 552 ERs have been submitted at Worthing (WGH*) in 25/26 compared to 461 in 24/25 **(16% increase).**
- 380 at St Richards Hospital (SRH) in 25/26 compared to 460 in 24/25 (21% decrease).
- 1003 at Royal Sussex County Hospital (RSCH**) in 25/26 compared to 795 in 24/25 **(21% increase)**.

- 131 at PRH in 25/26 compared to 69 in this period 24/25 **(a 47% increase)**.

There has been an early increase in number of ERs post exception reporting reforms implemented on 4.2.26 at RSCH sites (most striking at RACH site) and PRH.

Table 2: Exception reporting numbers by Quarter and pre and post reforms (4.4.26)

	WTG			**SRH**			**PRH**		
	pre	post	2024-5	pre	post	2024-5	pre	post	2024-5
Q1	108		104	86		146	22		21
Q2	179		125	126		108	35		24
Q3	124		128	74		107	31		13
Q4	55	**86**	108	21	**73**	102	7	**36**	6
	466		465	**307**		463	**95**		64
total	**552**			**380**			**131**		

Table 3: RSCH: ERs by site

RSCH - Total for year by site			
	pre	post	2024-5
BGH	14	11	12
RACH	24	15	21
RSCH	704	197	735
SEH	24	14	0
Total	**766**	**237**	768
	1003		

RSCH - Total by Quarter			
	pre	post	2024-5
Q1	228		133
Q2	223		110
Q3	251		289
Q4	64	**237**	236
Total	**766**		768
	1003		

ER reforms implemented in February 2026 has seen increases in ERs at UHSussex across most sites. This is demonstrated in Table 3 below with % increases (comparing data from this period last year in Feb / Mar 2025 to post ER reforms in Feb / Mar 2026).

Key reasons for increases in reporting are that ER reforms provide reporter anonymity for ERs <2hrs reducing detriment. More ERs are being submitted for payment (97% overall) - now payment v TOIL is by RD choice and only to be challenged by exception (Graph 1). There is a longer timeframe for RDs to submit an ER (a change from 7-14 to 28 days).

Increases to the cost incurred by ERs have also been seen due to more GOSW fines (in particular for NROC rotas) and more exception reporting among higher specialty trainees.

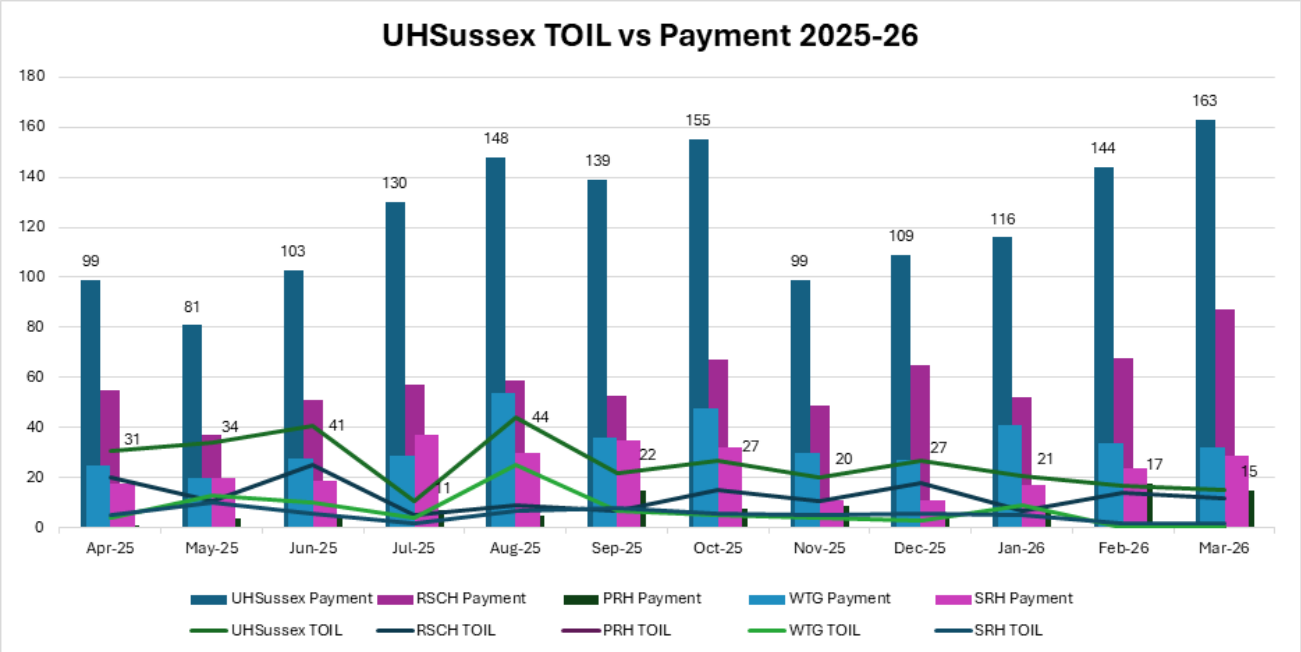
The below table focuses on ER at RSCH sites comparing data from February /March

Table 3: Comparing number of ER's Feb/March 25 and 26

	Feb-26	**Feb-25**	**% increase**	**Mar-26**	**Mar-25**	**% increase**	**total % increase**
PRH	19	2	850%	18	4	350%	517%

RSCH	74	89	-17%	94	58	62%	14%
RACH	5	1	400%	10	1	900%	650%
BTG	6	6	0%	0	1	-100%	-14%
SEH	3	0		11	0		
WTG	37	47	-21%	47	25	88%	17%
SRH	28	35	-20%	40	18	122%	28%

Graph 1: Increases in RDs requesting Payment over TOIL for ERs observed 25/26



Key point:
There has been an increase in the number of ERs in 2025/2026. This has been observed nationally and reflects contractual changes to ER (RDC) to benefit RDs and ensure payment / TOIL for hours worked. The greatest increase in ER at this early stage post ER reform has been observed at RSCH, RACH and PRH sites. Clinical and educational leads must consider the impact of ER this for patients, resident doctors and the Trust absorbing financial pressures at a time of fiscal scrutiny.
Clinical and rota leads must be empowered to initiate work schedule reviews based on this data to reverse historic trends and deliver safe rotas. This will ensure ER meets it purpose at UHSussex as a mechanism which highlights not just the need for a change in working practices but the sites, departments which present the highest risk and rotas which require intervention.

1.2 Categories of Exception report submitted post ER reform (4.2.26)

This graph provides bespoke data on categories of ER following ER reforms 4.2.26 a requirement of the National reporting template.

Type of exception report	Outcome	Number of exception reports

	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start	N/A	N/A	N/A		N/A
Additional hours an unscheduled late finish	**97%**	**3%**	**9%**		**34**
Breaches of non-resident on-call patterns	N/A	N/A	N/A		N/A
The inability to take contractual breaks			N/A	N/A	**2**
Inadequacy of clinical support				N/A	N/A
Inadequacy of rostered skills mix				N/A	N/A
Raising concerns of a suspected non-compliant rota pattern				N/A	N/A
Detriment or threat of detriment related to exception reporting				N/A	N/A
Information breach			N/A		N/A
Access and completion resolved in time				N/A	N/A
Access and completion breaches			N/A		N/A
Access and completion test				N/A	N/A
Missed educational opportunities	N/A	N/A	N/A	N/A	N/A
Total					**36**

1.3 ER Themes

At UHSussex agreed ERs are thematically analysed to take back a clear idea of contributants to change makers. Change makers can be clinical and rota leads (conducting a work schedule review) or educational and clinical supervisors at LFG fora. Post reform ER data must be reported in a way which does not identify reporting RDs (with resultant fines for data breaches). This can present challenges for specialties with <10 RDs where themes for ERs spikes require special consideration and RD consent for wider discussion.

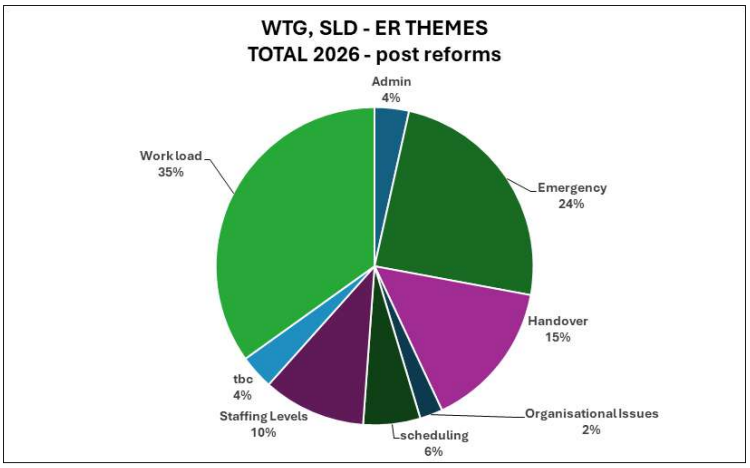
Thematic analysis has greatest relevance when teasing out key themes for high numbers in ERs within a specific specialty or across a specific rota. For example, ERs for high workload may require focus on agreed minimum staffing levels or working practices. Where high numbers of ERs are seen reflecting

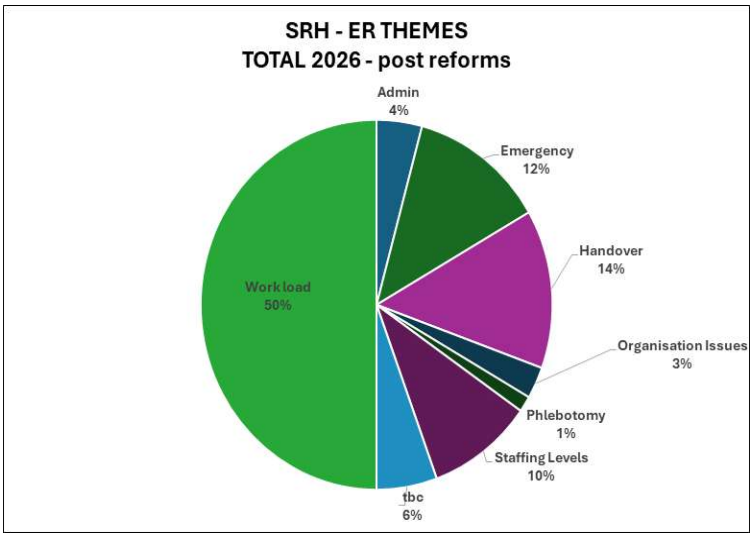
inability for RDs to handover or late-running handover meetings this may require focus on handover timing, good practice or senior lead decision making.

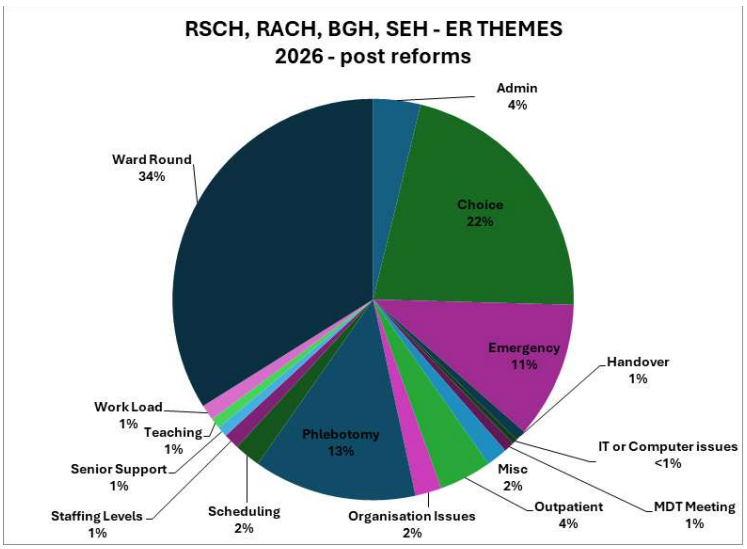
Table 4: Exception report themes (*a single ER may fulfil descriptive criteria for more than one theme)

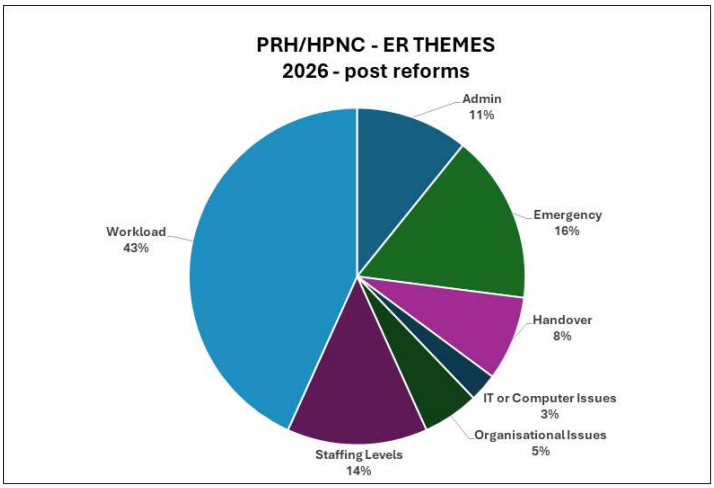
Theme	Description
Ward Round	Ward round issue e.g. long or starting late. This includes staying late to complete all the jobs that resulted from the late ward round.
Staffing Levels	Staffing Levels below agreed template for team or type of cover. This must be below minimum staffing e.g. understaffed shift due to gaps or sickness within the team mentioned specifically within ER or ward understaffed due to RDs/LEDs attending teaching.
Scheduling	Scheduling of duties outside normal working hours (this includes late scheduled handovers). (n.b. this only includes late handovers if planned i.e. scheduled handover meeting started late or ran over / this includes all planned activities out of hours - except over running ward rounds or MDTs which have their own theme.
Workload	Workload exceeding the capacity of a full team (n.b. 'busy day' - doing tasks on a ward beyond contracted hours but with replete team)
Emergency	Emergency occurring at close of day or after normal working hours required doctors continued presence (this does NOT include admin such as TTOs but includes all other late arising clinical care, including late running theatre case, MET call, deteriorating patient)
Teaching	Teaching e.g. required to attend scheduled teaching resulted in late stay Not missed teaching (which would be an Education ER – directed to DME)
Handover	Handover - doctor stayed as they felt handing over tasks to another team was unsafe or inappropriate Doctor decides to continue with a task as 'wouldn't be appropriate to handover' Includes having finished a task but waiting to wait to find someone to handover to / refer patient to (delay to unscheduled handover due to circumstances beyond the control of the reporter)
IT or Computer issues	IT or computer issues as the main cause of the exception
Phlebotomy	Phlebotomy issues as the main cause of the exception
Admin	Admin tasks taking up excessive time e.g. TTOs, theatre booking forms, printing ward round lists
Organisation Issues	Organisational issues e.g. becoming aware of new patients is under your care late in the day. High volume of outliers; high volume of new patients. (Only if given a patient to clerk late in the day is this organisational - otherwise handover ER)
Choice	Choice - doctor chose to come in early/stay late – not directed by seniors. This may require discussion with GOSW as may not be approved as ER.
Outpatient	Outpatient clinic
MDT Meeting	Multidisciplinary team meeting
Senior Support	Lack of senior support / inadequate clinical supervision – this should be the reporting 'reason' for the ER.

Graphs 2A-D UHSussex ER Themes at WGH, SRH, RSCH and PRH 25/26









Key points:

Specialities with high acuity, unpredictable work (acute specialities) and a high volume of outlier patients have continue to submit high volumes of ERs for workload. Staffing levels and unanticipated sickness compounds this issue. Greater focus of skill mix, senior lead decision making and resilient rota design are essential in addressing this problem with insight from clinicians and RDs.

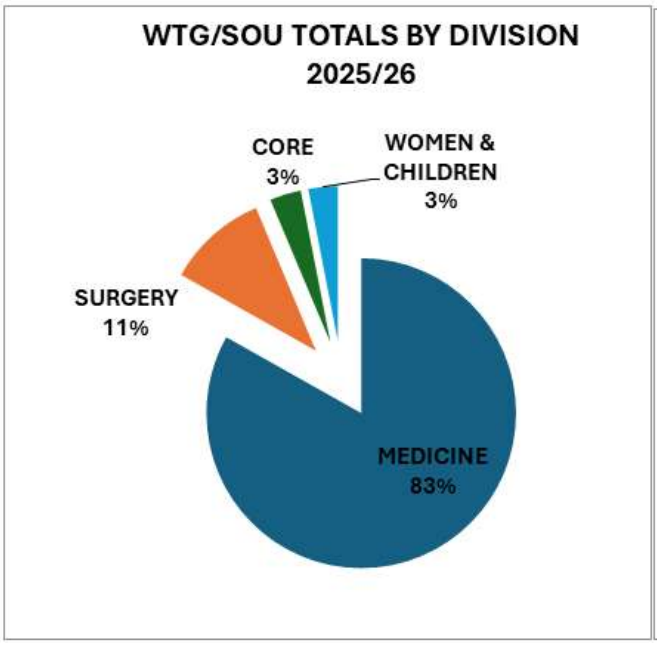
Following ER reforms a greater number of ERs have been submitted for doctors staying late for an Emergency. This is an event occurring at close of day or after normal working hours required doctors continued presence. It is likely that this reflects doctors previously under reporting (pre reforms) even when this was occurring on a regular basis. Under reporting may have been through fear of detriment a perception by their supervisor closing the report that this reflected a lack of competence, professionalism, or poor time management. ER behaviours have changed post reform with a greater willingness to submit.

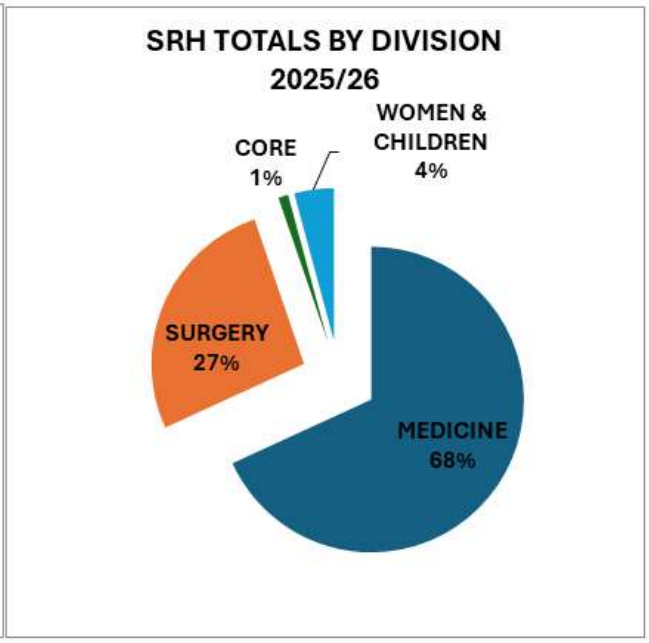
Addressing 'Emergency' as an emerging theme may require greater emphasis on senior clinician, modelling time management, selecting tasks which may be appropriate for the RD to handover and ensuring appropriate organisation of RD workload at the end of the shift.

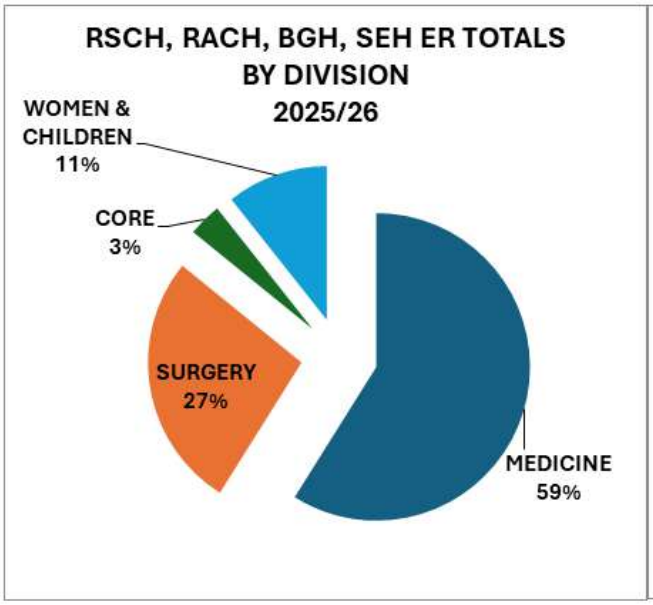
1.4 Exception reports by Division and Specialty department 25/26

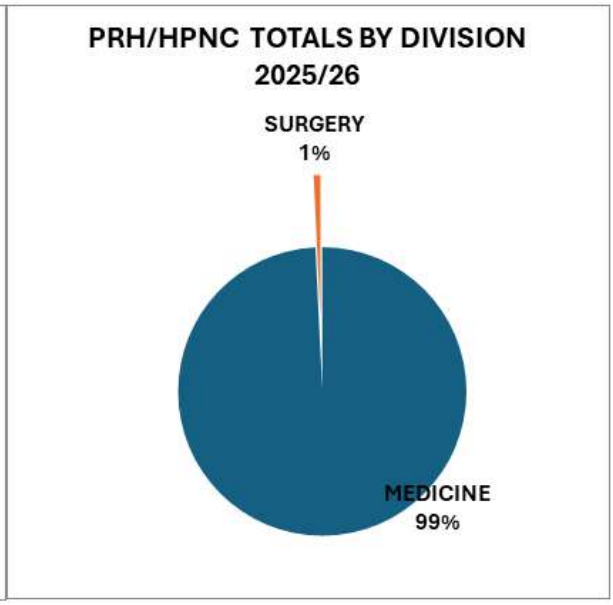
Highest numbers of ERs are submitted by Division of Medicine at each main site reflecting distribution of RD staff primarily. ER by specialty gives a clearer idea of spikes across divisional specialties.

Graphs 3A-D: Exception reports by Division 25/26



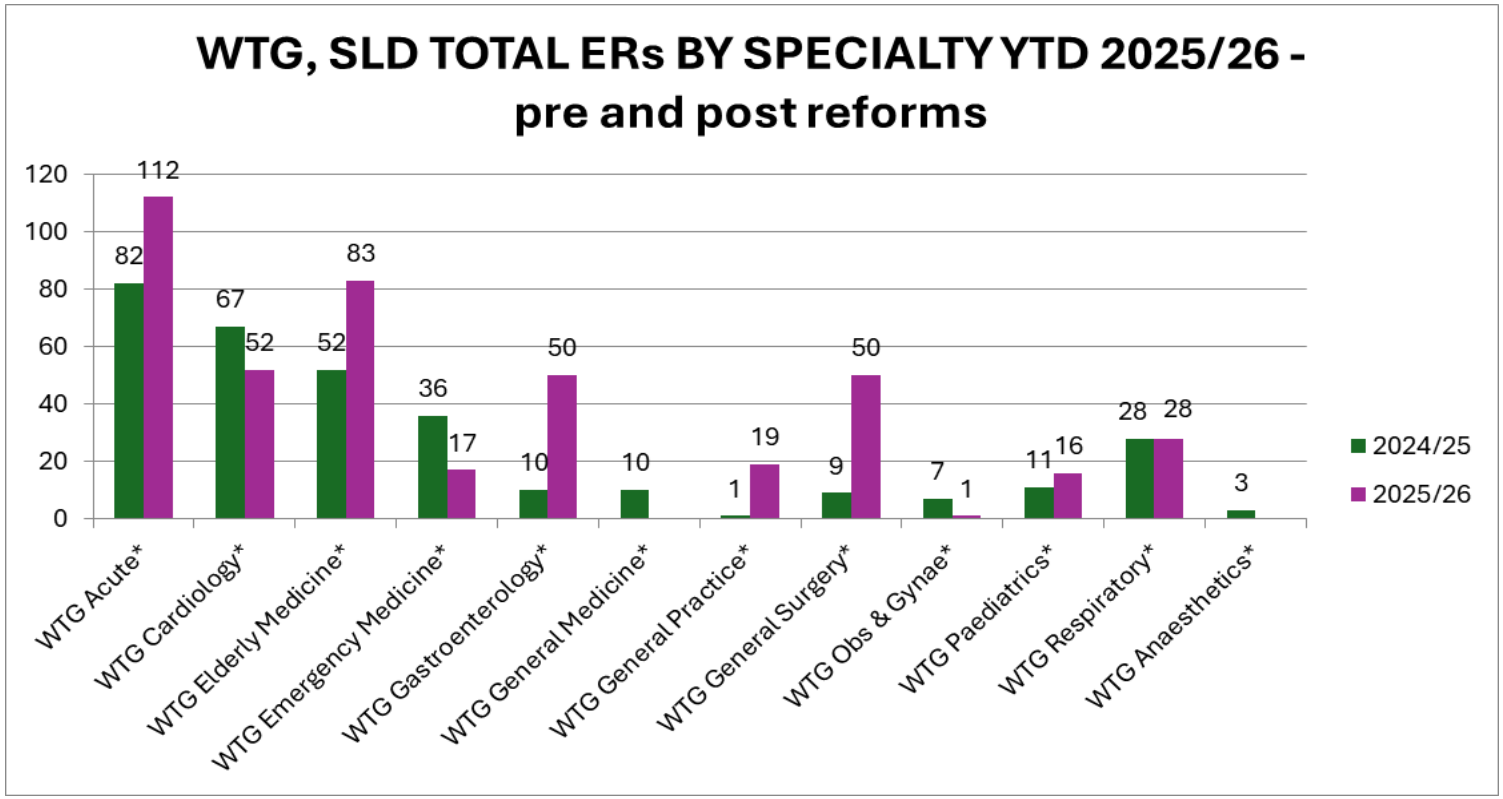




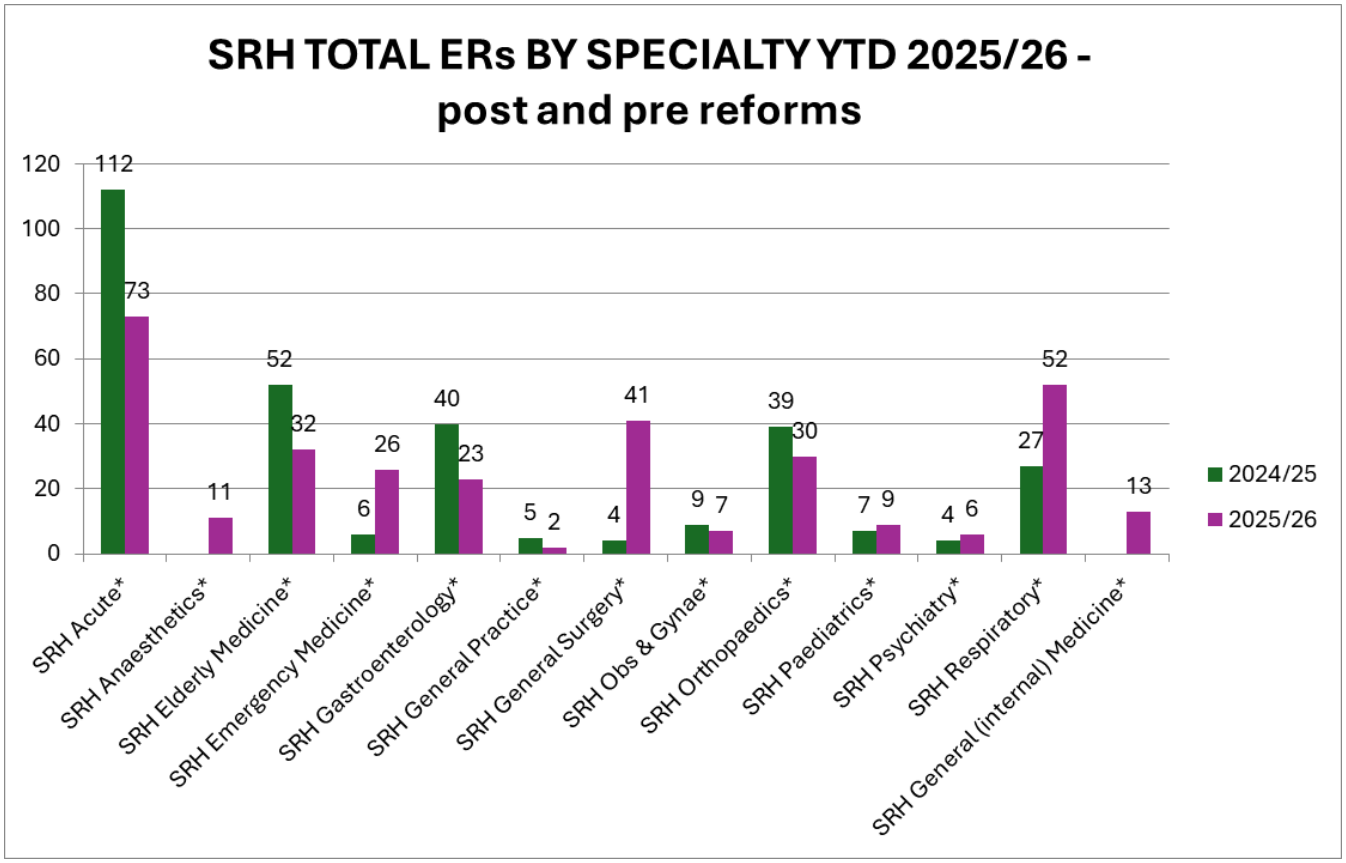


Graph 4A-D: UHSussex Total Exception reports by Specialty 25/26

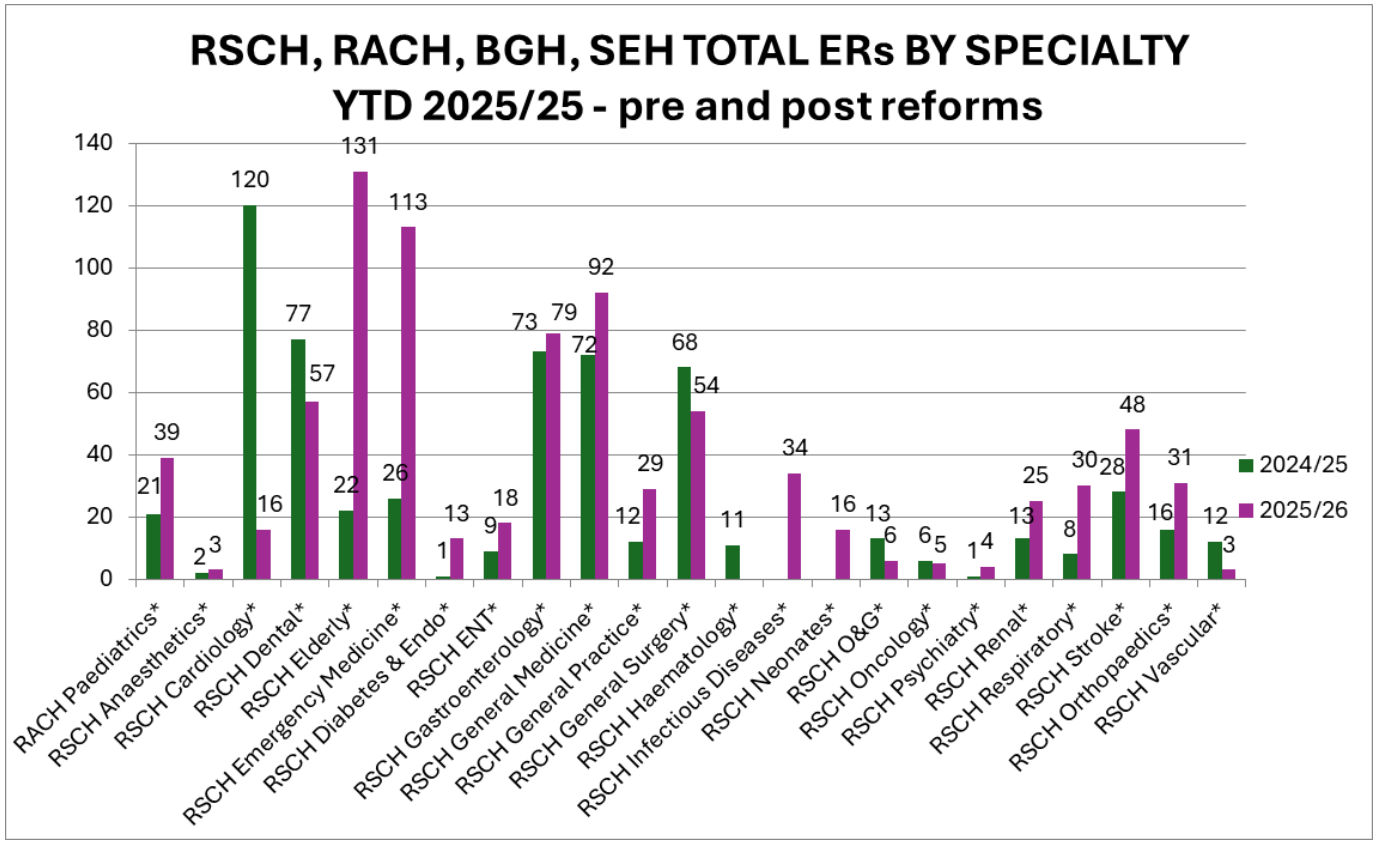
Graph 4A: UHSussex (WTG/SLD) Total Exception reports by Specialty 2025/26



Graph 4B: UHSussex (SRH) Total Exception reports by Specialty 2025/26



Graph 4C AND 4D: UHSussex (RSCH/RACH/BGH/SEH) Total Exception reports by Specialty 2025/26



4D UHSussex (PRH) Total Exception reports by Specialty 25/26

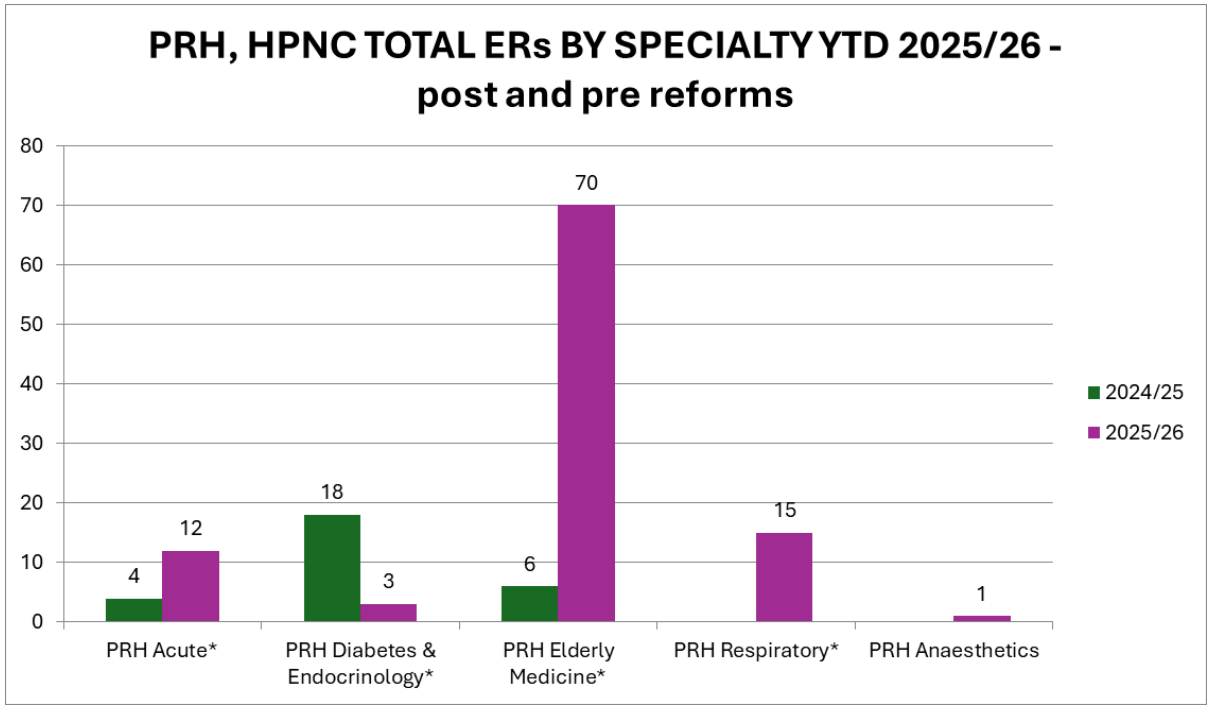


Table 5: Departments with Higher numbers of Exception Reports at each site 2025-26

WTG	
Acute medicine	112
Elderly medicine	83
Cardiology	52

SRH	
Acute medicine	73
Respiratory	52
General surgery	41

RSCH/RACH/BGH/SEH	
Emergency medicine	113
Elderly medicine	127
Paeds & neonates	94

PRH	
Elderly medicine	70
General (internal) medicine	22
Respiratory	15

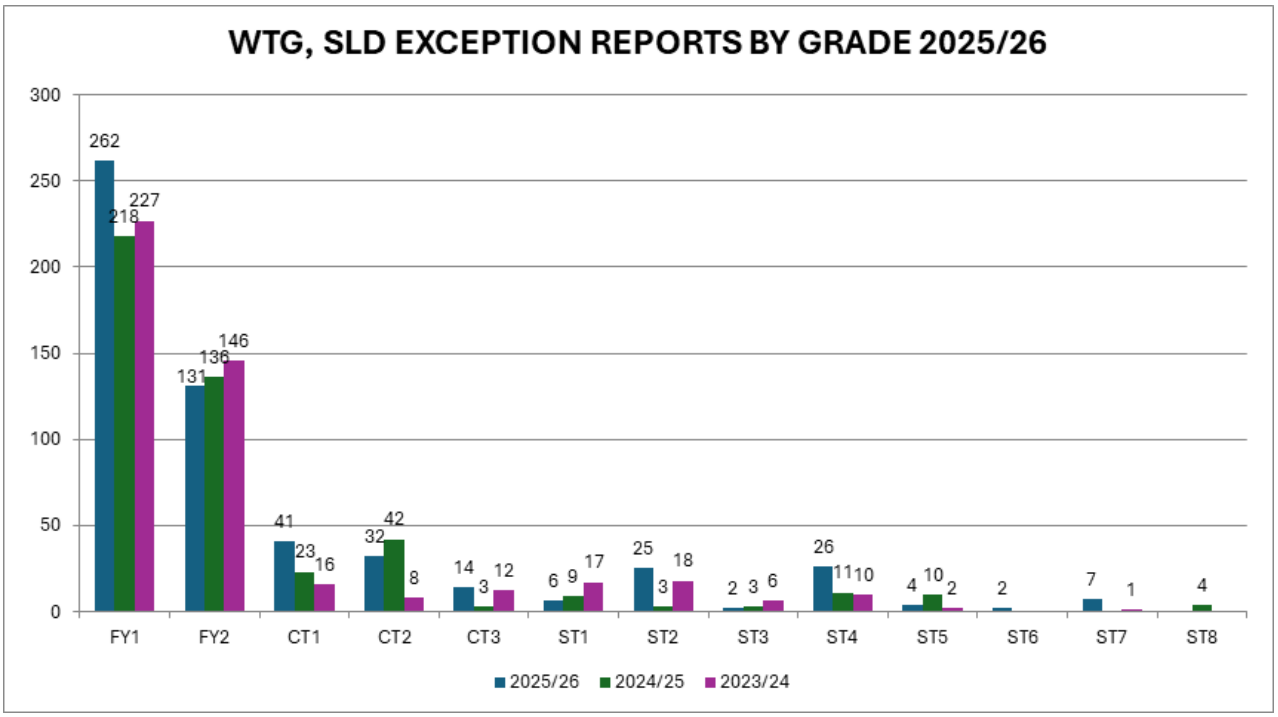
1.5 UHSussex Exception reports by Grade (25/26)

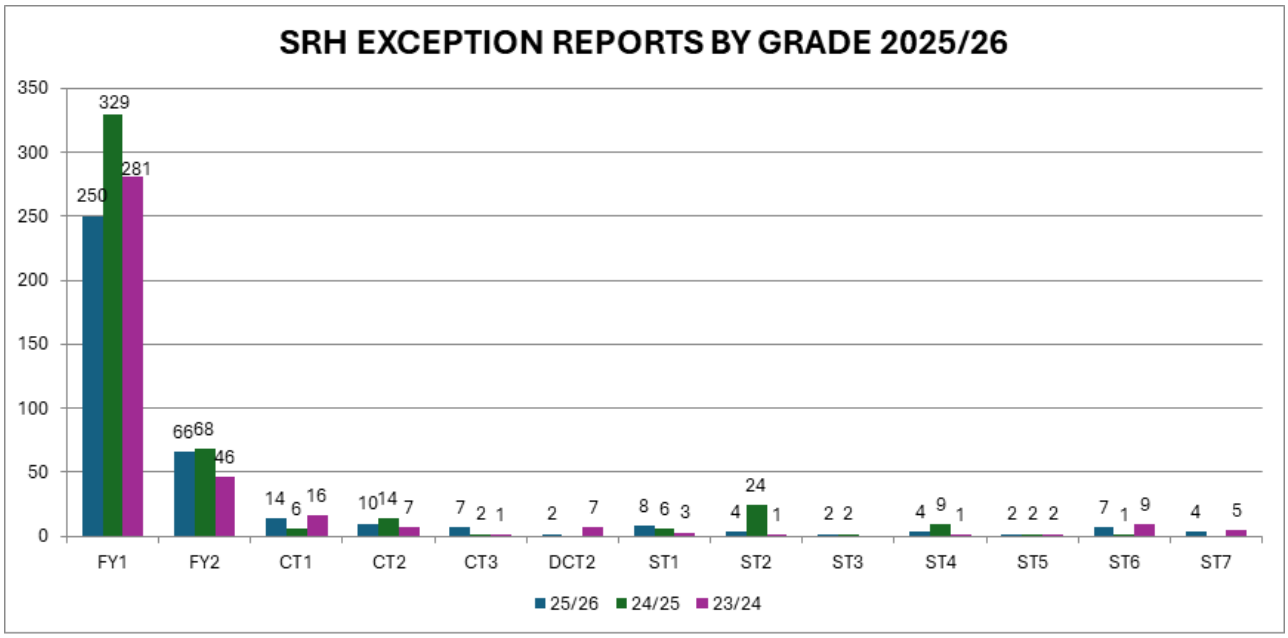
Most ERs at UHSussex are submitted by Foundation grades. A higher number of ERs have been submitted by HST higher specialty trainees post reform and for small specialties. These cannot be disclosed for the GOSW report (for specialties with <10RDs) but with RD consent have been discussed with clinical and educational leads to inform positive improvements and consider the need for work schedule review.

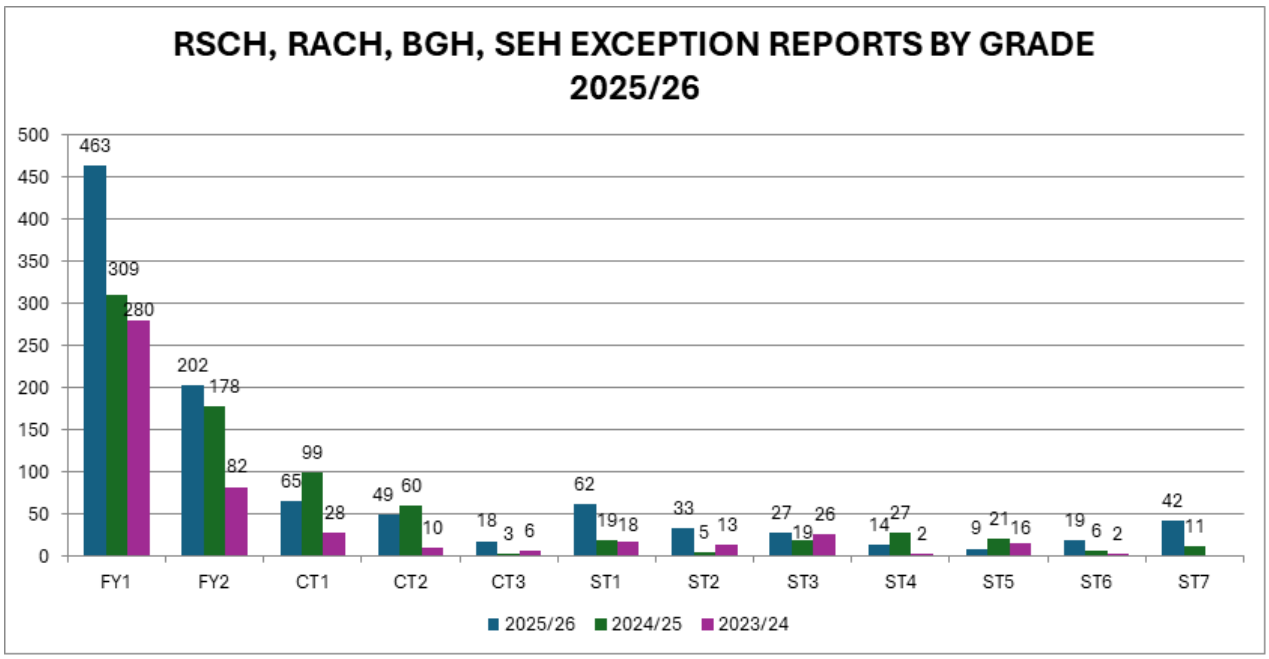
The RDF (Resident doctors forum) has created an opportunity to discuss fostering a positive ER culture at UHSussex and updating on progress under the 10-point plan. A new feature invites Trust leads to share the background to their role and responsibilities and answer questions directly from RDs on issues which relate to working lives. Speakers have included James Claydon (Head of workforce) and Simona Caronia (Deputy CMO). It is hoped this broadens perspective for RDs on challenges faced by the Trust in meeting the training needs of RDs while delivering service provision, safe patient care and meeting the needs of all NHS staff / employees.

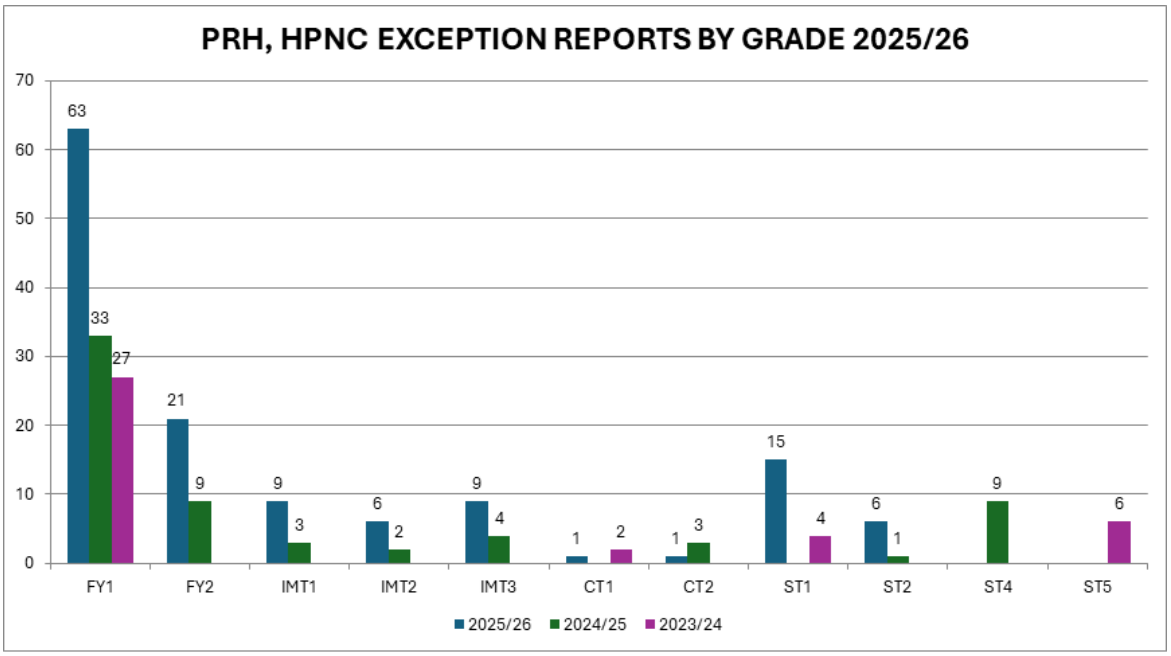
The GOSW also joins faculty at Consultant / SAS educational supervisors' courses throughout the academic year. This allows discussion on ER, supporting a positive ER culture and challenge misconceptions. In 25/26 ER reforms have been a key topic and providing updates on the responsibilities of consultants delivering safe working practices, providing supervision and for RDs reporting immediate safety concerns.

Graphs 5A-D UHSussex Total Exception reports by Grade 25/26




SRH EXCEPTION REPORTS BY GRADE 2025/26
350
300
250
200
150
100
50
0
FY1 250 329 281
FY2 66 68 46
CT1 14 6 16
CT2 10 14 7
CT3 7 2 1
DCT2 2 7
ST1 8 6 3
ST2 4 24 1
ST3 2 2
ST4 4 9 1
ST5 2 2 2
ST6 7 1 9
ST7 4 5
25/26
24/25
23/24


RSCH, RACH, BGH, SEH EXCEPTION REPORTS BY GRADE 2025/26
500
450
400
350
300
250
200
150
100
50
0
FY1 463 309 280
FY2 202 178 82
CT1 65 99 28
CT2 49 60 10
CT3 18 3 6
ST1 62 19 18
ST2 33 5 13
ST3 27 19 26
ST4 14 27 2
ST5 9 21 16
ST6 19 6 2
ST7 42 11
2025/26
2024/25
2023/24



2.0 ER processing by workforce team

Under the previous JDC (2016) educational supervisors have been required to action ERs within 7 days.

Post ER reform (Resident doctors contract) the workforce team are required to process all ERs <2hrs within 10 days (including those >2hrs requiring GOSW approval). This deadline will be reduced to 7 days by August 2026.

In 25/26 from April-Feb 2026 Educational supervisors (ES) have closed 48% of exception reports at UHSussex within 7 days of submission (in 24/25 this was 46%).

Post ER reforms (from 4.2.26)

- 92% of ER have been closed (processed by workforce team) ≤7 days (81% closed in < 3 days)
- 3% within 8 - 10 days
- 1.4 % were closed > 11 days
- 3.6% remain open at the time of report submission (with < 7 days remaining for closure)

3.0 Detriment survey

One of the guiding principles of the exception reporting reforms is to prevent doctors experiencing, either threatened or actual, detriment as a result of exception reporting or indicating intent to exception report. Detriment in an employment context is when an employer, or colleagues, treats an individual unfairly or subjects them to a disadvantage for the sole or main reason that they asserted an employment right.

A detriment survey was sent via email to all 1167 RDs on 17.3.26 (with a 2-week period for completion). There were 32 responses (2.7% response rate); 3 of 32 respondents reported that they had experienced detriment (9%) - (1 RSCH, 1 SRH,1 WGH). 1 respondent reported actual detriment and 2 respondents - threat of detriment.

Quarterly survey response rate	2.7% (32/1167)
Doctors experiencing actual detriment as a result of exception reporting	9% n = 3
Doctors feeling that they are not discouraged from exception reporting	91% n = 29

No further comments were provided on the details of detriment experiences, but some respondents did include comments on the reasons they are reluctant or have never previously submitted ERs at UHSussex.

> *'Always staying late related to theatre lists. Worried if exception reported the outcome would be loss of training opportunity.'* ***(Respondent PRH)***

> *'As an emergency medicine trainee we get 8 hours educational development time (EDT) per week. When I stay late or work through my breaks I use EDT time instead of exception reporting. This works better for me and is easier.'* ***(Respondent SRH)***

> *'As someone who works quite slow, I feel it would reflect poorly on my time management if I exception reported every time I stayed 30 -45 minutes late. I am wonder if it would be met with questions about why I did not hand something over. I would only exception report if I was specifically asked to stay late to do something - which has never happened'* ***(Respondent WGH)***

> *'We have a very approachable team both consultant and admin. The structure of the ITU handover is such that it is difficult to justify consistently staying late. On occasions I have stayed late, it's been for my own benefit and education as much as the patients, therefore is my choice. The rota team are incredibly approachable and accommodating, if I felt hours were owed - I'd contact them directly'* ***(Respondent RSCH)***

> *'[I am] slightly worried about report and repercussions. Don't want to negatively effect my training. I'm also of the slightly old school mindset that once the clock hits home time that it's not automatically time to down tools and if a consultant is still there so should you, until they send you away.'* ***(Respondent RSCH)***

4.0 ER Withdrawals

A doctor can choose to withdraw an ER that they have submitted at any point in the process following submission. Since 4.6.26 25 ERs have been withdrawn (WGH 7, SRH 3, RSCH 13, PRH 2).

Number of exception reports withdrawn over the last quarter	25

5.0 Access breaches

No access and completion ERs have been submitted since ER reform were implemented at UHSussex. RDs contacting the exception reporting enquiries are supported, submit a proof of access test report and are reissued with ER user guide. GOSW attends departmental teaching (recently regional GP teaching 24.4.26) to address any concerns raised at LFG fora directly, these are also discussed at monthly RDF meetings.

Number of access exception reports over the last quarter	0

6.0 Information / data breaches

Personally identifiable data relating to exception reporting must not be shared without the doctor's specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or have a legal obligation.

Immediate safety concerns (ISCs) fall outside data breach obligations however Clinicians receiving ISCs should be aware of the need for confidentiality, and only share the minimum details required to resolve the safety concern. While the raising of concerns by the doctor does not constitute an information breach, any further sharing of information related to the report of an ISC may constitute an information breach and be liable to a financial penalty (GOSW access fine).

All Consultants have received information specifically informing them of responsibilities around ISCs (Appendix 1) to ensure their responsibilities are clear. This has also been reinforced at MEMG (medical educational management group) with LFG leads and clinicians / supervisors at local faculty group meetings.

Number of exception reports disclosures over the last quarter	0

7.0 Guardian fines

187 GOSW fines have been levied in 25/26 (49 WGH, 29 SRH, 100 RSCH, 9 PRH).

Although most exception reports will result in either payment for the additional hours worked or TOIL, there are circumstances where financial penalties (GOSW fine) will also be levied. A GOSW fine is levied when an ER is agreed and meets the below breach criteria;

Breach A: Exceeding 13 hr shift length
Breach B: Unable to achieve the minimum 11 hours rest between resident shifts
Breach C: Unable to achieve minimum overnight continuous rest of 5 hours between 22:00 and 07:00 during a non-resident on call (NROC)
Breach D: Minimum daily Working Time Rest of 11 hours reduced to less than 8 hours
Breach E: Exceeding max 72hrs work in 7 days
Breach F: Exceeding max 7 working days consecutively
Breach G: Minimum 48hr rest after 4 consecutive long days not achieved
Breach H: Minimum 48hr rest after 7 consecutive days not achieved
Breach I: Max weekend frequency 1 in 3 exceeded

GOSW for ERs are remunerated at 4 x the basic hourly rate with 1.5 x basic hourly locum rate paid directly to RD and remainder contributed to GOSW fines fund for disbursement via bid at the RDF. Total contribution to GOSW fines fund for distribution by RDs 25/26 was £12,268.76.

The below table gives a clearer picture of the rotas with the highest number of GOSW fines levied in 25/26. The most common breach resulting a GOSW fine is finishing an on-call shift beyond contracted hours on an on call medical rota (thereby exceeding a 13-hour shift and failing to achieve 11 hours rests between shifts).

Table 6: Rotas with highest number of GOSW fines levied in 25/26

RSCH & PRH Medicine & Acute Floor	60
Worthing Medicine F1-SHO	34
St Richards Medicine F1-SHO	9
Medical Registrars RSCH & PRH	9

Key points:
Divisional leads for Medicine at UHSussex and Consultants on call should be aware of the high number of GOSW fines for RDs on the above rotas (Table 6). Fineable breaches represent an increased risk to RDs and patients through unsafe working patterns in addition to added financial pressure for divisional budgets.

On call Consultants require a clear awareness of the requirement for RDs to be released from long / late shifts. Rota coordinators leads also require greater support to recognise and respond to 'critical shifts' and escalate decision making to advertise and fill rota gaps within the staffing resources available.
Rota redesign should include discussion of patterns of ER (and ERs against which GOSW fines have been levied) to identify stress points and build rota resilience.

8.0 Immediate safety concerns 25/26

24 Immediate safety concerns have been submitted and upheld in 25/26 at UHSussex.

An immediate safety concern (ISC) represents a significant and immediate risk to patient or doctor safety. The majority of RDs submitting ISCs do so in error and on further review and discussion it is usually mutually agreed - while the event may merit an exception report, it does not fulfil the definition of an ISC. ERs which include clinical incidents are on occasion erroneously submitted as ISCs, with response from the GOSW to submit instead via the Datix system.

The definition of an ISC (and examples) are discussed at RDF meetings to ensure RDs are aware of what meets this definition and encourage submission. RDs are advised 'if you have concerns relating to safety and are in doubt as to their significance to submit as an ISC'. This ensures support for RDs and escalation of concerns but may result in over reporting of ISCs.

All ERs submitted as ISCs are reviewed by the GOSW. If upheld these are escalated for further review by the Chief of service, care group manager and rota lead to discuss contributants and the need for a work schedule review.

Table 7: Immediate safety concerns submitted at UHSussex 25/26

	Q4 2025-26		Q1 - Q3 2025		Total ISCs 25/26	
	Total	upheld	Total	upheld	**Total ISCs submitted / site**	**Total ISCs upheld / site**
WTG	6	1	32	7	**38**	**8**
SRH	3	0	20	1	**23**	**1**
RSCH	14	1	56	14	**70**	**15**
PRH	0	0	16	0	**16**	**0**

Table 8: Key themes of upheld ISCs 25/26

	Grade	Division	Theme
WGH 8			
Q1 24.6.25 (6585)	FY2	Medicine	(Burlington ward / Worthing Hospital) Consultant sickness resulting in a lack of clinical supervision / no senior review of patients on medical ward. Poor communication between operational management and resident doctors on steps taken to address staffing gaps and provide additional staffing.
Q1 24.6.25 (6586)	IMT	Medicine	
Q1 24.6.25 (6587)	FY1	Medicine	
Q1 23.6.25 (6745)	IMT	Medicine	
Q1 25.6.25 (6756)	FY2	Medicine	
Q1 27.6.25 (6751)	FY2	Medicine	
Q2 19.9.25 (8370)	FY1	Medicine	
Q4 19.3.26 (13856)	IMT	Medicine	Same day sickness resulting in understaffing of on-call night shift in acute medicine.
SRH 1			
Q1 21.6.25 (6546)	FY1	Medicine	Same day sickness resulting in understaffing of on-call shift in acute medicine.
RSCH 15			
Q1 7.6.25 (6382)	FY1	Medicine	Same day sickness resulting in understaffing of on-call shift in acute medicine.
Q1 8.6.25 (6377)	FY1	Medicine	Same day sickness resulting in understaffing of on-call shift in acute medicine.
Q1 15.6.25 (6451)	FY1	Surgery	Unsafe staffing due to large volume of high acuity outlier patients and inadequate clinical supervision.
Q1 15.6.25 (6451)	FY1	Surgery	Unsafe staffing due to patient acuity
Q2 3.7.25 (6707)	FY1	Surgery	Unsafe staffing due to large volume of high acuity outlier patients and inadequate clinical supervision.
Q2 3.7.25 (6800)	FY1	Surgery	Unsafe staffing due to large volume of high acuity outlier patients and inadequate clinical supervision.
Q2 3.7.25 (6711)	FY1	Surgery	Unsafe staffing due to large volume of high acuity outlier patients and inadequate clinical supervision.
Q2 8.7.25 (6772)	FY1	Surgery	Unsafe staffing due to large volume of high acuity outlier patients and inadequate clinical supervision.
Q2 8.7.25 (6774)	FY1	Surgery	Unsafe staffing due to large volume of high acuity outlier patients and inadequate clinical supervision
Q2 8.7.25 (6885)	FY1	Surgery	Locum grade doctor impersonating Registrar / providing unsafe care and inadequate clinical supervision
Q2 15.7.25 (6883)	FY1	Surgery	Unsafe staffing due to large volume of high acuity outlier patients and inadequate clinical supervision
Q2 19.7.25 (6883)	FY1	Surgery	Unsafe staffing due to staff sickness high volume outlier patients
Q2 21.7.25 (6965)	FY1	Surgery	High workload / doctor fatigue / unsafe level of staffing
Q2 25.8.25 (7672)	FY1	Surgery	Unsafe staffing due to large volume of high acuity outlier patients and inadequate clinical supervision
Q4 22.3.26 (13520)	FY1	Medicine	Same day sickness resulting in understaffing of on-call shift in acute medicine.

A high number of ERs were submitted in 25/26 by Foundation grade doctors at RSCH in Surgery. A thorough investigation followed involving Chief of service, Educational leads (DME) and appointed Surgical tutor. Safe levels of staffing were reviewed alongside consultant surgeon on call rota and availability with implementation of a revised Registrar grade staffing model. There has been an emphasis at induction on

patient safety and team communication alongside how to escalate concerns. There have been no ISCs submitted by Foundation doctors since September 2025.

Allegations of an SHO 'impersonating a registrar' (ER 6885) at RSCH (Surgery) were investigated within the department and referred to the GMC by an anonymous reporter. The GMC concluded their hearing and have not required any restrictions or sanction on that doctor. Administrative errors were considered contributory (issue of a security badge stating 'Locum Bank Registrar'). No patient safety issues were raised as a result. The doctor provided appropriate reflections on his error of judgement and testimonials from staff to the GMC (and Trust) who did not find any reason to impose restrictions on practice.

Key points:

ISCs were submitted in high volume (12) by RSCH F1s in Surgery (June - Jul 2025). These have been thoroughly investigated by senior clinical and educational leads resulting in positive changes in working practices for newly appointed RDs and no further ISCs.

Consultant sickness at WGH resulted in fragile senior cover of Burlington ward for a prolonged period (June 25). This was impactful for RDs who submitted 7 ISCs to highlight delays addressing their concerns. Reflections from WGH divisional leads included the need for improvement in communication between RD and operational management and greater emphasis on continuity of care.

An emerging issue remains late sickness resulting in rota gaps for out of hours shifts (specifically in acute medical specialties). The Trust does not have an acting down policy for consultant grades in these circumstances. At RDF fora RD have repeatedly raised concerns over rates of pay for vacant shifts (due to unanticipated sickness) - specifically *when* rota gaps are advertised and the process of decision making around *escalation of rates of pay* with requests for greater transparency.

Dr Caronia (Deputy CMO) attended the RDF on 14.4.26 to provide RDs with reassurances on this topic.

9.0 UHSussex Rota compliance 25/26

Table 9: Non-compliant rotas UHSussex 25/26 with proposed solution

	Rota Compliance	Proposed solution
Microbiology SpR WGH	No more than 3 on call duty periods in 7 days unless agreed at local level.	Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota of low intensity.
Microbiology SpR SRH	No more than 3 on call duty periods in 7 days unless agreed at local level.	Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota of low intensity.
St Wilfrid's Hospice SHO SRH	No more than 3 on call duty periods in 7 days unless agreed at local level.	Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota of low intensity
ENT (Otolaryngology) SpR RSCH	No more than 3 on call duty periods in 7 days unless agreed at local level.	Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota of low intensity.
Infectious Diseases	Friday On Call worked	The Friday can be moved alongside the

SpR RSCH (includes Microbiology on Calls)	separate to Saturday & Sunday Weekend Frequency greater than a 1 in 3. No more than 3 on call duty periods in 7 days unless agreed at local level.	Saturday & Sunday. Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota of low intensity.
Microbiology SpR RSCH	Friday On Call worked separate to Saturday & Sunday Weekend Frequency greater than a 1 in 3. No more than 3 on call duty periods in 7 days unless agreed at local level.	The Friday can be moved alongside the Saturday & Sunday. Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota of low intensity.
Cardio Thoracic Surgery SpR RSCH	No more than 3 on call duty periods in 7 days unless agreed at local level.	Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota of low intensity
Neurology SpR RSCH (includes Med Reg On calls)	Friday On Call worked separate to Saturday & Sunday Weekend Frequency greater than a 1 in 3. No more than 3 on call duty periods in 7 days unless agreed at local level.	The Friday can be moved alongside the Saturday & Sunday. Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota of low intensity.
Neurology SpR RSCH (No Med Reg Cover)	Friday On Call worked separate to Saturday & Sunday Weekend Frequency greater than a 1 in 3. No more than 3 on call duty periods in 7 days unless agreed at local level.	The Friday can be moved alongside the Saturday & Sunday. Local agreement can be sought to maintain the current rota. Note: this rota is a non-resident on call rota of low intensity.

10.0 Work schedule reviews

2 Work schedule (WS) reviews have been conducted in 25/26.

A Ophthalmology RSCH SpR rota WS review was triggered by a high volume of ERs and a discrepancy of weekend frequency (weekend frequency *below* that for which RDs pay banding was calculated, resulting in over payment). This remains in the process of agreement with involvement of Chief of service (Dr S Drage) and rota lead (Mr R Purbrick).

A work schedule review for GP / ENT ITP was requested and confirmed RDs work their contracted hours (4 X GP ENT ITPs - 42 hours). No further changes were made to the work schedule on this basis.

Key point:

WS reviews may be triggered by a request from the RD, ISCs or patterns of exception reporting, including high volumes of ERs or ERs >2hrs.

Non-resident on call rotas (undisclosed due to risk of data breach) have seen higher volumes of ER post reform. It is highly likely that more WS reviews will be triggered for these reasons, clinical leads should be responsive to the request for WS review and should lead on requisite adjustments based on the pattern of ERs and their knowledge of service demands and staffing resources available.

11.0 UHSussex Medical Workforce: Vacancy data and forward plan 25/26

Appendix 3 provides current data on rota gaps with forward plan.

Total number of rota gaps on all shifts over the last year	7% (109 / 1568)

12.0 UHS Sussex Agency and Locum Expenditure

This is detailed in Appendix 4.

13.0 Resident doctors fora (RDF)

The RDF remains a monthly meeting chaired by GOSW and well attended by LFG representatives, DME/ deputy DME, workforce and rota representatives, well-being nurse educational fellows, education leads, This meeting has changed to a face to face meeting, rotating around UHSx sites with an agenda focused and lead by issues raised by LFG representatives at the host site. The meeting is catered to improve attendance (with pizza funded at the request of RD representatives from GOSW fines).

A senior leadership figure at UHSussex is invited to attend the meeting to provide some background to their role, set out priorities and invite questions on how this relates to working lives of resident doctors (RDs). Recent attendees have included James Claydon (Head of workforce) and Simona Caronia (Deputy CMO for Appraisal and Revalidation and Professional Standards). Hot topics at RDF have included improving communication with RDs (via Teams channel), progress within the 10-point plan (with specific attention to hot food provision and on call parking) and GOSW fines disbursement.

'Too tired to drive policy'

A 'Too tired to drive' policy was approved in February 2026 at Trust management committee. This ensures RDs who declare themselves too fatigued to safely drive home after a long shift / night shift are provided with rest space / accommodation or the return cost of travel (taxi) home. This has been positively received and promoted throughout the Trust at RDF, with posters and e-flyers.

UHSx: 'Too tired to drive' process promotional poster displayed in WGH ED where RDs are at risk of fatigue

GOSW fines bids 25/26:

Bid	Amount	Cohort
Small freezer for storing food on call	£139	Worthing Anaesthetics department
Group Yoga Class at Hotpod Worthing - Wellbeing Event	£500	Worthing F2s
A boat trip along the Brighton coast, followed by a beach social event (no alcohol) Saturday, 7th June 2025	£1675	Worthing F2s
Group Clay Wellbeing Event	£450	Worthing F2s
A water sports social event hire kayaks and paddleboards for resident doctors to use after work one evening	£450	SRH Mess event
Art box SRH mess (paints, pencils, colouring, and craft supplies)	£300	SRH Mess
Cushions Fleece throws Hot water bottles Storage baskets Items to improve the atmosphere in both RSCH and PRH Resident Doctors' Mess to encourage more doctors	£281.56	RSCH Mess

to use the Mess and ensure a tidy, welcoming, relaxing inclusive space.		
RDF November 2025 GOSW / RDF winter safety campaign 230 x ice scrapers, 230 x LED bike lights 220 x High vis jackets 230 x Personal safety alarms	£5721.20	RDF representatives all sites

Winter safety campaign Dec 2025: This successful UHSx campaign has been replicated at other Trusts as an example of utilising GOSW fines to improve RD working lives and safety:

Appendix 1: (email sent to all UHSx Consultants / Clinical leadership teams 14.2.26)

IMMEDIATE SAFETY CONCERNS (EXCEPTION REPORTING REFORMS): UPDATE FOR CLINICIANS / CONSULTANTS AND CLINICAL LEADERSHIP TEAMS

An IMMEDIATE SAFETY CONCERN (ISC) represents a significant and immediate risk to patient or doctor safety.
There are changes to the Resident doctors contract (Doctors and dentists in training employed on the 2016 TCS (England)) which including reforms to the exception reporting process and immediate safety concerns. These changes come into effect from 4.2.2026.

What counts as an immediate safety concern (ISC)
Any situation where there is an immediate risk to the safety of patients or of the doctor making the report. Examples of immediate safety concerns include;

- Unsafe staffing levels - presenting a significant risk to patient safety
- Excessively long or unsafe working hours - presenting a risk to doctor safety
- Clinical situations where a resident doctor is asked to work beyond their competence or without appropriate supervision

How should a resident doctor report an ISC
This should be raised immediately (orally) by the resident doctor with the clinician responsible for the service in which the risk is thought to be present (typically, this would be the head of service or the consultant on-call). The Consultant on call or Head of service decides on next steps.

What are the clinician responsibilities when an ISC has been raised
The clinician must consider whether this constitutes an ISC and provide timely mitigation. This can include granting the doctor immediate time off from their agreed work schedule and/or (depending on the nature of the reported variation) ensure the immediate provision of support to the doctor.

What next steps are required for the clinician and reporting resident doctor

- If **an immediate safety concern is agreed** the clinician shall notify the Guardian of safe working hours (GOSW) within 24 hours of the concern. (GOSW Dr Charlotte Ford email charlotte.ford8@nhs.net / uhsussex.exceptionreportingenquiries@nhs.net). The GOSW then undertakes an immediate work schedule review, and will ensure appropriate (and where necessary, ongoing) remedial action is taken.

- Where the clinician receiving the report considers that there are **serious but not immediate concerns**, the clinician shall ask the doctor to submit an exception report via HealthRota and ask for the GOSW to request a work schedule review.

- Where the clinician receiving the report considers that the concern raised is **significant but not serious** or understands that there are persistent or regular similar concerns being raised, the clinician shall ask the doctor to raise an exception report via HealthRota. The GOSW will view the report as confidential and only share the minimum details in a proportionate manner to resolve the immediate safety concern.

How are concerns escalated
If an ISC cannot be resolved quickly at consultant/departmental level this can be escalated to the GOSW who oversees all exception reports. The GOSW identifies safety patterns and ensure safe working hours compliance. The GOSW may escalate further to the Director of Medical Education or Trust leadership when required.

What are the Trust / organisational responsibilities in relation to ISCs
Employers must act promptly when an exception report indicates safety issues. The organisation must ensure that working hours limits are safe, staffing levels are maintained and that work schedules remain safe and deliverable. After addressing the immediate issue, a work schedule review may be triggered by one or more exception reports. As part of a work schedule review employers (and supervisors) must identify whether changes to duties, staffing, training opportunities, or rota design are required to prevent recurrence.

Immediate safety concerns and confidentiality
Exception reports are confidential and only authorised persons (GOSW, DME Director(s) of medical education, Medical Workforce, Payroll) are allowed access to the data related to them. Any exception report made as part of an ISC will be treated as confidential in the same manner as any other exception report. Raising concerns to the clinician responsible for the service does create the situation where a supervising clinician is made aware of the circumstances of a doctor's exception report. Clinicians receiving such reports should be aware of the need for confidentiality, and only share the minimum details required to resolve the safety concern. While the raising of concerns by the doctor does not constitute an information breach, any further sharing of information related to the report of an ISC may constitute an information breach and be liable to a financial penalty (GOSW fine).

Important contact information
Exception reporting enquiries (Medical workforce): **uhsussex.exceptionreportingenquiries@nhs.net**
Guardian of safe working hours UHSussex: Dr Charlotte Ford **charlotte.ford8@nhs.net**

Appendix 2:

UHSussex Guardian fines

Breach A: Exceeding 13 hr shift length
Breach B: Unable to achieve the minimum 11 hours rest between resident shifts
Breach C: Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on call (NROC)
Breach D: Minimum daily Working Time Rest of 11 hours reduced to less than 8 hours
Breach E: Exceeding max 72hrs work in 7 days
Breach F: Exceeding max 7 working days consecutively
Breach G: Minimum 48hr rest after 4 consecutive long days not achieved
Breach H: Minimum 48hr rest after 7 consecutive days not achieved
Breach I: Max weekend frequency 1 in 3 exceeded
Breach J: Following on call shift, max 10hr shift exceeded
Breach K: Exceeding max 4 consecutive shifts longer than 10 hours
Breach L: 46 hours of rest required after any number of rostered night shifts

GoSW Fines 2025/26 pre reforms WGH

WTG

Breach	Number of fines applied	Value of fines applied

		Doctor receives	GoSW receives
A, B	33	£1,033.22	£1,722.25
A, B, E, G	1	£28.34	£47.24
A, B, L	1	£47.45	£79.07
B	1	£24.48	£40.83
E	2	£50.51	£84.20
Total	38	£1,184	£1,973.59

GoSW Fines 2025/26 post reform WGH

WTG

Breach	Number of fines applied	Value of fines applied	
		Doctor receives	GoSW receives
A, B	10	£297.90	£496.52
A, B, E	1	£32.64	£54.44
Total	11	£330.54	£550.96

GoSW Fines 2025/26 pre reforms SRH

SRH

Breach	Number of fines applied	Value of fines applied	
		Doctor receives	GoSW receives
A	1	£65.01	£108.33
A, B	11	£438.97	£731.72
B	2	£55.66	£92.79
E	4	£154.58	£257.67
F	5	£133.24	£222.06
H	1	£35.75	£59.60

GoSW Fines 2025/26 post reforms SRH

Breach	Number of fines applied	Value of fines applied

		Doctor receives	GoSW receives
A, B	5	£240.37	£400.63
Total	5	£240.37	£400.63

GoSW Fines 2025/26 pre reforms RSCH

RSCH

Breach	Number of fines applied	Value of fines applied	
		Doctor receives	GoSW receives
A	4	£191.35	£318.96
A, B	60	£2,230.30	£3,718.13
B	6	£195.82	£326.44
E	1	£23.83	£39.73
G, K	1	£41.39	£68.96
I	1	£56.69	£94.49
J	1	£94.90	£158.14
Total	74	£2,834.27	£4,724.83

GoSW Fines 2025/26 post reforms RSCH

RSCH

Breach	Number of fines applied	Value of fines applied	
		Doctor receives	GoSW receives
A	1	£20.08	£33.48
A, B	18	£928.69	£1,548.17
B	3	£90.61	£151.06
C	3	£382.59	£637.61
L	1	£94.90	£158.14
Total	26	£1,516.87	£2,528.46

GoSW Fines 2025/26 pre reforms PRH

PRH

Breach	Number of fines applied	Value of fines applied	
		Doctor receives	GoSW receives
A, B	5	£287.05	£478.35
E	1	£23.83	£39.73
Total	6	£310.88	£518.08

GoSW Fines 2025/26 post reforms PRH

Breach	Number of fines applied	Value of fines applied	
		Doctor receives	GoSW receives
A, B	3	£94.42	£157.38
Total	3	£94.42	£157.38

Appendix 3: UHSussex Medical Workforce: Vacancy data and forward plan (accurate Q4 25/26)

WGH Q4 25/26

Site	Department	Gaps for Q4 Jan - Mar)	WTE	Duration	Challenge and forward plan for this period
WTG	Emergency Medicine	1 x F2	1	4 months	Deanery vacant post. Filled from April 2026
WTG	Gastroenterology	1 x ST3+	1	12 months	Deanery vacant post. Filled from March 2026
WTG	General Medicine	1 x Trust Dr (CT1)	1	4 months	Filled from April 2026
WTG	Elderly Medicine	1 x Trust Dr (CT1)	1	4 months	Filled from April 2026
WTG	Cardiology	1 x Trust Dr (CT1)	1	4 months	Filled from April 2026
WTG	Paediatrics	1 x ST3+	1	6 months	Deanery vacant post. Ongoing recruitment
WTG	Anaesthetics	1 x ST3+	1	6 months	Deanery vacant post
WTG	Anaesthetics	1 x ST1	1	6 months	Deanery vacant post
WTG	Ophthalmology	1 x Trust Dr (CT1)	1	6 months	Ongoing recruitment
WTG	Trauma & Orthopaedics	1x Trust Dr (CT1)	1	6 months	Ongoing recruitment

SRH Q4 25/26

Site	Department	Gaps for Q4 Jan - Mar)	WTE	Duration	Challenge and forward plan for this period
SRH	Acute Medicine	1 x CT	1	6 months	Deanery vacant post
SRH	Acute Medicine	1 x Trust Dr (CT1)	1	6 months	Resignation. Ongoing recruitment
SRH	Stroke Medicine	1 x F2	1	4 months	Deanery vacant post. Filled from April 2026
SRH	Elderly Medicine	1 x ST4+	1	8 months	Deanery vacant post
SRH	Elderly Medicine	1 x CT1	1	3 months	Displaced due to ITU placement
SRH	Elderly Medicine	3x Trust Dr (CT1)	3	4 months	Ongoing recruitment

SRH	General Medicine	1 x Trust Dr (CT1)	1	2 months	Ongoing recruitment
SRH	Gastroenterology	1 x Trust Dr (CT1)	1	2 months	Ongoing recruitment
SRH	Microbiology	1 x ST3+	1	6 months	Deanery vacant post
SRH	Histopathology	1 x ST1	1	12 months	Deanery vacant post
SRH	Palliative Medicine	1 x GPST	1	4 months	Deanery vacant post
SRH	Palliative Medicine	1 x F2	1	8 months	Deanery vacant post
SRH	Anaesthetics	1 x Trust Dr (CT1)	1	6 months	Ongoing recruitment
SRH	Orthodontics	1x ST3+	1	12 months	Deanery vacant post
SRH	Trauma & Orthopaedics	1 x ST3+	1	12 months	Deanery vacant post

RSCH Q4 25/26

Site	Department	Gaps for Q4 Jan - Mar)	WTE	Duration	Challenge and forward plan for this period
RSCH	Emergency Medicine	1 x ST4+	1	6 months	Maternity leave. Filled from March 2026
RSCH	Emergency Medicine	3 x CT3	3	12 months	Deanery vacant post. Ongoing recruitment
RSCH	Emergency Medicine	3 x GPST	3	12 months	Deanery vacant post. Filled from April 2026
RSCH	Emergency Medicine	1 x F2	1	6 months	Deanery vacant post
RSCH	Emergency Medicine	1 x Clinical Fellow	1	6 months	HEMS doctor
RSCH	Cardiology	1 x Clinical Fellow	1	6 months	Ongoing recruitment
RSCH	Respiratory Medicine	1 x Clinical Fellow	1	6 months	Filled from April 2026
RSCH	Dermatology	1 x ST4+	1	12 months	Deanery vacant post
RSCH	Gastroenterology	1 x ST4+	1	6 months	Deanery vacant post. Filled from March 2026
RSCH	Gastroenterology	2 x Clinical Fellow	2	6 months	Ongoing recruitment

RSCH	Elderly Medicine	1 x GPST	1	4 months	Deanery vacant post. Filled from April 2026
RSCH	Elderly Medicine	2 x ST4+	2	6 months	Deanery vacant post. Filled from April 2026
RSCH	Intensive Care	4 x ST3+	4	6 months	Deanery vacant post
RSCH	Intensive Care	2 x Clinical Fellow	2	6 months	Ongoing recruitment
RSCH	Anaesthetics	13 x Clinical Fellow	13	6 months	Ongoing recruitment
RSCH	General Surgery	1 x F1	1	4 months	Deanery vacant post. Filled from April 2026
RSCH	General Surgery	4 x Clinical Fellow	4	6 months	Ongoing recruitment. 2 x WTE filled from April 2026
RSCH	Trauma and Orthopaedics	9 x Clinical Fellow	9	12 months	Ongoing recruitment
RSCH	Ophthalmology	1 x ST3+	1	6 months	Deanery vacant post
RSCH	Ophthalmology	4 x Clinical Fellow	4	12 months	Ongoing recruitment
RSCH	Vascular Surgery	3 x Clinical Fellow	3	6 months	Ongoing recruitment
RSCH	Renal Medicine	3x Clinical Fellow	3	12 months	Ongoing recruitment
RSCH	Obstetrics and Gynaecology	1 x Clinical Fellow	1	6 months	Ongoing recruitment
RACH	Paediatrics	1 x ST4+	1	6 months	Maternity leave. Filled from April 2026
RACH	Neonatology	1 x ST4+	1	6 months	Deanery vacant post. Filled from March 2026
RACH	Neonatology	1 x ST1	1	6 months	Deanery vacant post. Ongoing recruitment
RSCH	Haematology	1 x ST3+	1	12 months	Maternity leave
RSCH	Histopathology	1 x ST4	1	6 months	Deanery vacant post. Filled from April 2026
RSCH	Histopathology	1 x ST1	1	6 months	Deanery vacant post
RSCH	Oncology	2 x ST4	2	6 months	Deanery vacant post. 1 WTE filled from March 2026
RSCH	Nuclear Medicine	2 x Clinical Fellow	2	12 months	Resignation. Ongoing recruitment
RSCH	Nuclear Medicine	1x ST3+	1	12 months	Deanery vacant post

PRH Q4 25/26

Site	Department	Gaps for Q4 Jan - Mar)	WTE	Duration	Challenge and forward plan for this period
PRH	Renal Medicine	1 x ST3+	1	6 months	Deanery vacant post. Filled from April 2026
PRH	Urology	2 x Clinical Fellow	2	6 months	Ongoing recrutment
PRH	Trauma and Orthopaedics	3 x F2	3	4 months	Deanery vacant post. Filled from April 2026
PRH	Trauma and Orthopaedics	2 x Clinical Fellow	2	8 months	Ongoing recrutment

Appendix 4: Summary of Medical and Dental Agency / Locum spend 2025 - 2026

	2025-26 Medical & Dental Staff Spend (Figures in £000s)													Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Ave	Average	Average	Average	Average
Medical Locum Spend	£3,558	£3,283	£3,507	£4,139	£3,878	£3,388	£2,972	£2,540	£3,975	£4,127	£3,313	£4,022	£3,471	£4,171	£3,999	£3,225	£3,730
Medical Agency Spend	£532	£639	£830	£698	£756	£593	£583	£647	£538	£466	£475	£425	£646	£708	£619	£514	£891
Total Medical & Dental Spend	**£29,459**	**£28,790**	**£29,503**	**£34,790**	**£31,053**	**£31,374**	**£30,630**	**£30,579**	**£31,088**	**£31,931**	**£30,764**	**£31,547**	**£30,807**	£31,264	**£31,544**	**£32,029**	**£29,571**
Agency/Locum Spend as a % of Total Medical Pay	13.88%	13.62%	14.70%	13.90%	14.92%	12.69%	11.60%	10.42%	14.52%	14.39%	12.31%	14.10%	13.36%	13.92%	13.14%	11.94%	15.62%

Medical & Dental Agency Spend by Division

2024-25 Comparison Data

	2025-26 Medical & Dental Staff Spend (Figures in £000s)	Quarter 1	Quarter 2	Quarter 3	Quarter 4

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Ave	Average	Average	Average	Average
Cancer Division	£135	£163	£242	£154	£215	£174	£103	£177	£183	£150	£127	£112	£172	£108	£153	£171	£213
Surgery (RSCH & PRH) Division	£26	£54	£17	£242	£97	£106	£144	£68	£55	£53	£45	£57	£90	£151	£158	£86	£121
Surgery (WOR & SRH) Division	£13	£4	£19	£60	£75	£23	£81	£79	£64	£71	£47	£65	£47	£29	£83	£5	£50
Women & Children Division	-£2	-£5	£0	£34	-£24	£5	£0	£0	£0	£0	-£0	£0	£1	£65	£56	£20	£28
CSS Division	£109	£88	£165	-£75	£94	£58	£32	£9	£25	£16	-£6	-£10	£56	£93	£64	£54	£99
Medicine (RSCH & PRH) Division	£4	£10	£12	£13	£0	£0	£0	£0	£0	£0	£4	£0	£4	£2	£10	£11	£13
Medicine (WOR & SRH) Division	£109	£157	£173	£182	£129	£137	£111	£158	£91	£80	£145	£132	£138	£78	£88	£58	£179
Specialist Division	£124	£167	£199	£92	£171	£91	£111	£155	£120	£97	£114	£69	£137	£104	£181	£95	£175
Corporate	£13	£1	£3	-£5	£0	£0	£0	£0	£1	-£1	£0	£0	£1	£14	£9	£13	£12
TOTAL	**£532**	**£639**	**£830**	**£698**	**£756**	**£593**	**£583**	**£647**	**£538**	**£466**	**£475**	**£425**	£646	**£644**	**£802**	**£514**	**£891**

Medical & Dental Locum Spend by Division

2024-25 Comparison Data

	2025-26 Medical & Dental Staff Spend (Figures in £000s)													Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Ave	Average	Average	Average	Average
Cancer Division	£108	£52	£93	£171	£118	£107	£88	£74	£92	£114	£86	£202	£100	£77	£125	£123	£172
Surgery (RSCH & PRH)	£1,010	£792	£858	£1,051	£1,017	£713	£476	£693	£864	£1,138	£756	£1,058	£831	£802	£982	£894	£886

Division																	
Surgery (WOR & SRH) Division	£332	£394	£264	£468	£523	£538	£410	£408	£596	£622	£579	£230	£437	£486	£584	£381	£353
Women & Children Division	£431	£400	£518	£476	£340	£495	£395	£343	£292	£561	£469	£317	£410	£521	£471	£431	£479
CSS Division	£407	£485	£364	£381	£258	£426	£413	£198	£400	£372	£324	£497	£370	£351	£357	£362	£445
Medicine (RSCH & PRH) Division	£287	£303	£310	£294	£434	£135	£121	-£15	£477	£234	£197	£229	£261	£442	£336	£163	£264
Medicine (WOR & SRH) Division	£697	£706	£804	£944	£827	£739	£725	£640	£890	£847	£637	£943	£775	£1,147	£806	£669	£793
Specialist Division	£283	£146	£292	£344	£354	£226	£352	£195	£339	£254	£257	£541	£281	£337	£333	£192	£330
Corporate	£3	£4	£5	£9	£7	£8	-£7	£4	£24	-£14	£9	£4	£6	£8	£5	£9	£8
TOTAL	**£3,558**	**£3,283**	**£3,507**	**£4,139**	**£3,878**	**£3,388**	**£2,972**	**£2,540**	**£3,975**	**£4,127**	**£3,313**	**£4,022**	**£3,471**	**£4,171**	**£3,999**	**£3,225**	**£3,730**

Agency & Locum Spend as a % of Total Medical Pay

2024-25 Comparison Data

	2025-26 Medical & Dental Staff Spend (Figures in £000s)													Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Ave	Average	Average	Average	Average
Cancer Division	17.0%	16.2%	21.8%	19.0%	21.4%	18.2%	12.7%	16.5%	17.9%	16.8%	13.9%	19.3%	17.9%	16.7%	21.7%	18.8%	26.2%
Surgery (RSCH & PRH) Division	17.2%	14.5%	15.2%	18.3%	18.2%	13.9%	10.7%	12.7%	14.8%	18.6%	13.5%	17.6%	15.1%	18.0%	20.7%	15.1%	17.0%
Surgery (WOR & SRH) Division	9.5%	11.5%	8.0%	12.4%	15.7%	14.0%	12.7%	12.4%	16.5%	16.7%	15.6%	8.0%	12.5%	15.0%	18.6%	9.9%	11.5%
Women & Children	11.2%	10.4%	12.9%	11.2%	7.9%	11.8%	9.8%	8.4%	7.5%	12.7%	11.2%	7.8%	10.1%	16.6%	14.8%	10.6%	12.8%

Division																	
CSS Division	22.0%	24.0%	22.6%	12.3%	14.8%	19.6%	18.6%	9.0%	17.6%	16.0%	13.7%	20.5%	17.8%	21.0%	20.0%	16.6%	22.7%
Medicine (RSCH & PRH) Division	8.8%	9.7%	9.7%	8.0%	12.3%	4.1%	3.7%	-0.5%	13.9%	7.0%	6.0%	6.8%	7.7%	14.9%	12.1%	5.3%	8.5%
Medicine (WOR & SRH) Division	21.6%	22.2%	24.8%	23.4%	23.2%	20.3%	19.4%	19.3%	23.7%	21.8%	18.7%	23.8%	22.0%	34.6%	26.7%	18.1%	24.5%
Specialist Division	14.3%	12.0%	17.2%	12.9%	17.3%	10.7%	15.1%	12.0%	14.8%	11.8%	12.3%	19.1%	14.0%	17.0%	18.8%	10.7%	17.8%
Corporate	19.1%	22.4%	27.3%	20.8%	23.1%	18.7%	19.6%	20.8%	19.4%	15.9%	17.7%	15.2%	21.2%	1.1%	0.7%	0.9%	0.9%
Agency/Locum Spend as a % of Total Medical Pay	**13.9%**	**13.6%**	**14.7%**	**13.9%**	**14.9%**	**12.7%**	**11.6%**	**10.4%**	**14.5%**	**14.4%**	**12.3%**	**14.1%**	**13.4%**	**18.1%**	**17.8%**	**11.9%**	**15.6%**

SRH Resident doctors using Bell Tents funded by GOSW fines fund on recent group trip (Easter 2026)

University Hospitals Sussex
NHS Foundation Trust

Workforce Equality Standards Report 2026

If you would like this report in another format (e.g. large print) please contact uhsussex.inclusion@nhs.net

Contents

Workforce Equality Standards Report 2026 Executive Summary 2

Workforce Race Equality Standard (WRES) 2026 5

Workforce Disability Equality Standard (WDES) 2026 13

Gender Pay Gap (GPG) 2026 21

Ethnicity Pay Gap (EPG) 2026 33

Disability Pay Gap (DPG) 2026 40

Appendix 46

NHS
University Hospitals Sussex
NHS Foundation Trust

Workforce Equality Standards Report 2026 Executive Summary

uhsussex.inclusion@nhs.net

www.uhsussex.nhs.uk/equality

Background

This **Workforce Equality Standards Report** brings together the organisation's statutory workforce equality and pay reporting, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap and supporting pay gap analyses. It is – by design – an analytical report. The **Annual Equality Report**, to be published later in the year, complements this, providing further insight and a more detailed programme of management action.

- **The nine WRES indicators** are derived from Electronic Staff Record (ESR) workforce data (indicators 1, 2, 3, 4 and 9) and NHS Staff Survey responses (indicators 5, 6, 7 and 8), alongside data from Trac recruitment systems (indicator 2), employee relations disciplinary records (indicator 3) and IRIS training platform (indicator 4) data.
- **The ten WDES indicators** are derived from ESR workforce data (indicators 1, 2, 3 and 10) and NHS Staff Survey responses (indicators 4, 5, 6, 7, 8 and 9), alongside data from Trac recruitment systems (indicator 2) and employee relations capability records (indicator 3).
- **Pay gap reporting** is derived from ESR hourly pay and bonus data, as of 31 March 2026.

This report sets out the Trust's statutory workforce equality standards and pay gap reporting, focusing on **nationally mandated indicators and metrics**. It does not include wider equality measures or additional analysis beyond these requirements. This report is necessary to meet the NHS England **May 2026 upload deadline** for the Trust's WRES / WDES data. A more comprehensive overview is provided within the Trust's Annual Equality Report, which will go to public board later in the year, and once published should be read alongside this report.

Overall position

There is evidence of progress in representation, sharing and perceived equality of opportunity, but structural inequalities persist across race, disability and gender, particularly in senior roles, formal processes (disciplinary and capability), experiences of discrimination and pay outcomes, as they do amongst many NHS employers.

Race (WRES)

- **Four of nine indicators improved**, including appointment from shortlisting and perceptions of career opportunity
- **Racial disparities remain** in disciplinary outcomes, senior progression, discrimination and Board representation
- **The ethnicity pay gap is close to parity**, but the bonus pay gap remains significant and masks variation between groups.

Disability (WDES)

- **Three of ten indicators improved**, with increased sharing of disability information, workforce representation, reasonable adjustments and perceptions of opportunity
- **Disabled staff continue to experience inequity** in capability processes, senior clinical progression and experiences of bullying or harassment
- **The disability pay gap remains material**, with disabled staff earning less on average than non-disabled staff.

Gender Pay Gap (GPG)

- **The average gender pay gap remains considerable**, driven by female under-representation in senior and consultant roles
- **The bonus pay gap remains substantial**, reflecting historic and consultant-level award scheme national eligibility, though newer schemes show early signs of improved balance.

Focus for 2026-27

Delivery of the Workforce Inclusion Programme (WIP) will prioritise inclusive leadership accountability, fair recruitment and progression, safer and more equitable formal processes, improved data quality, and consistent access to reasonable adjustments, aligned to the NHS National EDI Improvement Plan.

NHS
University Hospitals Sussex
NHS Foundation Trust

Workforce Race Equality Standard (WRES) 2026

uhsussex.inclusion@nhs.net

www.uhsussex.nhs.uk/equality

Introduction

The Workforce Race Equality Standard (WRES) provides a nationally mandated framework for assessing the experiences of staff from different ethnic backgrounds within NHS organisations. It brings together workforce, recruitment, employee relations and staff survey data to identify disparities in experience, opportunity and outcomes. At UHSussex, the WRES supports a systematic approach to understanding racial inequality, monitoring progress over time, and informing targeted action through the Workforce Inclusion Programme and organisational strategy.

Use of Data and Information

This report draws on workforce data required to meet national reporting standards that NHS organisations are mandated to complete annually, i.e. the Workforce Race Equality Standard (WRES). These standards set expectations regarding the scope, format, terminology and minimum reporting requirements, to support consistency and comparability across organisations. This report has been written as a standalone report, in line with national guidance.

Staff can update their personal information, including ethnicity, on their staff record via the Employee Self-Service online portal at any time. All data used for reporting is anonymised and handled in line with information governance and data protection requirements. Anonymised data is analysed to identify and respond to issues affecting groups of staff who share protected characteristics.

Terminology

Throughout this report, we use the term *global majority* as a narrative descriptor to refer to staff from ethnic groups other than White, recognising that these groups represent the majority of the global population, while also acknowledging that they may be under-represented or experience inequity within the Sussex or wider UK context. The term is widely used across EDI research, public sector organisations and is starting to be adopted in various parts of the NHS. Use of this term does not replace standard NHS ethnicity categories or alter how WRES indicators are calculated, and in this context refers to the same staff as the term black and minority ethnic.

We use the term ***"distance from equity"*** as a descriptive, non-technical phrase commonly used in equality analysis to explain the size of differences in outcomes or experiences between groups. For likelihood questions, this refers to how far the number is from zero. For other indicators, it refers to the percentage difference between global majority and white experiences. For example, if 20% of White staff face bullying and harassment then it would be equitable if 20% of global majority staff also face bullying and harassment. Here, the greater the percentage difference, the greater the inequity.

Data collection

The WRES is an annual benchmarking tool mandated by NHS England. Trusts are only required to submit data for indicators 1-4 and indicator 9. The data for indicators 5-8 comes from our staff survey results. Bank-only workers are excluded from this data submission. The WRES data must be submitted on the Data Collections Framework (DCF) system by 31 May 2026.

Summary

Overview

The report outlines the data from the **National Workforce Race Equality Standard (WRES)**. The WRES is an annual benchmarking tool introduced by NHS England to assess the progress made towards achieving race and disability equality within NHS organisations. It assesses how the trust has improved against 9 indicators designed to close the gap between the experiences of White and global majority colleagues. These include:

1. Clinical and non-clinical diversity and representation across all bands and pay grades (from ESR workforce data)
2. Successful job appointment and shortlisting (from ESR workforce and Trac recruitment systems data)
3. Entering formal disciplinary processes (from ESR workforce and employee relations disciplinary records data)
4. Access to CPD and non-mandatory training (from ESR workforce and IRIS training platform data)
5. Incidents of bullying, harassment or abuse from public (from NHS Staff Survey data)
6. Incidents of bullying, harassment or abuse from staff (from NHS Staff Survey data)
7. Perceptions around equal opportunities for progression or promotion (from NHS Staff Survey data)
8. Incidents of bullying, harassment or abuse from managers, team leads or other colleagues (from NHS Staff Survey data)
9. Proportional representation of the overall workforce at board level (from ESR workforce data).

Main Findings

Four of the nine WRES Indicators improved in 2026 although there is **still disparity in key areas** such as disciplinary cases, appointments, career progression, experiences of discrimination and board representation. We do not have racial equity in 7 of our 9 WRES indicators. We have seen improvements in:

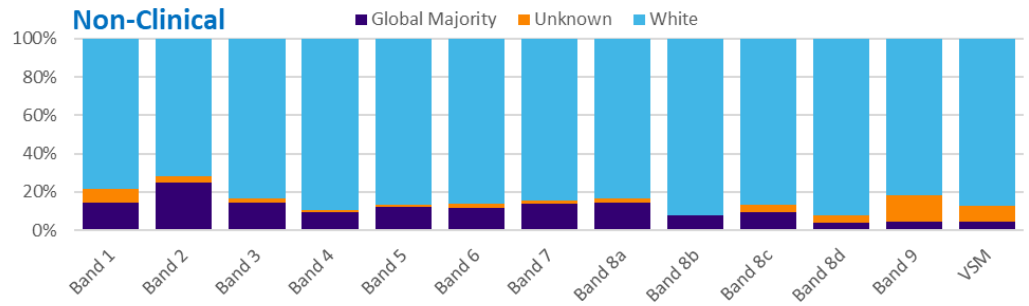
- the percentage of global majority staff in our workforce, especially in entry-level roles.
- the likelihood of global majority staff being appointed from shortlisting.
- the percentage of global majority staff believing in equality of opportunity for career progression or promotion.

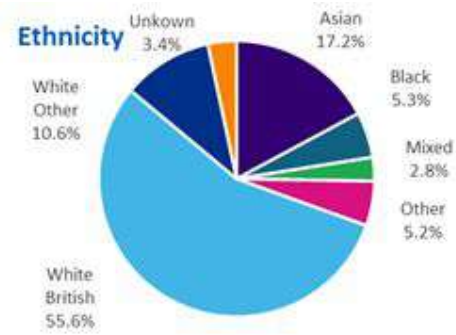
Workforce Profile

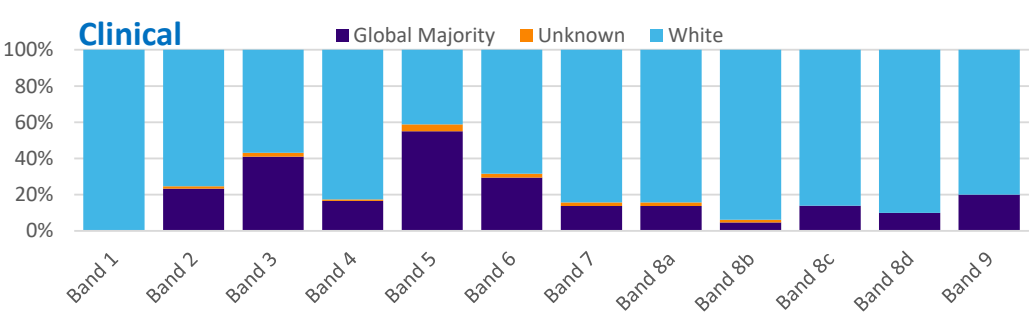
This section outlines the Trust's workforce profile by ethnicity, including overall representation and variation across pay bands and staff groups. The charts below show how staff are distributed across non-clinical, clinical, and medical and dental roles. The proportion of staff who chose not to share their ethnicity was 3.4%, representing a **small improvement** compared with 3.6% in the previous year (2025) and 4.4% in 2024.

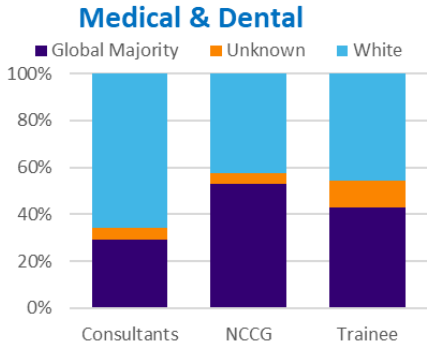
As of 31 March 2026, the Trust's permanent workforce comprised 30.6% global majority staff (5,796 individuals). This proportion is higher than the 19% global majority population across England and 9% across East Sussex, West Sussex, and Brighton & Hove combined (Census 2021, ONS). This represents an **increase of nearly three percentage points** compared with the previous reporting year (2025: 27.7%) and five percentage points compared to 2024 (25.3%).

As the graphs below illustrate, the ethnic workforce profiles are highly structured by staff group and pay band. Staff from global majority backgrounds have higher representation in middle pay bands within clinical roles, with a reduction in representation at senior pay bands in both non-clinical and clinical staff groups, and at consultant level within medical and dental roles. The accompanying pie chart provides the overall Trust ethnicity context for these patterns.









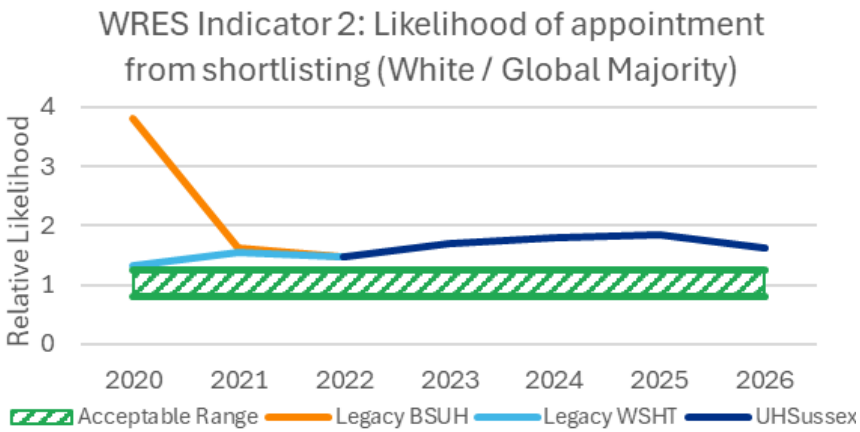
Indicators derived from ESR Data

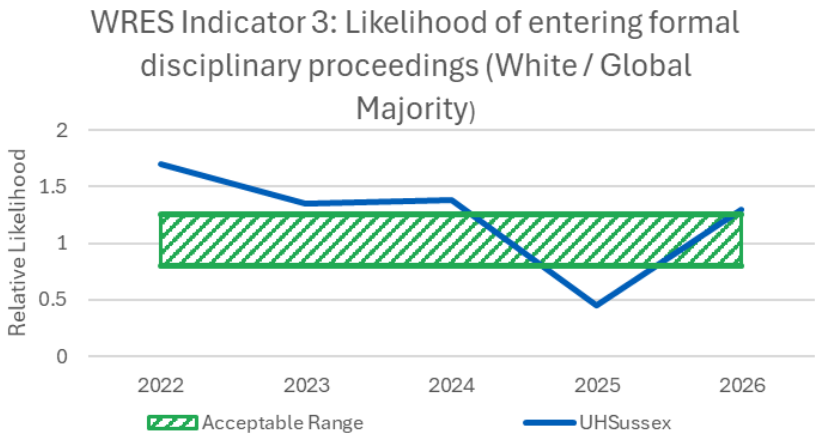
The table below brings together results for WRES indicators derived from our secure and confidential electronic staff record system (ESR) data, highlighting changes from 2025 and the relative distance from equity. The data shows progress in representation and recruitment, including increased global majority workforce presence and improved appointment outcomes. However, inequalities remain in disciplinary processes, training access and senior representation, particularly at Board level.

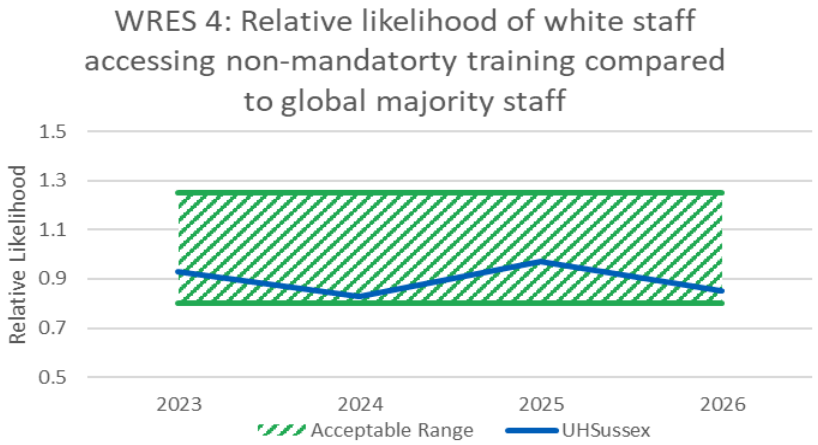
Improvement/Better
Decline/Worse

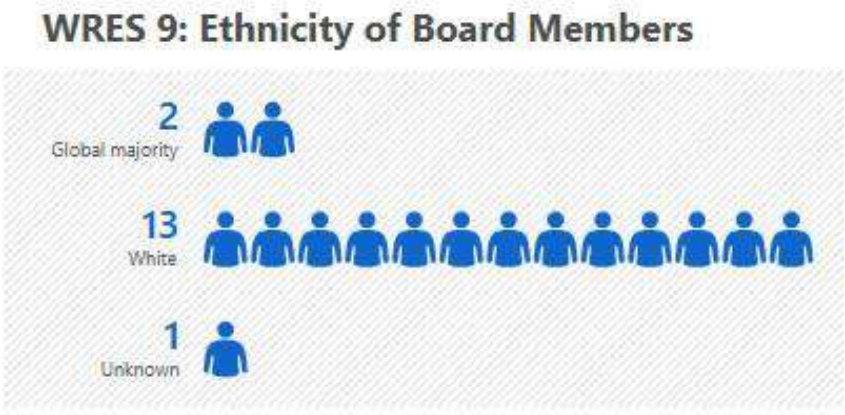
Indicator number and description	Results	Change from 2025	Distance from equity
Indicator 1: Global majority representation in the workforce by pay band			
Overall	**30.6%**	**2.9%-point increase**	
Non-Clinical	**15.8%**	**1.2%-point increase**	
Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7)	1.41	0.10 increase	0.41
Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM)	1.26	0.36 decrease	0.26
Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM)	1.77	0.34 decrease	0.77
Clinical	**35.0%**	**3.6%-point increase**	
Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7)	2.73	0.12 increase	1.73
Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM)	2.30	0.39 increase	1.30
Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM)	6.28	1.29 increase	5.28
Medical & Dental	**38.2%**	**2.1%-point increase**	
Disparity ratio - Trainee to NCCG	0.76	0.03 decrease	-0.24
Disparity ratio - NCCG to Consultant	2.80	0.19 increase	1.80
Disparity ratio - Trainee to Consultant	2.12	0.06 increase	1.12
Indicator 2: Likelihood of appointment from shortlisting			
Likelihood ratio White / global majority	**1.63**	0.21 decrease	0.63
Indicator 3: Likelihood of entering formal disciplinary proceedings			
Likelihood ratio White / global majority	**1.30**	0.87 increase	0.30
Indicator 4: Likelihood of undertaking non-mandatory training			
Likelihood ratio White / global majority	**0.85**	0.12 decrease	-0.15
Indicator 9: Difference between global majority representation on the board and in the workforce			
Overall global majority representation on the Board	**12.5%**	**3.5%-point decrease**	**-37.5%-points**
Executive Director	0%	unchanged	-50%-points
Voting Director	12.5%	5.1%-point decrease	-37.5%-points

The charts below present WRES Indicators 2, 3, 4 and 9, showing trends in relative likelihood ratios. Taken together, these data show mixed progress across key WRES indicators, with improvements over time in appointment from shortlisting and access to non-mandatory training, alongside continued disparity in disciplinary outcomes and under-representation of staff from global majority backgrounds at Board level. Additional analysis relating to WRES Indicator 4 is included in the Appendix WRES 4: Non-mandatory training.









Indicators derived from NHS Staff Survey Data

The data in the table below show changes across WRES indicators derived from annual NHS National Staff Survey data since 2025 and the relative distance from equity between staff from global majority backgrounds and White staff. The data indicate that two of the four indicators improved in 2026, while disparities remain across three indicators, including experiences of harassment, bullying or abuse and discrimination.

Improvement/Better
Decline/Worse

Indicator number and description	Results	Change from 2024	Distance from equity	National Average
Indicator 5: Harassment, bullying or abuse from patients, relatives or the public in last 12 months				
Global majority	**34.4%**	1.7%-point increase	6.8%-points	29.0%
White	**27.6%**	0.5%-point increase		22.9%
Indicator 6: Harassment, bullying or abuse from staff in last 12 months				
Global majority	**21.4%**	0.7%-point increase	-1.5%-points	24.1%
White	**23.0%**	1.6%-point decrease		20.5%
Indicator 7: Believing in equality of opportunity for career progression or promotion				
Global majority	**57.9%**	6.5%-point increase	5.1%-points	49.1%
White	**52.7%**	1.0%-point decrease		55.5%
Indicator 8: Discrimination from a manager/team leader or other colleagues in last 12 months				
Global majority	**10.9%**	0.3%-point decrease	3.7%-point	14.7%
White	**7.2%**	3.2%-point decrease		6.4%

Graphs and narrative relating to the above WRES indicators is included in the Appendix WRES 5-8: Staff experience indicators.

Delivery actions linked to WRES and the Ethnicity Pay Gaps from the Workforce Inclusion Programme (WIP)

Indicator	Linked WIP action
WRES 1 WRES 9	**Board and Top 70 leaders' inclusion objectives** - Embed equity objectives into Board and Top-70 leader goals, including accountability for workforce equality standard and pay gap outcomes and inclusive leadership behaviours.
WRES 1 WRES 2	**Enhanced panel briefings for NMAHP 8a+ roles** - Deliver enhanced panel inclusion briefings and Post-Interview Development Needs feedback for 8a+ roles (including ESM/VSM) to improve fairness, transparency and progression.
WRES 1 WRES 2	**Accountability in Senior Recruitment (Imperial Explain or Comply Model)** build the case for investment to require recruiting managers to either follow agreed inclusive recruitment standards or clearly justify, with evidence, why they are departing from them to ensure accountability and reduce bias within senior recruitment (8a+ / ESM / VSM).
WRES 1	**Build career development plans into the appraisal system** - Integrate structured career development planning into appraisal conversations to support equitable progression for global majority staff.
WRES 1	Increased awareness and uptake of the **Career Navigation Support Service (CNSS)**
WRES 1 WRES 7	**Career Sponsorship Scheme** - Continue delivery and evaluation of the Career Sponsorship Scheme to address disparities in career progression and promotion at senior levels.
WRES 1 WRES 7	**Reverse Mentoring Scheme funding case** - Develop a funding case to sustain and scale the Reverse Mentoring Scheme, strengthening senior leader understanding of lived experience and race equity.
WRES 1 WRES 5	**Top 1,000 Inclusive Leadership training offer** – Develop a plan to deliver inclusive leadership training to the top 1,000 leaders, with a focus on race equity, psychological safety and accountability for WRES outcomes.
WRES 5	**Hate Incident and VPR hotspot intervention** - Implement targeted interventions in identified hate incident and Violence Prevention & Reduction (VPR) hotspots to improve safety and reporting confidence. This includes reviewing discrimination coding and reporting, post-incident support and introduce inclusive investigation training.

NHS
University Hospitals Sussex
NHS Foundation Trust

Workforce Disability Equality Standard (WDES) 2026

uhsussex.inclusion@nhs.net

www.uhsussex.nhs.uk/equality

Introduction

The **Workforce Disability Equality Standard (WDES)** provides a nationally mandated framework for assessing the experiences of disabled staff and those with long-term conditions within NHS organisations. It brings together workforce, recruitment, employee relations and staff survey data to identify disparities in experience, opportunity and outcomes. At UHSussex, the WDES supports a systematic approach to understanding inequality, monitoring progress over time, and informing targeted action through the Workforce Inclusion Programme and our organisational strategy.

Use of Data and Information

This report draws on workforce data required to meet national workforce equality reporting standards that NHS organisations are mandated to complete annually, i.e. the Workforce Disability Equality Standard (WDES). These standards set expectations regarding the scope, format, terminology and minimum reporting requirements, to support consistency and comparability across organisations. The WDES section has been written as standalone report, in line with national guidance.

Staff can update their personal information on their staff record via employee self-service at any time. All data used for reporting is anonymised and handled in line with information governance and data protection requirements. Anonymised data is analysed to identify and respond to issues affecting groups of staff who share protected characteristics.

The WDES utilises data from the Electronic Staff Record (ESR) and the national staff survey. The rate in 2026 that our staff shared their disability was 17.2%-points higher in the staff survey than in ESR. The former is representative for all other characteristics so we can assume that the staff survey rate for disability is more likely to be accurate than the ESR rate for disability.

Terminology

Disability and long-lasting health conditions or illnesses may be used interchangeably in this report. This due to a change in language used nationally within the National Staff Survey which compiles qualitative data on the experiences of staff with long-term conditions (LTC) that may meet the legal criteria to be considered a disability.

Throughout this report, we will also mention **'Distance from Equity'**. For likelihood questions, this refers to how far the number is from zero. For other metrics, it refers to the percentage difference between disabled and non-disabled experiences. For example, if 20% of Disabled staff face bullying and harassment then it would be equitable if 20% of non-disabled staff also face bullying and harassment. Here, the greater the percentage difference, the greater the inequity.

Data collection

The WDES is an annual benchmarking tool mandated by NHS England. Bank-only workers are excluded from this data submission. The WDES data must be submitted on the Data Collections Framework (DCF) system by 31 May 2026.

Summary

Overview

The report outlines the data from the **National Workforce Disability Equality Standard (WDES)**. The WDES is an annual benchmarking tool introduced by NHS England to assess the progress made towards achieving disability equality within NHS organisations. It assesses how the trust has improved against 10 metrics designed to close the gap between the experiences of staff with declared disabilities and other colleagues. These include:

1. Clinical and non-clinical diversity and representation across all bands and pay grades (from ESR workforce data).
2. Successful job appointment and shortlisting (from ESR workforce and Trac recruitment systems data).
3. Numbers entering formal capability processes (from ESR workforce and employee relations disciplinary records data).
4. Incidents of bullying, harassment or abuse from
    a. Patients, relatives or the public (NHS Staff Survey responses data),
    b. Managers (NHS Staff Survey responses data),
    c. other colleagues (NHS Staff Survey responses data)
    d. Incidents of bullying, harassment or abuse reported by victims or colleagues compared to those without a disability (NHS Staff Survey responses data).Perceptions around equal opportunities for progression or promotion (from NHS Staff Survey responses data).
6. Pressure to work when not feeling well enough to do so (from NHS Staff Survey responses data).
7. Feeling valued by the organisation (from NHS Staff Survey responses data).
8. Receiving adequate adjustments to carry out work (from NHS Staff Survey responses data).
9. Engagement:
    a. compared to non-disabled staff and the trust average score (from NHS Staff Survey responses data) and
    b. ability to feel heard and listened to (from Disabled Staff Network).
10. Proportional representation of the overall workforce at board level (from ESR workforce data).

Main Findings

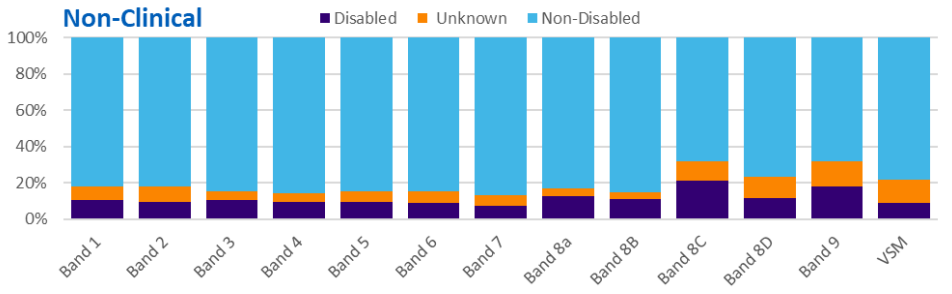
Three of the 13 WDES Indicators improved in 2026. There is still disparity in capability cases, appointments, career progression in senior clinical roles, experiences of harassment, bullying or abuse, and board representation. We have seen improvements in:

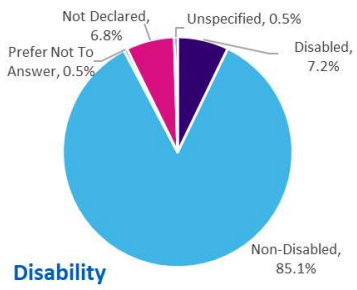
- the percentage of disabled staff in our workforce, and the percentage of staff stating their disability status.
- the likelihood of disabled staff being progressing into senior non-clinical and mid-level clinical roles.
- the percentage of disabled staff believing in equality of opportunity for career progression or promotion
- the percentage of disabled staff receiving reasonable adjustments.

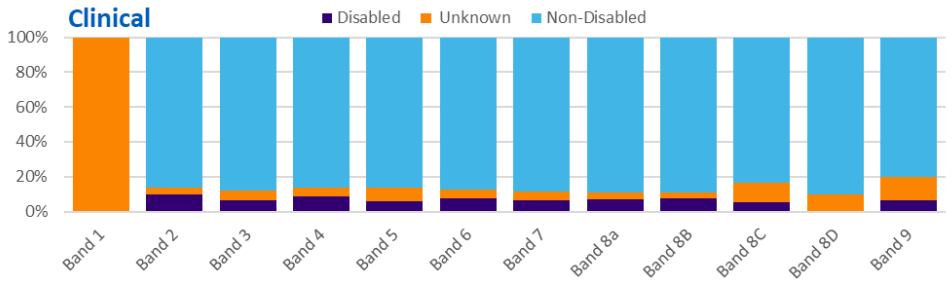
Workforce Profile

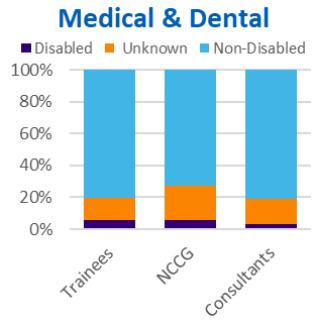
As of 31 March 2026, 7.2% (1,367) of the Trust's permanent workforce identified as disabled. This compares with 18% of the population across East Sussex, West Sussex, and Brighton & Hove combined (Census 2021, ONS) and represents a **marginal increase** compared with the previous reporting years (6.7% in 2025 and 5.8% in 2024). Data from the 2025 NHS Staff Survey indicates that 24.4% of Trust respondents reported having a disability or long-term health condition.

The graphs below show differing patterns of disability representation across staff groups: higher representation of disabled staff at senior pay bands within non-clinical roles, lower representation at higher pay bands within clinical roles and at consultant level in medical and dental roles, and a notably higher proportion of unknown disability status across senior pay bands and medical and dental grades. The accompanying pie chart provides the overall Trust disability context for these patterns. The proportion of staff who chose not to share their disability status was 7.7%, **improved** from 8.5% in 2025 and 12.3% in 2024.









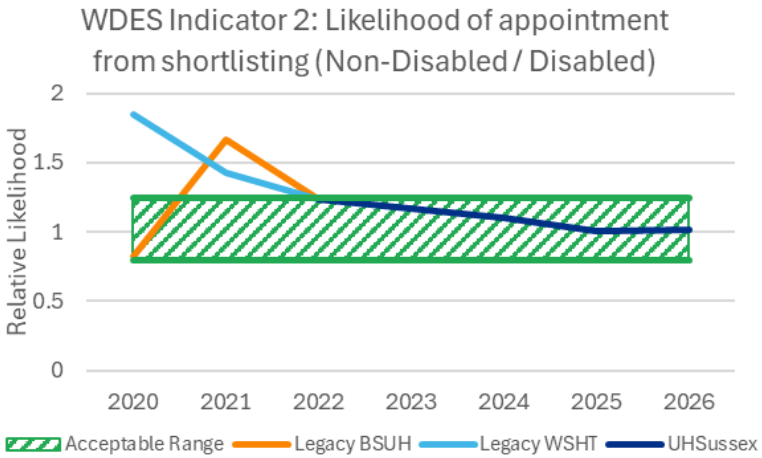
Indicators derived from ESR Data

The data in the table below show changes across WDES indicators derived from ESR data since 2025 and the relative distance from equity between disabled and non-disabled staff. None of the four main indicators improved in 2026 (green) and disparities remain across all indicators, including capability, appointments, career progression in senior clinical roles, and board representation.

Indicator number and description	Results	Change from 2025	Distance from equity
Indicator 1: Disabled representation in the workforce by pay band			
Overall	**7.2%**	**0.5%-point increase**	
Non-Clinical	**9.8%**	**1%-point increase**	
Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 2 (Bands 5-7)	1.13	0.12 increase	0.13
Disparity ratio - Cluster 2 (Bands 5-7) to Cluster 3 (Bands 8a & 8b)	0.72	-0.01 decrease	-0.28
Disparity ratio - Cluster 3 (Bands 8a & 8b) to Cluster 4 (Bands 8c - VSM)	0.59	0.11 decrease	-0.41
Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 4 (Bands 8c - VSM)	0.48	0.03 decrease	-0.52
Clinical	**6.8%**	**0.3%-point increase**	
Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 2 (Bands 5-7)	1.05	0.07 decrease	0.05
Disparity ratio - Cluster 2 (Bands 5-7) to Cluster 3 (Bands 8a & 8b)	0.92	0.04 decrease	-0.08
Disparity ratio - Cluster 3 (Bands 8a & 8b) to Cluster 4 (Bands 8c - VSM)	1.40	0.55 increase	0.40
Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 4 (Bands 8c - VSM)	1.36	0.44 increase	0.36
Medical & Dental	**4.6%**	**0.7%-point increase**	
Disparity ratio - Trainee to NCCG	0.89	0.86 decrease	-0.11
Disparity ratio - NCCG to Consultant	2.01	1.07 increase	1.01
Disparity ratio - Trainee to Consultant	1.80	0.15 increase	0.80
Indicator 2: Likelihood of appointment from shortlisting			
Likelihood ratio Non-disabled / Disabled	**1.02**	**0.02 increase**	**0.02**
Indicator 3: Likelihood of entering formal capability proceedings			
Likelihood ratio Non-disabled / Disabled	**1.58**	**1.58 increase**	**0.58**
Metric 10: Disabled representation on the board			
Overall	**0%**	**5.6%-point decrease**	**-50%-points**
Executive	0%	11.1%-point decrease	-50%-points
Voting	0%	5.9%-point decrease	-50%-points

Improvement/Better
Decline/Worse

The charts below present WRES Indicators 2 and 10, showing trends over time in the relative likelihood of appointment from shortlisting for disabled staff compared with non-disabled staff, alongside the current disability composition of Board membership, highlighting progress over time in recruitment outcomes and under-representation of disabled staff at Board level, and a relatively high proportion of Board members with unknown disability status.



Indicators derived from NHS Staff Survey Data

The data in the table below show changes across WDES indicators derived from annual NHS National Staff Survey data since 2025 and the relative distance from equity between disabled and non-disabled staff. The data indicates three of nine indicators improved in 2026, while disparities remained across six indicators, including experiences of harassment, bullying or abuse and career progress, presenteeism and feeling valued. Further graphs and narrative are in Appendix WDES 4(2) and 6-7: Staff experience indicators.

Indicator number and description	Results	Change from 2024	Distance from equity	National Average
Metric 1 (equivalent): Proportion with a long-term condition or illness				
Disabled	**24.4%**	0.3%-point decrease		24.45%
Indicator 4a: Harassment, bullying or abuse from patients, relatives or the public in last 12 months				
Disabled	**32.7%**	0.3%-point increase	4.2%-points	29.1%
Non-disabled	**28.5%**	1.3%-point increase		22.6%
Indicator 4b: Harassment, bullying or abuse from line managers in last 12 months				
Disabled	**15.8%**	0.6%-point increase	7.8%-points	14.1%
Non-disabled	**8.0%**	0.3%-point decrease		7.6%
Indicator 4c: Harassment, bullying or abuse from other colleagues in last 12 months				
Disabled	**25.7%**	0.3%-point increase	9.9%-points	24.5%
Non-disabled	**15.8%**	0.2%-point decrease		15.6%
Indicator 4d: Reporting last incident of harassment, bullying or abuse				
Disabled	**51.5%**	0.4%-point increase	-0.9%-points	53.2%
Non-disabled	**52.5%**	2.8%-point increase		52.9%
Indicator 5: Career progression				
Disabled	**48.3%**	0.9%-point increase	-6.6%-points	47.8%
Non-disabled	**55.9%**	1.2%-point increase		55.1%
Indicator 6: Presenteeism				
Disabled	**31.0%**	1.32%-point increase	12.2%-points	27.2%
Non-disabled	**18.8%**	0.6%-point decrease		18.2%
Metric 7: Feeling valued				
Disabled	**31.0%**	0.7%-point decrease	-13.8%-points	32.1%
Non-disabled	**44.8%**	3.0%-point increase		45.1%
Metric 8: Reasonable adjustments				
Disabled	**75.1%**	0.3%-point increase		73.7%
Metric 9a: Staff engagement				
Disabled	**6.19**	0.01 decrease	0.70	6.29
Non-disabled	**6.89**	0.15 increase		6.91

Improvement/Better
Decline/Worse

Delivery actions linked to WDES and the Disability Pay Gaps from the Workforce Inclusion Programme (WIP)

Indicator	Linked action in WIP
WDES 1	**Board and Top 70 leaders' inclusion objectives** - Embed equity objectives into Board and Top-70 leader goals, including accountability for workforce equality standard and pay gap outcomes and inclusive leadership behaviours.
WDES 1 WDES 2	**Enhanced panel briefings for NMAHP 8a+ roles** - Deliver enhanced panel inclusion briefings and Post-Interview Development Needs feedback for 8a+ roles (including ESM/VSM) to improve fairness, transparency and progression.
WDES 1	Increased awareness and uptake of the **Career Navigation Support Service (CNSS)**
WDES 1	**Career Sponsorship Scheme** – Expand the scheme to more groups of disabled staff and evaluate the Career Sponsorship Scheme to address disparities in career progression and promotion for disabled doctors in medical careers.
WDES 8	**Centralised Reasonable Adjustments** - Evaluate the new centralised reasonable adjustments service to ensure timely, consistent and transferable adjustments for disabled staff across the organisation.
WDES 1 WDES 4b,c	**Top 1,000 Inclusive Leadership training offer** – Develop a proposal to deliver inclusive leadership training focusing on disability inclusion, adjustment confidence, and accountability for WDES outcomes.
WDES 3	**Capability processes bias review** - Undertake a focused review of capability processes to identify and address structural bias affecting disabled staff, including reasonable adjustment considerations.
WDES 3	**Inclusive investigation training** - Deliver inclusive investigation training to reduce bias in disciplinary, capability and grievance processes and improve disabled staff experience.
WDES 4	**Hate Incident and VPR hotspot intervention** - Implement targeted interventions in identified hate incident and Violence Prevention & Reduction (VPR) hotspots to improve safety and reporting confidence. This includes reviewing discrimination coding and reporting, post-incident support and introduce inclusive investigation training.

NHS
University Hospitals Sussex
NHS Foundation Trust

Gender Pay Gap (GPG) 2026

uhsussex.inclusion@nhs.net

www.uhsussex.nhs.uk/equality

Introduction

Gender Pay Gap reporting shows the difference in average hourly pay and bonus payments between men and women. The Trust analyses the information to identify:

- the level of gender equality
- the balance of male and female employees in each of four salary range quartiles
- how effectively talent is being maximised and rewarded

and to use this to identify any underlying root causes for the gender pay gap and put in place remedial actions to address and mitigate this.

The Trust submits data annually to the Government's statutory gender pay gap reporting portal https://gender-pay-gap.service.gov.uk/employers/21657

Important information

This report follows the legal requirements for organisations with over 250 employees, as set out in the Equality Act 2010. It covers the pay period from 1 April 2025 to 31 March 2026 and includes data from 18,346 employees who were classed as 'relevant employees' for these calculations.

Six mandatory reported calculations:

1. Proportion of males and females in each pay quartile
2. Mean (average) gender pay gap for ordinary pay
3. Median gender pay gap for ordinary pay
4. Proportion of males and females receiving a bonus payment
5. Mean (average) gender pay gap for bonus pay
6. Median gender pay gap for bonus pay

What is the Gender Pay Gap?

The gender pay gap shows the difference in average earnings between men and women across the organisation. It is shown as a percentage of men's earnings.

Types of Pay Gap Calculations

- **Mean Pay Gap:** The average hourly pay for all men is compared to the average hourly pay for all women. Hourly pay includes basic pay and any allowances paid through payroll, but excludes overtime and expenses.
- **Median Pay Gap:** he hourly pay of the middle-paid man is compared to the hourly pay of the middle-paid woman when all employees are listed from highest to lowest pay. Hourly pay includes basic pay and allowances, but excludes overtime and expenses.

The gender pay gap is not the same as equal pay for doing the same job. The Trust uses a national pay system and job evaluation process for staff under Agenda for Change and medical/dental contracts.

Summary

As on the 31 March 2026:

- Women earned 98p for every £1 men earned (median hourly pay)
- Women made up 61.7% of employees in the highest paid quarter, compared with 70.1% in the lowest paid quarter. Relative to their representation in the lowest pay quartile, men were around 1.4 times more likely than women to be in the highest pay quartile
- 0.48% of women received bonus pay, compared with 2.14% of men
- Women's mean bonus pay was 26.57% lower than men's.

Table 1 Summary chart of pay gaps 2026

Measure	Mean	Median
Male	£27.06	£20.10
Female	£22.50	£19.78
Difference	£4.57	£0.32
Pay Gap %	16.87%	1.57%
For every £1 a man earns, a woman earns	£0.83	£0.98

The ordinary (hourly rates) pay gap has increased marginally

In 2025/26, women earned £0.83 for every £1 earned by men, representing **a one-penny decrease compared to the previous year**. "Ordinary pay" refers to pay received in the pay period that includes the snapshot date, including basic pay, allowances and shift pay, but excluding bonus pay. Overall, the **ordinary pay gap has remained broadly consistent** over recent years, with limited movement. This gap is largely driven by the continued over-representation of male staff in senior management and consultant roles, particularly within the highest pay quartile.

Our gender bonus gap has increased and remains substantial

The proportion of male staff receiving a bonus was **over 300% higher** than the proportion of female staff. Male staff also received **higher average and median bonus payments** than female staff. As in previous years, this gap is primarily driven by eligibility for consultant-level awards and legacy arrangements, including Discretionary Points and protected Clinical Excellence Awards, which historically benefit a greater proportion of male staff.

Pay quartile representation has remained largely unchanged, but progression into higher pay levels remains uneven

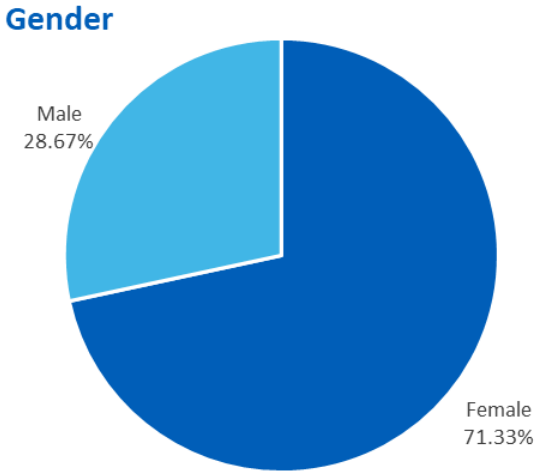
Gender representation across pay quartiles has shown **minimal year-on-year movement**. Despite women comprising the majority of the workforce, their representation decreases at higher pay levels, particularly within the top pay quartile.

New national award schemes show early signs of improved balance for bonus outcomes

Because bonuses apply to a small and specific group of staff, relatively small changes in the number or type of awards can have a disproportionate effect on reported bonus pay gaps. More recent schemes, such as National Clinical Impact Awards, demonstrate a more balanced gender distribution and may support improved equity over time as historic arrangements phase out.

Gender Pay Gap: Representation

This section sets out how males and females are distributed across the workforce and pay quartiles, providing context for the Trust's gender pay gap and the structural factors that influence it.



Headcount

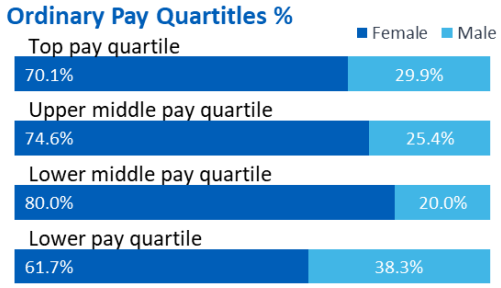
This section sets out the workforce profile used for statutory gender pay gap reporting, including the proportion of male and female staff within the Trust. In line with the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, this includes all relevant employees who are employed on the snapshot date and receive full pay, as defined by the regulations, and excludes those not receiving full pay due to, for example, long-term leave. The figures presented include substantive and bank staff who meet the statutory definition. Non-executive directors are not included, as they are not employees for the purposes of gender pay gap reporting.

The chart shows the overall gender composition of staff counted for statutory pay gap reporting purposes, 71.6% (13,140) were female, and 28.4% (5,206) were male.

Gender Representation by Ordinary Pay Quartiles

This section shows how males and females are distributed across pay quartiles, providing insight into how workforce composition influences the gender pay gap. To understand how males and females are distributed across different pay levels, all full-pay employees are divided into four equal groups (called quartiles), based on their earnings, from the lowest to the highest.

The chart on the right shows the percentage of male and female employees in each pay quartile, helping us assess gender balance across different pay levels:



- 4,581 staff were in the lower pay quartile, of these 3,212 (61.7%) were female
- 4,475 staff were in the lower middle pay quartile, of these 3,337 (80%) were female
- 4,701 staff were in the upper middle pay quartile, of these 3,759 (74.6%) were female
- 4,589 staff were in the top pay quartile, of these 2,832 (70.1%) were female.

Our quartile pay representation has remained broadly consistent over recent years, indicating limited structural movement.

The data shows that women make up the majority of the workforce overall and are strongly represented across all quartiles. However, the proportion of female staff reduces at higher pay levels, with a corresponding increase in the proportion of male staff in the top pay quartile relative to the middle quartiles.

This indicates that the gender pay gap is not driven by unequal pay for equal work, but by the distribution of men and women across different roles, pay bands, and seniority levels. In particular, male staff are comparatively more concentrated in higher paid roles than would be expected based on their overall representation in the workforce.

Male staff were **2.5 times more likely** to be in the top pay quartile than female staff, compared to their representation in the upper middle pay quartile. This is up (worse) from 2.4 times in 2025 and 2.2 times in 2024.

The top-upper middle disparity ratio is calculated by dividing the relative representation of male staff by the relative representation of female staff. The relative representation is the number of staff in the top pay quartile divided by the number of staff in the upper middle pay quartile for each sex.

What we are doing

The Trust has established action plans to address these structural drivers, set outon pages on page 30 and 31. This includes targeted action on:

- Inclusive recruitment and selection at senior levels
- Career progression and talent management for women
- Addressing barriers in specific staff groups and professions where disparities are most pronounced
- Strengthening accountability through Workforce Inclusion Programme delivery and governance

This page should be read alongside those sections, which set out the specific interventions and measures of success.

Gender Pay Gap: Ordinary Pay

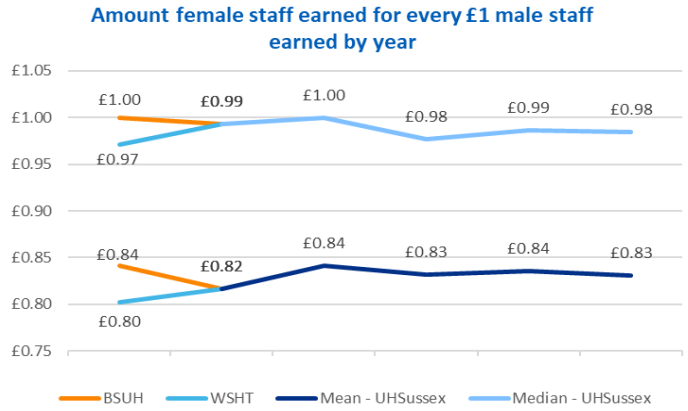
This section establishes the **average and median differences in hourly rates of ordinary pay** between male and female employees. As on the 31 of March 2026, the average hourly pay for male staff is £27.06. It is £22.50 for female staff. This makes our average gender pay gap 16.87% and the median gender pay gap is 1.57%.

Comparing average hourly wages, women earned eighty-three pence for every £1 men earned, **one penny less (worse) than in 2025**. Comparing median hourly wages (accounting for the effect of outliers), women earned ninety-eight pence for every £1 men earned, **one penny less (worse) than in 2025**.

The table below shows how the gender hourly pay gap has changed over recent years, increasing marginally from 2023 to 2024, narrowing marginally in 2025, and widening again marginally in 2026; while the mean pay gap in 2026 approaches the 2024 level, the median shows a similar pattern with a less pronounced increase.

Table 2 Chart showing average mean and median hourly pay

Gender Hourly Pay Gap	Average (Mean) Hourly Pay				Median Hourly Pay			
	2023	2024	2025	2026	2023	2024	2025	2026
Male £	22.26	24.01	25.85	27.06	16.84	18.10	19.25	20.10
Female £	18.73	19.97	21.60	22.50	16.84	17.69	18.98	19.78
Difference	3.53	4.04	4.25	4.57	0.00	0.41	0.27	0.32
Pay Gap %	15.86%	16.83%	16.43%	16.87%	0.00%	2.29%	1.40%	1.57%



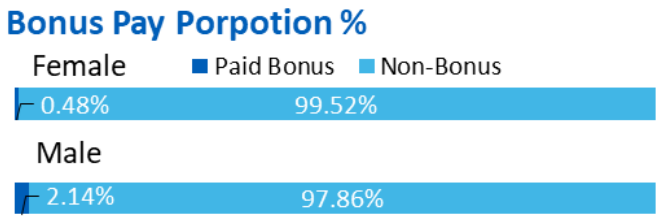
The chart opposite shows changes in the mean and median hourly pay gap over recent years, with limited movement and can largely be attributed to the higher proportion of male staff in senior management and consultant roles.

Gender Pay Gap: Bonuses

This section outlines differences between males and females in bonus payments given to eligible employees during the 12 months leading up to the 31 March 2026. Bonus pay is one or more of the following payments:

- Clinical Excellence Awards (CEA)
- National Clinical Impact Awards (NCIA)
- Discretionary pay for consultants with extra responsibilities

Staff who receive more than one type of bonus are counted only once.



Who Received Bonus Pay?

The chart on the top right shows the percentage of male and female employees who received bonuses:

- 2.14% of male employees received a bonus
- 0.48% of female employees received a bonus
- This means the proportion of male employees receiving a bonus is over 340% higher than the proportion of female employees.
- 137 male and 75 female staff received at least one type of bonus.

Percentages are calculated using all relevant employees in full pay on the snapshot date as the denominator.

Bonus Pay Differences

The second chart above right shows changes in the mean and median bonus pay gap historically; it shows that male staff continue to receive a higher overall amount in bonus pay compared to female staff. This disparity is primarily due to a greater proportion of male staff receiving bonuses, as well as some male staff receiving multiple types of awards.

Female staff received lower average (£8,931.86) and median (£4,180.20) bonus pay than male staff (£12,164.13 and £ 8,143.20 respectively). This translates to an average pay gap of 26.57% and a median pay gap of 48.67%.

Discretionary Points Pay

Discretionary Points are legacy consultant payments awarded to consultants in recognition of additional responsibilities under previous national arrangements and closed to new entrants. This was awarded to one male employee within the 12 months.

Clinical Excellence Award

Clinical Excellence Awards (CEAs) are intended to recognise consultants who make sustained contributions beyond the standard expectations of their role, including excellence in patient care, service development, teaching, research, and leadership. To be eligible, consultants must hold a substantive post and normally have completed at least one year of service at the Trust at the time of application. This includes:

- Local awards - granted by the Trust.
- National awards - granted by the Department of Health and Social Care but paid through the Trust's payroll.
- 129 (66%) male and 67 (34%) female staff received CEA-related payments within the 12-month reporting period.

There have been national changes to the CEA scheme for consultant medical staff. Local CEAs are no longer awarded, and no new CEAs have been made under post-2018 contract arrangements. However, consultants who received awards prior to these changes retain them on a protected basis until they leave NHS service.

National Clinical Impact Awards (NCIA)

National Clinical Impact Awards (NCIAs) are the current national scheme intended to recognise consultants who demonstrate clinical impact beyond their employing organisation, such as regional or national leadership, guideline development, research, education, or service transformation. NCIAs replaced national Clinical Excellence Awards for consultants on newer contract arrangements and are awarded through a nationally managed process. This includes:

- National awards - granted by the Department of Health and Social Care but paid through the Trust's payroll.
- 8 female (53%) and 7 male (47%) staff received a National Clinical Impact Award within the 12 months.

Gender Pay Gap: Menopause Action Plan

This section is included in line with current Government guidance on voluntary equality action plans alongside gender pay gap reporting. Employers with 250 or more employees may publish an action plan in conjunction with their gender pay gap data, and the guidance indicates that these plans may include actions to address the gender pay gap and to support employees experiencing menopause. This aligns with the Employment Rights Act 2025, which inserted section 78A into the Equality Act 2010, enabling the introduction of such requirements through regulations. Trust actions include:

Manager Confidence and Training

- Support for managers includes a menopause e-learning module, inclusion of menopause within the Mental Health Training for Managers programme, menopause-focused peer support sessions, and a managers' Menopause Guide. This guidance includes practical advice and information on recording menopause-related absence.

Peer Support and Awareness

- The Trust has delivered a quarterly Menopause Café since 2024, with approximately 400 members and around 800 cumulative attendees to date. Sessions typically attract 60-70 colleagues and include specialist input on menopause-related topics. Resources are shared via the staff intranet, and Menopause Awareness Day is marked annually. Feedback indicates the initiative is valued for both information and peer support.

Workplace Adjustments

- Menopause Guidance outlines a range of reasonable workplace adjustments to support colleagues, enabling flexibility and supporting staff to remain in work.

Café user quotes

"I know that going through this is a very lonely and frustrating time for women. I often felt that no one was listening and had not a clue what to do. This group is going to empower those women and be a much needed source of information."

- Tracy

"Love the menopause café and the community that's been built, it is such a relief to have a place to learn and not feel alone, thank you." - Sue

Delivery actions linked to the Gender Pay Gaps from the Workforce Inclusion Programme (WIP)

Indicator	Linked action in the WIP
Representation Quartiles	**Self-rostering implementation** - Continue to progress self-rostering arrangements to improve flexibility, work-life balance and retention, particularly for staff with caring responsibilities, supporting participation and progression into higher-paid roles.
Representation Quartiles	**Supervisor Self-Service implementation** - Implement Supervisor Self-Service to improve data accuracy and timely decision making on flexible working.
Representation Quartiles & Ordinary Pay	**Flexible working job adverts** - Continue to emphasise flexible working options in job advertisements to attract a more diverse applicant pool and reduce barriers to senior and higher-paid roles.
Representation Quartiles	**Nursing position title modernisation** - Explore modernisation of nursing position titles to better reflect role responsibility, skill and scope, supporting fair evaluation and progression pathways.
Representation Quartiles & Ordinary Pay	**Board and Top 70 leaders' inclusion objectives** - Embed equity objectives into Board and Top-70 leader goals, including accountability for workforce equality standard and pay gap outcomes and inclusive leadership behaviours.
Representation Quartiles	**Enhanced panel briefings for NMAHP 8a+ roles** - Deliver enhanced panel inclusion briefings and Post-Interview Development Needs feedback for 8a+ roles (including ESM/VSM) to improve fairness, transparency and progression.

Indicator	Linked action in the WIP
Representation Quartiles	**Accountability in Senior Recruitment (Imperial Explain or Comply Model)** build the case for investment to require recruiting managers to either follow agreed inclusive recruitment standards or clearly justify, with evidence, why they are departing from them to ensure accountability and reduce bias within senior recruitment (8a+ / ESM / VSM).
Representation Quartiles	**Build career development plans into the appraisal system** - Integrate structured career development planning into appraisal conversations to support equitable progression for global majority staff.
Representation Quartiles	Increased awareness and uptake of the **Career Navigation Support Service (CNSS).**
Representation Quartiles	**Career Sponsorship Scheme** - Continue delivery and evaluation of the Career Sponsorship Scheme to address disparities in career progression and promotion at senior levels.
Representation Quartiles	**Reverse Mentoring Scheme funding case** - Develop a funding case to sustain and scale the Reverse Mentoring Scheme, strengthening senior leader understanding of lived experience and race equity.

NHS
University Hospitals Sussex
NHS Foundation Trust

Ethnicity Pay Gap (EPG) 2026

uhsussex.inclusion@nhs.net

www.uhsussex.nhs.uk/equality

Introduction

As part of our duties under the Equality Act and under the NHS EDI Improvement Plan, we are conducting a comprehensive analysis of **pay disparities** and outlining actions we are taking to eradicate pay differences on the basis of protected characteristics.

Each pay gap is the difference between the average pay of different groups according to their characteristics. The **ethnicity pay gap** is calculated using a comparator approach in which White British staff are used as the reference group, in line with recommended methodology. This compares average hourly and bonus pay between White British staff and other ethnic groups across the workforce.

As with gender pay gap reporting, this does not measure differences in pay for the same role, but differences in average pay across the workforce, influenced by representation across roles, grades and pay bands.

UK employers with 250 or more employees are required to report their gender pay gap data annually. NHS Trusts are now additionally required to report Gender, Ethnicity and Disability pay gaps, with data taken from a 31 March snapshot date.

In 2026, we analysed data relevant for Ethnicity Pay Gap calculations from 18,346 employees. There are six mandatory calculations:

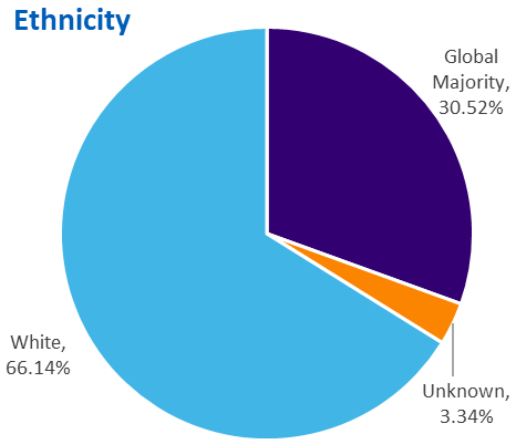
1. Proportion of ethnic groups in each pay quartile
2. Mean (average) ethnicity pay gap for ordinary pay
3. Median ethnicity pay gap for ordinary pay
4. Proportion of ethnic groups receiving a bonus payment
5. Mean (average) ethnicity pay gap for bonus pay
6. Median ethnicity pay gap for bonus pay

We also review:

- the proportion of our total UK workforce from different ethnic groups.
- the proportion of our employees who have shared their ethnicity.

Summary

As on the 31 March 2026, the average hourly pay for white staff is £23.58, and £23.76 for global majority staff, making our average ethnicity pay gap -0.79% and the median ethnicity pay gap -0.33%. Our average bonus ethnicity pay gap is 28.78%. The pie chart shows the overall composition of staff counted for ethnicity pay gap reporting purposes, with global majority staff making up 30.52% and white staff 66.14%.



The ordinary pay gap has decreased

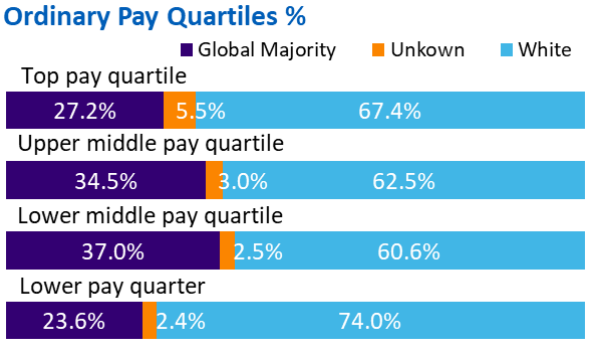
The **pay gap has been slowly decreasing** year-on-year, improving by -3.75% (average) and -1.76% (median) from 2024 to 2025, and again by -2.91% (average) and -2.73% (median) from 2025 to 2026, bringing the overall position **close to parity**.

Our ethnicity bonus gap remains substantial

White staff were substantially more likely to receive a bonus than global majority staff, with the proportion of white employees receiving a bonus around 270% higher. White British staff also received **higher average and median bonus payments** than most global majority groups. All percentages are based on staff included in the pay gap dataset (those in full pay on the snapshot date).

Our quartile pay gap is slowly changing

The narrowing ethnicity pay gap coincides with increased representation of global majority staff in the lower and lower-middle pay quartiles, reflecting growth in entry-level and early-career roles. Improved ethnicity recording has also contributed by increasing the visibility of staff in lower-paid roles.



The chart to the right shows the percentage of global majority and white staff as well as the percentage of employees with unknow ethnicity in each pay quartile, indicating a lower percentage of global majority staff in lower and top pay quartiles.

The steps outlined in *'Delivery actions linked to WRES and the Ethnicity Pay Gaps from the* Workforce Inclusion Programme (WIP)*'* on page 12 is how we address the ethnicity pay gaps findings.

Disaggregated analysis highlights significant variation between ethnic groups

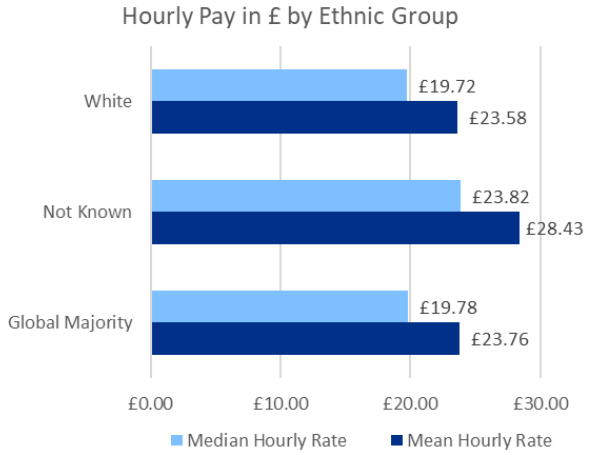
More detailed breakdowns highlight substantial differences in pay outcomes within aggregate ethnic categories. While some groups, including East Asian staff, have higher average and median pay, other historically marginalised groups, particularly South-East Asian and Black staff, continue to experience lower average pay.

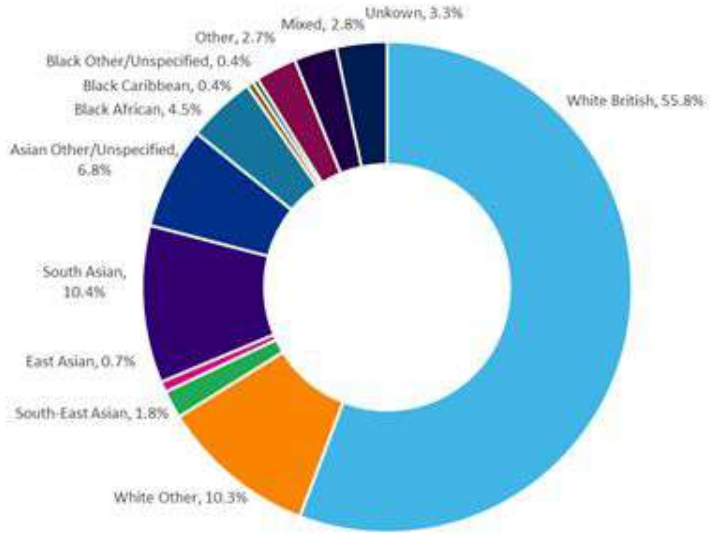
Disaggregating Ethnic Groups

We provide a breakdown of ethnicity pay gaps that moves away from only a simple white and global majority model. Consistent with Government ethnicity pay reporting guidance, single aggregate pay gaps cannot adequately reflect differences between ethnic groups which more detailed breakdowns can. We utilised ONS categories to reflect our largest workforce demographic groups:

- Splitting White British groups (British, English, Scottish, Welsh, Cornish) from all other white groups.
- Splitting South-East Asian, East Asian and South Asian groups
- Splitting Black African and Black Caribbean.

The chart below compares mean and median hourly pay for White staff and global majority staff, providing a snapshot of how pay levels differ by broad ethnic group.





The chart above shows the workforce ethnicity profile disaggregated by detailed ethnic groups, which inform the following analyses.

Ethnicity Pay Gap: Ordinary Pay

Significant pay gaps exist between ethnic groups

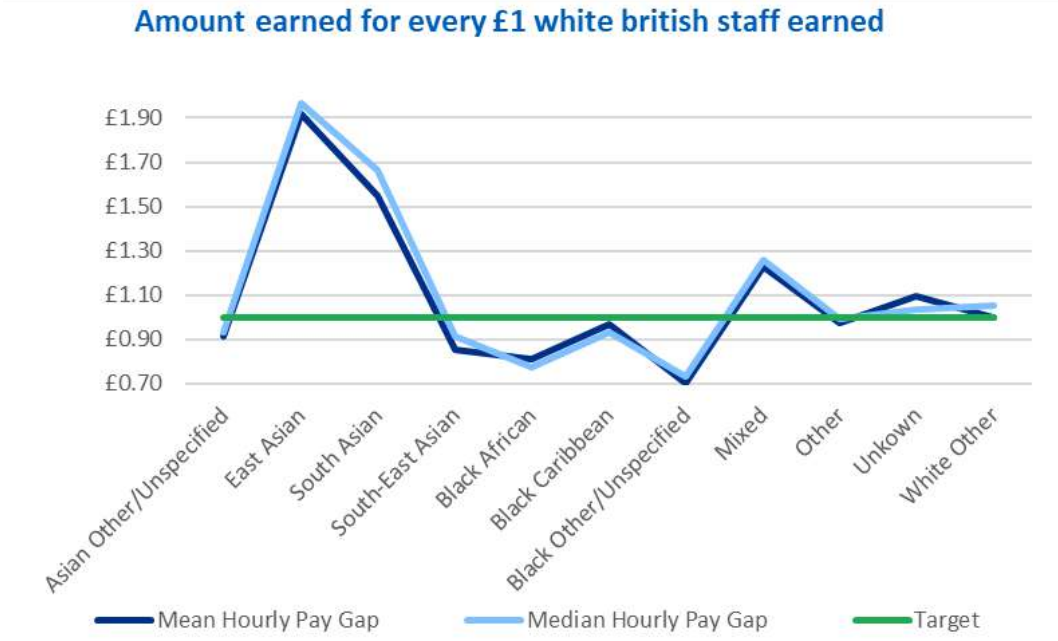
The graph below shows how mean and median hourly earnings compare across detailed ethnic groups, expressed as the amount earned for every £1 earned by White British staff, highlighting variation in pay outcomes between groups:

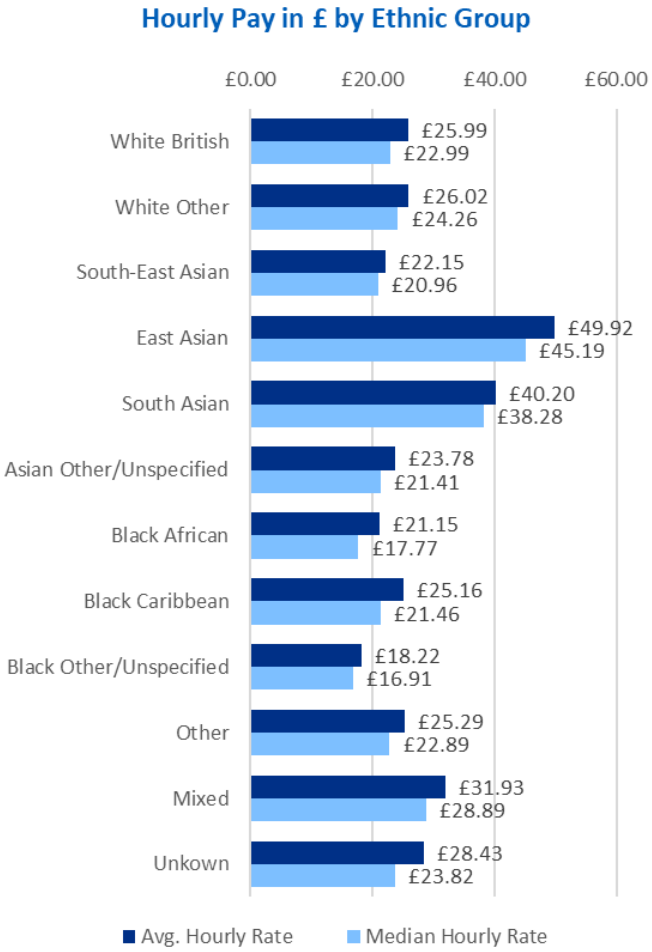
- **Highest Hourly Pay -** The ethnic group with the largest hourly pay is East Asian staff at £49.92 average and £45.19 median. This is significantly higher than the average Asian aggregate hourly pay of £24.03
- **Lowest Hourly Pay -** The ethnic group with the lowest hourly pay is staff from other or unspecified Black backgrounds at £18.22 average and £16.91 median. This is significantly lower than the average Black aggregate hourly pay of £21.30
- **The difference in hourly pay** between these groups is £31.70 / hour on average and £28.27 / hour on median. For reference, the National Living wage on 31 March 2026 was £12.21 / hour.

Some historically marginalised ethnic groups continue to experience lower average pay

Historically marginalised groups, defined here as ethnic groups that have experienced structural disadvantage, including global majority groups, continue to face pay disparities.

This is particularly evident among South-East Asian and Black staff, who earn substantially less on average than several other ethnic groups. Smaller but persistent average pay gaps relative to White British staff are also observed among staff who selected ‘Other’ and Asian Other/Unspecified categories.





White British and White Other groups show similar outcomes

The difference in average pay between White British and White Other staff is **small and has remained stable** in recent years, with White Other staff earning £1.00 for every £1 earned by White British staff. This is consistent with previous years (£1.02 in 2025 and £1.01 in 2024), indicating no material divergence in pay outcomes between these two groups.

Significant variation in pay outcomes between Asian ethnic groups

The chart on the left compares mean and median hourly pay across detailed ethnic groups, providing a more granular view of pay levels beyond the broad demographic groupings.

Average hourly pay differs markedly between Asian ethnic groups. The disparity between East Asian and South-East Asian staff is particularly pronounced, with a difference of £27.77 per hour on average and £24.23 per hour at the median, indicating substantial heterogeneity in pay outcomes that is not visible when Asian groups are considered in aggregate.

Pay differences by ethnicity and occupational distribution

Some ethnic groups, including East Asian, South Asian, staff from mixed ethnic backgrounds, and staff with unknown ethnicity, have higher average pay than White British staff. This is likely to be influenced by higher representation of these groups in medical and dental roles which attract higher average pay, such as Non-Consultant Career Grade (NCCG) roles.

Ethnicity Pay Gap: Bonuses

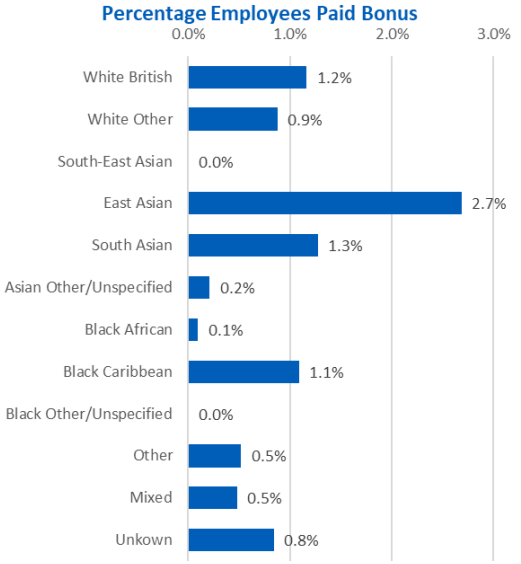
Bonuses were given to eligible employees during the 12 months leading up to the March 2026. Anyone who received more than one type of bonus is counted only once. Bonus payments include:

- Clinical Excellence Awards (CEA)
- National Clinical Impact Awards (NCIA)
- Discretionary pay for consultants with extra responsibilities

Who Received Bonus Pay?

The chart on the right shows the percentage of employees who received bonuses:

- 1.12% of white employees received a bonus
- 0.66% of global majority employees received a bonus
- The proportion of white employees receiving a bonus is around 270% higher than the proportion of global majority employees.

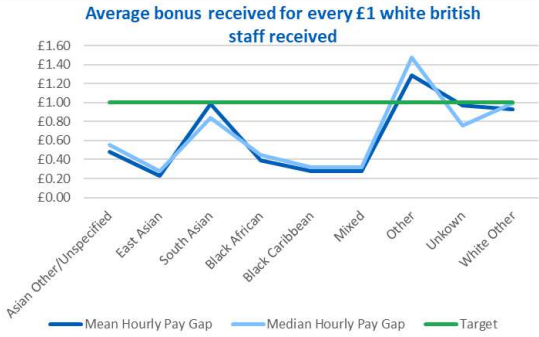


Percentages are calculated using all staff included in the ethnicity pay gap dataset as the denominator, while the counts below reflect the number of staff who received bonus payments during the 12-month reporting period. Only certain staff groups are eligible for these bonuses. In total:

- 161 white, 43 global majority, and 8 staff with unknown ethnicity received at least one type of bonus.

Bonus Pay Differences

The chart opposite shows the mean and median bonus pay gap by ethnic group. White British staff received a higher overall amount in bonus pay than global majority staff, except for staff recorded from an “Other” ethnic group. This is due to a greater number of White British staff receiving bonuses, as well as some staff receiving multiple types of awards.



The largest difference in bonus pay to White British staff (with an average bonus of £10,875.29 and a median bonus pay of £9,496.77) was for East Asian staff (£2,516.27, and £2,612.21 respectively). This works out to a mean pay gap of 76.86% and a median pay gap of 72.49%.

University Hospitals Sussex
NHS Foundation Trust

Disability Pay Gap (DPG) 2026

uhsussex.inclusion@nhs.net

www.uhsussex.nhs.uk/equality

Introduction

As part of our duties under the Equality Act 2010 and under the NHS EDI Improvement Plan, we are conducting a comprehensive analysis of pay disparities and outlining actions we are taking to eradicate pay differences on the basis of protected characteristics.

Each pay gap is the difference between the average pay of different groups according to their characteristics. The **disability pay gap** is the difference between non-disabled staff hourly and bonus pay compared to other groups.

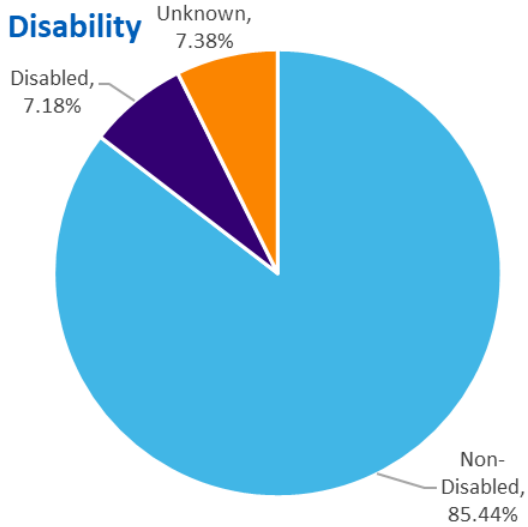
UK employers with 250 or more employees are required to report their gender pay gap data annually. NHS Trusts are now additionally required to report Gender, Ethnicity and Disability pay gaps, with data taken from a 31 March snapshot date.

In 2025, we analysed data relevant for Disability Pay Gap calculations from 18,303 employees. There are six mandatory calculations:

1. Proportion of disability status in each pay quartile
2. Mean disability pay gap for ordinary pay
3. Median disability pay gap for ordinary pay
4. Proportion of disability status groups receiving a bonus payment
5. Mean disability pay gap for bonus pay
6. Median disability pay gap for bonus pay

Summary

As on the 31 of March 2026, the average hourly pay for non-disabled staff is £23.44. It is £21.37 for disabled staff, making our average disability pay gap 8.85% and the median gender pay gap 10.50%. Our average bonus disability pay gap is -64.13%. The top chart shows the overall composition of staff counted for disability pay gap reporting purposes, with disabled staff making up 7.18% and non-disabled staff 85.44%.



The ordinary disability pay gap remains significant

As of 31 March 2026, the average disability pay gap was 8.85% and the median gap was 10.50%, with disabled staff earning £0.91 on average and £0.89 at the median for every £1 earned by non-disabled staff. This indicates a meaningful disparity in pay outcomes between disabled and non-disabled staff.

The bottom chart shows the percentage of disabled and non-disabled staff as well as the percentage of employees with unknow disability status in each pay quartile, indicating a lower percentage of disabled staff the top pay quartile and a higher percentage of staff with unknown disability status in this quartile.

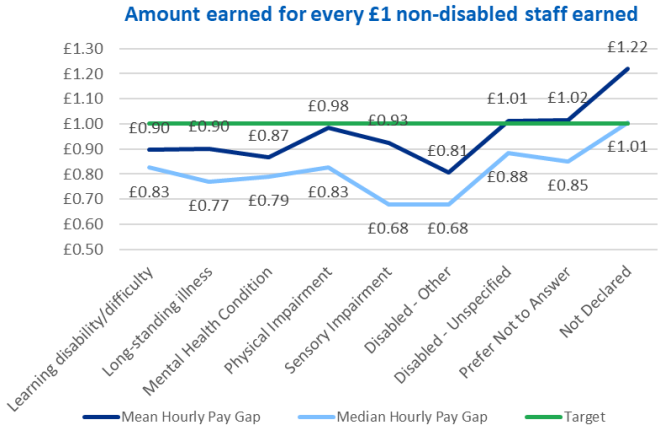
Pay outcomes vary considerably across disability groups

Disaggregated analysis shows that most disability groups experience lower average pay relative to non-disabled staff, with the largest gaps observed among staff with long-standing illnesses, mental health conditions, and those reporting ‘other’ disabilities. The widest difference is between staff with ‘other’ disabilities and those who have not shared their disability status.

Our disability bonus gap is mixed and reflects eligibility patterns

Non-disabled staff were around 70% more likely to receive a bonus than disabled staff. However, among those who did receive a bonus, disabled staff had a higher average bonus value, resulting in a negative average bonus gap (-64.13%). This reflects the very small number of disabled staff receiving bonuses and the concentration of awards within a limited number of roles.

The steps outlined in *'Delivery actions linked to WDES and the Disability Pay Gaps from the* Workforce Inclusion Programme (WIP)*'* on page 20 is how we address the disability pay gap findings.



Disability Pay Gap: Ordinary Pay

This section establishes the average and median differences in hourly rates of ordinary pay between disabled and non-disabled employees.

As on the 31 of March 2026, the average hourly pay for non-disabled staff is £23.44. It is £21.37 for disabled staff. This makes our average disability pay gap 8.85% and the median gender pay gap 10.50%.

Comparing average hourly wages, disabled staff earned ninety-one pence for every £1 non-disabled staff earned.

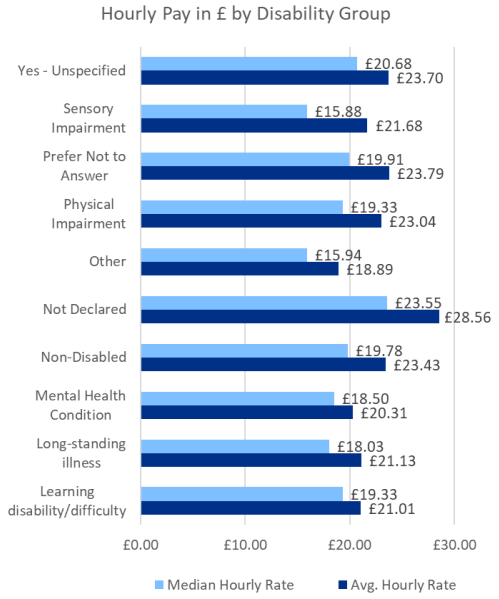
Comparing median hourly wages (accounting for the effect of outliers), disabled staff earned eighty-nine pence for every £1 non-disabled staff earned.

Significant pay gaps exist between disability groups.

The disaggregated data reveals more information about pay disparity within disability types.

The top chart compares mean and median hourly earnings across disability types, expressed as the amount earned for every £1 earned by non-disabled staff. It highlights variation in relative pay outcomes by disability status. Average pay gaps relative to non-disabled staff are observed among most disability groups, with the largest gaps for staff with long-standing illnesses, mental health conditions and 'other' disabilities.

The bottom chart compares mean and median hourly pay across disability types, highlighting how average hourly pay differs markedly between types. The largest



disparity is between staff with ‘other’ disabilities and staff who have not shared their disability status, with a difference of £9.67 per hour on average and £7.61 per hour at the median.

Disability Pay Gap: Bonuses

Bonuses were given to eligible employees during the 12 months leading up to the snapshot date. Anyone who received more than one type of bonus is counted only once. Bonus payments include:

- Clinical Excellence Awards (CEA)
- National Clinical Impact Awards (NCIA)
- Discretionary pay for consultants with extra responsibilities

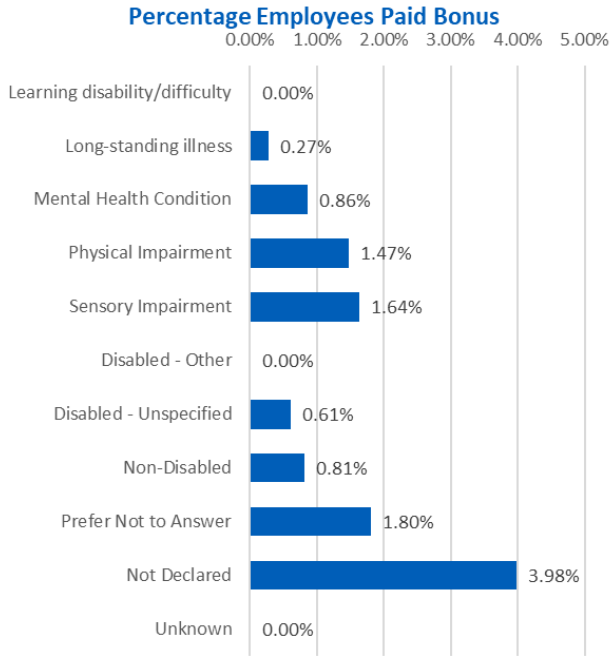
Who Received Bonus Pay?

- 0.47% of disabled employees received a bonus.
- 0.81% of non-disabled employees received a bonus.
- This means the proportion of non-disabled employees receiving a bonus is around 70% higher than the proportion of disabled employees.

Only certain staff groups are eligible for these bonuses. In total:

- 151 non-disabled, 8 disabled staff, and 87 staff with unknown disability status received at least one type of bonus.

The chart on the right shows the proportion of employees receiving bonus payments by disability type, highlighting variation across types and a notably higher proportion of bonus recipients among staff with a disability status not declared. Numbers in individual categories are small, which limits further detailed analysis by disability type.



Bonus Pay Differences

Disabled staff received a higher average bonus payment (£22,301.58) than non-disabled staff (£13,587.82), resulting in a mean bonus pay gap of -64.13%. This reflects the very small number of disabled staff receiving bonus payments, meaning that a small number of higher-value awards can disproportionately influence the average. Non-disabled staff remain more likely to receive a bonus overall.

Appendix

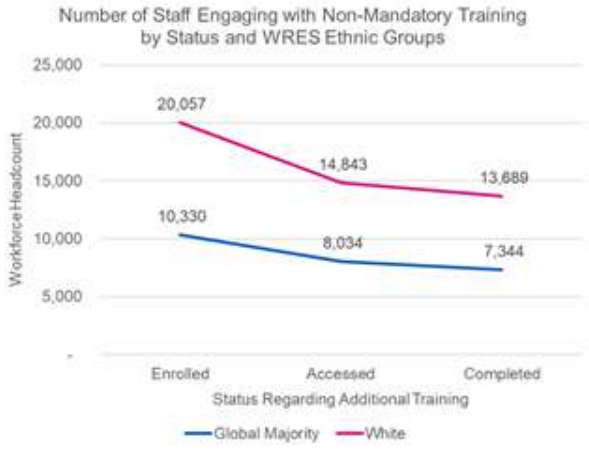
WRES 4: Non-mandatory training

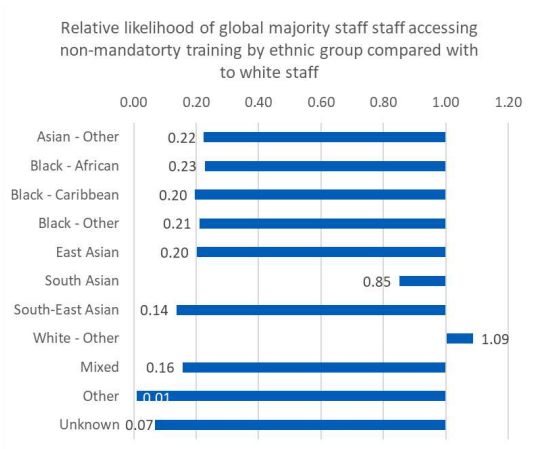
The WRES Indicator 4 assesses the relative likelihood of staff accessing non-mandatory training and Continuing Professional Development (CPD). Analysis shows that White staff (n = 14,843) were **as likely as global majority staff** (n = 8,034) to access non-mandatory training, with a relative likelihood ratio of 0.85. This ratio falls within the WRES equality range (0.8-1.25) and has remained stable over the past four years, indicating **sustained equity in access at an aggregate level**.

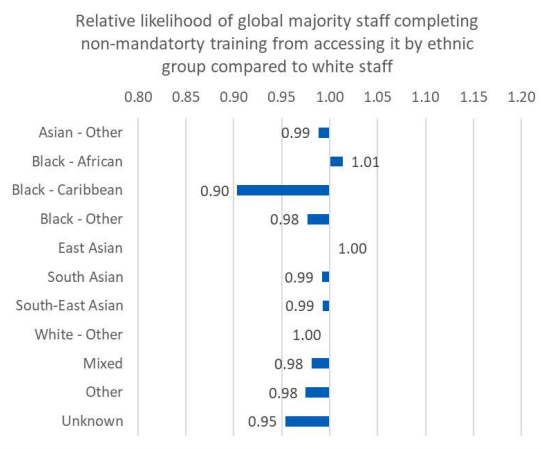
While the aggregate comparison suggests broadly equitable access, this can mask variation between individual ethnic groups.

To better reflect the Trust's ethnic diversity and move beyond the binary White versus global majority comparison, a more granular analysis was also undertaken. When comparing access to non-mandatory training, **most ethnic groups were found to be substantially less likely to access training opportunities than White British staff**. The exceptions to this pattern were South Asian and White Other staff, whose access rates were more comparable to those of White British staff.

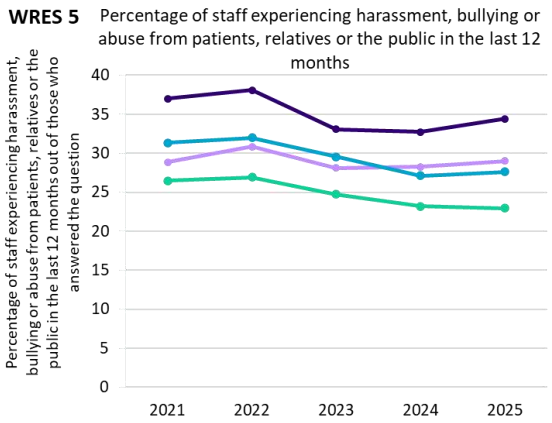
Importantly, once non-mandatory training was accessed, **completion rates were equitable across all ethnic groups**, indicating that observed disparities relate primarily to access rather than progression or completion.

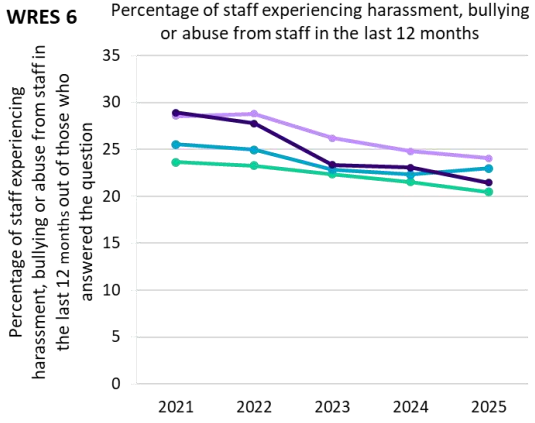


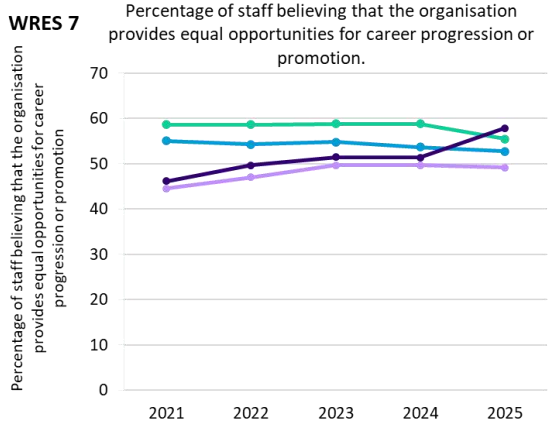


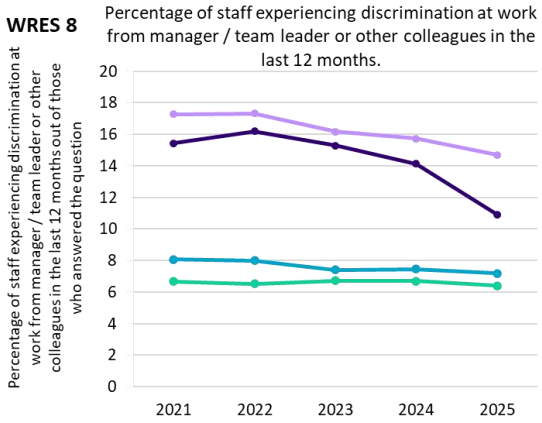


WRES 5-8: Staff experience indicators









White staff: UHSussex

All other ethnic groups*: UHSussex

White staff: National Average

All other ethnic groups*: National Average

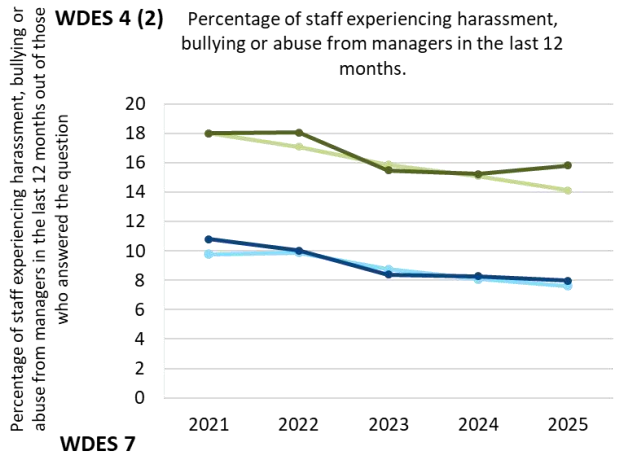
These charts show trends over time for staff survey indicators 5 to 8, comparing the experiences of White staff and all other ethnic groups at UHSussex with national averages.

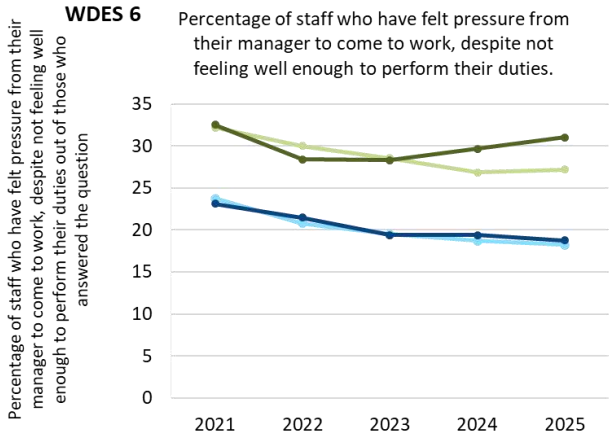
For indicator 5, UHSussex reports **higher levels of bullying, harassment or abuse from patients, relatives or the public** than the national average for both White staff and all other ethnic groups.

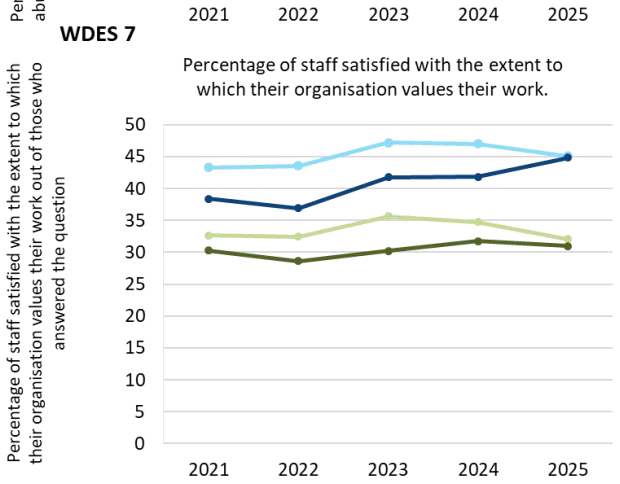
For indicator 6, White staff report **higher levels of bullying, harassment or abuse from staff than the national average**, while staff from all other ethnic groups report lower levels than the national average.

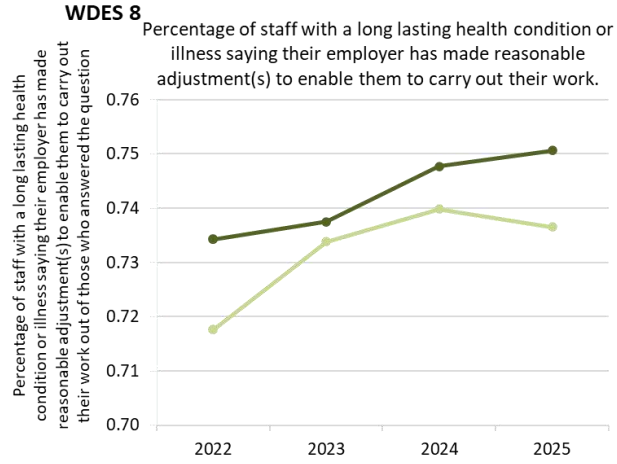
Indicator 7 shows a **marked increase in the proportion of staff from all other ethnic groups who believe the organisation provides equal opportunities for career progression or promotion**, now exceeding both White staff locally and national averages.

For indicator 8, reported **discrimination for staff from all other ethnic groups has decreased significantly** over time; while levels remain higher than for White staff, the **rate of improvement exceeds that seen nationally**. Overall, these indicators show a mixed position, with areas of poorer performance against national benchmarks alongside evidence of improvement over time.









WDES 4(2) and 6-7: Staff experience indicators

These indicators show trends over time for staff with and without a long-term condition at UHSussex compared with national averages.

Across indicators 4 and 6, staff with a long-term condition consistently report poorer experiences than those without, including **higher levels of harassment and pressure from managers.**

Indicator 7 shows some improvement in staff satisfaction over time for both groups, but this has **stalled in the past year for staff with a long-term condition**.

- Staff with a LTC or illness: UHSussex
- Staff without a LTC or illness: **UHSussex**
- Staff with a LTC or illness: National Average
- Staff without a LTC or illness: National Average

Indicator 8 demonstrates an increase in the proportion of staff with a long-term condition reporting that reasonable adjustments have been made. Overall, while there is evidence of improvement in some areas, disparities in staff experience between those with and without a long-term condition persist.

University Hospitals Sussex
NHS Foundation Trust

Perinatal Quality Oversight Model (PQOM)
Trust wide summary report

February 2026 Data

Purpose and background

NHS
University Hospitals Sussex
NHS Foundation Trust

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

NHS
University Hospitals Sussex
NHS Foundation Trust

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.

NHS
University Hospitals Sussex
NHS Foundation Trust

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

University Hospitals Sussex NHS Foundation Trust

Escalations for April meeting

- UHSussex maternity services received significant negative media coverage in February, including interviews with a number of families who have lost babies while in our care.
- The sustained scrutiny of maternity and neonatal services presents a risk to confidence in services.
- Announcement made regarding an investigation, scope to be confirmed, chaired by Donna Ockenden.
- Mitigations are in place, including information on our website, and social media which makes clear that according to the most recent MBRRACE, UHSussex is one of the safest maternity services in the country.
- The divisional leadership team have provided online forums for maternity staff affected by the media coverage. These were very well attended and reflected the impact these very difficult events have had on them.
- National Maternity and Neonatal Investigation (NMNI) visited SRH and Worthing in February and extra interviews with Senior Management Team have continued through early March.
- Human Tissue Authority is expected to visit the Trust in April 2026; it is expected all four sites to be inspected and remedial works are needed to ensure Maternity and Neonatology areas meet regulations; these are being actively addressed by the Heads of Midwifery and Head of Quality and Safety
- Concerns with Estates across all sites.

Celebrations for April meeting

- Remedial actions required to comply with HTA recommendations have been undertaken in RSCH and PRH; still await CCTV and Swipe access as indicated but now all refrigerators are installed.
- Work has started on the Bereavement Suite at PRH
- ROTEM Devices have arrived; a ROTEM (Rotational Thromboelastometry) device is a point-of-care, bedside analyzer used to rapidly assess a patient's blood clotting ability during, or after, major surgeries and trauma, enabling clinicians to tailor treatment for bleeding.
- Improved signage on all four sites as per the Maternity Care Bundle

2. Risk register updates

New and closed risks:

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

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

Domains

NHS
University Hospitals Sussex
NHS Foundation Trust

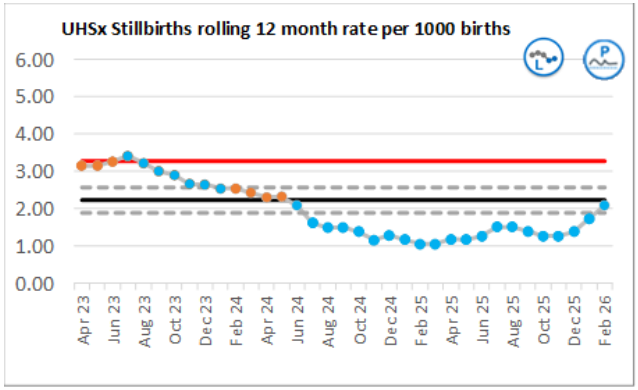
3a) Deaths and Harm

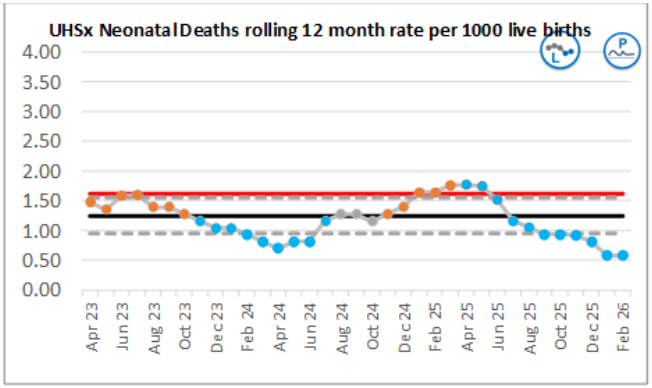
- Perinatal Mortality cases for February 2026
- RSCH: PMRT case – No care concerns identified on initial review
- RSCH: PMRT case - No care concerns identified on initial review
- SRH: PMRT case: No care concerns identified on initial review

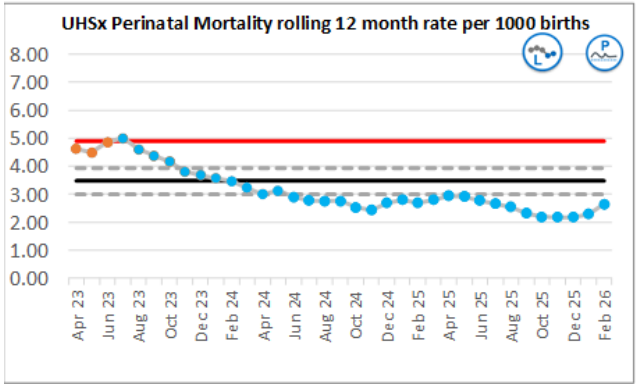
- Perinatal Morbidity cases for February 2026
  - PRH: 1 ELR – DVT

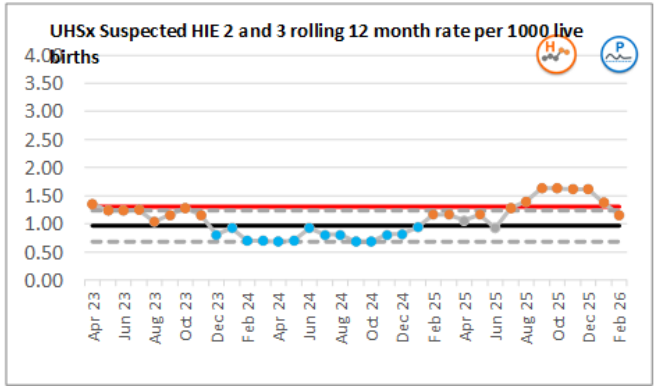
3a) Deaths and Harm
Perinatal Mortality Statistical Process Control (SPC) charts

University Hospitals Sussex NHS Foundation Trust









Outcomes from April 2024 using 24/25 data as a baseline.

Analysis:

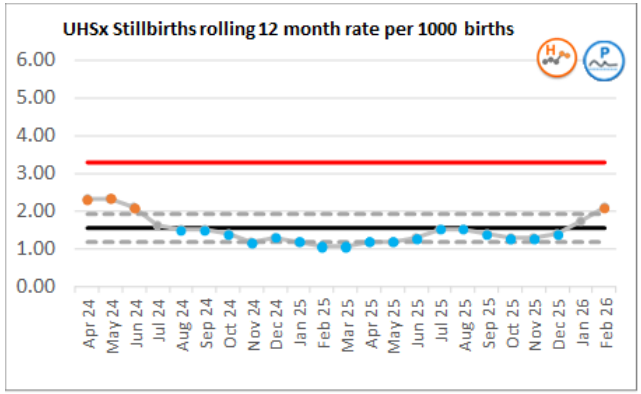
The Board can take assurance that perinatal mortality and stillbirth rates remain stable, significantly below national rates and better than aspirational national targets for 2025.

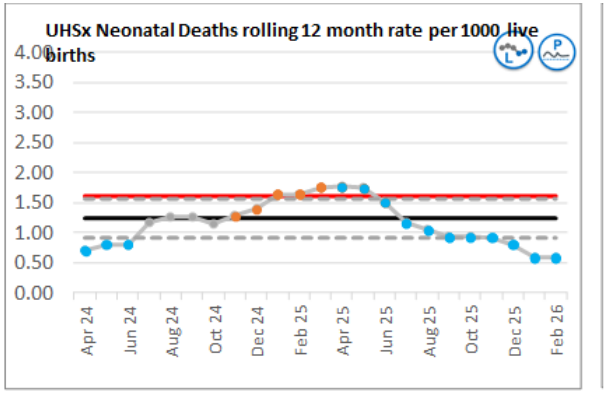
As previously reported, a thematic review has been completed for suspected HIE (brain injury) cases. Final MNSI reports on the cases have been received, a second review to triangulate the internal thematic review findings against the MNSI investigation findings has taken place and results will be shared with March data.

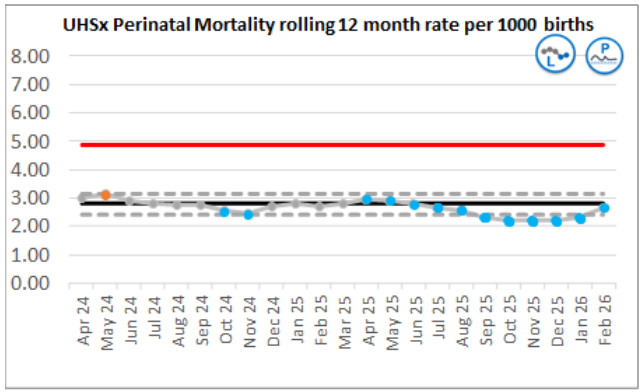
No HIE cases have occurred on any site in January and February 2026

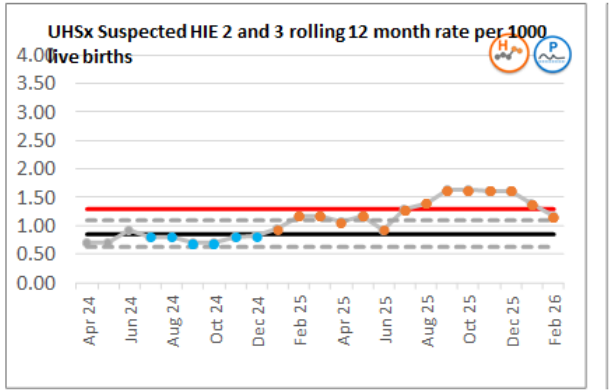
UHSx Stillbirths, NND, PMR and suspected HIE 2 & 3 from Apr 2024

University Hospitals Sussex NHS Foundation Trust









Due to the small numbers involved, Rare Event SPC chart for Neonatal deaths is now included in appendix 1, to allow for monitoring of mortality and morbidity outcomes.

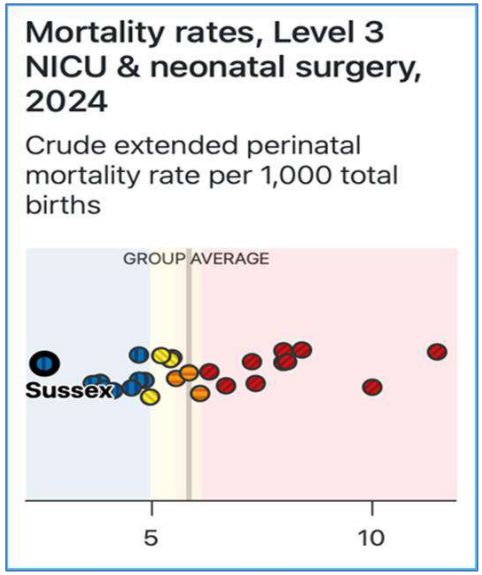
Although trending down in February, the HIE data point remained above the mean. The thematic review panel has now happened (March 2026) and learning will follow imminently. Thematic review of stillbirth will take place after a planned review for PPH.

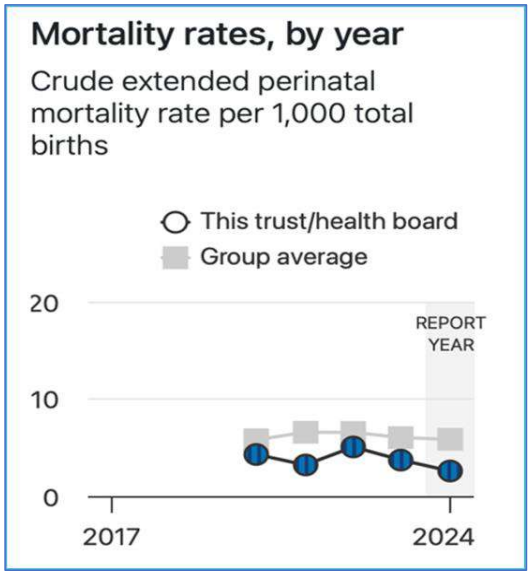
MBRRACE data (2024)

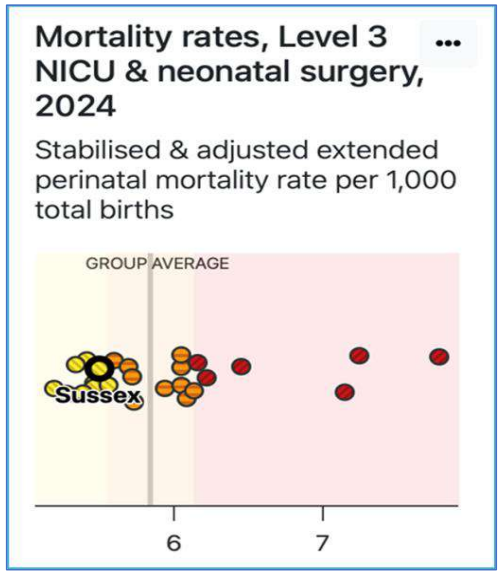
University Hospitals Sussex NHS Foundation Trust

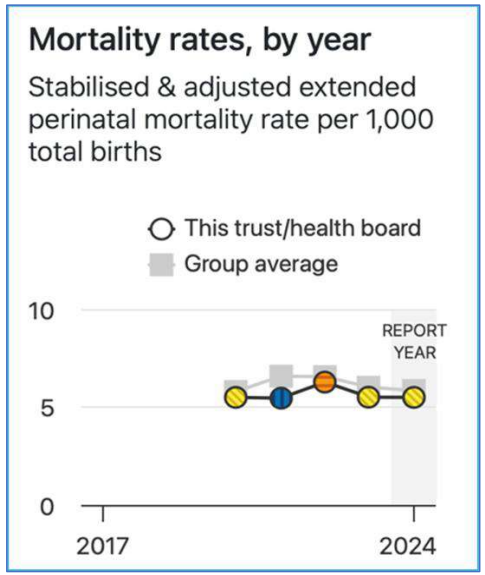
MBRRACE published their latest comparison data in March 2026. The data both for our comparator group (Trusts with a level 3 neonatal intensive care unit and a neonatal surgical service) demonstrate that UHSx have some of the lowest mortality rates in the country. Source: https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/data-viewer/

Extended Perinatal mortality (stillbirths and neonatal deaths combined) - comparator group data





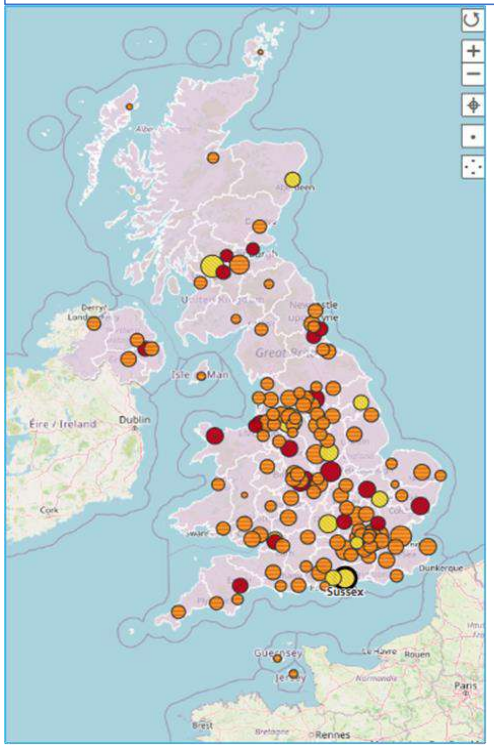


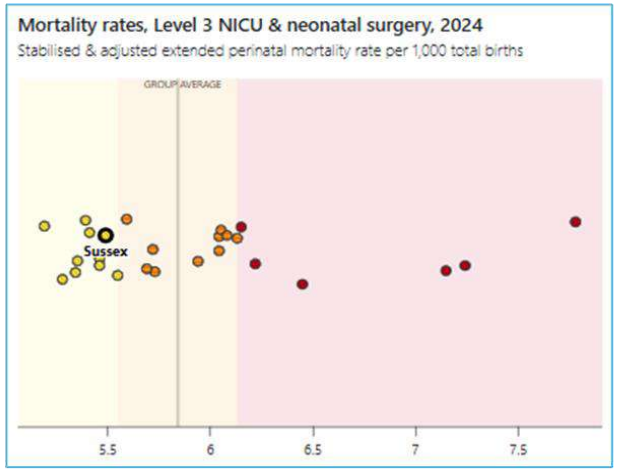


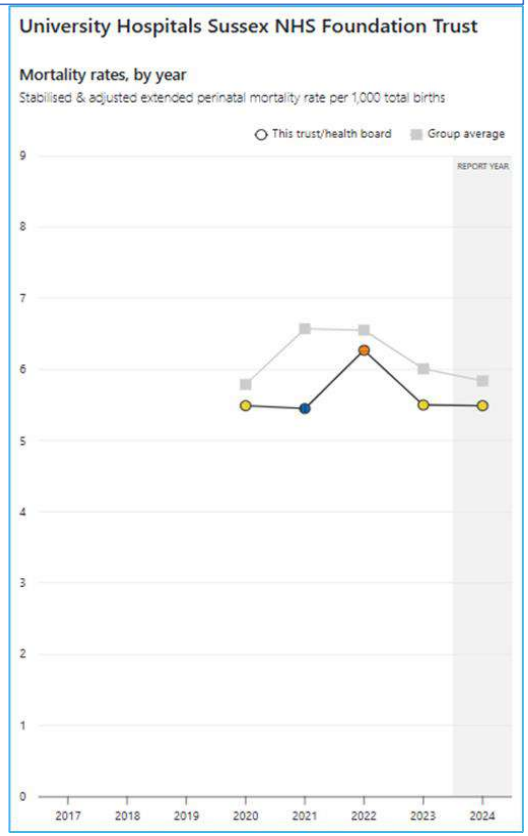
University Hospitals Sussex NHS Foundation Trust

National data

UHSx was one of only nine Trusts in the UK to have stabilised and adjusted perinatal mortality rates 5 to 15% lower than average.







Health inequalities

University Hospitals Sussex NHS Foundation Trust

- 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.

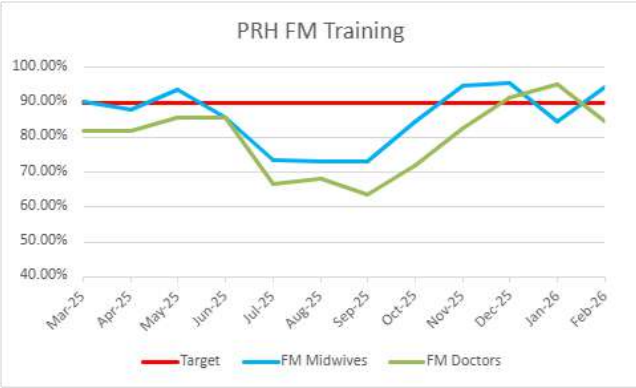
Analysis of February data:

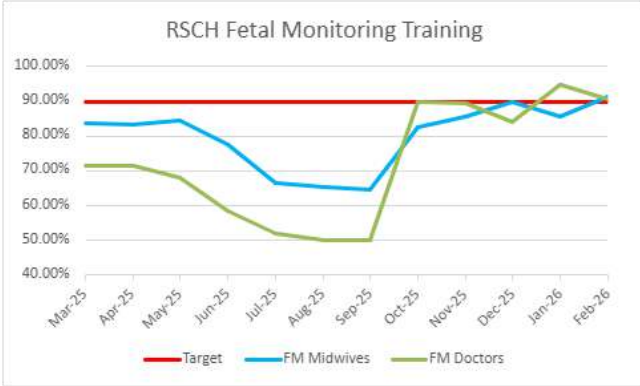
Awaiting data from LMNS

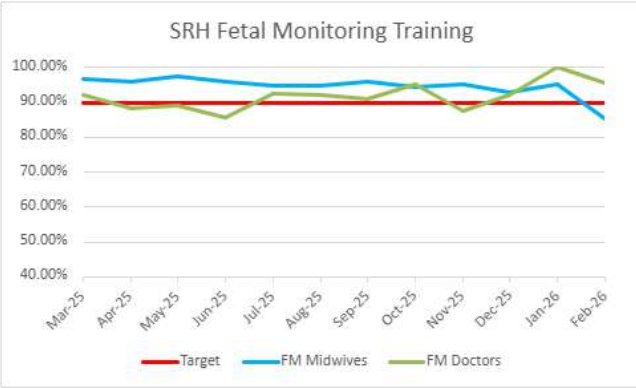
Numbers of women in these groups are very small, therefore, any case can trigger a 'significant deterioration' flag. However, the stillbirth cases will be reviewed via PMRT with a focus on Health Inequalities and risks associated with Global majority groups in pregnancy to consider if the stillbirths could have potentially been avoided.

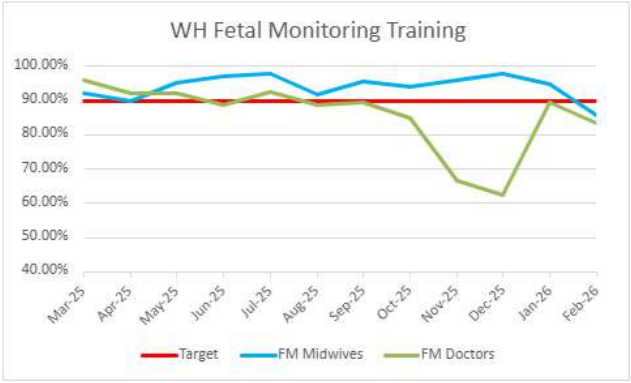
3b) Leadership and training: Fetal Monitoring

NHS
University Hospitals Sussex
NHS Foundation Trust









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.

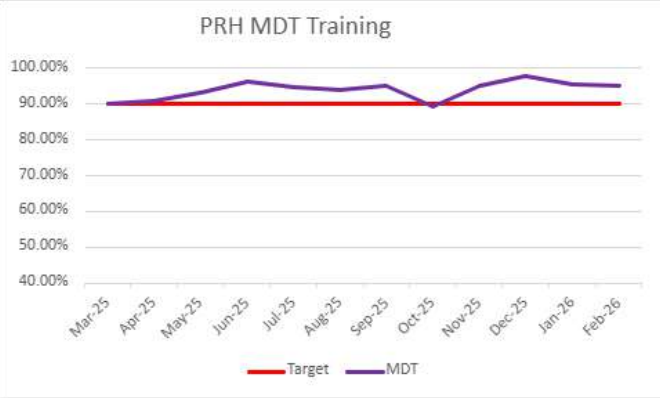
A working group has been established to resolve this issue and ensure responsive communication and accountability.

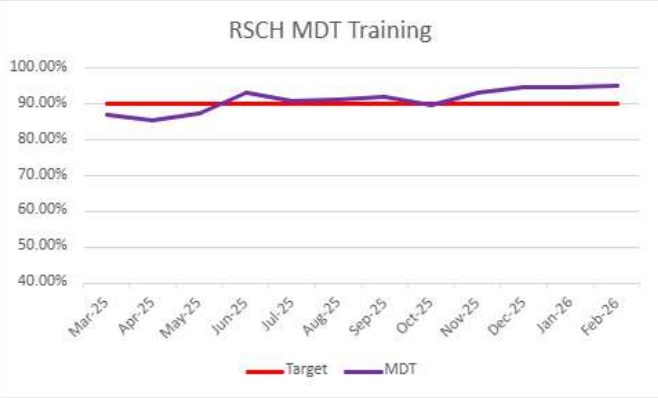
WH has seen a drop incompliance due to a number of new Obstetricians joining the trust in October and not being able to be released from the rota until early 2026. They are all booked on to attend in the next few months.

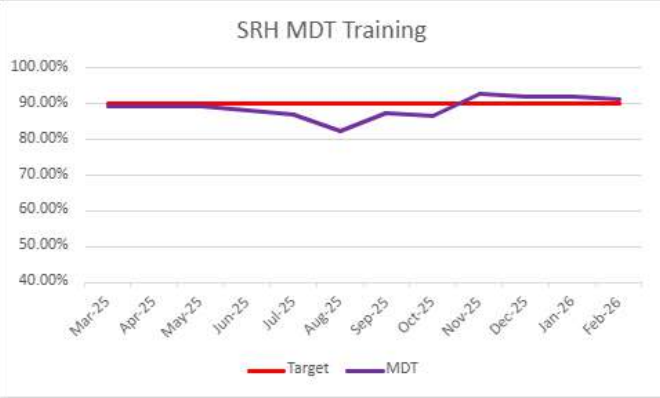
The reporting for Jan 26 onwards compliance will follow CNST guidance which is not to include new members of staff under 6 months in post in reporting.

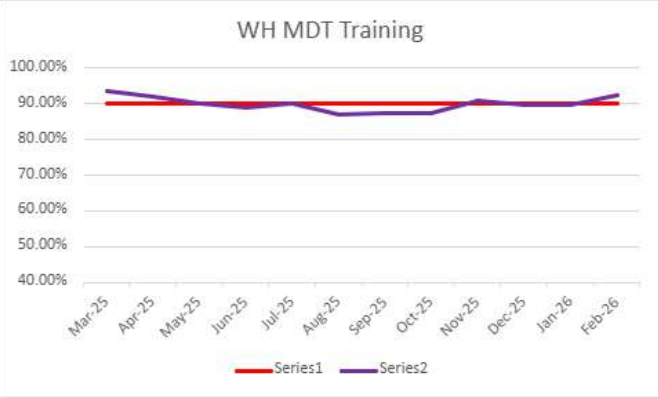
3b) Leadership and training: Multidisciplinary Training

University Hospitals Sussex NHS Foundation Trust





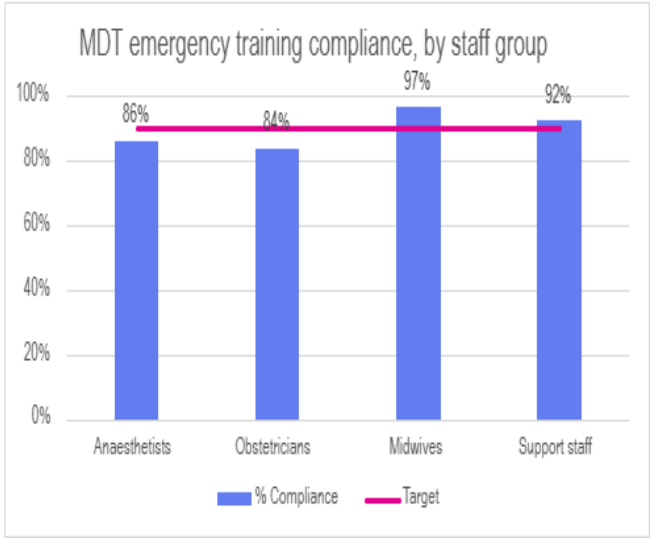




Charts to left display all staff groups combined compliance with staff specific compliance below for February.

Each staff group needs to reach 90% by two dates to achieve CNST compliance for Year 8:

- 30th November



3c) Voice of the user

University Hospitals Sussex NHS Foundation Trust

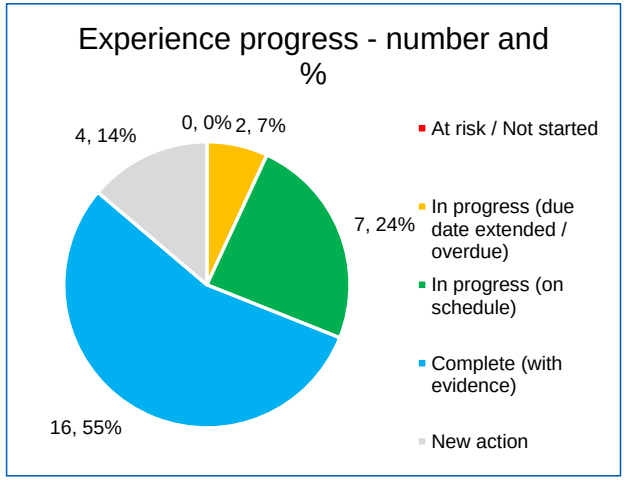
Voice of the user	Princess Royal, Haywards Heath	Royal Sussex County Hospital, Brighton	St Richards Hospital, Chichester	Worthing Hospital, Worthing
FFT (% and response rate)	100% (RR8%)	94.44% (RR10%)	86.67% (RR 9.49%)	93.75% (RR11.27%)
Complaints	3	3	3	1
Legal Claims	0	2	0	1
MNVP concerns	0	0	0	0

Scores remain well above national benchmarks at all sites in February 2026 with a concerning downturn at SRH. Response rate continues to be a challenge across all sites . Sustainable improvement in this area is known to be difficult from national learning. The local QI around this is still being developed.

Whole numbers of new complaints received (10) were within normal limits in February The chief theme of those complaints was documented to be concerns related to Clinical Care although there were no overarching themes as the source of the complaints were from different stages of pregnancy/labour. These themes will be triangulated with patient safety and claims data to inform further quality improvement.

MatNeo Service user experience workstream

- Overall, feedback about the service continues to be positive from FFT, Tendable, MNVP and quarterly reports.
- Complaints have reduced since a peak in Oct-Dec 2025



Escalations:

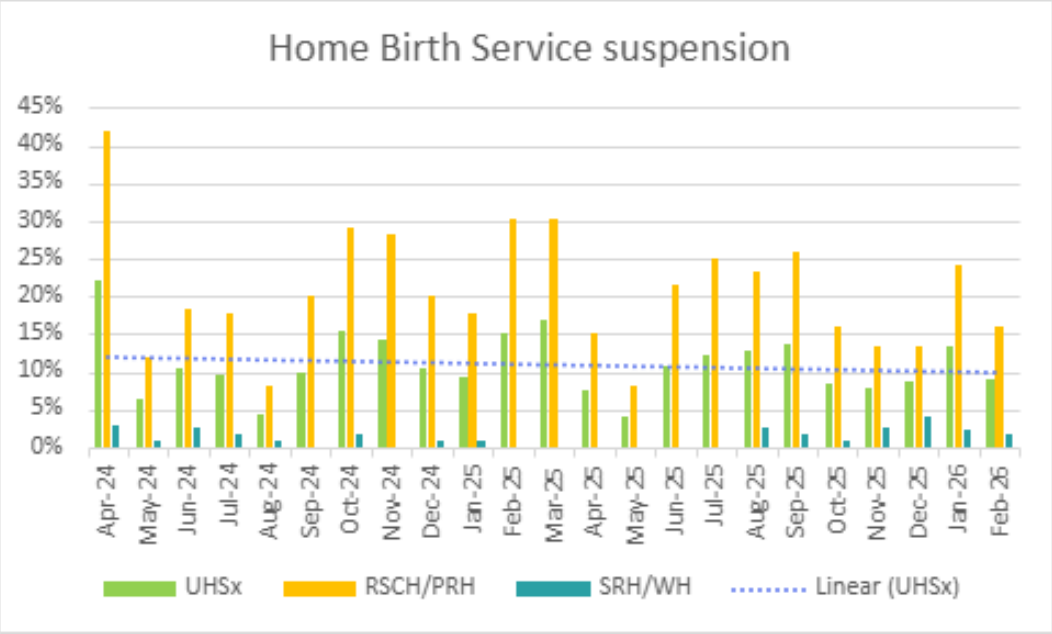
- Low Neonatal FFT responses – investigating barriers

Celebrations

- Venue found for infant feeding classes
- Postnatal posters developed to remind parents of meal times, ‘Who’s Who?’
- Increase in positive birth stories being shared on social media.

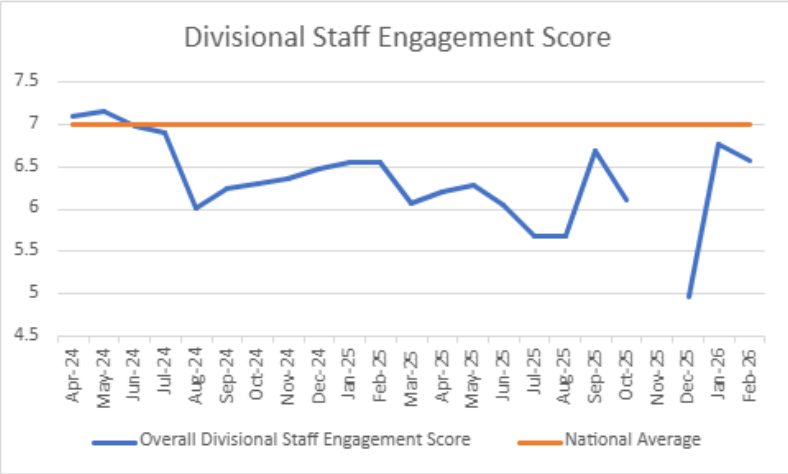
Homebirth suspensions

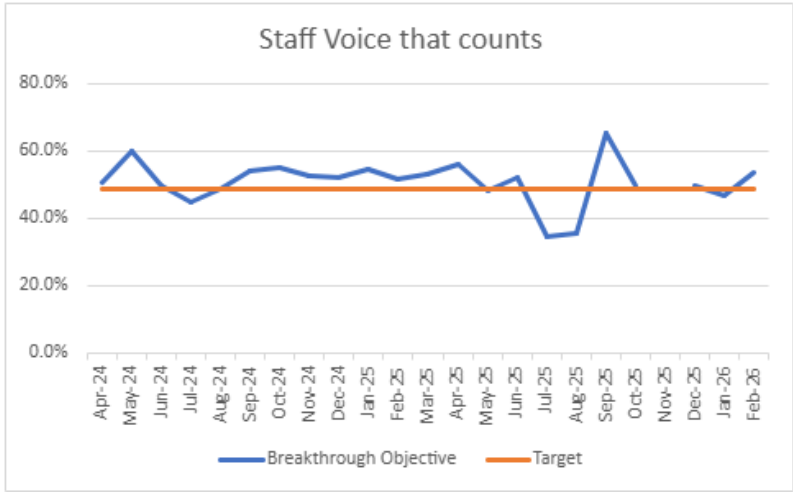
University Hospitals Sussex NHS Foundation Trust



- February showed a decrease for suspensions to 18% of the 12 hours shifts suspended. This was due to recruitment into the team.
- This meant that the Homebirth service was cancelled for 10 shifts out of 56. This translated to 1 women/people out of 22 (5%) having to give birth outside of their preferred birth location as a result of suspending the homebirth service.
- Continuity of care team continue to cover the gaps within the homebirth team to maintain a lower suspension rate.
- Rotation of passionate core/community midwives taking bank shifts to continue to cover vacancy within the Homebirth team.
- The team will have a vacancy rate of 2.45WTE.
- Benchmarking completed for home birth service against Prevention of Future Deaths notice from Manchester case.

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.
- Maternity leadership is looking at the staff survey around the two points that have fallen since last year: flexible working and value of appraisals.

Actions

- Exploring the issues surrounding flexible working as many staff members are on flexible working agreements; this will be done via ImproveWell
  - The new appraisal document in the trust has launched recently therefore will be used for FY26/27
- 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.
- Separate Listening Events have been completed to prepare and support staff for the media coverage.

MatNeo Leadership and Culture

NHS
University Hospitals Sussex
NHS Foundation Trust

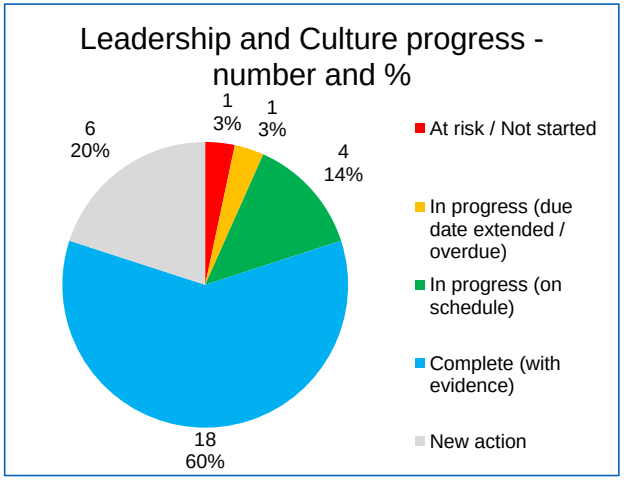
- The workplan has been updated with the most recent actions from staff survey feedback, GMC survey, culture coaches work and other staff feedback.
- Further, the Maternity Clinical Governance day held in March focussed on workplace culture. Outputs from this meeting will also be included in this workplan.

Escalations:

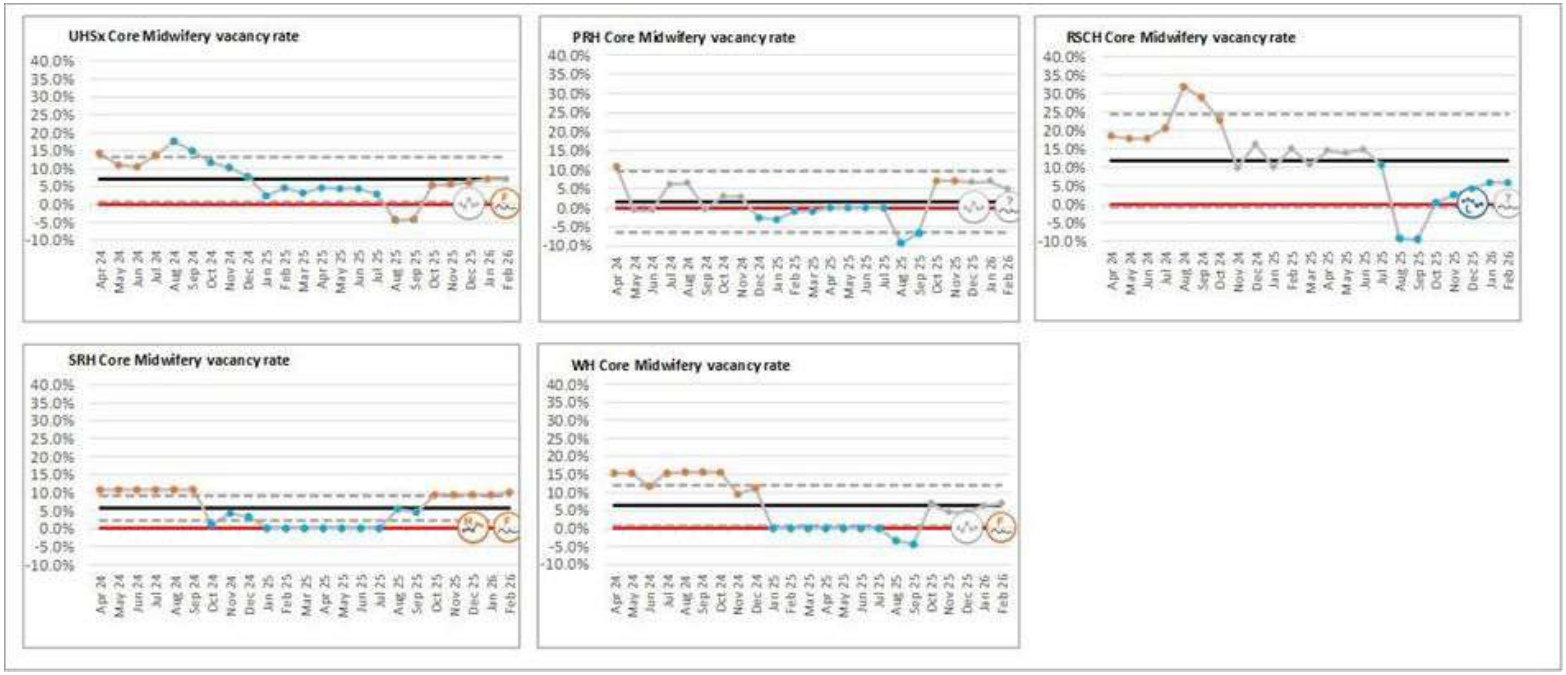
- Morale impacted by NMNI, media attention and recent changes to staffing.

Celebrations:

- PMA model finalised
- Culture coach training beginning



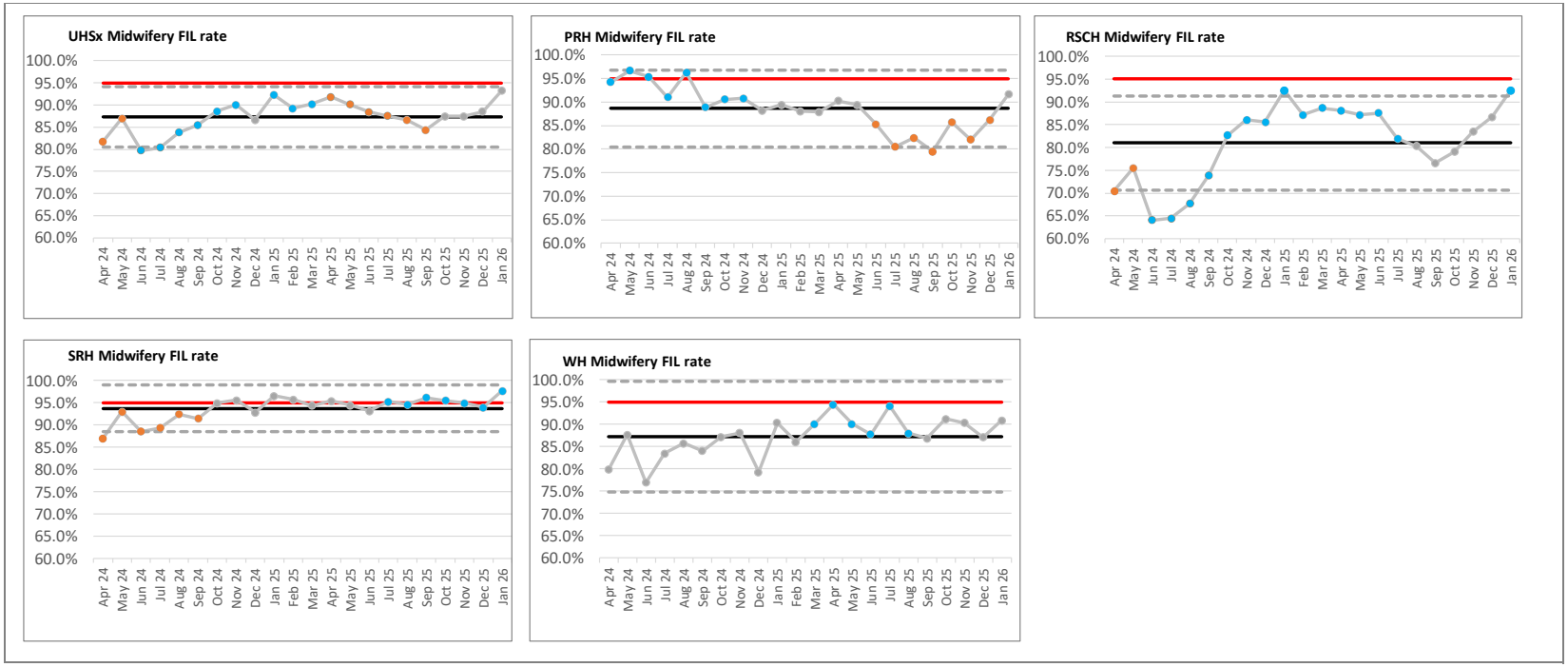
Perinatal workforce – Midwifery vacancy rate



The overall substantive midwifery vacancy remains at 0%. However, where parental leave and secondments to other teams is included, the current vacancy has increased to 7.1%. We are actively recruiting into these gaps and expect the numbers to rebound in later months. The current model of one preceptorship cohort a year in October who start at a Band 5 and progress to a B6 after around 12 months affects are ability to recruit to B6 vacancies over the spring and summer as these roles are essentially 'held' for these staff members. We are exploring alternatives such as fixed term Band 5 contracts and the potential to run 2 preceptorship cohorts each year.

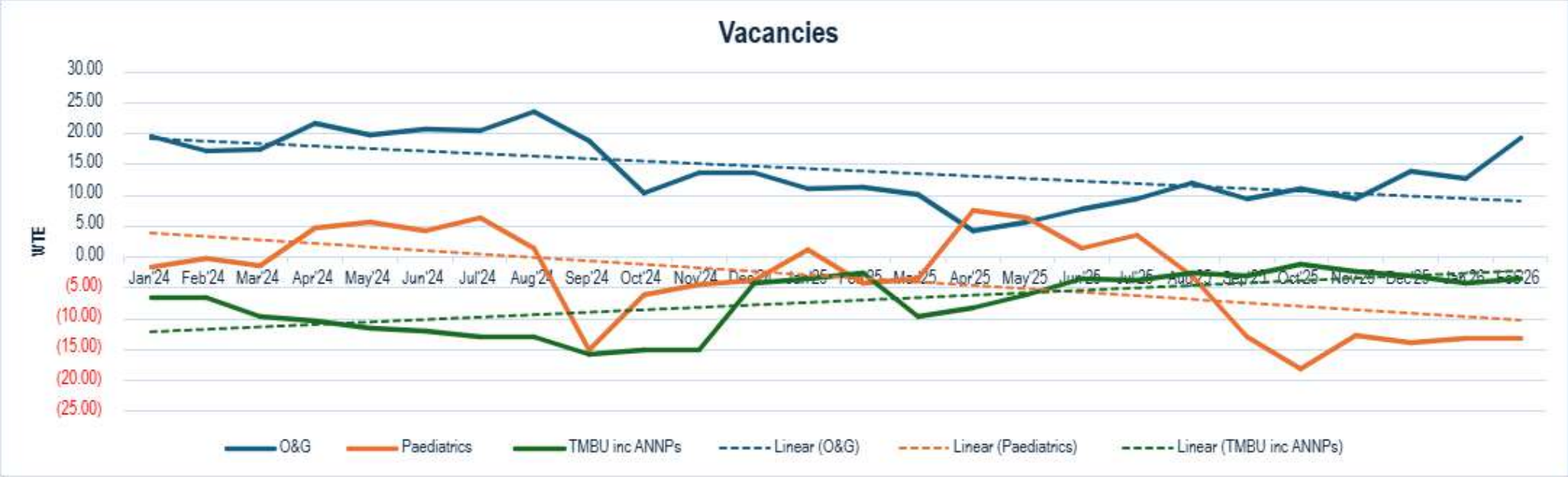
Perinatal workforce – Midwifery Fill rate

University Hospitals Sussex NHS Foundation Trust



- Fill rates are significantly improved overall since summer 2024, however some volatility remains, particularly at PRH.
- At PRH & RSCH reductions in fill rates in summer 2025 can be accounted for due to progression of B5 Preceptorship midwives to the B6 line, leaving B5 posts unfilled until the next cohort start in October. If plans for B5contracts to move to 12-month fixed term contracts in autumn 2026 are agreed, this will help to mitigate this risk in future.
- Agency use has completely ceased since Nov 2025 alongside a reduction in bank use.
- High sickness and parental leave rates remain a challenge. Fixed term contracts can sometimes mitigate these gaps, however advertised vacancies are not always filled.
- One-to-one care during established labour is consistently provided, though occasionally midwives are redeployed from other services, like the postnatal ward or homebirth service, to achieve this which is not accounted for in this data.

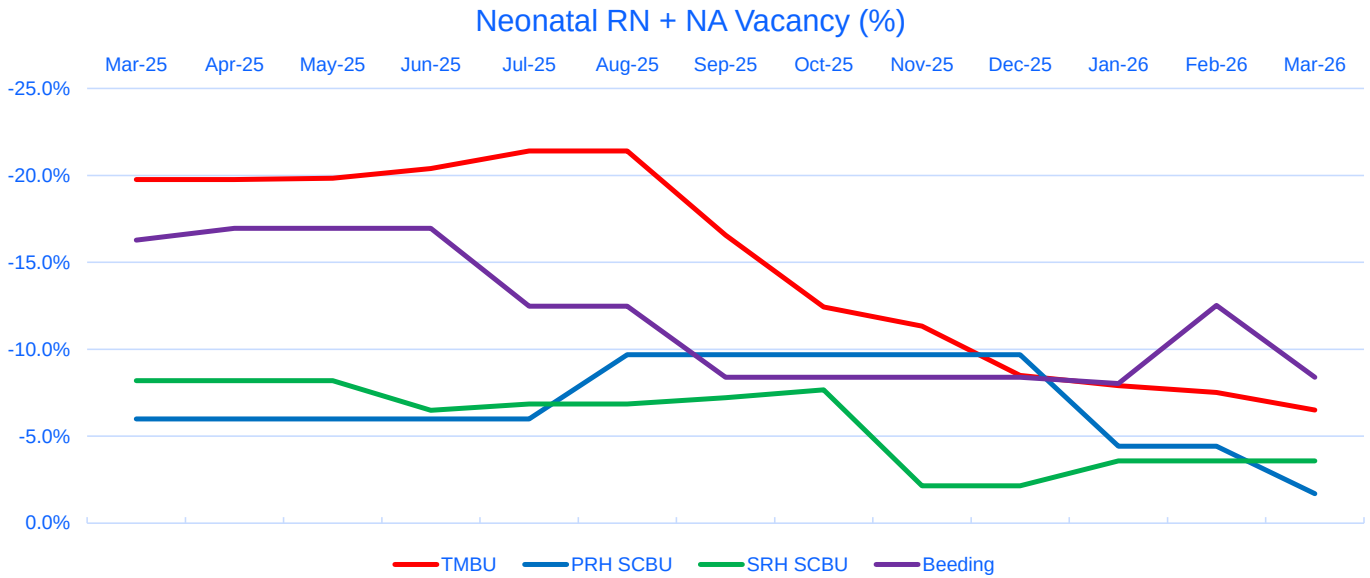
Perinatal workforce - medical



Obstetrics: Maternity cover now in place at RSCH. Interviews for vacancy at SRH taking place 24/04/2026. Middle grade and SHO recruitment being undertaken across all sites. It is thought that a driver for the current vacancy rate is that specialty trainee's cover only a percentage of the intended roles. At Worthing, there is a business case being drafted to change two middle grade to SAS contracts to cover the shortfall identified.

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



Beeding	12.5%
PRH SCBU	4.4%
SRH SCBU	3.6%
TMBU	7.5%
OVERALL	**7.0%**

In February, the clinical registered nursing vacancies across a 4 sites (B7-B4) average of 7% which is slightly up from last month 6% due to the internal promotion of the Band 7 ward manager to Matron role.

Band 6 QIS coverage at TMBU remains static at 42%, 10 WTEs completing QIS course predicted to finish in May 2026. 14 started QIS course in February 2026, with a potential 8 to start QIS in June 2026.

Actual verses Planned

Overall, in February there was no large variation/difficulties within registered staffing.

TMBU refusals

University Hospitals Sussex NHS Foundation Trust

	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	2	0	2	0	0	0	0	0	2
Refusals Ex Utero	0	0	0	0	0	0	0	0	2	2*

December 31 referrals (13 IUT/18 EUT, 3 being surgical)
January 30 referrals (15 IUT/15 EUT, 5 being surgical)
February 23 referrals (11IUT/11 EUT, 6 being surgical)

Referrals accepted February 2026

IUT (9/11) accepted. 2 refused by Maternity.

EUT (9/11) accepted. 2 refused (this was the same baby, 44wks – inappropriate referral and should be looking to the RACH).

EUT (surgical) (6/6) accepted.

There was an 77% occupancy rate overall in February for TMBU of which 23% ITU, 57% HDU and 141% SCBU days.

Maternity Safety Support Programme

Maternity and Neonatal Improvement Plan

Maternity (Perinatal) Incentive Scheme

Maternity (Perinatal) Incentive Scheme

CNST – Year 8 launch

University Hospitals Sussex NHS Foundation Trust

- New guidance for Year 8 was released on 31st March.
- There are now six safety standards (originally 10), RAG rated below:
  A. Workforce and capacity
  B. Training
  C. Learning from reviews and investigations
  D. Service-user voice and equity
  E. Care bundles
  F. Board oversight, governance, culture and leadership
- A gap analysis has been undertaken against the guidance in full with the following assurances and gaps highlighted (see next page)

MIS Year 8 – key points

University Hospitals Sussex NHS Foundation Trust

- **Risks to compliance – Board support required:**
  - Safety Action A - Workforce planning
    - Budget setting implications impact ability to:
      - Demonstrate progress against BAPM neonatal nursing workforce action plans (submitted as part of Year 5-7 compliant CNST declarations)
        - Further, In order to support staff to pass their Qualified in Specialty (QIS), nurses will need 150 hours supernumerary time, as set out by NHS England. For those staff working on SCBUs at PRH, WH and SRH this would mean having 150 hours at TMBU to gain NICU experience. This is currently completely un-funded.
      - Provide evidence to show Board approved funding for BR+ recommended midwifery establishment every 3 years
  - Safety Action B - Training
    - Obstetric and anaesthetic doctors to have training planned into rotas throughout the year, to achieve 90% compliance **twice** a year
      - 31/07/26 (first date proposed) and 30/11/26 (mandated by CNST)
    - Obstetric and anaesthetic doctors to be given time to ensure MDT faculty

- **Assurances**
  - Safety Actions C, D, E and F are mostly well embedded processes, or require minor changes to current practice.
  - Where there are new sub-standards within CNST (Maternal Care Bundle implementation, Neonatal pulse oximetry testing and accessible information, including equitable translation services), there are working groups already progressing improvements before this guidance was published.

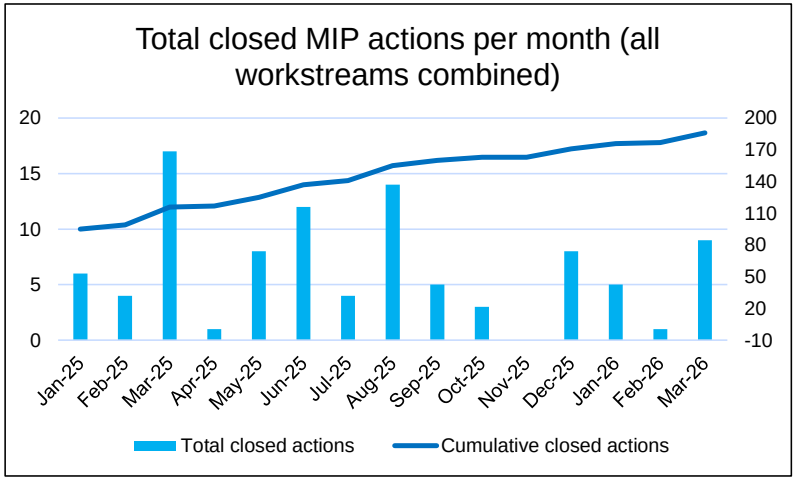
MIS Year 8 - Gap analysis detail

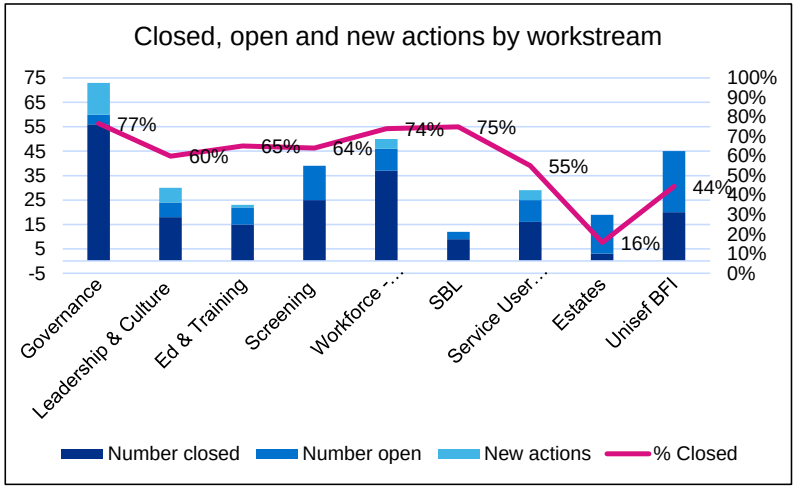
NHS University Hospitals Sussex NHS Foundation Trust

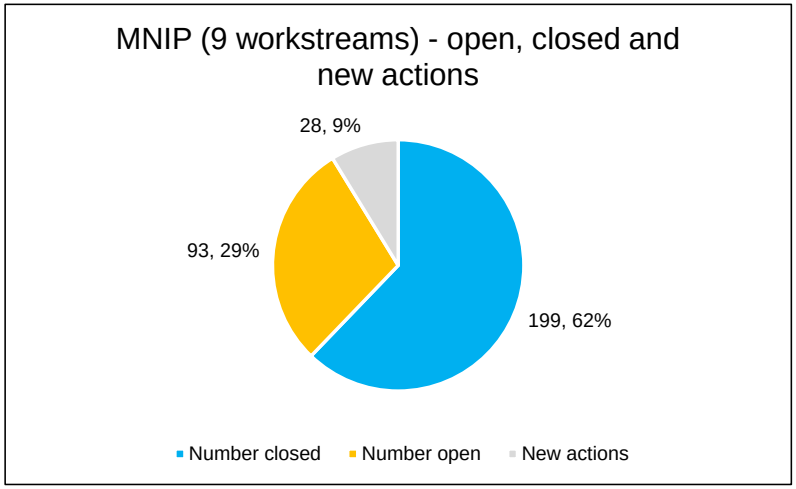
Safety Action	Title	Compliance forecast	Next steps
A - Workforce and capacity	Consultant attendance (obstetric workforce)	High - minor gaps in current processes	Increase compliance with monitoring tool
	Short-term locum certification (obstetric workforce)	High - minor gaps in current processes	Ensure Temporary Staffing processes align with guidance in full
	Neonatal workforce establishment (nursing & medical)	Low - significant gaps	Budget setting implications impact ability to show progress against BAPM compliance action plans
	Midwifery workforce establishment	Low - significant gaps	Budget setting implications impact ability to demonstrate meeting BR+ establishment as minimum baseline.
	Anaesthetic workforce	High - minor gaps in current processes	Ensure anaesthetic assistant rotas are available
	Planned Caesarean birth capacity mapping	High - minor gaps in current processes	Part of MNIST elective theatre mapping for all sites.
	Board and governance oversight (as detailed in Safety Action F)	High - minor gaps in current processes	Ensure all of the above included in perinatal workforce reports
B - Training	Obstetric emergency training	Low - significant gaps	Develop robust plan for obstetric and anaesthetic compliance to be maintained at 90%+ twice in the year, including evidence of MDT faculty – support staff to be released.
	Neonatal resuscitation	Medium - requires sustained focus	In-house training meets BAPM standard but must maintain 90% compliance twice in the year.
	Fetal monitoring training	Medium - requires sustained focus	Develop robust plan for compliance to be maintained at 90%+ twice in the year, including evidence of MDT faculty – support staff to be released.
	In situ multi-professional perinatal emergencies simulations	High - minor gaps in current processes	Continue unit simulations and plan community-based sim.
	Training compliance oversight (as detailed in Safety Action F)	BAU	Part of monthly CNST reports
C – Learning from reviews and investigations	Notify all qualifying events via SPEN	BAU	Continue
	Seek parents views of care	High - minor gaps in current processes	Review family engagement prompts in line with guidance
	External multi-disciplinary reviewers	BAU	Continue
	Provide relevant information about investigations, inc DoC	High - minor gaps in current processes	Review family information documentation in line with guidance
	Offer parents a meeting with relevant specialists	High - minor gaps in current processes	Ensure availability of specialists and recording of offer and meeting outcomes.
	Thematic reports of learning and actions	BAU	Review quarterly reports in line with guidance
D – Service-user voice and equity	Communication equity, language support and accessible information	Medium - requires sustained focus	Review availability of translation services and accessible information in line with guidance. Ensure equity across sites.
	Service-user voice driving safety and quality improvement	High - minor gaps in current processes	Continue through Service User Experience and Cultural Safety workstreams within MatNeo Improvement Plan
E – Care bundles	Saving Babies Lives Care Bundle (SBLCBv3.2) - Quarterly reporting to the Trust Board	High - minor gaps in current processes	Continue reporting.
	Maternal Care Bundle Implementation Plan	Medium - requires sustained focus	Working groups to progress recently developed plan.
	Neonatal pulse oximetry testing	Medium - requires sustained focus	Draft guideline aligns with standard, but local and Trust wide review and ratification processes are often delayed.
F – Board oversight, governance, culture and leadership	Board Oversight of Maternity and Neonatal Quality and Safety	BAU	Continue quality and safety reporting
	Maternity Outcomes Signal System	Medium - requires sustained focus	Leads to ensure alignment to national SOP.
	Maternity and Neonatal Board Safety Champions	BAU	Continue Board Safety Champion support
	Perinatal Culture Improvement Plan	BAU	Continue via Leadership and Culture plans within MatNeo Improvement Plan.

Progress overview across MNIP

University Hospitals Sussex NHS Foundation Trust







Key successes / challenges:

- Postnatal workstream launched
- Maternal Care Bundle gap analysis complete
- Leadership and culture workstream reviewed and revised data sources feeding into new actions
- Insight actions progressing through relevant workstreams

Maternity and Neonatal Improvement Support Team' (MNIST) and National Maternity and Neonatal Investigation

University Hospitals Sussex NHS Foundation Trust

MNIST

- The scope of the MNIST programme is to achieve a solution to provide separate theatre access for planned caesarean section lists on all sites. This work is overseen by a monthly meeting with MNIST colleagues, service leads and executive representation.

Progress to date:

- RSCH – full access in place, funded and staffed
- PRH – options appraisal to be presented to CTPB in April meeting
- SRH – partial (50%) solution in place, discussions for increased capaity ongoing
- WH – solution agreed for PRH to be replicated at WH.

National Maternity and Neonatal Investigation (NMNI)

- All maternity and neonatal units have now been visited by the NMNI team
- Media coverage related to the investigation has been heavily focussed on services at UHSx, causing distress to both families and staff. Support and signposting continues to be offered.
- The Terms of Reference for the separate investigation into up to 15 families' care is yet to be released, though media attention on this investigation has picked up again in April

Conclusion and recommendations

NHS
University Hospitals Sussex
NHS Foundation Trust

Perinatal services remain under close oversight, with comprehensive opportunities to support staff following intense media scrutiny and the national investigation. Perinatal mortality remains below national benchmarks. There have been no HIE cases occurred since November. Training compliance is improving and user feedback remains highly positive. Workforce pressures persist, including midwifery and neonatal nursing gaps, though recruitment is progressing and agency use has ceased. Capacity and skill-mix challenges continue to drive TMBU refusal. CNST and MNIST workstreams are progressing with the MIS declaration for Year 7 confirmed as compliant by NHS Resolutions.

Several high-scoring risks remain including a new issue surrounding homebirth service assurance following a prevention of future deaths notice, theatre capacity for emergencies and elective caesareans, merged guidance requirements, estates and temperature issues, security and emergency access concerns at Sussex House, and constrained access to early pregnancy and surgical miscarriage pathways. Maintaining staff and public confidence during MNIST targeted support and the Amos investigation remains a priority.

University Hospitals Sussex
NHS Foundation Trust

Appendix 1

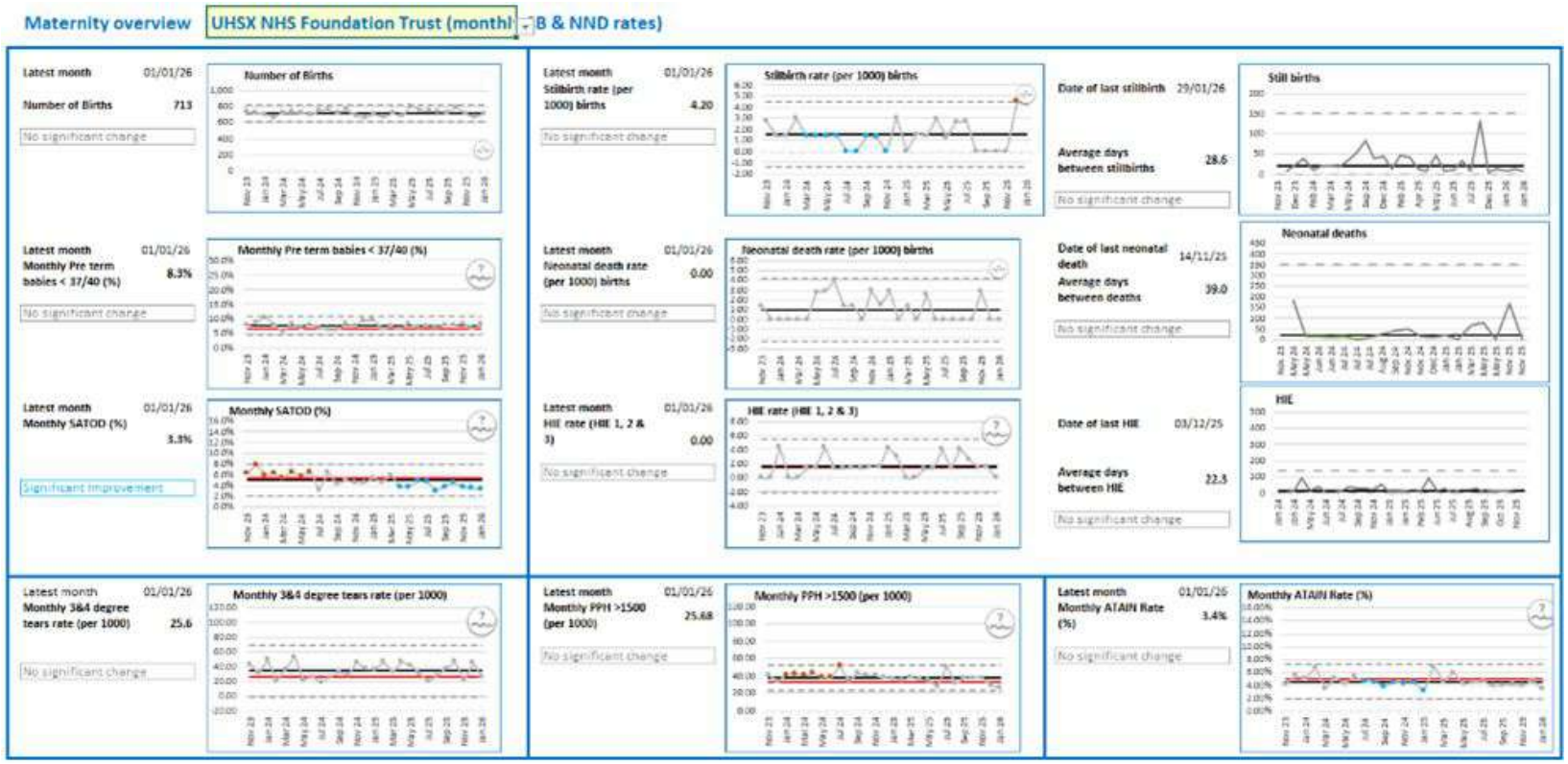
Morbidity and Mortality Outcome Data

Latest data available - January 2026 – *(These will be updated once charts received from LMNS)*

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

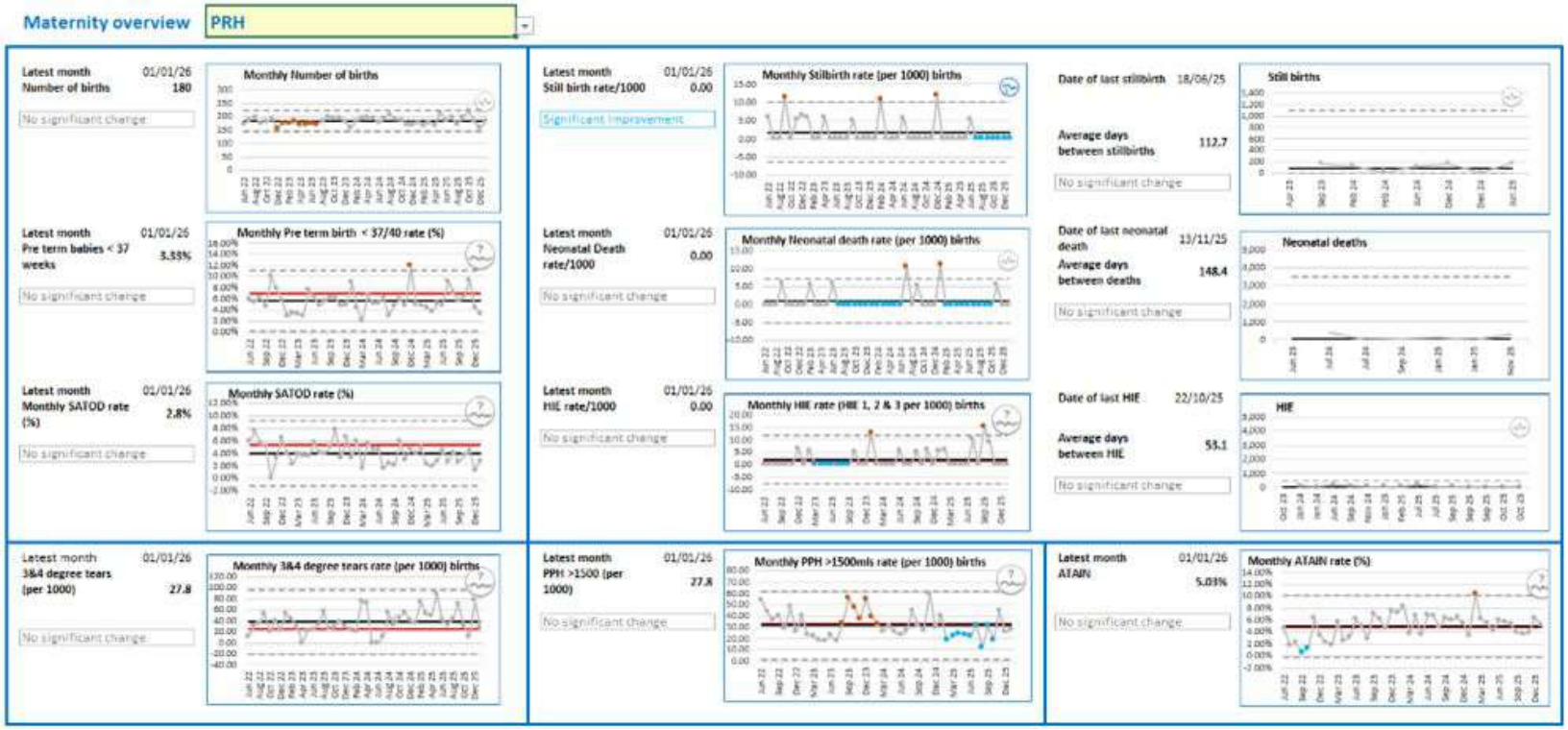
UHSx

NHS
University Hospitals Sussex
NHS Foundation Trust



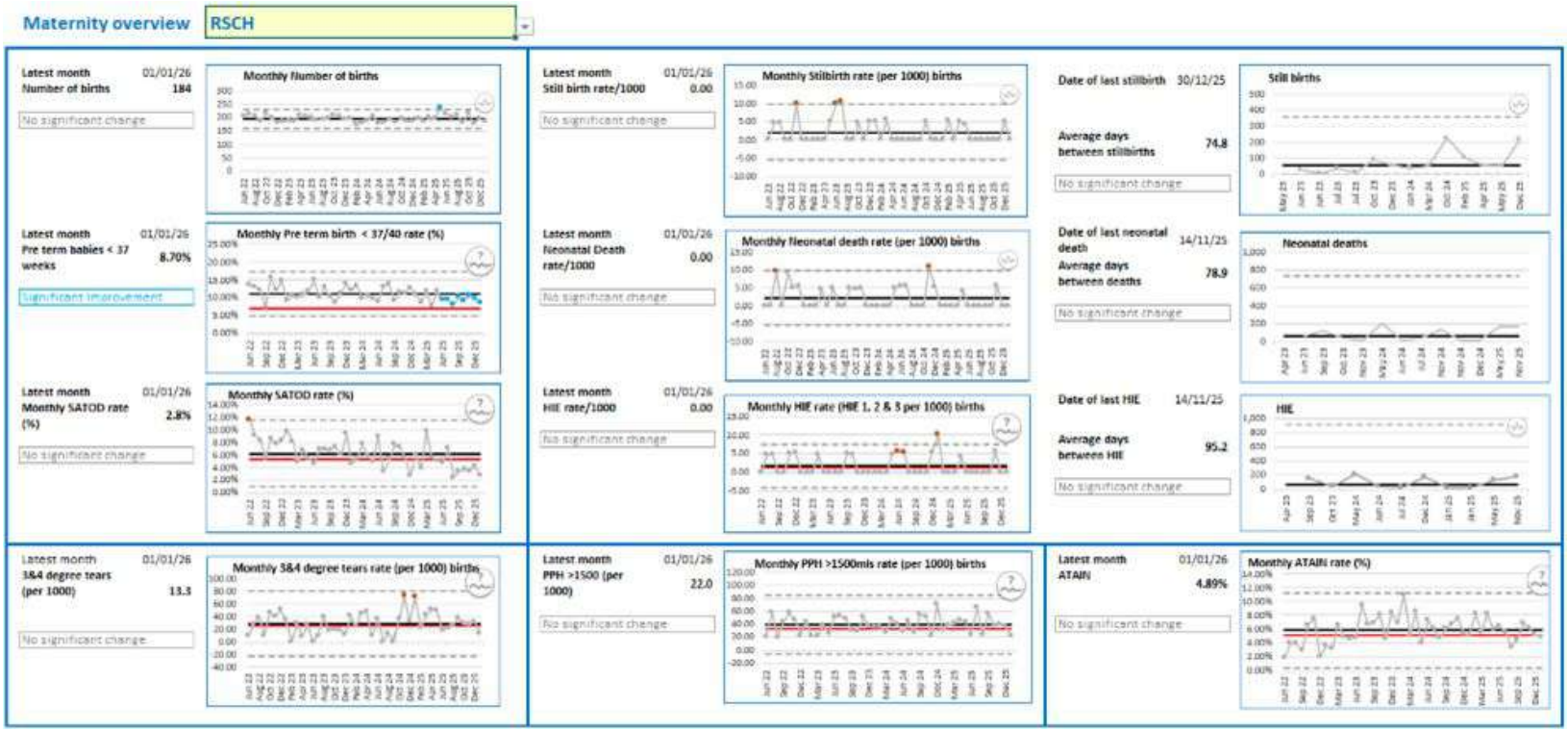
NHS
University Hospitals Sussex
NHS Foundation Trust

Haywards Heath



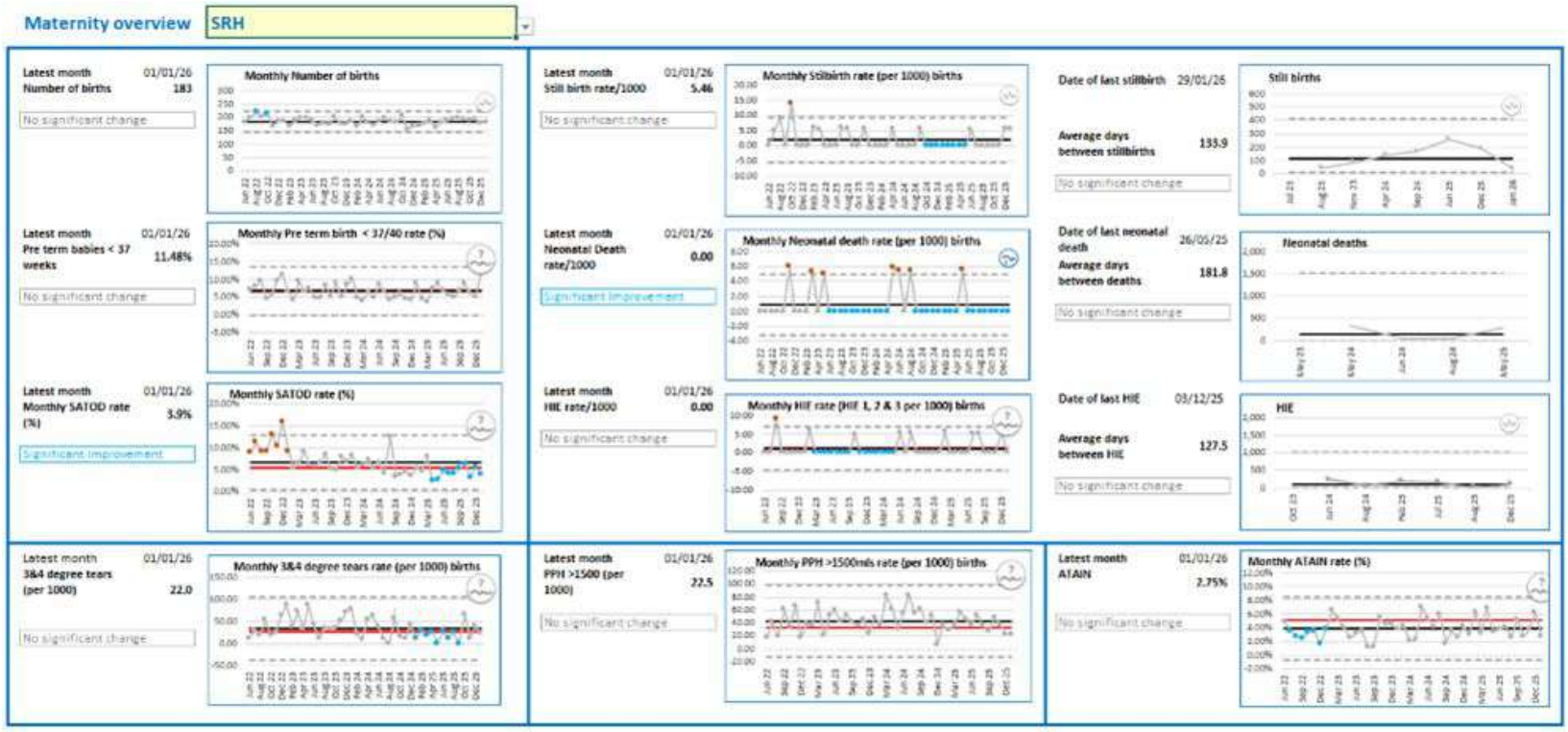
Brighton

NHS
University Hospitals Sussex
NHS Foundation Trust



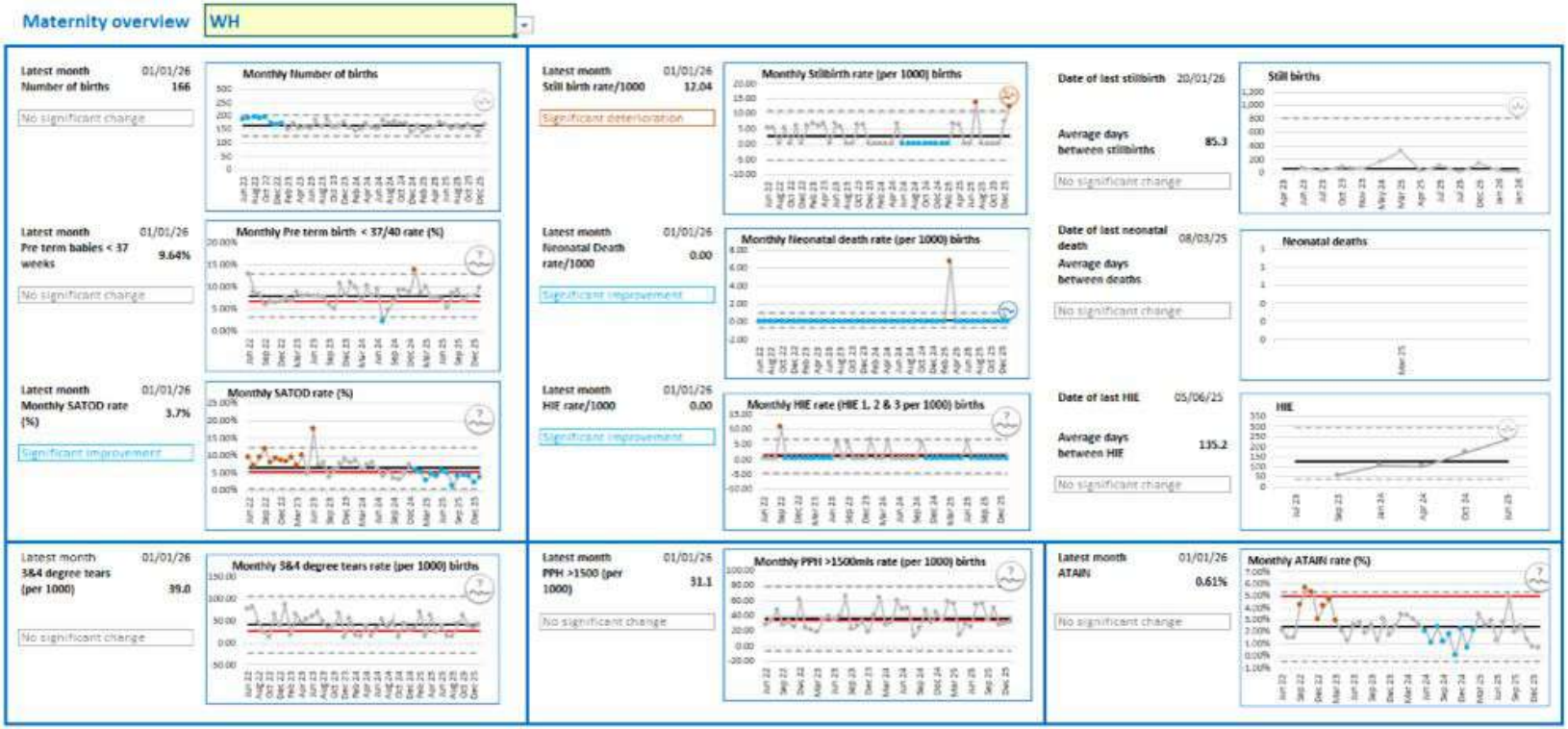
Chichester

University Hospitals Sussex NHS Foundation Trust



NHS
University Hospitals Sussex
NHS Foundation Trust

Worthing



NHS
University Hospitals Sussex
NHS Foundation Trust

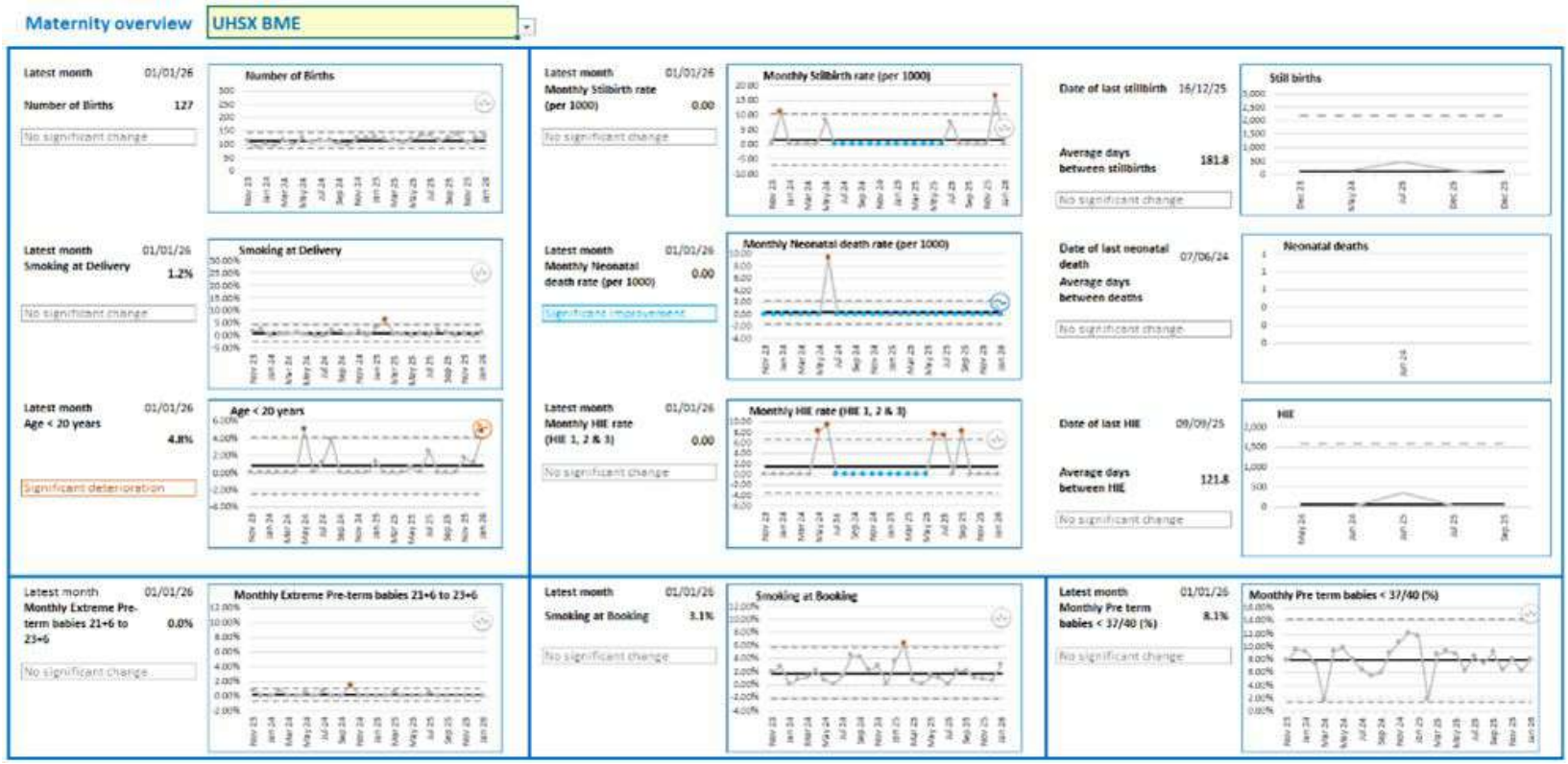
Appendix 2

Health Inequalities Segmented Data

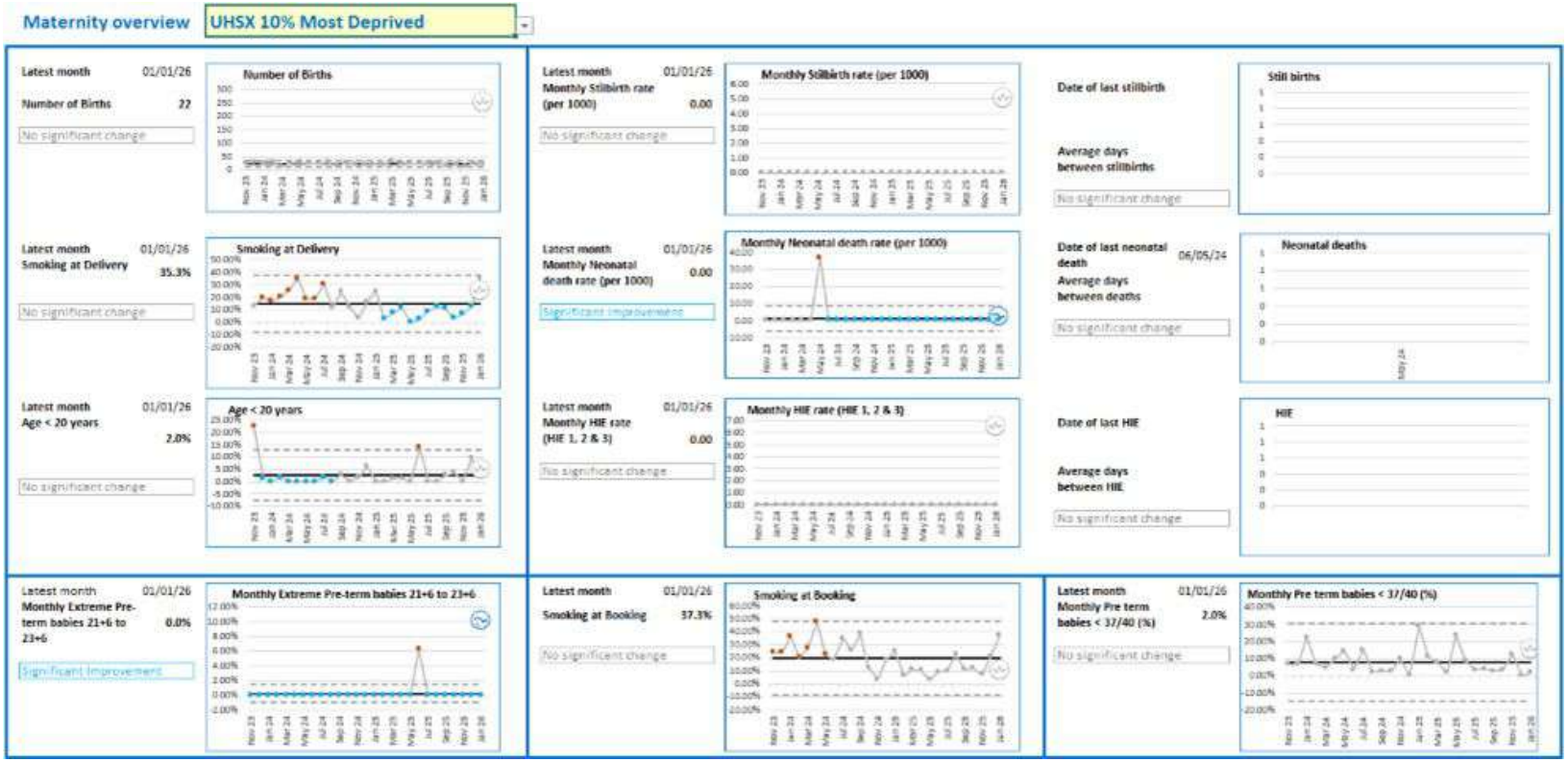
Latest data available - January 2025

University Hospitals Sussex
NHS Foundation Trust

UHSx– Global Majority

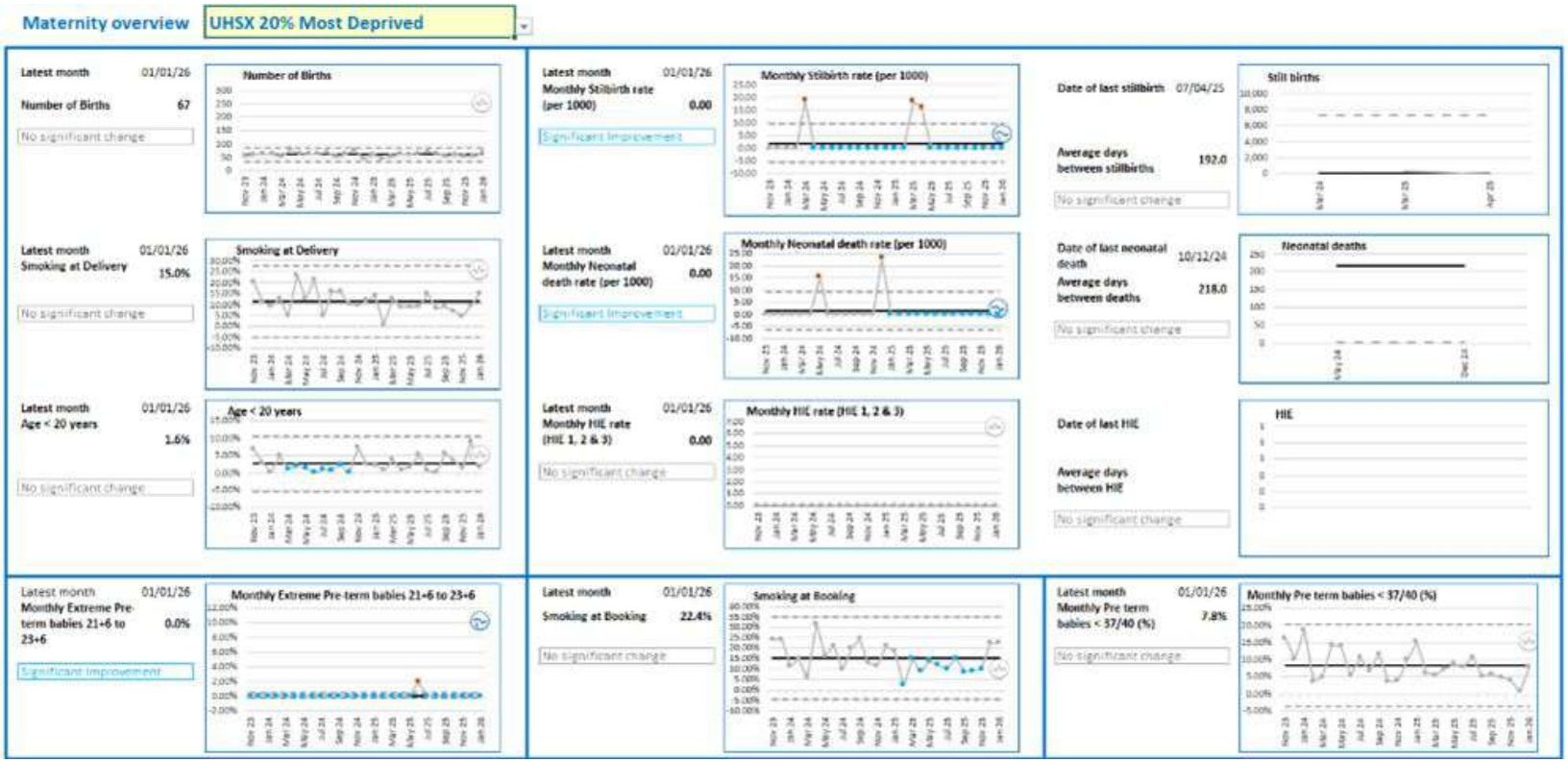


UHSx– 10% most deprived

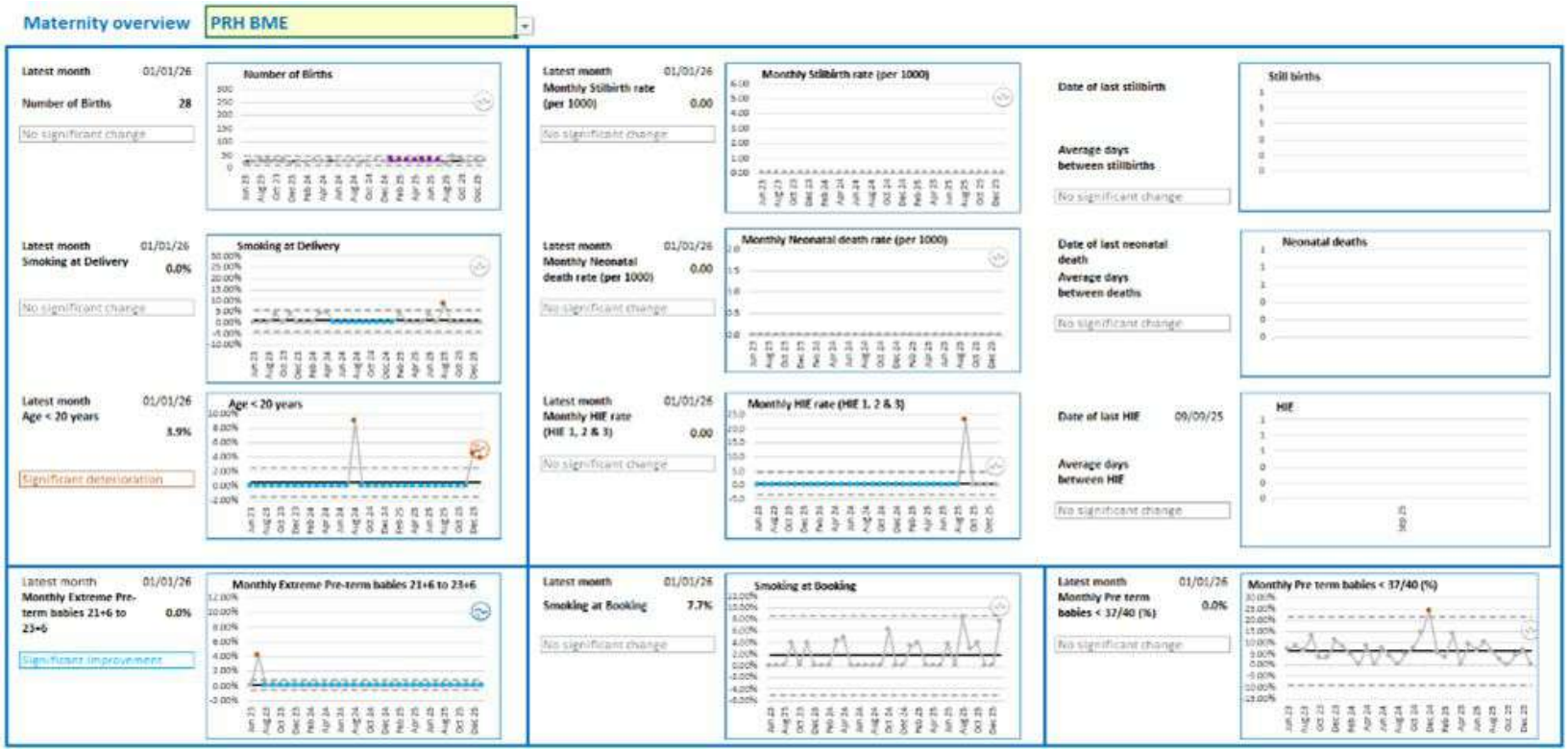


NHS
University Hospitals Sussex
NHS Foundation Trust

UHSx – 20% most deprived

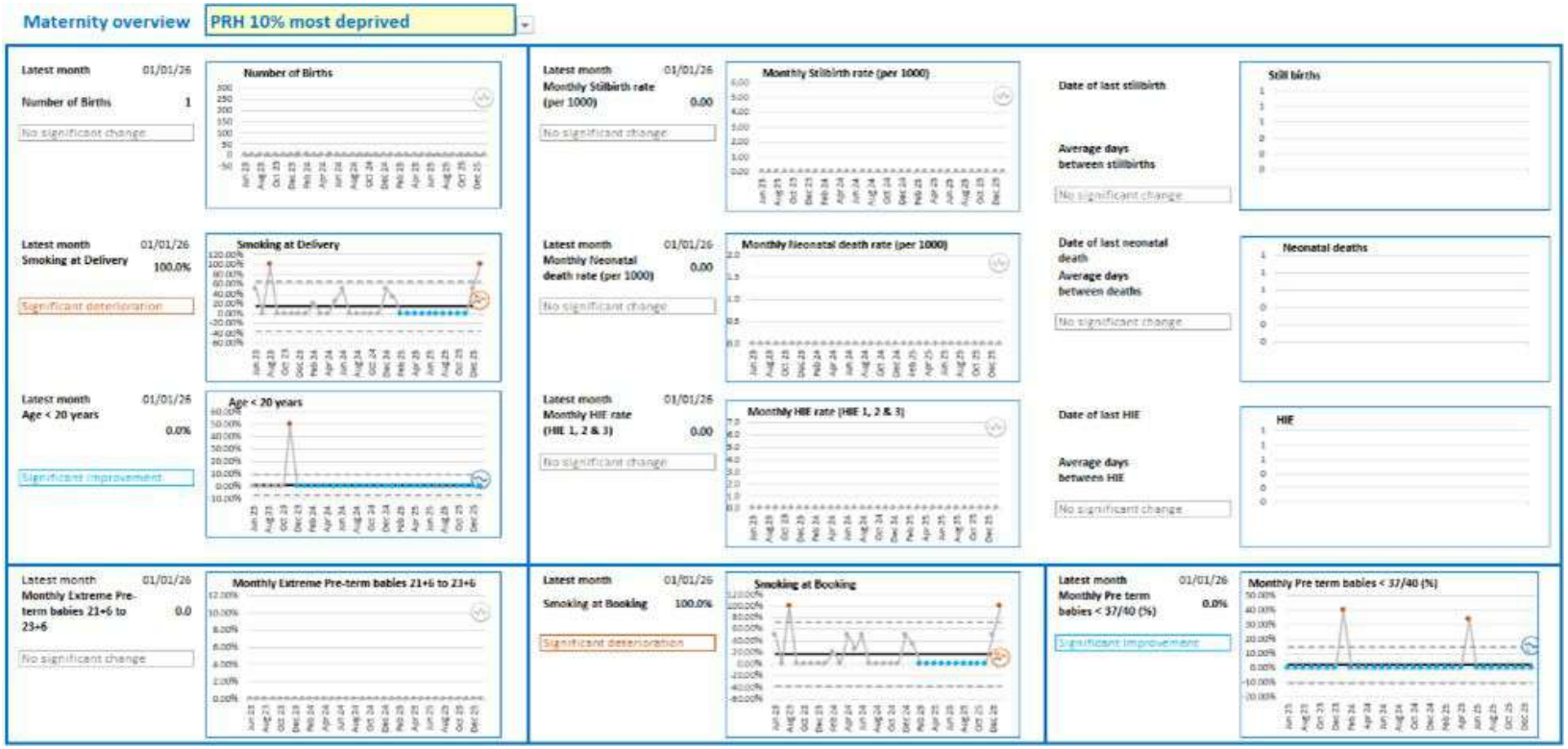


Haywards Heath – Global Majority

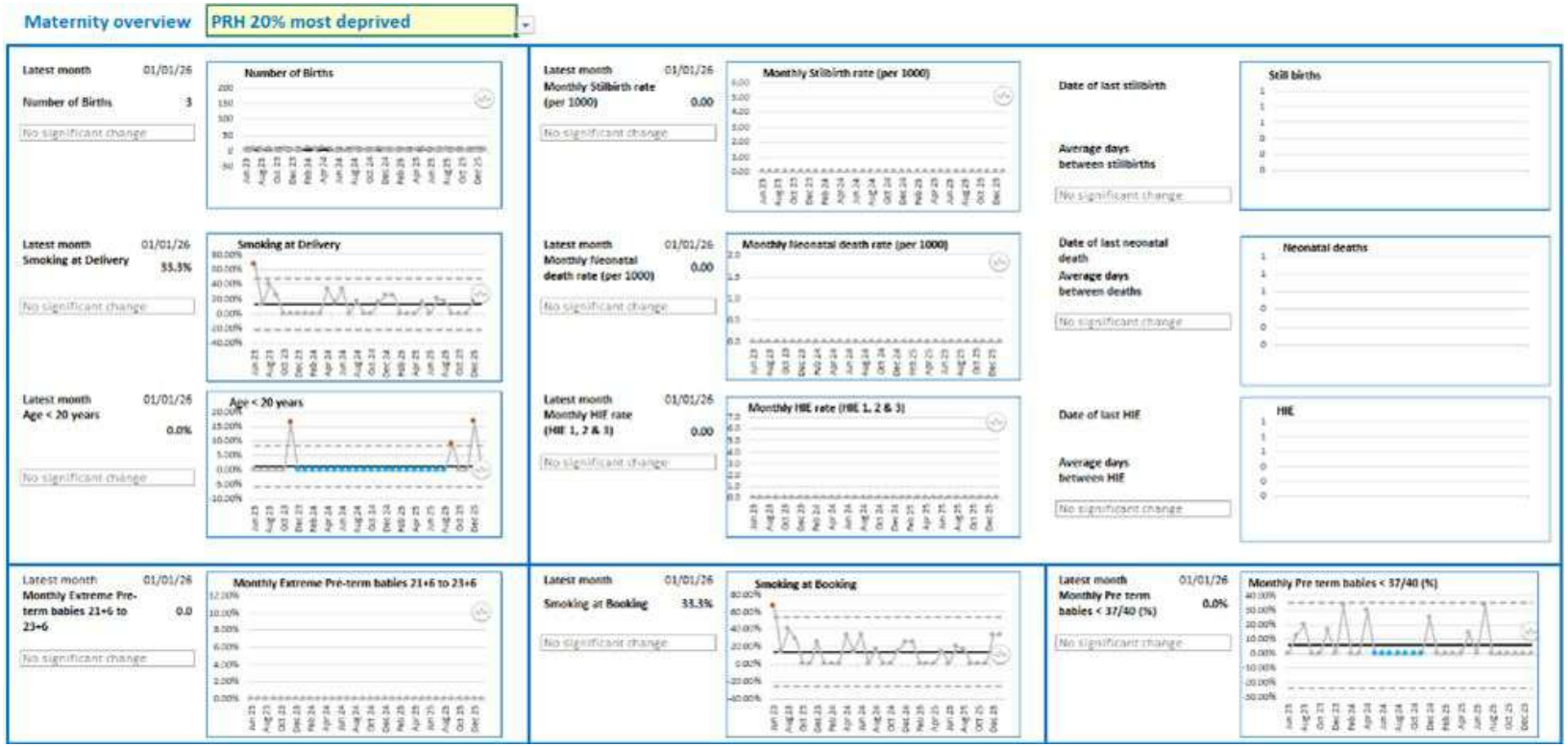


Haywards Heath – 10% most deprived

NHS
University Hospitals Sussex
NHS Foundation Trust

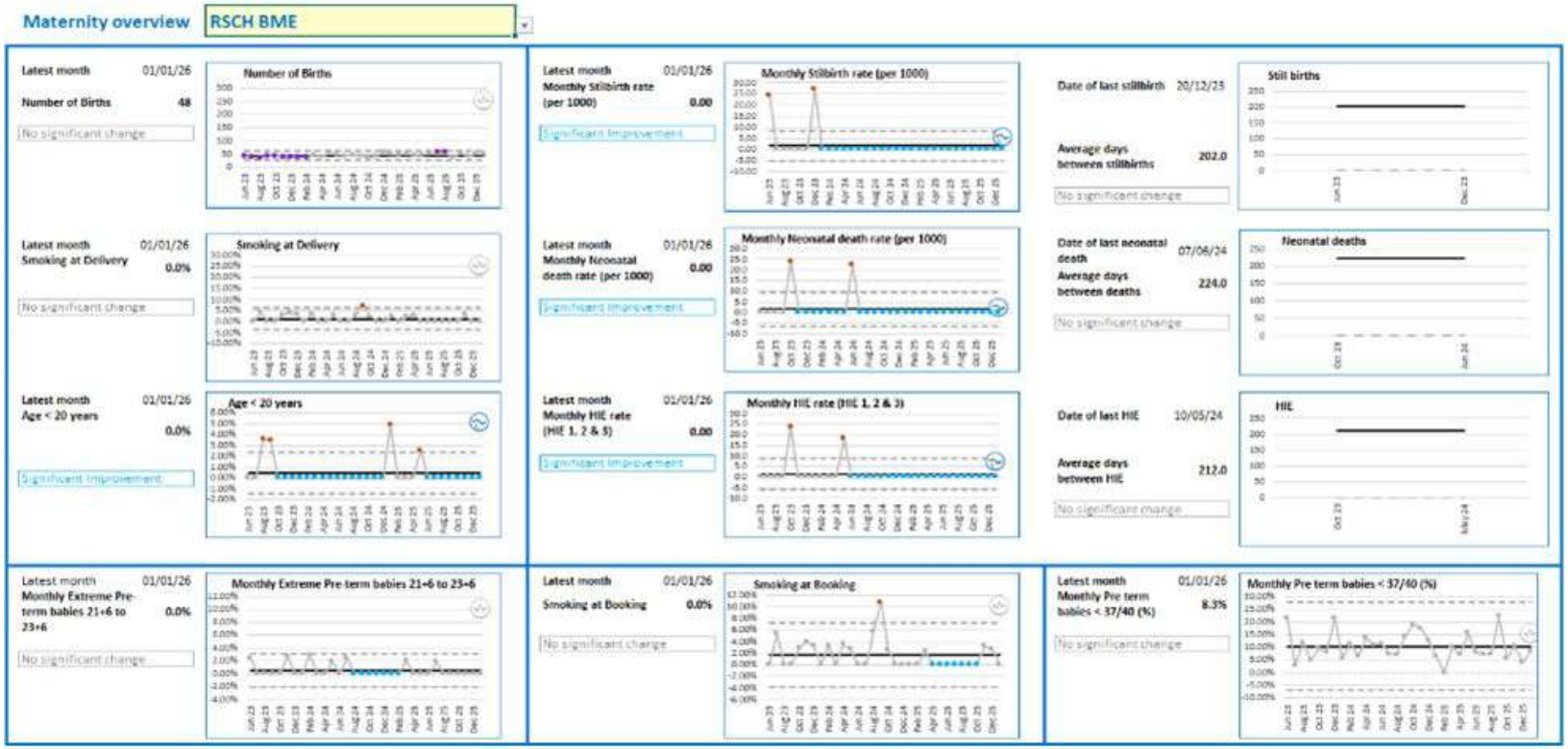


Haywards Heath – 20% most deprived

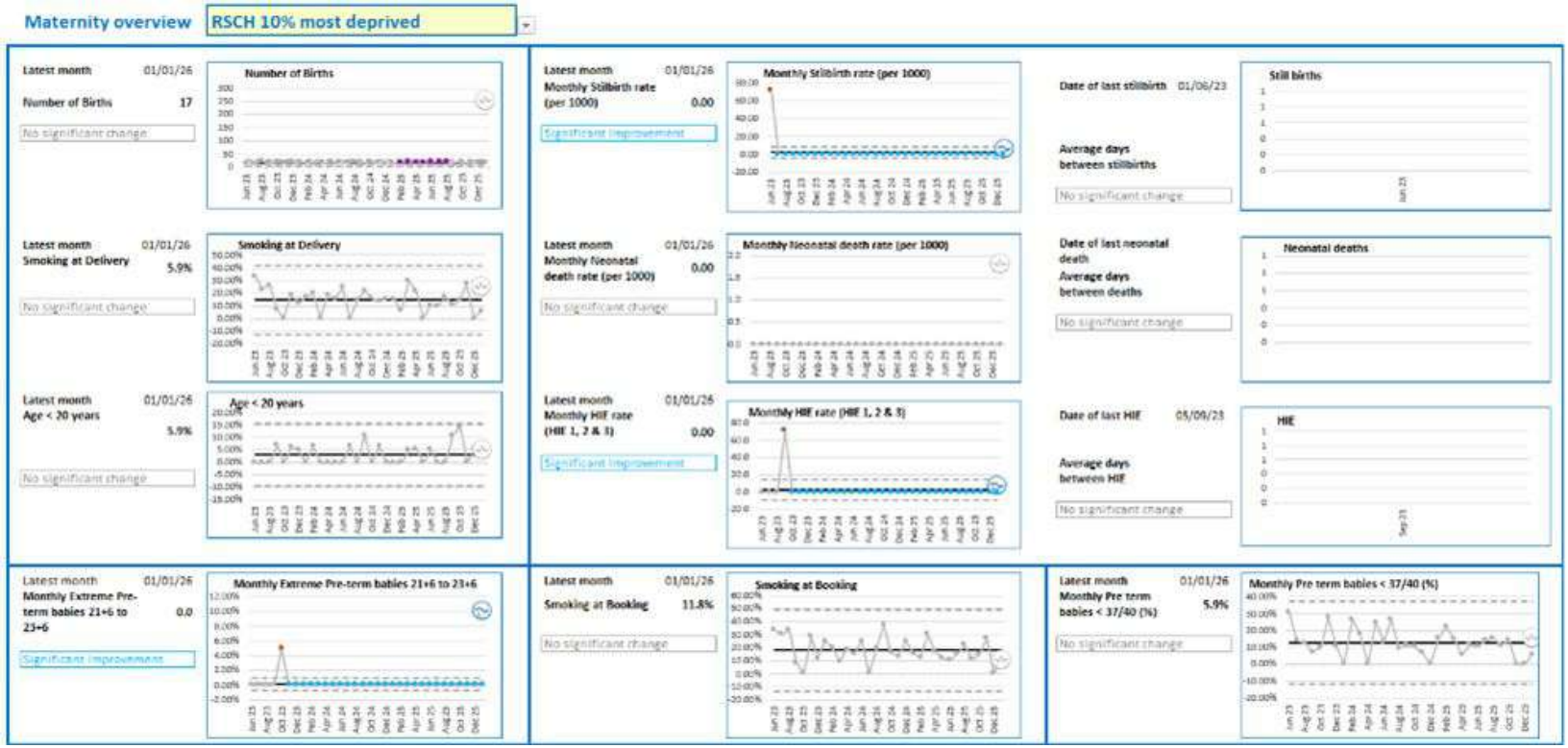


NHS
University Hospitals Sussex
NHS Foundation Trust

Brighton – Global Majority

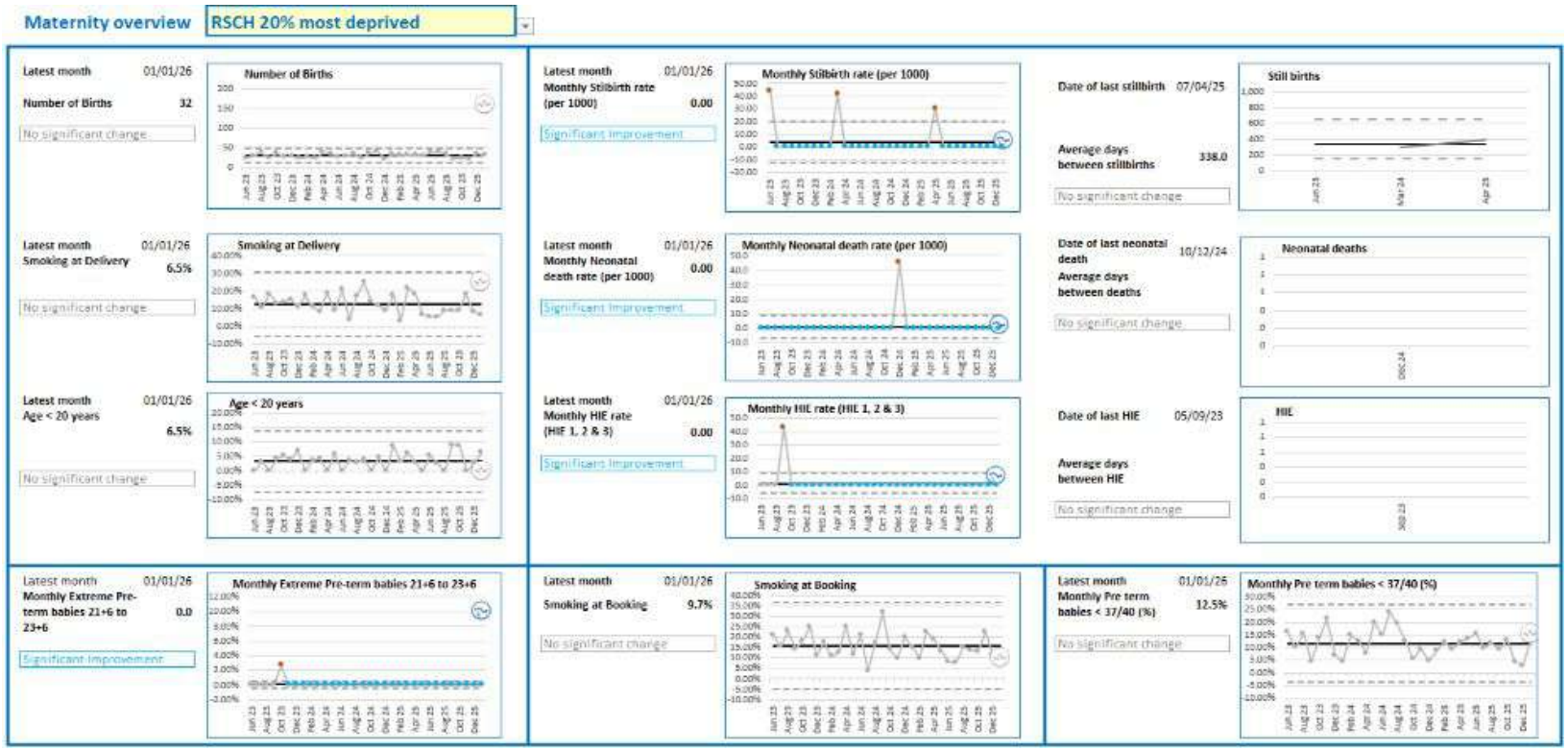


Brighton – 10% most deprived



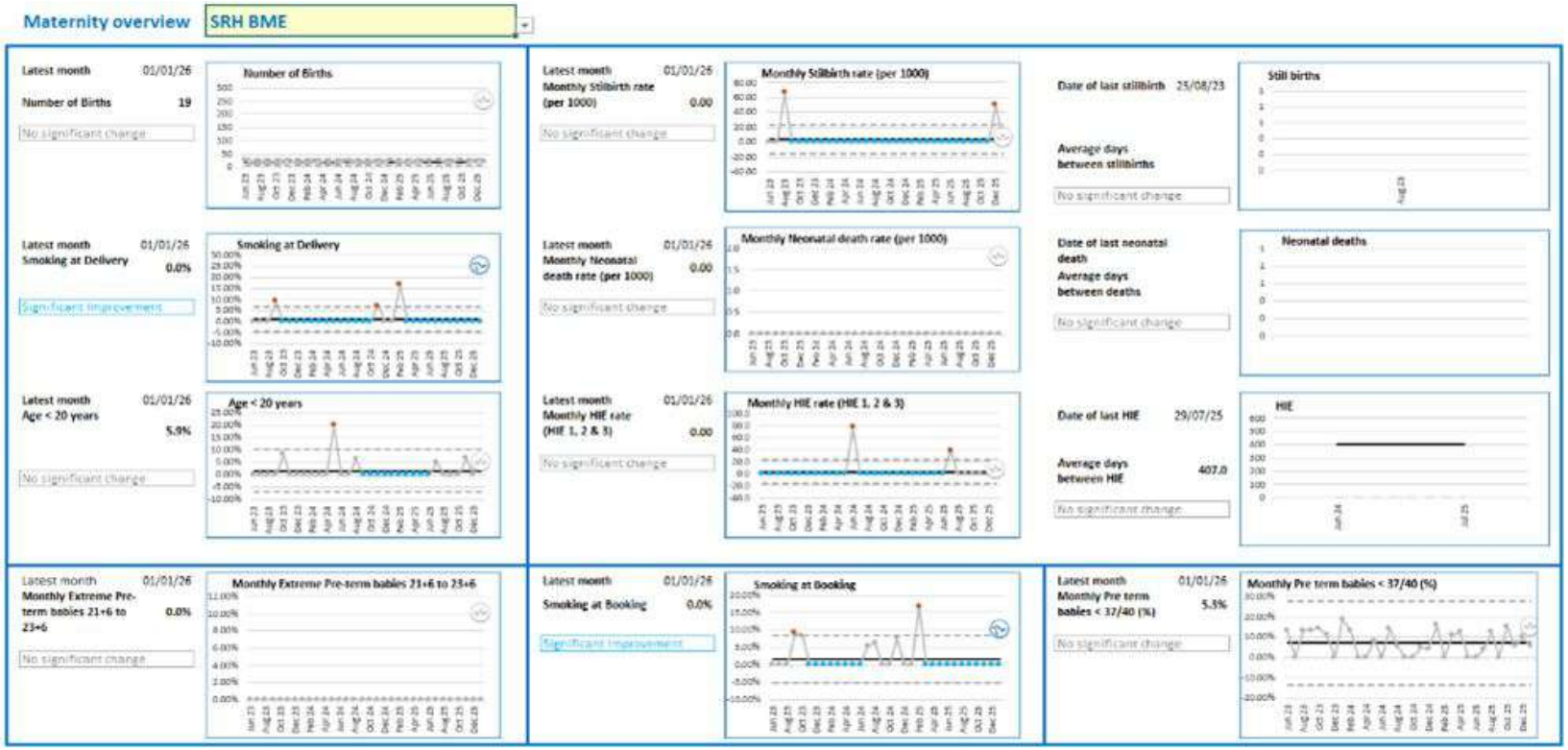
NHS
University Hospitals Sussex
NHS Foundation Trust

Brighton 20% most deprived



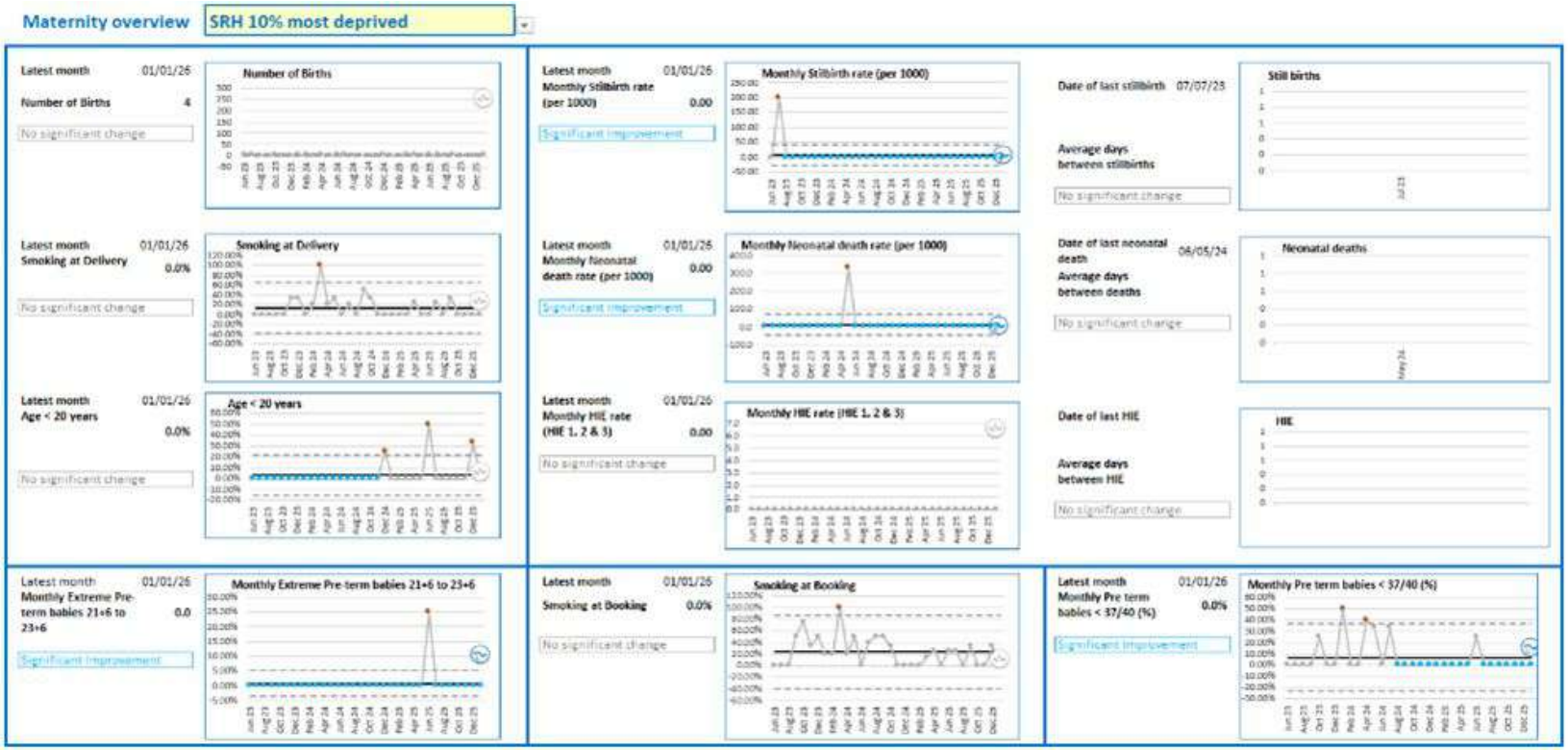
Chichester – Global Majority

University Hospitals Sussex NHS Foundation Trust

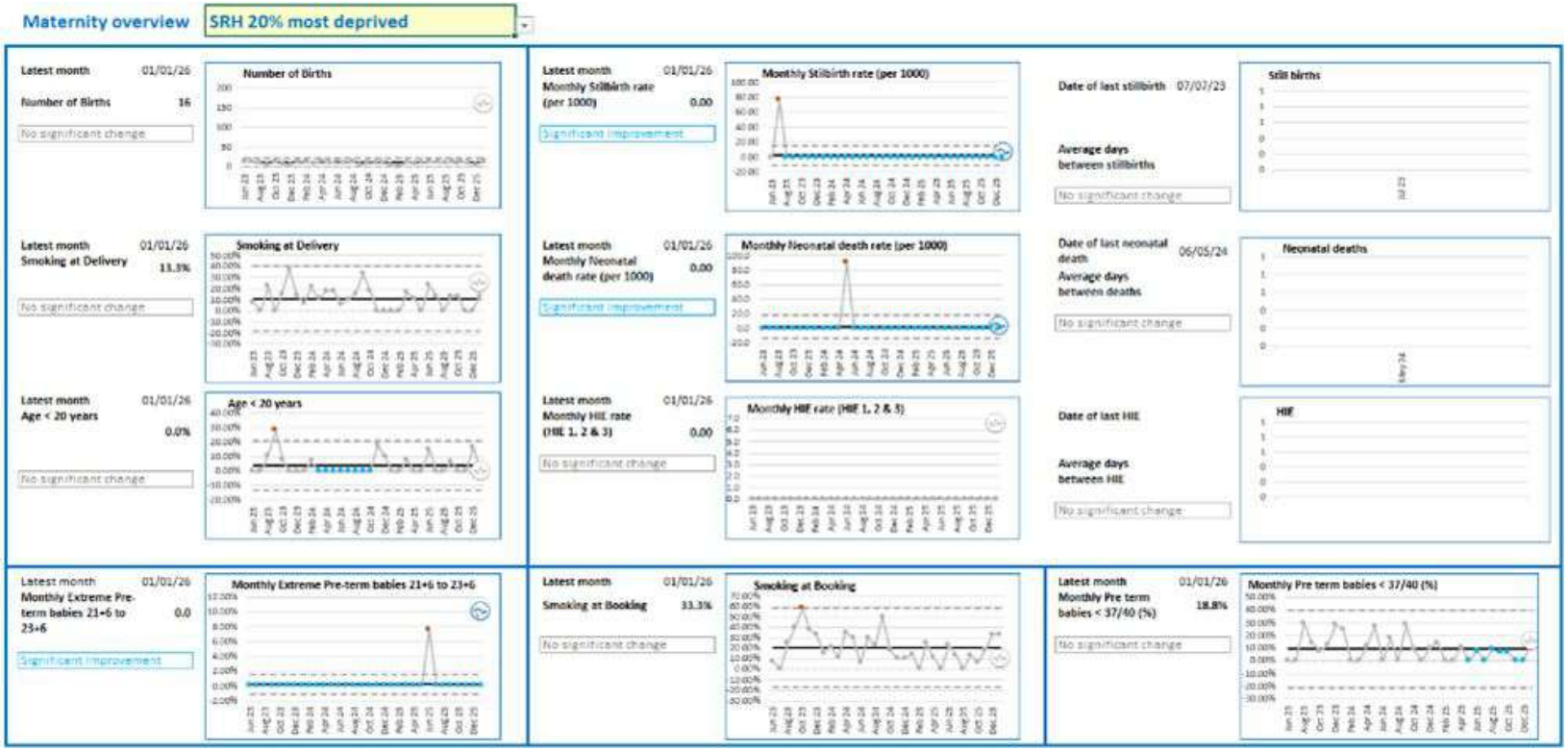


NHS
University Hospitals Sussex
NHS Foundation Trust

Chichester – 10% most deprived

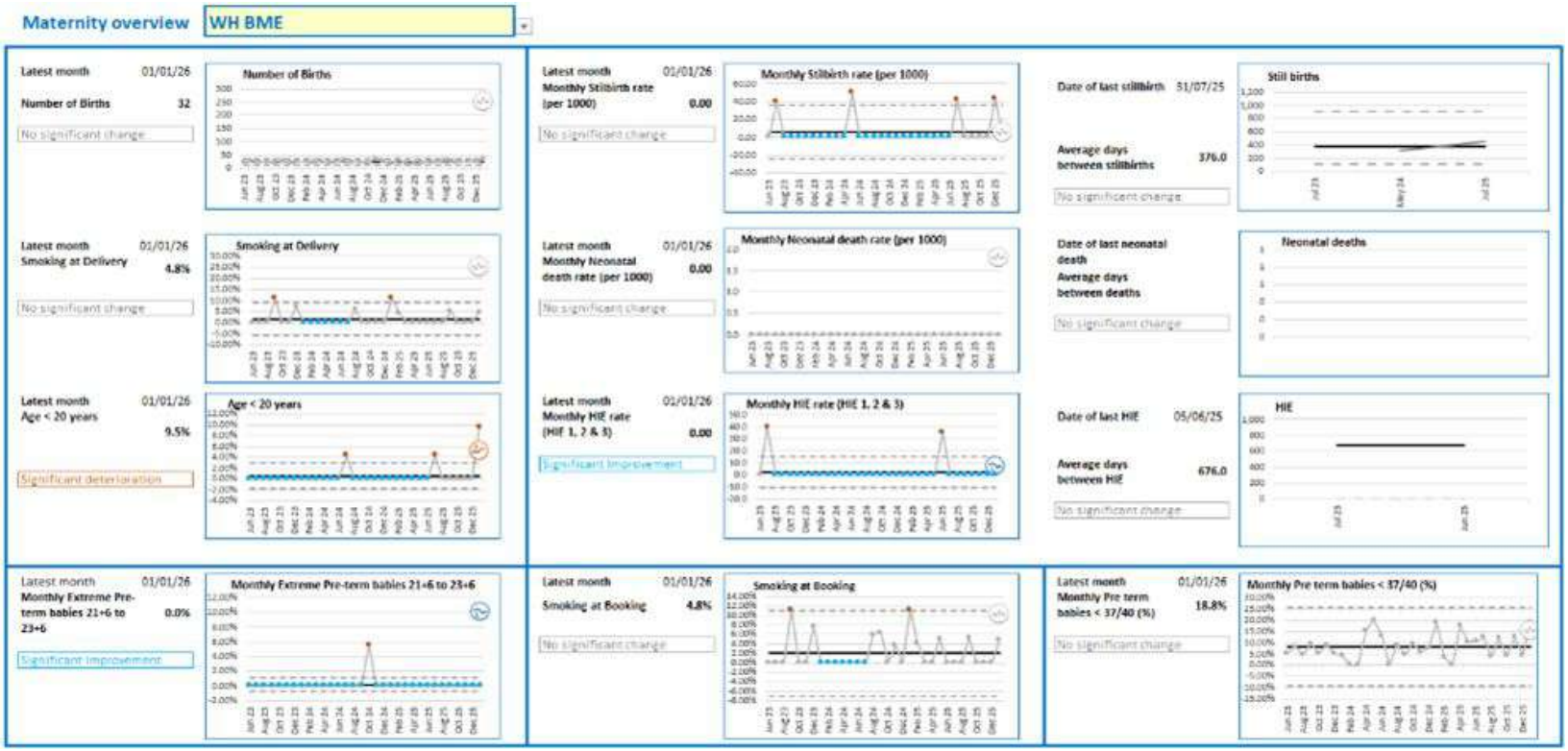


Chichester – 20% most deprived



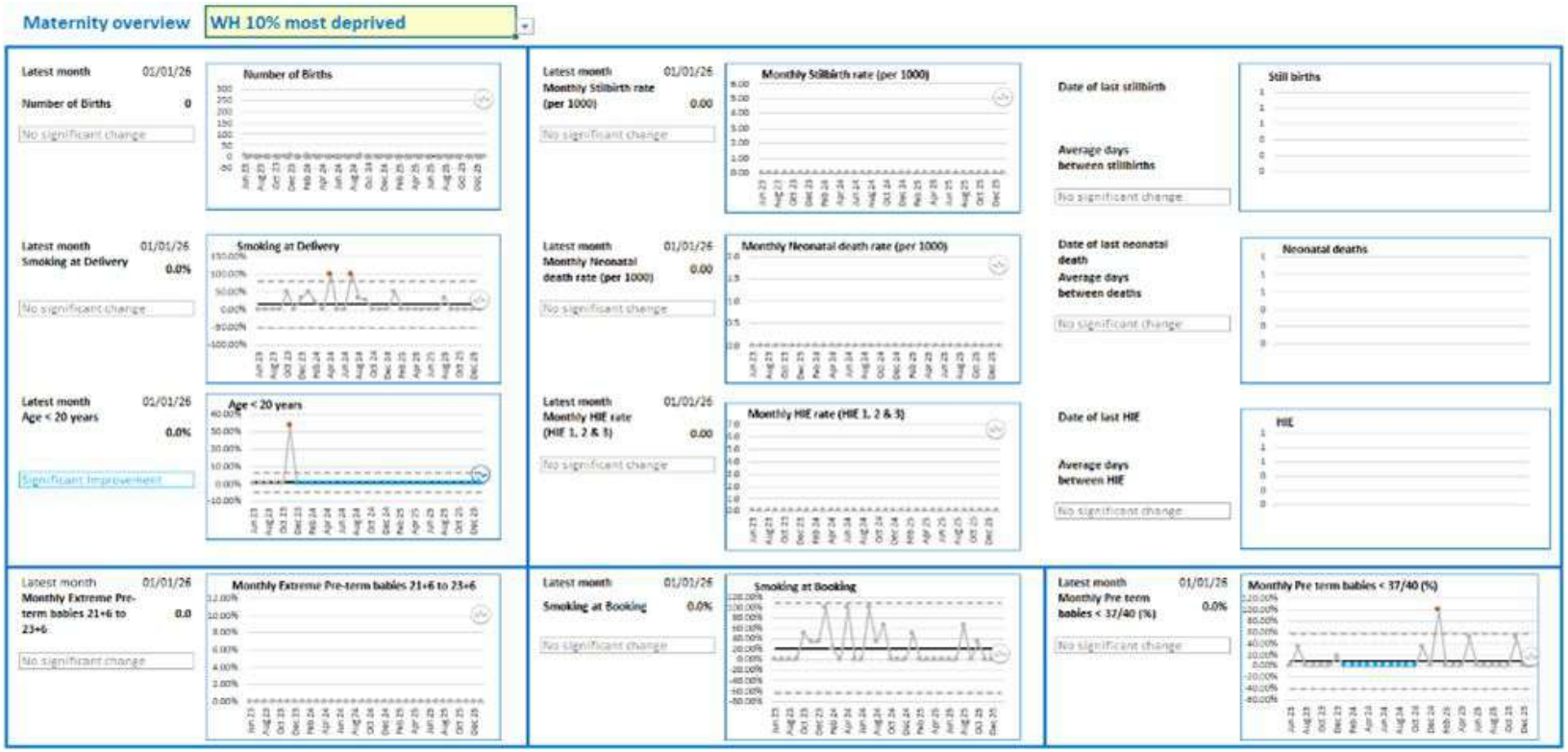
NHS
University Hospitals Sussex
NHS Foundation Trust

Worthing – Global Majority



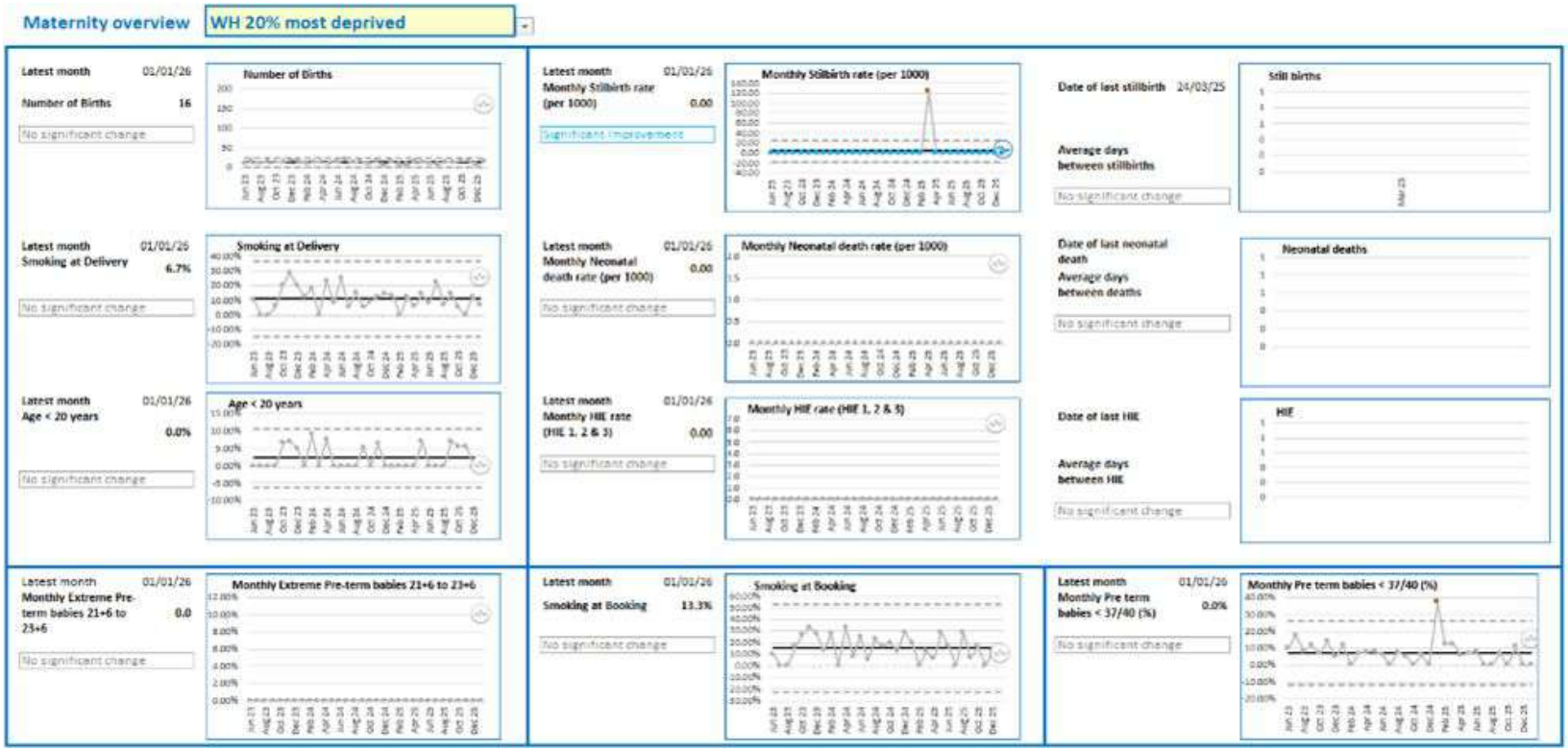
Worthing – 10% most deprived

University Hospitals Sussex NHS Foundation Trust



Worthing – 20% most deprived

NHS
University Hospitals Sussex
NHS Foundation Trust



University Hospitals Sussex

PERINATAL SURVEILLANCE DASHBOARD

DOMAINS				
Perinatal Quality Surveillance and National Ambitions	**Unit of measurement**	**Numerator**	**Denominator**	**Benchmark**
Monthly number of Stillbirths	Number	Stillbirths occuring at or after 24 weeks gestational age excluding TOP's		
12 Month rolling number of Stillbirths	Number	Stillbirths occuring at or after 24 weeks gestational age excluding TOP's		
Stillbirth rate (rolling 12 months) **National Benchmark 2.6/1000**	Per 1000 births	Stillbirths occuring at or after 24 weeks gestational age excluding TOP's	Livebirths plus stillbirths occuring at or after 24 weeks gestational age excluding TOPs	**3.3**
Monthly number of NND	Number	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding TOP's		
12 Month rolling number of NND	Number	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding TOP's		
Neonatal rate (rolling 12 months) **National Benchmark 1.5/1000**	Per 1000 births	All NND's > 24 weeks gestation with signs of life at delivery up to 28 days excluding TOP's	Livebirths occuring at or after 24 weeks gestational age excluding TOPs	**1.4**
Overall Perinatal Mortality (Total NND & stillbirths)- rolling 12 months data **National Benchmark 4.1/1000**	Per 1000 births	All Stillbirths and Neonatal deaths > 24 weeks gestational age excludes TOP's	Livebirths plus stillbirths occuring at or after 24 weeks gestational age excluding TOPs	**4.7**
Maternal deaths (rolling 12 months)	Number	Number of people who died during or up to one year after end of pregnancy		
Brain injury	Per 1000 births	Birth episodes containing a diagnosis of HIE	Total birth episodes	
Pre term births	Per 1000 biths	All liveborn babies born < 27 weeks gestation (by place of birth)	Total number of liveborn babies	
ATAIN	Percentage	Number of live born singleton babies born => 37 weeks gestation admitted to a neonatal unit	Number of live singleton babies born => 37 weeks gestation	
Apgar score < 7 @ 5 mins of age	Per 1000 births	Number of single babies born to a person => 37 weeks gestation and APGAR score between 0 and 6	Number of single babies born to a person +> 37 weeks gestation and APGAR score between 0 and 10	
	Percentage	Number of people reaching 29 weeks gestation with a valid continuity of carer pathway status	Number of people reaching 29 weeks gestation	
	Percentage	Number of Black/Asian people reaching 29 weeks gestation with a valid continuity of carer pathway status	Number of Black/Asian people reaching 29 weeks gestation	
Continuity of Carer	Percentage	Number of people living in the most deprived reaching 29 weeks gestation with a valid continuity of carer pathway status	Number if people living in the most deprived area reaching 29 weeks gestation	
Number of MNSI referrals	Number	Term babies sent for cooling, HIE grade 2 & 3, term intrapartum stillbirths, term NND's and maternal deaths	N/A	
Number of SI's declared	Number	Number of SI declared	N/A	
Number of incidents reported as Moderate Harm	Number	Incident that causes moderate harm where investigation has identified learning (date of event)	N/A	
Operational Delivery				
Midwifery safe staffing (hand counted data)	Hours	Number of actual hours worked	Number of actual hours planned	
Obstetric cover on the delivery suite	Hours	Number of actual hours worked	Number of actual hours planned	
Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week- number of days x2 LW ward rounds have taken place.	Number	Number of days x 2 twice daily ward rounds have taken place	Number of days per month x 2	
1:1 Care in labour	Percentage	Number of people who received 1:1 care in labour	Total number of people who gave birth	
Maternity service has identified capacity issues and the trust escalation procedure has been activated. Demand is being managed with the Trust with no requirements to divert pregnant women to other Trusts	Number	Escalation requirements - Number of times Amber declared	N/A	
Maternity service is unable to manage demand and has escalated to the temporary suspension of admissions to the service, and all amber actions will have been implemented	Number	Escalation requirements - Number of times Red declared	N/A	
Ockenden				
	Percentage	Fetal monitoring Midwives (rolling 12 months)		
	Percentage	Fetal monitoring Doctors (rolling 12 months)		
Training compliance - % currently trained staff	Percentage	MDT skills (rolling 12 months)		
Progress with Ockenden audits - Board oversight of the completion of Ockenden audits which support specific IEAs	Yes/No	N/A	N/A	
Safety Champions & NED Walkabout this month - provide board oversight of completed walkabouts	Yes/No	N/A	N/A	
MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Yes/No	N/A	N/A	
Coroner Reg 28 made directly to Trust (A Coroner has the power to make a report to prevent future deaths)	Yes/No	N/A	N/A	
Maternity Workforce Midwives				
Monthly vacancy rate	Percentage	Monthly vacancy rate	N/A	
Sickness	Percentage	% of staff per month who are sick (ALL)	N/A	
Parental/Maternity leave	Percentage	% of staff per month on parental/maternity leave	N/A	
Voice of the user				
Friends & Family recommended rate	Percentage	% of women (against total number of responses received) who would recommend our services to Friends & Family		
Formal Complaints	Number	Number of monthly formal complaints that have gone through complaints team	N/A	
Duty of candour compliance	Percentage	% of compliance	N/A	
Number of potential Obstetric claims	Number	Number of Obstetric legal claims	N/A	
MVP meeting held on alternate months	Yes/No	Did a MVP meeting take place on alternate mon	N/A	
Team feedback				
Board level Maternity Safety Champion meeting held	Yes/No	N/A	N/A	
Freedom to Speak up cases	Number	Numer of cases per month	N/A	

NHS
University Hospitals Sussex
NHS Foundation Trust

Perinatal Workforce Report
April 2026

Background

University Hospitals Sussex NHS Foundation Trust

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

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

The Maternity Incentive Scheme Year 7 declaration evidenced workforce planning to the required standard. A Birth Rate Plus (BR+) assessment was completed in summer/Autumn 2025, with the final report received in January 2026, assessing the midwifery and maternity support worker workforce. Current staffing models for maternity reflect the previous BR+ recommendations in 2023. Confirmation of the new recommendations from The Trust Board is awaited.

Maternity

University Hospitals Sussex NHS Foundation Trust

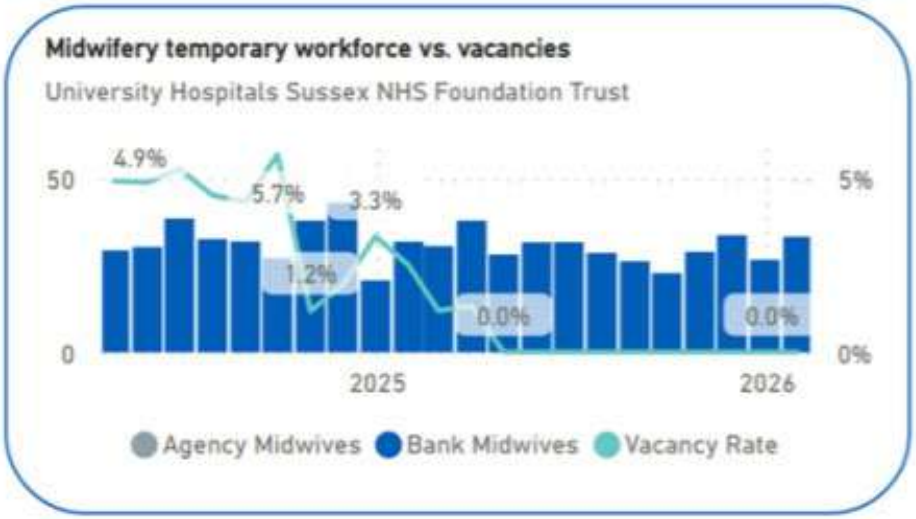
Since September 2024, UHSx maternity has had two WTE 8a Recruitment & Retention Matrons in post, with initial 12 month contracts extended to March 2026 to also support Neonatal Services. From April 2026 this role is expected to be substantively funded as 1WTE 8a.

Vacancy data for midwives, nurses and support workers is now well understood, with short and long-term workforce strategies in place. Cross-site recruitment events are now established, an initiative shortlisted for the Nursing Times Workforce Awards in 2025. Workforce establishment tools for both maternity and neonatal teams now provide real-time data, reducing vacancy length and enabling proactive planning.

For the past 2 years, all student midwives at UHSx have been offered substantive hours at their first-choice site. Whilst anticipated that this initiative would result in a significantly over recruited position, this has not been the case, with the anticipated excess absorbing parental leave and secondment opportunities and improving fill rates. Agency use has now ceased completely alongside a reduction in Bank use and improvement in fill rates. Decision regarding the 2026 recruitment strategy for newly qualified midwives is awaited from the Perinatal Leadership Team following review of the latest BR+ recommendations at Trust Board.

Registered nursing roles on Postnatal wards have been disestablished due to the significantly improved workforce position. 20WTE Band 5 nursing roles were created in 2022 in response to significant midwifery workforce vacancy and a national shortage of midwives. Nurses have been redeployed to different clinical areas across UHSx and are expected to leave the maternity service by the end of April 2026.

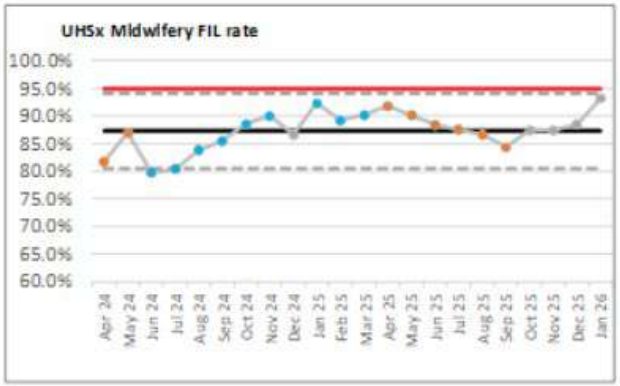
Midwifery Vacancy

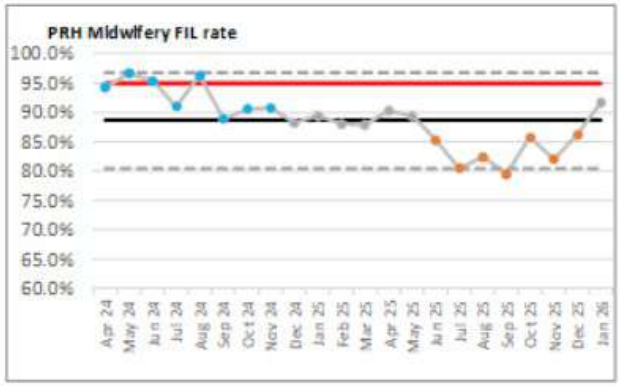


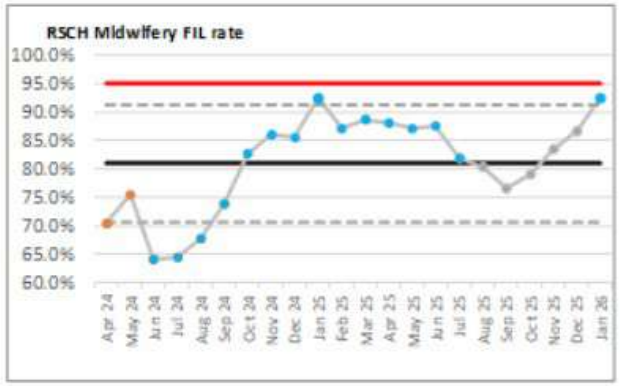
- **Midwifery Vacancy:**
- Since October 2025, all midwifery posts are fully recruited to (based on current templates), compared to a national and regional rate of 3.2%.
- Fixed term cover for parental leave and secondments is proactively sought, alongside a pool of 'bank only' staff who can be offered substantive contracts via the internal 'bank to substantive' process as vacancies become available.
- Agency use has completely ceased since Nov 25.
- 20 WTE B5 registered nursing posts have been disestablished, with all staff in these roles expected to be redeployed by April 2026.
- Turnover is currently 4.5% (compared to 7.7% regionally and 6.1% nationally) with a current leaver rate of 2.5% (compared to 3.8% regionally and 3.9% nationally). Staff who leave are offered an exit interview with the R&R Matrons, but uptake is low. Movement within the directorate is more common as staff move cost codes e.g. hospital to community.
- The recruitment plan for B5 newly qualified Preceptorship roles is yet to be confirmed. NHSE introduced the 'Graduate Guarantee' scheme in Aug 2025, to ensure all new nursing and midwifery registrants are offered jobs.

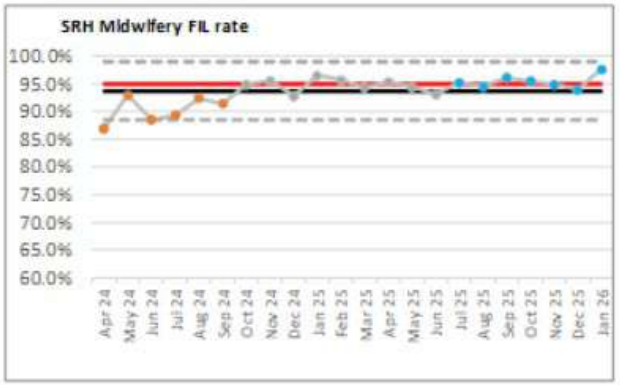
Current position - Midwifery

NHS
University Hospitals Sussex
NHS Foundation Trust





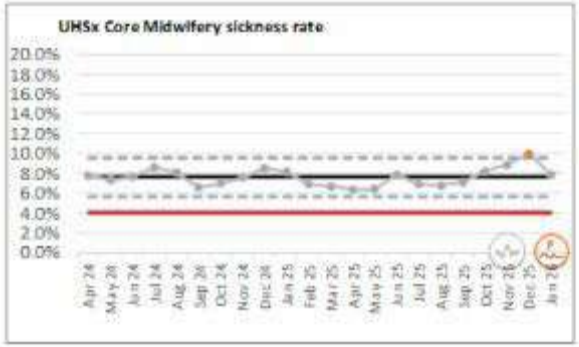


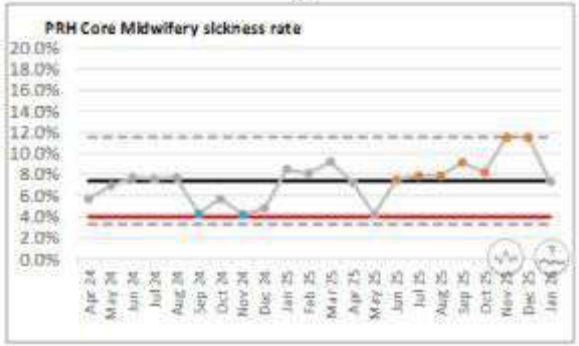


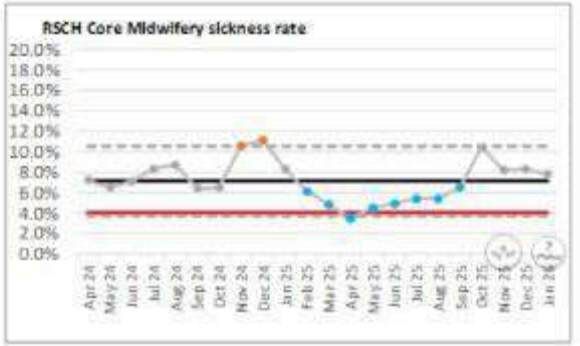
- **Staffing Overview.**
- Fill rates are significantly improved overall since summer 2024, however some volatility remains.
- At PRH & RSCH reductions in fill rates in summer 2025 can be accounted for due to progression of B5 Preceptorship midwives to the B6 line, leaving B5 posts unfilled until the next cohort start in October.
- Agency use has completely ceased since Nov 2025 alongside a reduction in bank use.
- High sickness and parental leave rates remain a challenge. Fixed term contracts can sometimes mitigate these gaps, however advertised vacancies are not always filled.
- **One-to-one care during established labour is provided 100% of the time**, though occasionally midwives are redeployed from other services, lsuch as the postnatal ward or homebirth service, to achieve this which is not accounted for in this data.

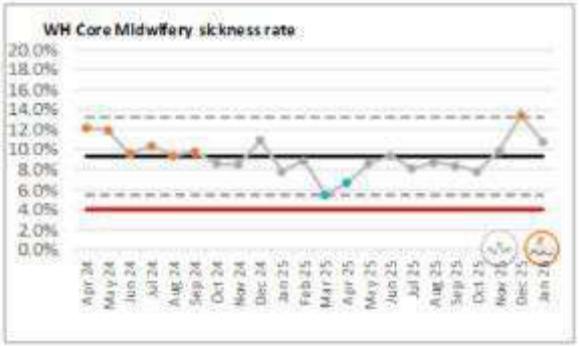
Midwifery Sickness

University Hospitals Sussex
NHS Foundation Trust







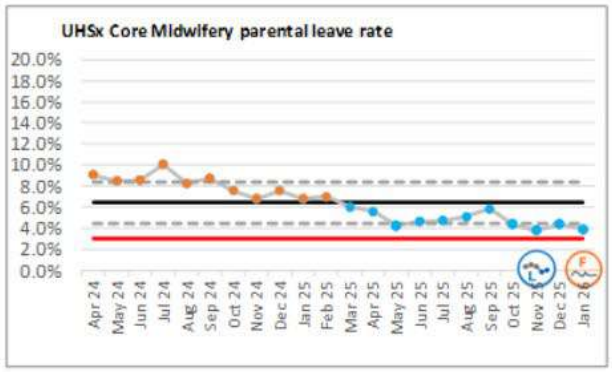


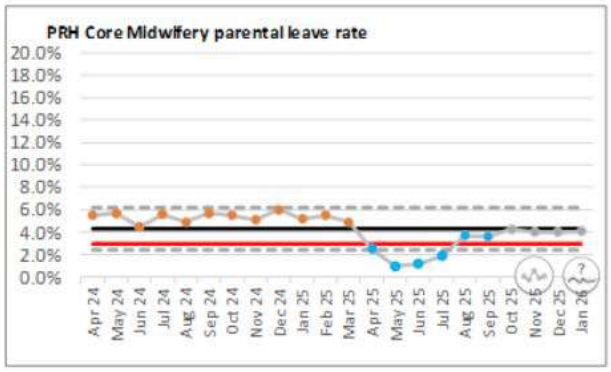
Sickness

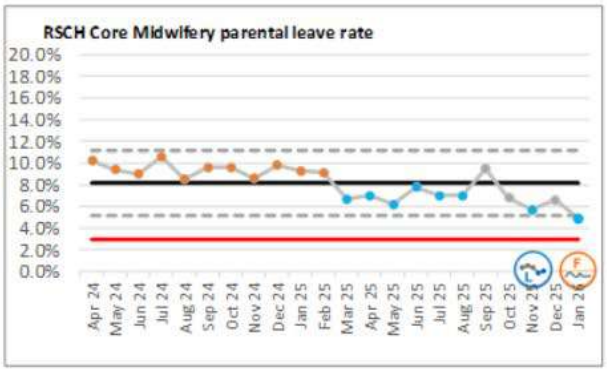
- High levels of both short and long term sickness remain a challenge across maternity and track above the 4% target. Regionally sickness rates are 7.1% and nationally 7.3%.
- All sites have seen an increase in sickness over Q3.
- The current media spotlight on maternity services alongside the national maternity review and high profile coroners cases is thought to be significantly affecting sickness and staff wellbeing.
- Proactive support from the HR team to improve sickness rates continues at all sites with regular review
- Substantive funding for 1WTE Professional Midwifery Advocate Lead Midwife has been approved, to support staff wellbeing and development at work and all midwives working for the service have a named sessional PMA.
  Other support and wellbeing offers are in place across the Division, included Listening Events, regular updates via newsletters and video messages, and increased visibility of leaders.

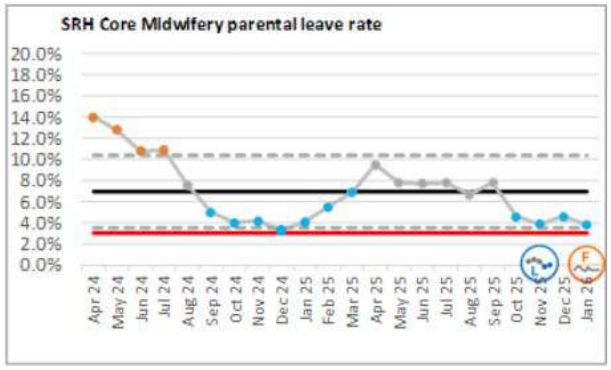
Midwifery Parental Leave

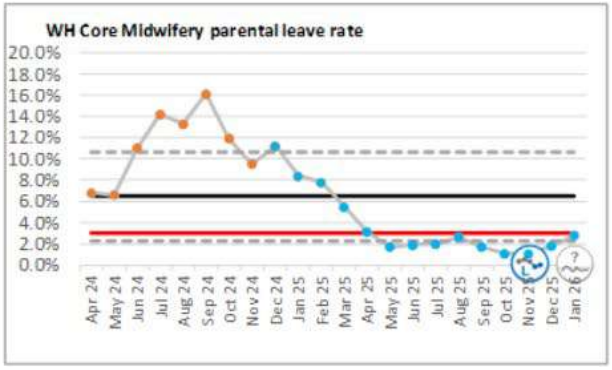
University Hospitals Sussex
NHS Foundation Trust









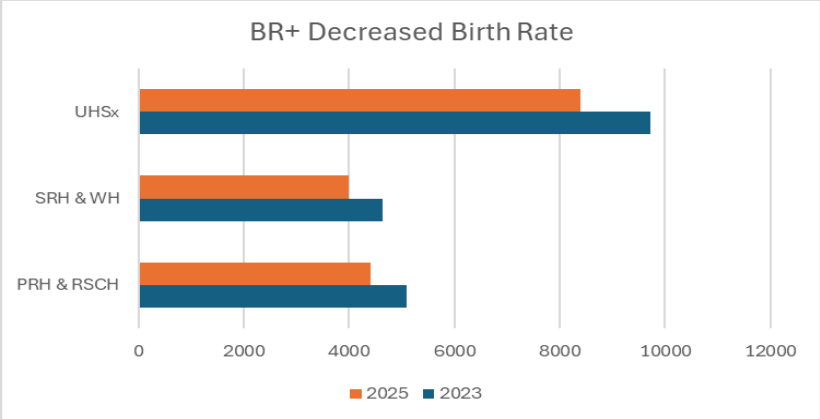


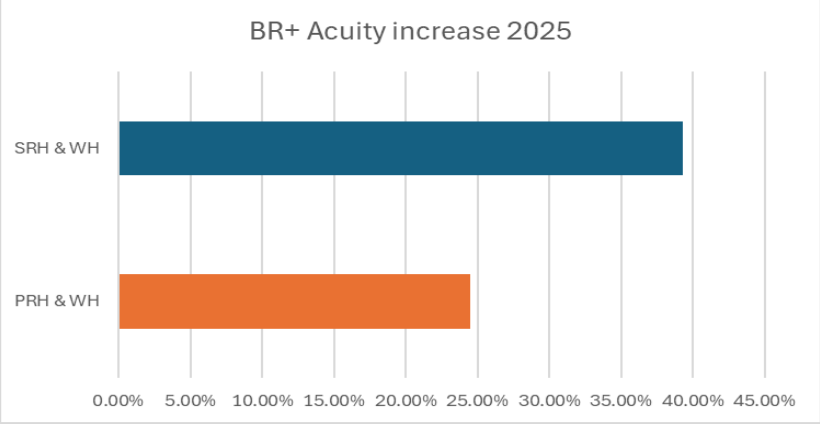
Parental Leave:

- Midwifery parental leave rates track above the Trust the 3% accounted for in headroom at all sites and are currently particularly high at RSCH and SRH although WH previously experienced very high rates in 2024.
- The majority of these vacancies are currently mitigated for by the over recruitment to Preceptorship roles in Oct 25. Fixed term cover is sought at sites where there are gaps due to parental leave and secondments.
- Parental leave represents a unique challenge in a service with an almost exclusively female workforce. The removal of the bursary for student midwives has resulted in a younger newly qualified midwifery workforce and higher parental leave.

Birth Rate + - Births & Acuity

University Hospitals Sussex NHS Foundation Trust

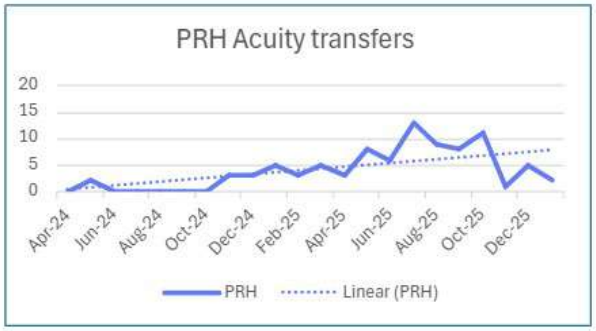


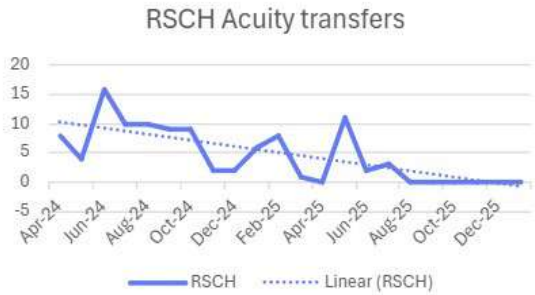


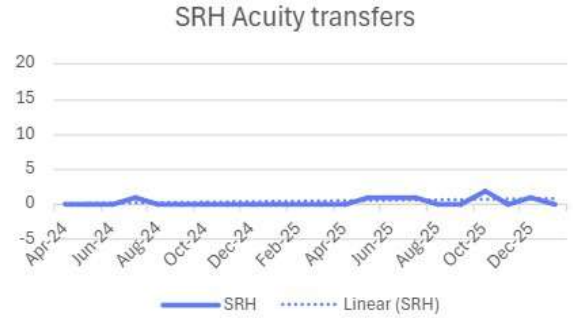
- The 2025 BR+ report demonstrates a decreased birth rate at all sites, seen nationally.
- However, the BR+ report also demonstrates a significant increase in acuity.
- Factors impacting acuity include more co-morbidities such as diabetes, mental health, raised BMI and increased induction of labour rates in line with national clinical guidance. Increase in operative deliveries and neonatal factors are also contributing reasons.
- PRH & RSCH:
  - Case mix acuity for categories IV & V have increased across both services by 24.5%
- SRH & WH:
  - Case mix acuity across categories IV & V have increased across both sites by 39.3%.

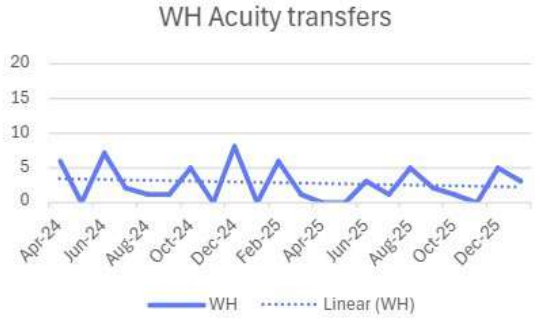
Acuity - Maternity

University Hospitals Sussex NHS Foundation Trust





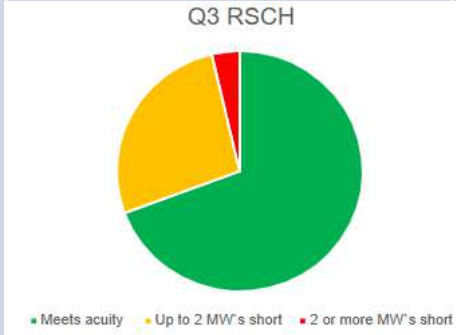
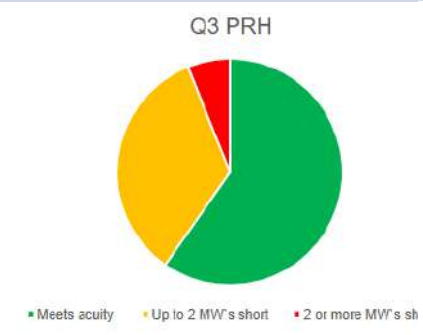
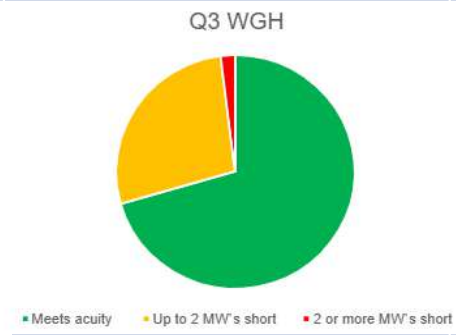
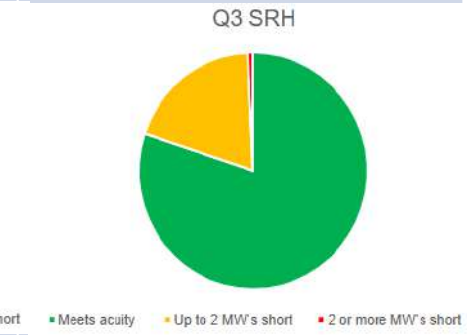
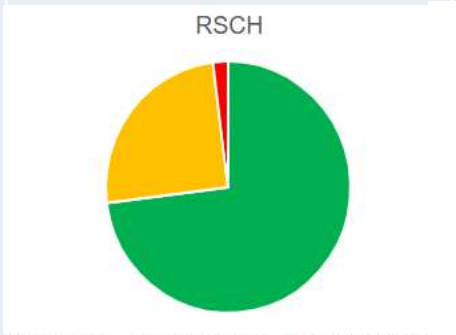
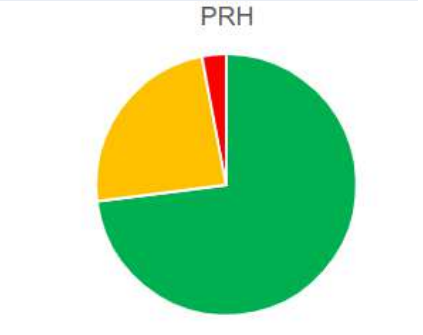
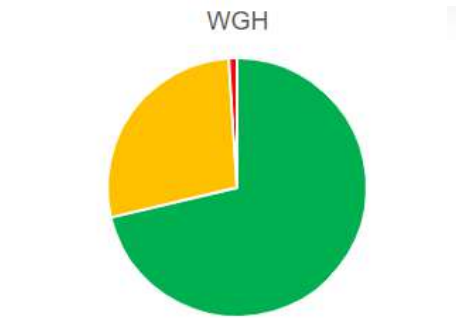
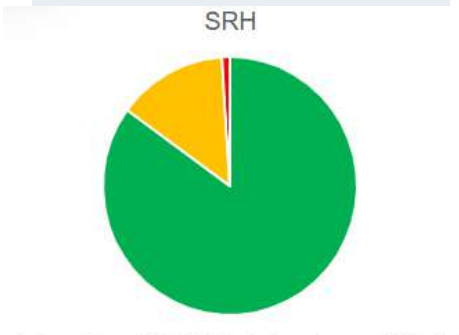




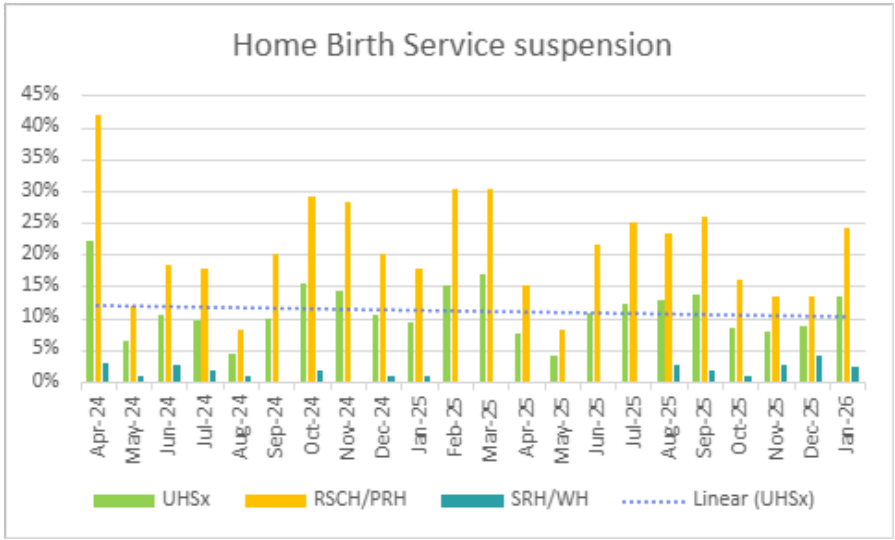
- The **BR+ Acuity tool** tracks compliance with supernumerary status for labour ward coordinators (LWC), one-to-one care during labour, and addresses staffing shortfalls.
- The target for tool completion is 85%, achieved at SRH & WH. Compliance at PRH & RSCH fluctuates month to month and is not always met. Mitigations are in place to address this gap.
- Labour ward coordinators must be supernumerary and not provide 1:1 care during labour. 'Red Flag' incidents related to coordinator status are captured in acuity reports and are shared in divisional and Maternity Safety Champion meetings. The service meets CNST Maternity Incentive Scheme requirements for year 6 and 7.
- While there is no national midwife-to-birth ratio benchmark, UHSx's staffing is based on a 2023 BR+ assessment. The current ratio is 1:22, a decline from 1:21 in April 2024. The new report is due to go to Trust Board for approval in Q1.
- Acuity is measured every 4 hours the BR+ tool, considering case complexity and staffing. Activity in maternity can vary, with peaks and troughs; the escalation policy ensures service support when staffing does not meet acuity needs.
- In addition, twice daily Safety Huddles led by the Matrons review staffing versus acuity. This information is shared daily across sites with senior leadership. On some occasions women/birthing people need to be diverted to an alternative site within the Trust at times of escalation.

Quarterly acuity (midwife : activity)

University Hospitals Sussex NHS Foundation Trust

	Brighton	Haywards Heath	Worthing	Chichester
Q3 2025 *This data does not include midwives redeployed from other areas for periods of time to mitigate.				
Jan 26 *This data does not include midwives redeployed from other areas for periods of time to mitigate.				

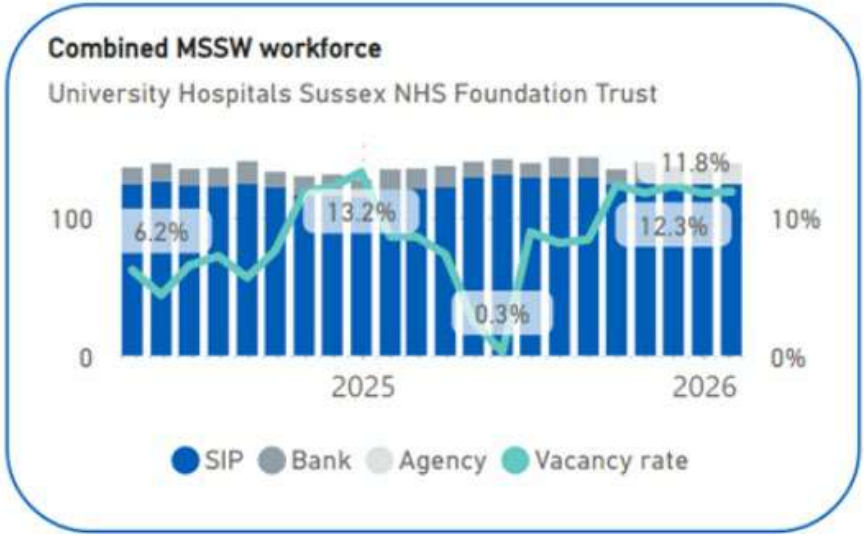
Home Birth Service



- Homebirth service suspensions remain low at SRH/WH.
- Maintaining the Homebirth service at PRH/RSCH remains a challenge.
- New team members have recently been recruited and are now in post reducing vacancy in the team to 10% from a peak of 60% in September 2025.
- Burnout was frequently cited as a reason for team members leaving.
- The working model is now under review following the national Prevention of Future Deaths report from coroners in the Manchester Cahill case.
- Formal consultation for all Homebirth Services at UHSx is due to begin in Q1 2026.

Maternity Support Workers and Nursery Nurses

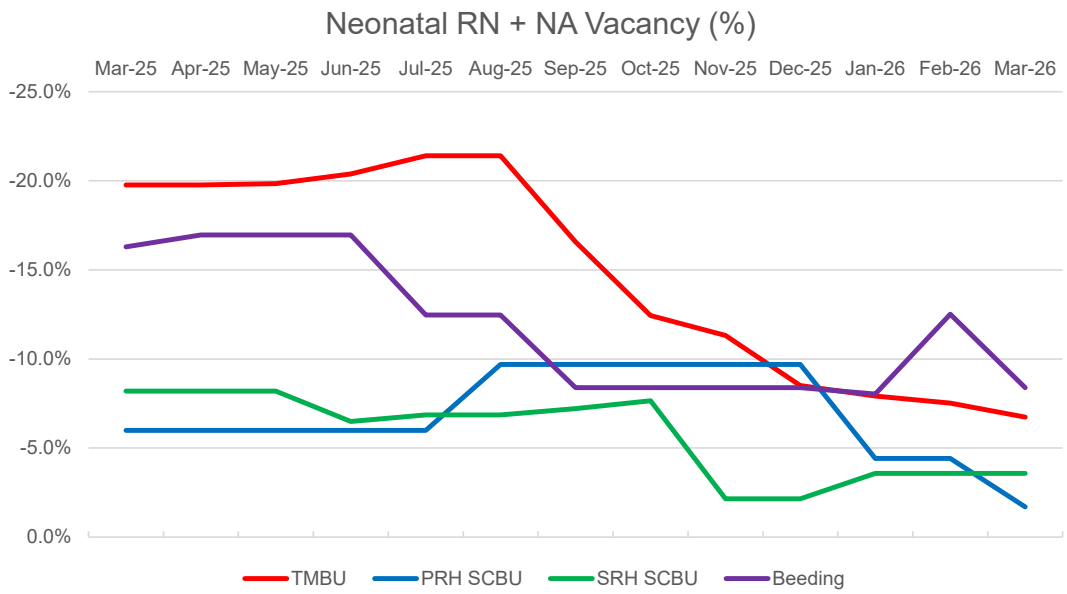
University Hospitals Sussex NHS Foundation Trust



- MSWs and NNs are vital to maternity care, supporting both service users and the midwifery team.
- Retention is challenging due to competing roles with similar pay but fewer responsibilities and unsocial hours, with turnover higher than midwifery. Many staff leave to start midwifery training, reflecting the role as a pathway into the profession.
- UHSx rates of 11.8% are broadly aligned with national (11.9%) and regional rates (12.2%) although will fall imminently to <5% when those recently recruited complete employment checks.
- R&R Matrons run regular cross-site recruitment events, predicting attrition (e.g. September university intakes), this process needs refinement to ensure greater stability. Suitable candidates not immediately placed are held on a 3-month wait list and appointed to any new vacancies in that timeframe. Recent campaigns have attracted international recruits, increasing team diversity.
- The Band 2 MSW development role is now live and currently being recruited to. This role is for 'new to care' candidates who will progress to B3 following the completion of core competencies. This pathway is anticipated to broaden domestic recruitment and widen opportunities for local communities.
- Midwifery apprenticeships remain a priority, though progress depends on government funding for backfill.

Neonatal nursing – current position

University Hospitals Sussex NHS Foundation Trust



- Significant improvement in vacancy has been seen across neonatal nursing, below 5% at PRH and SRH and below 10% RSCH and WGH.
- The spike on Beeding at WGH in Feb 2026 is accounted for by 1WTE B7 vacancy due to internal promotion.
- Band 6 QIS coverage at TMBU is static at 42%.

  *** 10 staff to qualify QIS training in May 2026*

  *** 9 predicted to start final module September 2026*

  *** 14 started the first SCBU module Feb 2026*

  *** potential 8 to start first SCBU module June 2026*
- Registered (Band 7–Band 5) and unregistered (Band 4) staff are included together in the nursing workforce trajectory, reflecting that both groups are counted towards the clinical staffing ratios required to deliver care across the levels of care (ITU/HDU & SCBU).

Neonatal – Referrals

University Hospitals Sussex NHS Foundation Trust

Inutero (IUT) - Refers to the period before birth
Exutero (EUT) - Refers to the period after birth

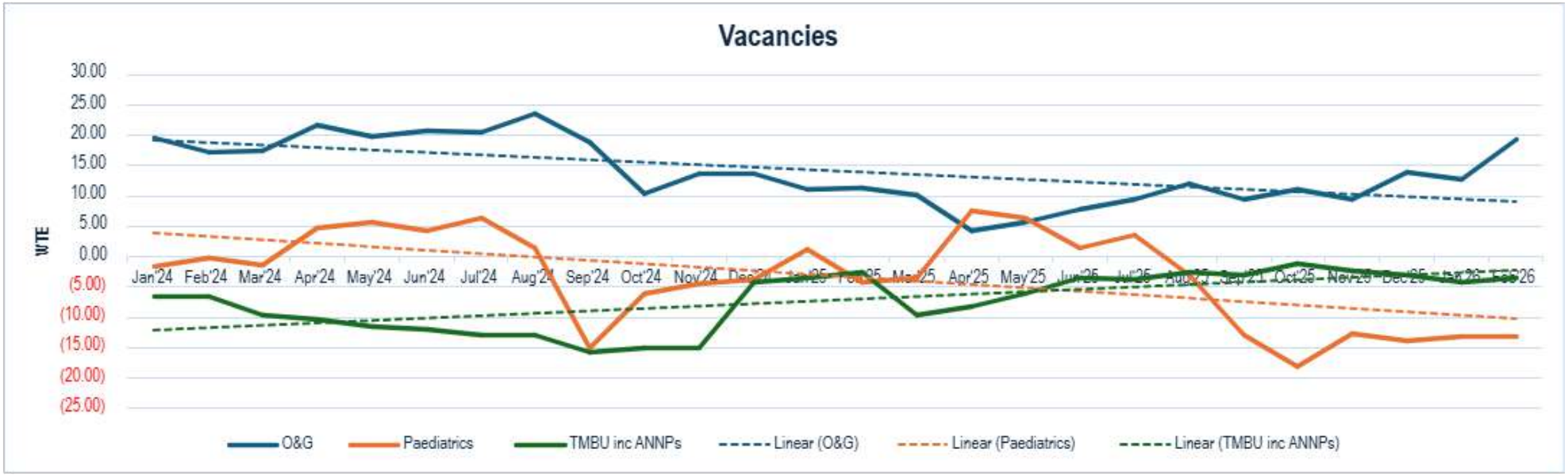
	Surgical Babies	Extreme Prem 22Wks -29wks	Refused - Staffing	Refused - Maternity refusal	Refused - TMBU Full	Refused from Worthing	Out of Network	Refused Unknown	Refused Other	Total number of babies refused
Refusals IN Utero	0	7	1	0	6	2	2	2	0	9
Refusals Ex Utero	1	0	2	0	2	0	0	1	1	6

November 30 referrals (23 IUT/7 EUT, 3 being surgical)
December 31 referrals (13 IUT/18 EUT, 3 being surgical)
January 30 referrals (15 IUT/15 EUT, 5 being surgical)

Referrals accepted January 2026
IUT (6/15) accepted. 9 refused
EUT (9/15) accepted. 6 refused
EUT (surgical) (4/5) accepted. 1 refused

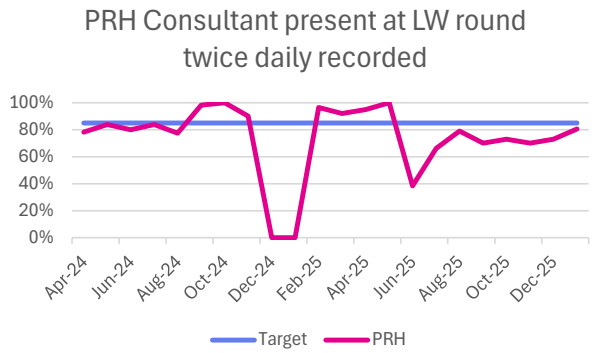
There was an 88% occupancy rate overall in January for TMBU of which 28% ITU, 79% HDU and 159% SCBU days. Skill mix (reduce numbers of QIS) and capacity continue to be the drivers behind the refusals.

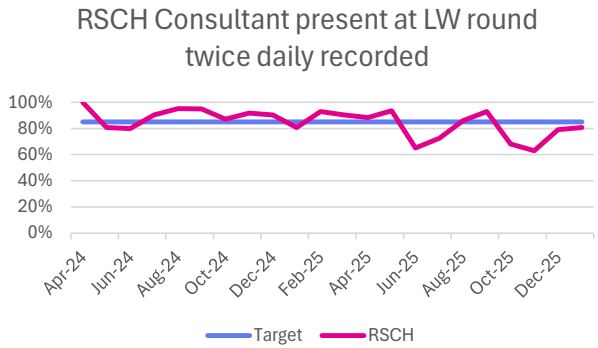
Perinatal workforce - Medical

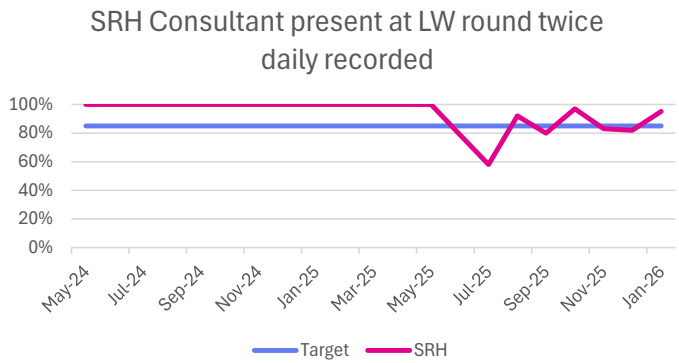


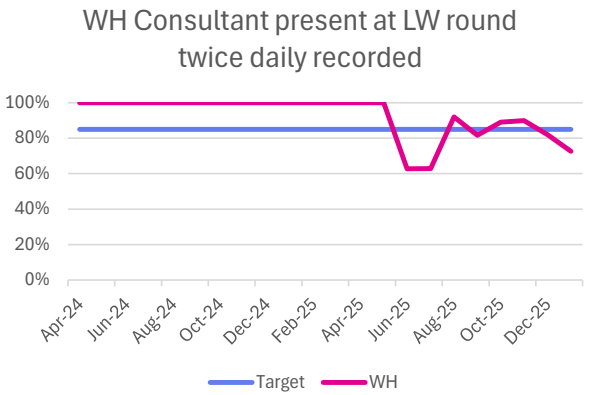
- **Obstetrics**: Maternity cover now in place at RSCH. Interviews for vacancy at SRH taking place 24/04/2026. Middle grade and SHO recruitment being undertaken across all sites. It is thought that a driver for the current vacancy rate is that specialty trainees cover only a percentage of the intended roles. At Worthing, there is a business case being drafted to change two middle grade to SAS contracts to cover the shortfall identified.
- **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.

Twice Daily Consultant Obstetric Ward Round Compliance



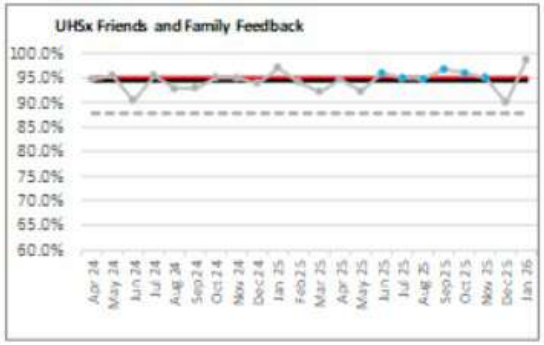


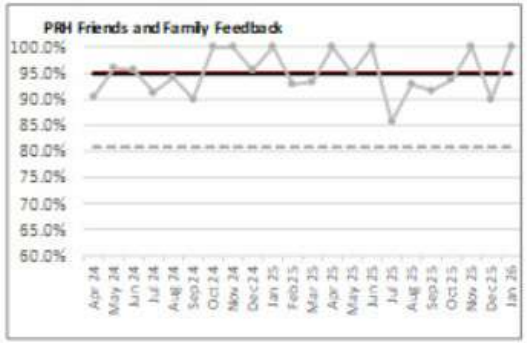


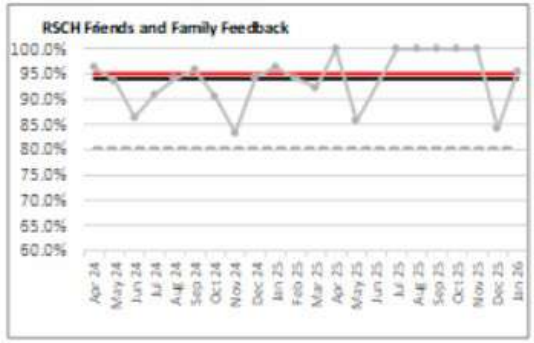


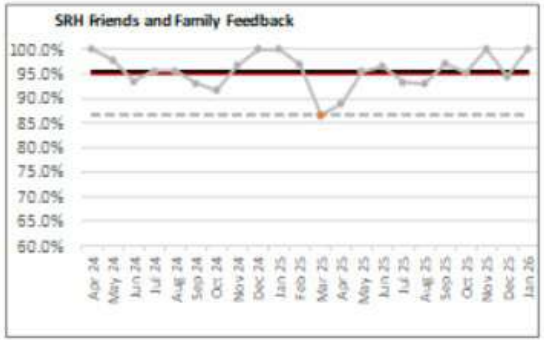
Chief of W&C relays that this data is being reviewed as staff experience discussions do not reflect the data seen here therefore it is felt to be a data capture issue contributing to the numbers seen in these charts. Work on this is on-going to ensure a true problem with compliance is not present and to address the data capture issues.

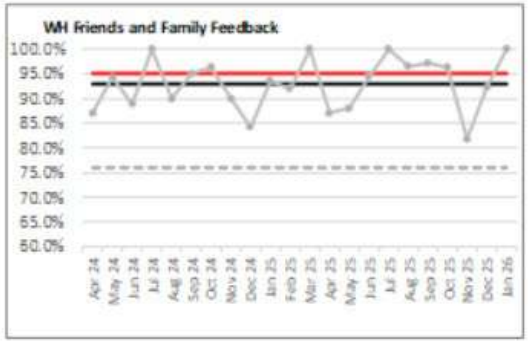
Service User Voice











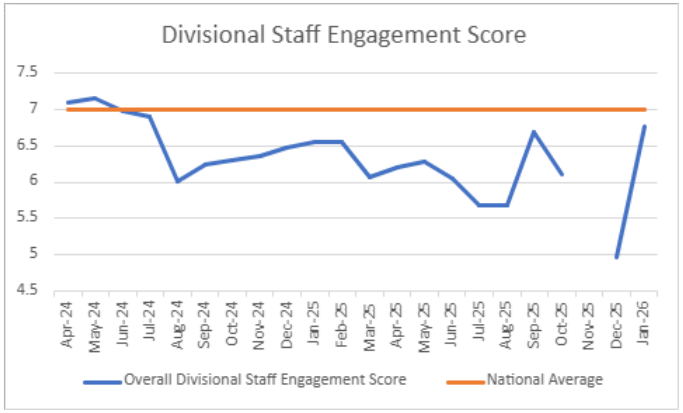
Top 3 Negative Themes

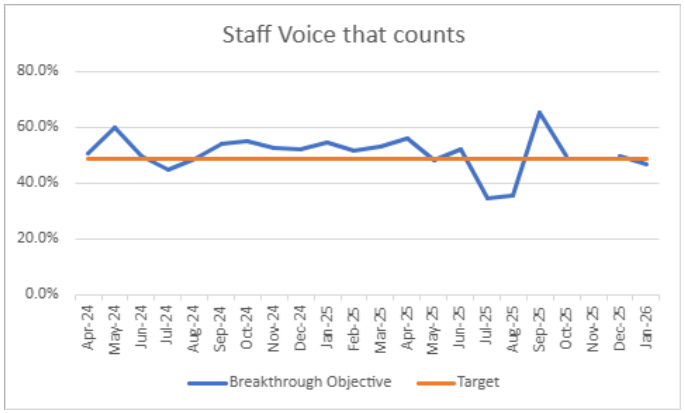
- Staffing Shortages and Delays
- Inconsistent or Poor Communication
- Lack of Continuity and Administrative Issues

Top 3 Positive Themes

- Exceptional Staff Attitude and Support
- Positive Birth Experiences (Including Home and Water Births)
- Continuity and Quality of Care

Divisional staff engagement scores





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.
- Separate Listening Events have been completed to prepare and support staff for the media coverage.

Analysis

NHS
University Hospitals Sussex
NHS Foundation Trust

- Fill rates across perinatal services have improved but remain below recommended templates due to vacancy, sickness and parental leave. High sickness rates and the impact of national maternity scrutiny continue to affect wellbeing and resilience.
- The 2026 Birth Rate Plus review identifies significant acuity increases across all sites, despite falling birth numbers.
- Recruitment initiatives are delivering strong results. All midwifery posts are fully recruited to, based on current templates, agency use has ceased, and proactive vacancy management has created a significantly improved position for the first time in several years.
- The recruitment plan for the current cohort of 3rd year student midwives is awaited following review of the latest BR+ recommendations. NHSE introduced the Graduate Guarantee Scheme for nursing and midwifery graduates in summer 2025.
- Neonatal nursing vacancies have reduced to below 5–10% across sites, with a clear pipeline to increase QIS coverage from 42% to 51%.
- Gap analysis for triage services across the four sites will likely lead to a recommendation for increasing middle grade capacity.
- FFT feedback remains predominantly positive, though negative themes consistently relate to delays, waits for pain relief and communication issues linked to staffing pressures.
- Engagement and morale remain variable across teams. Sickness, parental leave and the impact of national scrutiny continue to influence staff experience. Targeted support is in place, including PMA leadership, restorative culture work, listening events and increased leadership visibility.
- Operational risks remain in specific areas, including homebirth service suspensions, variable acuity compliance and consultant ward-round attendance. These continue to be closely monitored with mitigations in place.

Conclusion

University Hospitals Sussex NHS Foundation Trust

- The 2026 BR+ report acknowledges significantly increased acuity and intervention rates despite a falling birth rate. Approval and implementation of the recommendations are essential to provide safe staffing and meet CNST requirements.
- Perinatal staffing is on a positive trajectory, with improved recruitment, reduced vacancies and cessation of agency use. The Clinical Operating Model is now fully recruited to, strengthening leadership visibility and stability.
- Recruitment and retention strategies are delivering sustained impact, including 98% retention of the 2024 preceptorship cohort, 100% of the 2025 preceptorship cohort and achievement of the national Preceptorship Quality Mark Trust wide.
- Workforce pressures persist, particularly sickness, parental leave and low morale. These continue to influence service experience and require ongoing targeted support.
- Safety continues to improve, supported by robust escalation processes, twice-daily oversight, acuity monitoring and delivery of national programmes such as CNST and Saving Babies' Lives care bundle.
- Service user experience remains strong, with FFT positivity above national rates, though delays linked to staffing remain a recurring theme.
- Further improvement is expected in the next quarter as recruitment pipelines strengthen, vacancies reduce and new staffing models including the homebirth hybrid model and PMA leadership embed across services.