NHS
University Hospitals Sussex
NHS Foundation Trust

Quality Account 2025-26

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Part 1: Chief Executive Officer's Foreword

There is no doubt that 2025/26 has been another challenging year for University Hospitals Sussex, but also one in which we laid the foundations for a strong future with the publication of our new Trust strategy, **Excellent Care Everywhere**.

The strategy covers the period 2025-30 and sets out how we will deliver safe, high-quality services over the remainder of the decade. It builds on our organisation's strengths, recognises the improvements we have already made, and is clear about the long-standing issues where we have not yet made the progress we need. It also responds to the change taking place around us: above all, the evolving needs of the population we serve and the priorities for the NHS set out in the government's 10-year Health Plan for England.

There are five important ambitions at the heart of our strategy. We want to provide:

- **Excellent care for our patients:** fast, fair, high-quality care for all
- **Excellent care for our people:** supporting all our colleagues to be their best
- **Excellent care for our communities:** helping local people live well and thrive
- **Excellent care for the future:** being ready for the world ahead
- **Excellent care together:** becoming one UHSussex, united for success

Each ambition has a set of priorities to achieve the quality of care we all want to see, helping us to think, organise and work differently to improve. To do that, we will need to transform clinical services, use our resources efficiently, make better use of technology, improve our systems and processes, and develop our culture so our people are supported and motivated to deliver the excellent care our patients deserve, wherever they need it.

However, we should be confident we can make this change and be optimistic about our future. We are investing hundreds of millions of pounds in our facilities and developing a positive shared culture of One UHSussex. Above all, we have brilliant people who are committed to doing the very best for their patients and who live our values of compassion, inclusion and respect every day.

We have already made important early progress on some of the strategy's key elements. Clinical centres of excellence are at the heart of our ambitions for patients. During the year, we established the first of these by consolidating colorectal cancer surgery at Worthing, and made important progress on the biggest as the government confirmed £250 million of funding for the new Sussex Cancer Centre. Based in Brighton, this will be a major asset for the whole of Sussex, supporting the development of modern, specialist cancer services for patients across the county and helping us to provide more joined-up, high-quality care in the years ahead.

We also appointed a supplier for our electronic patient record, one of the most important advances in technology at the heart of our ambition to provide **Excellent Care for the Future**. A modern digital EPR is not simply an IT system. It is a foundation for safer, more reliable and more connected care. It will give clinical teams better access to the information they need, reduce duplication, support more consistent ways of working across our hospitals, and improve the experience of patients as they move between services. It

will also help us use data more effectively to improve care, plan services and support our staff.

We ended the year ready to introduce a new Trust operating model that will be the foundation of how we work together as One UHSussex. In simplifying how we lead and collaborate, the new model will help us deliver our strategy in the best and most consistent way. It will be accompanied by a new leadership structure, designed to strengthen accountability, improve decision-making and support greater consistency across our hospitals and services.

As Chair and Chief Executive, we are committed to leading the Trust in line with the values of our new strategy. Above all, we want trust and transparency to be the hallmarks of this organisation, and we will seek to earn the former through the latter over the lifetime of the strategy.

That means continuing to be open about the challenges we face. Our strategy is clear about our difficulties around performance and finance, but also about what we need to do to address them. In some areas, our most significant challenge is the delays patients experience in accessing that care. Those delays matter. They affect patients, families and colleagues, and they must improve. Our focus is therefore on reducing waits, improving flow, making better use of our capacity and ensuring patients receive the right care, in the right place, at the right time.

Openness also means being willing to accept external judgement and use it to direct our improvement efforts. It was in this spirit that we published in July the findings of the Developmental Well-led Review we commissioned from the independent evaluator Niche. We were not obliged to do so, but we wanted all colleagues and stakeholders to be able to consider the issues it raised. These concerns, and the discussion of them, fed into the strategy development process and are at the heart of the work we are undertaking around values and behaviours in 2026-27.

We continue to take the same approach to cooperating with the external inquiries into UHSussex services that began or continued during the year. Operation Bramber, the police investigation into historic patient deaths and harm at the Royal Sussex County Hospital, is ongoing. In June, UHSussex was also included in the national investigation into NHS maternity and neonatal care announced by the Secretary of State. Our hospitals have been visited by Baroness Amos, who is leading one part of the investigation, while UHSussex is also one of up to 10 trusts where the circumstances and causes of specific deaths will be subject to independent review.

The other difficulty we faced across much of the year was industrial action taken by resident doctors in their dispute with the government around pay and conditions. We would like to put on record our thanks to all those colleagues, from the front lines of clinical care to all the support and administrative services that stand behind them, whose efforts have kept patients safe, maintained access to urgent and emergency care, and enabled as many planned services as possible to continue. Given the wider pressures we face, we are very conscious of the additional burden this places on our people and hope the dispute can be resolved as soon as possible.

More within our gift are the measures required by our strategy to deliver **Excellent Care Everywhere**. Over the year ahead, we want to continue the Big Conversation that informed the strategy's development, but break it into a series of smaller conversations that can help us agree how best we should achieve its goals at individual service level. We will need everyone's ideas, innovations and energy to move forward at the pace we want to see. Thank you for all those that have been contributed so far. We look forward to continuing to work together to deliver **Excellent Care Everywhere**.

Dr Andy Heeps | Chief Executive
Philippa Slinger | Chair

1.1 Introduction to the Quality Account 2025/26

What we do

University Hospitals Sussex NHS Foundation Trust (UHSussex) was formed on 1st April 2021. The Trust was created by a merger of University Hospitals Sussex NHS Foundation Trust and Western Sussex Hospitals NHS Foundation Trust.

UHSussex serves a population of around 1.8 million people across a catchment area covering Brighton & Hove, East Sussex and West Sussex. The Trust employs nearly 20,000 people across five main hospital sites in Sussex and has an operating budget of more than £1 billion.

UHSussex runs seven hospitals, St Richards Hospital - Chichester, Worthing General Hospital - Worthing, Southlands Hospital - Shoreham, Princess Royal Hospital - Haywards Health and Royal County Hospital - Brighton and Hove, as well as numerous community and satellite services. The Trust is responsible for all district general acute services for Brighton and Hove, West and Mid Sussex and parts of East Sussex. It also provides specialised and tertiary services across Sussex and parts of the South East, including neuroscience, arterial vascular surgery, neonatology, specialised paediatric, cardiac, cancer, renal, infectious diseases and HIV medicine services.

Purpose of the Quality Account

NHS Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012, and the National Health Service (Quality Account) Regulations 2010, to produce an annual document detailing information in relation to the quality of services provided to local communities, any achievements and/or improvements made and any areas where further improvements may be required for each financial year. The Quality Account is therefore a key mechanism to enhance the Trust's accountability to the public and its commissioners, providing demonstrable evidence of measures undertaken in improving the quality of the Trust's services, and what further improvement is required. Quality accounts are therefore both retrospective and forward looking.

As part of the development of the Quality Account all Foundation Trusts are required to identify measurable priorities that are mapped against the three Darzi headings of Safe, Effective and Patient Experience.

The purpose of the account is to:

- promote quality improvement across the NHS
- increase public accountability
- allow the Trust to review the quality of care provided through its services
- demonstrate what improvements are planned
- respond and involve external stakeholders to gain their feedback including patients and the public.

UHSussex will continue to follow any advice and guidance put forward from NHS England to ensure patients continue to receive high quality care. For the completion of this quality account, NHS England has confirmed that NHS providers are no longer expected to obtain assurance from their external auditors in the preparation of their quality account /quality

report, however the trust has undertaken its own internal review to provide assurance that the required elements have been met (See Annex 1).

All elements of the Quality Account have also been assigned an Assurance Self-Assessment rating and explanation statement:

Self-Assessment Rating	Description of Rating
Limited Assurance	There are significant gaps in assurance of performance, systems or processes
Partial Assurance	There are gaps in assurance of performance, systems or processes
Assurance	Minor improvements needed in assurance of performance, systems or processes
Significant Assurance	There are no gaps in assurance of performance, systems or processes

Compared to last year's quality account UHSussex have improved assurance self-assessment rating in 3 areas;

- Patient Experience
- Regulation 20: Duty of Candour
- Staff Survey

Self-assessment ratings have reduced in 4 areas and were rated as having 'Limited Assurance'

- Patient Reported Outcome Measures
- Patients readmitted to hospital
- Patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)
- Emergency Department Performance

Statements of Assurance from the Board

All NHS trusts are required in accordance with the statutory regulations to provide prescribed information in their Quality Account. This enables the Trust to inform the reader about the quality of their care and services during 2024/25 according to the national requirements. The data used in this section of the report has been gathered within the Trust from many different sources or provided to us from the Health and Social Care Information Centre (HSCIC). The information, format and presentation of the information in this part of the Quality Account is as prescribed in the National Health Service (Quality Accounts) Regulations 2010 and Amendment Regulations 2017.

Part 2: Priorities for Improvement and Statements of Assurance from the Trust Board

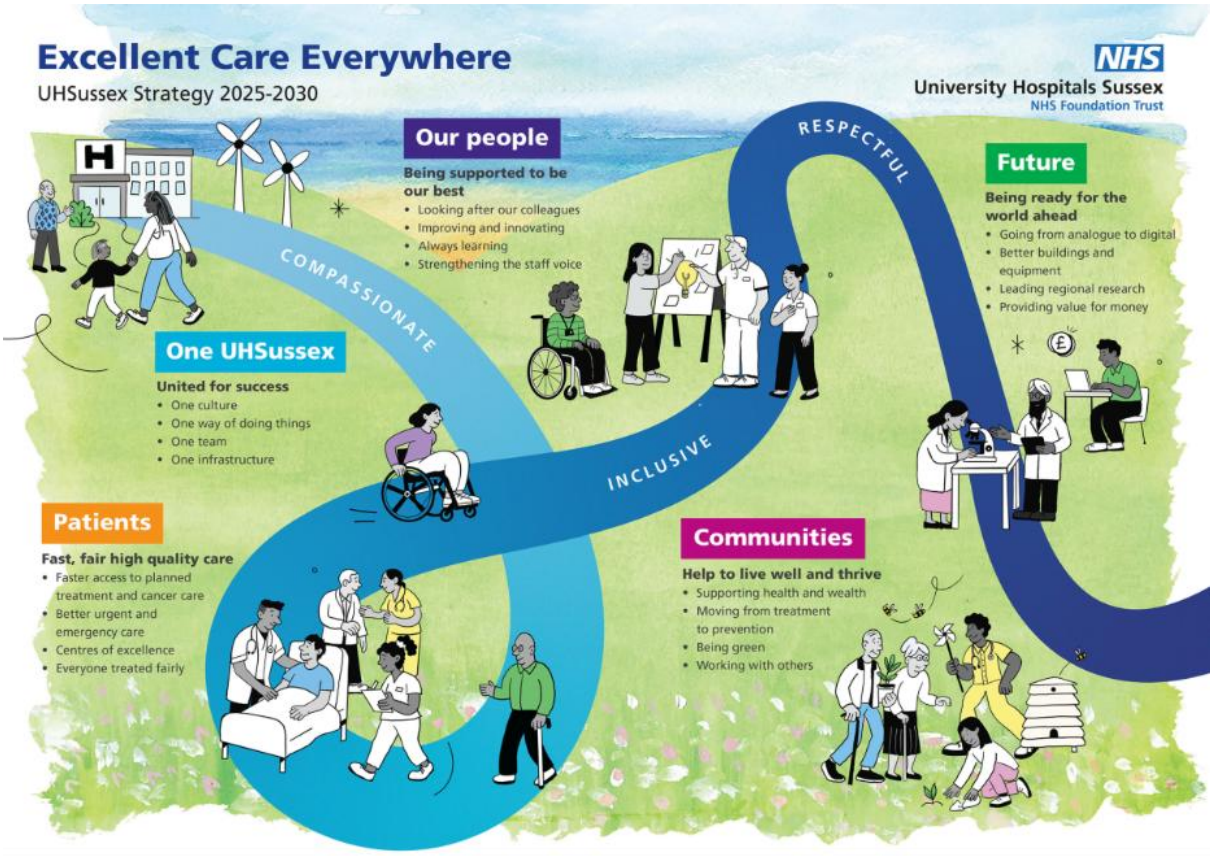
2.1 Our Approach to Improvement

2.1. Excellent Care Everywhere - Five Year Strategy

In October 2025, we launched our five year Trust Strategy, setting a clear route to achieving *Excellent Care Everywhere* by 2030. The strategy builds on early improvements since our merger while addressing the structural and cultural challenges that have limited our ability to operate as a single, coherent organisation. It was informed by our 'Big Conversation', which produced over 12,000 pieces of feedback from Staff, Patients and our Partners.

The strategy enables the Trust to deliver both the immediate improvements required for timely access to care and the long term capacity and capability needed to meet the growing and ageing Sussex population.

It is structured around five strategic ambitions, brought together in our plan on a page (Figure x). To deliver the ambitions and priorities set out in our strategy, we have introduced a new strategy and delivery plan, which has a clear set of actions to ensure we achieve our plans. To address the identified gap in our strategic governance, we have established the Clinical Transformation Programme Board (CTPB), the Strategy and Major Projects Board and the Strategy and Major Projects Assurance Committee (SMPC), which provide robust oversight to ensure effective delivery of our plan



Ambition One: Our Patients

Overarching ambition:

We want all our patients to have the best possible outcomes and experiences, wherever and whenever they need us. That means giving them fast and fair access to high quality care. We have made real progress in improving the quality, safety and accessibility of our hospital services in recent years. We are treating more patients than ever before and achieved the biggest reduction in waiting lists in the entire NHS. But we know we need to do more and do so quickly. We therefore have four priorities we will focus on to achieve the standards we all want to see:

Priorities

1. **Faster access** - reducing waiting times for planned treatment and cancer care
2. **Better urgent and emergency care** - improving access, quality, safety and environments
3. **Centres of excellence** - raising standards and providing access to expertise
4. **Fairness for all** - improving equality of access, outcomes and experience so no-one is left behind

In 2025/26 we made the following progress towards achieving our priorities:

- Worked in partnership with an external partner to run a **diagnostic of Urgent and Emergency Care** across UHSussex to enable us to understand how the whole organisation will work more effective end to end, and where we can make rapid improvements to patient flow.
- Capital and operation plan agreed for the **Helideck** at the Royal Sussex County Hospital (RSCH), with first test flight completed on 24th February 2026
- RSCH **Acute Medical Unit** (AMU) opened to patients on the 2nd December 2025
- **Same Day Emergency Care** (SDEC) opened at Worthing and St Richard's
- £250 million **Sussex Cancer Centre** funding agreed

We are undertaking the following projects and programmes to enable delivery of this ambition:

- **Urgent and Emergency Care (UEC) Transformation Programme**, including:
    - Implementing learning from our **diagnostic of Urgent and Emergency Care**, including admission avoidance and supporting patients to smoothly reach medical optimisation
    - RSCH **Acute Floor Reconfiguration** and 3-year ED transformation
    - Expansion of **Same Day Emergency Care** (SDEC), upgraded **Urgent Treatment Centres** (UTCs), strengthened frailty and non-elective pathways
    - Trust-wide **Daily Management System** roll out to ensure consistent standards of care and rapid escalation of operational issues and contribute to improved ward flow and length of stay
- **Elective Recovery Programme** including:
    - Two new **Southlands theatres** to increase day case capacity

    - **Rightsizing theatre capacity** across our Trust
- **Improvements to planned care:**
    - **Single patient tracking lists (PTL),** aligned end to end **patient pathways,** greater use of **Patient Initiated Follow Up (PIFU)**
- **Centres of Excellence** development:
    - **New Cancer Centre** at RSCH
    - **Stroke Centre of Excellence** at St Richard's
    - Operationalising our **Helideck** at RSCH
- **Diagnostics expansion**:
    - New **Community Diagnostic Centre (CDC)** spoke at **Bognor Regis**, expanded **MRI and FIT testing** at **Southlands**
    - **Laboratory Information Management System** procurement
- **Clinical Sustainability Review**, prioritising maternity and neonatal services

Ambition Two: Our People

Overarching ambition

Our people are the foundation of our work. Across our hospitals, thousands of colleagues deliver compassionate, skilled care every day. To achieve *Excellent Care Everywhere*, we must create an environment where they feel valued, supported and inspired. The Big Conversation and our culture inquiry show we need stronger leadership, clearer expectations, and better support for wellbeing and development. In response and aligned with national priorities such as the NHS People Promise and forthcoming Staff Standards, our strategy sets out four key priorities.

Priorities

1. **Looking after our colleagues** - helping everyone to be healthy and happy at work
2. **Improving and innovating** - creating the culture and conditions in which positive change can happen
3. **Always learning** - educating and developing our people throughout their careers
4. **Strengthening the staff voice** - helping colleagues shape our future

In 2025/26 we made the following progress towards achieving our priorities:

- In depth cultural improvement project identifying seven areas of improvement, with plans to address these commencing at the end of April 2026
- 142 Staff recruited as members of the **new Staff Panel**
- **Education and training plan** approved
- £230k of funding secured for **inclusion of staff Networks**
- £26k of charity funding deployed to **improve staff amenities**
- Development of 10-point plan to **improve resident doctors working lives**

We are undertaking the following projects and programmes to enable delivery of this ambition:

- Adoption of **a new Trust wide improvement methodology** enhancing training to support local innovation
- Introduction of our new **behavioural compass** which is a handy tool that will help us act on our core values - being **compassionate, inclusive and respectful** – in our everyday work lives.
- **Workforce Development Plan** with aligned plans across all professions
- **Workforce Inclusion Plan** to strengthen diversity and belonging
- Expansion of **Advanced Clinical Practitioners** (ACP) roles and **Nursing Associate** pathways
- Full introduction of **Enhanced Care Support Workers** for those patients who need **mental health support**
- A newly launched employer brand **'excellent care starts with you'** has been launched and will provide the foundation for our recruitment strategy over the next five years.

Ambition Three: Our Communities

Overarching ambition

Our hospitals are rooted in the communities we serve across Sussex. As the region's largest employer and a major economic contributor, our impact extends well beyond healthcare. We have a responsibility to support the health, wellbeing and prosperity of our communities through treatment, prevention, sustainability and partnership.

Building on our leadership in the Sussex Provider Collaborative and insights from the Big Conversation, this strategy responds to rising demand, constrained resources and the national shift toward care closer to home. It sets out four priority areas to help our communities live well and thrive

Priorities

1. **Supporting health and wealth** - Being a strong community partner by spending and recruiting locally
2. **Moving from treatment to prevention** - Helping people to stay well and access healthcare closer to home
3. **Being green** - Reducing our environmental impact and championing sustainability
4. **Working with others** - Collaborating to improve services, pathways and patient experience

In 2025/26 we made the following progress towards achieving our priorities:

- New UHSussex **Jobs Newspaper** published
- Range of **events with local schools and colleges** and **jobs fairs** delivered

- Collective agreement at the Clinical Transformation Programme Board (CTPB) to move to **'reuse by default'** as a Trust policy
- **Volunteer celebration events** delivered with positive feedback received
- Continuation of the **Worthing Heat Network programme**, which is on track for delivery in October 2026

We are undertaking the following projects and programmes to enable delivery of this ambition:

- **Sussex Provider Collaborative leadership**, structuring programmes around the Neighbourhood Alliance with a focus on Integrated Community Teams and the Acute Alliance focusing on acute service transformation including
    - System-wide **Maternity & Neonatal Review**
    - **Ear Nose Throat (ENT) reconfiguration**
    - **Elective Single Point of Access (SPOA)** and standardised referral criteria
    - **Urgent and Emergency Care & Rehabilitation Major Service Review**
    - **Integrated mental and physical health pathways** with Sussex Partnership NHS Foundation Trust
    - **Health Inequalities Plan**, including strengthened data quality, targeted CVD and asthma programmes, expanded smoking cessation
    - **Anchor Institution commitments** – local recruitment, procurement, and Green Plan delivery

Ambition Four: Our Future

Overarching ambition

As one of the largest hospital trusts in the country, we have an important role to play in the future development of the NHS, and an opportunity for that role to be a leading one. But we can only shape that future if we are ready for it. The Big Conversation identified challenges around outdated infrastructure, fragmented digital systems and financial pressures that are limiting our ability to innovate, improve and set ourselves up for long term success. This strategy responds to those challenges with a commitment to change, enabled by four ambitions for the five years ahead.

Priorities

1. **Going from analogue to digital** - Using technology to improve care and communication
2. **Better buildings and equipment** - Investing in modern facilities and the most advanced kit
3. **Leading regional research** - Becoming a centre of excellence that widens access to research and innovation
4. **Providing value for money** - Running our services efficiently and sustainably

In 2025/26 we made the following progress towards achieving our priorities:

- The **sale of St Marys Hall in Brighton completed** in December
- **Electronic Document Management System** (eDMS) **rollout** achieved at Worthing and St Richard's
- **Over 5,500 participants recruited** into 236 different **research** studies in quarters 1-3 of 2025/26
- Reinforced Autoclaved Aerated Concrete (**RAAC**) **redesign of options** completed **for St Richard's**

We are undertaking the following projects and programmes to enable delivery of this ambition:

- **Digital transformation portfolio**, including:
    - Procurement and implementation of a single **Electronic Patient Record (EPR)**
    - Trust wide **Electronic Records & Document Management System**
    - Expanded digital communication (MyHCR, Patient Knows Best, hybrid mail)
    - AI enabled **patient communication tools**
    - Infrastructure and **cyber security** modernisation
- **Capital and estate programmes**:
    - **RAAC remediation** at St Richard's
    - **Estate rationalisation** and ward refurbishments
    - Urgent and Emergency Care **facility upgrades**
    - **Additional theatres** at **Southlands**
    - RSCH **Cancer Centre** (Stages 2 & 3)
- **Research & Innovation programmes**:
    - **Clinical Research Facility**
    - **Commercial** Research Delivery Centre
    - One UHSussex Research **Workforce Model**
    - Joint clinical **academic posts**
    - Sussex Research **Engagement Network**
- **Productivity improvement programme** focusing on:
    - Elective **productivity** (job planning, utilisation)
    - Emergency care **benchmarking** and Getting Right First Time (GIRFT) "Further Faster"
    - **Priority pathway** reviews identified
    - Outpatient modernisation (Advice and Guidance (A&G) optimisation, Patient Initiated Follow Up (PIFU) growth)

Ambition Five: One UHSussex

Overarching ambition

UHSussex was created so our hospitals could achieve together what they could not do alone. As one of the largest NHS trusts, we have a rare opportunity to deliver a wide range of high quality services, offer rewarding careers, and be a powerful force for good in our communities.

Realising that potential has been challenging. The merger coincided with the pressures of the COVID-19 pandemic, and colleagues highlighted duplication and inconsistency across sites, as well as concerns about fairness, visibility and role clarity.

Our new strategy responds directly to these issues, setting out four priorities to unite our organisation and position us for long term success as One UHSussex

Priorities

1. **One culture** - Living our values in everything we do
2. **One way of doing things** - Consistent practices and pathways that make sense for patients
3. **One team** - Getting the right people with the right skills working towards common goals
4. **One infrastructure** - Combined systems that help us do our jobs better

In 2025/26 we made the following progress towards achieving our priorities:

- Launch of the new **Everyday Star awards**, 3,600 stars awarded to date
- Concluded consultation on our **Trust Operating Model** (TOM), which sets out the **organisational structure** through which we will deliver our strategy, and defines how we will lead and work together to make UHSussex simpler, stronger, and better connected to our patients, our communities, and our teams.
- Definition, scope, and governance of **safety culture framework finalised**
- Active Bystander and Human Factors **training integrated** into **wider Safety Culture** rollout

We are undertaking the following projects and programmes to enable delivery of this ambition:

- **Trust-wide culture programme**, embedding new values and behaviours
- Implementation of **single pathways and processes** across all sites
- Alignment of **staff terms and conditions**
- **Digital alignment** of systems and data
- Strengthened governance through refreshed committee architecture and Board Assurance Framework (BAF)

Making change happen

We are delivering our strategy by equipping staff with the tools and resources they need to drive improvement. A new Clinical Transformation Programme Board is leading strategic change, supported by our robust Strategy Delivery Plan. Oversight is provided by our

Strategy and Major Projects Assurance Committee, which ensures milestones are met and learning is captured and applied to future programmes.

Our Values

The Strategy also introduces a reset of our core values, ensuring they are easily recognisable and remembered, consistently visible in interactions with patients, the public, colleagues, partners, and prominent in how we lead and manage services. The document outlines our three core values. We are:

- **Compassionate** - we communicate and act kindly
- **Inclusive** - we work collaboratively
- **Respectful** - we behave professionally

We know that the best-performing organisations empower their people and are values-driven, so it is important we show pride in these values and make them more visible in all we do.

Improvement Methodology

Standardised improvement methodologies can be an effective tool to enact change across a large organisation. UHSussex's Patient First improvement methodology has worked well across several services, but uptake and implementation of this method across the Trust is mixed. Utilising this strategy, we will refresh, refocus and build on the strengths of the Patient First improvement methodology to create a community of 17,800 people with the simple tools and support they need to deliver real improvement quickly, for patients and colleagues. Through an open-minded and ambitious policy, we will empower and invest in staff who wish to work at the cutting edge of healthcare. The Strategy also commits to reforming existing resources into a new Improvement and Organisation Development team to enhance focus and communication and support those making improvements on the frontline.

This new approach to change and improvement will form the basis for the delivery of several improvement priorities, including but not limited to:

- Improving provision for people's basic needs
- Implementing single waiting lists
- Reviewing and implementing single pathways
- Improving our corporate and business processes
- Improving productivity
- Improving our approach to booking and managing appointments
- Improving compliance with NICE guidelines
- Implementing GIRFT recommendations
- Improving Theatre Utilisation
- Improving discharge processes

2.2 Priorities for Improvement

2.2.1 Progress against our 2024/25 Quality Account Priorities

The Trust 2024/25 Quality Account set out the following quality account priorities;

Achievement Rating:	Not Met	Partially Met	Met

Quality Priority One:

Improve the Identification and management of deteriorating patients including preventing sepsis, ensuring that all admitted patients have a Treatment & Escalation Plan

Measure	Description	Achievement
1	**95% of NEWS2 admitted adult patient observations completed within agreed timeframe** How this is measured: 95% of all adult patients have a documented NEWS2 Score within agreed timeframe.	

Narrative: Data taken from Power BI NEWS Dashboard. Timeliness of NEWS score now a focus across many clinical areas as part of DMS and driver lanes. Performance monitored through Divisional structure and through Nursing Quality Assurance Group. NEWS observation training has recently been added to the IRIS learning platform which is now augmented by a face to face "Deteriorating Patient" course. NEWS timeliness is also incorporated into many clinical areas through the use of DMS to drive improvement

Q1 - 77.73%			**Q2** - 80.83%			**Q3** - 82.06%			**Q4 -** 83.26%		
Apr	**May**	**Jun**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
77.1%	78.1%	78%	79.4%	81.5%	81.6%	81.7%	81.1%	83.4%	82.4%	83.7%	83.7%

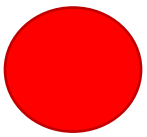
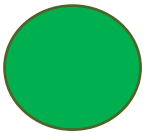
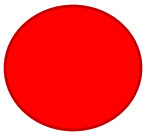
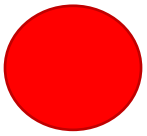
2	**75% of admitted adult patients have a Trust wide Treatment Escalation Plan (TEP) completed** How this was measured: Completion and reporting of the Critical Care Outreach Team (CCOT) TEP/DNACPR Metric, including comparative analysis with MET Call outcome data	

Narrative: A dashboard to reflect CCOT data re TEP/MET calls is in development with the Senior Information Analyst (COEG). Due to capacity within the team this has been delayed. As of Q4 25/26 development of an automated excel dashboard has begun which will provide monthly and cumulative MET call data and breakdown data by site and ward. Progress meeting with Critical care outreach charge nurse 28/04/26 identified some further updates needed to the dashboard. Expected to be in place for Q2 2627.

3	**100% of adult patients who trigger Sepsis Six Bundle receive this within the required timeframe** How this was measured: 100% of patients deemed as high risk received the Sepsis Six Bundle within 1 hour.	

Narrative: Sepsis recognition and management now a key focus for all areas. Noticeable improvement through Q1 due to increased education, and promotion. Monthly Sepsis improvement meeting chaired by Deputy Chief Nurse exists to review progress. Sepsi recognition training has recently been added to the IRIS learning platform which is now augmented by a face to face "Deteriorating Patient" course. Sepsis recognition and management is also incorporated into many clinical areas through the use of DMS to drive improvement

Q1 -37.1%			**Q2** - 46.96%			**Q3** - 47.9%			**Q4 -** 51.46%		
Apr	**May**	**Jun**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
33.3%	38%	40%	41.3%	33.3%	38%	49.6%	44.3%	49.8%	51.5%	50.8%	52.1%

4	**100% of adult patients who trigger Sepsis Six Bundle receive this within the required timeframe** How this was measured: 100% of patients deemed as moderate risk received the Sepsis Six Bundle within 3 hours.	
	Narrative: This is not being measured	
5	**Completion of the Trust wide ED Sepsis Audit** How this was measured: Submission of a Part B Audit form outlining outcomes from the audit	
	Narrative: Data collection took place in Q3, with analysis and development of improvement actions in Q4. The outcome of the audit is provided in Section 2.7.10 Sepsis.	
6	**Completion of the Trust wide In-Patient Sepsis Audit** How this was measured: Submission of a Part B Audit form outlining outcomes from the audit	
	Narrative: This audit was delayed due to capacity with the Clinical Outcomes & Effectiveness Team and has now been re-scheduled for Q2 of 2026/27.	
7	**95% of PEWS admitted paediatric patient observations completed within agreed timeframe** How this is measured: 95% of all paediatric patients have a documented NEWS2 Score within X of admission	
	Narrative: Improvement work continues within Paediatrics, changes to recording of non-compliance now in place which should improve performance over Q1 2026/7	

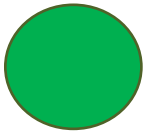
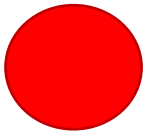
Q1 - 71.2%			**Q2** - 75.3%			**Q3** - 69.76%			**Q4 - 68.76%**		
Apr	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
67.9%	71.5%	74.2%	73.9%	73.5%	78.5%	72.2%	69.9%	67.2%	67.2%	69.5%	69.6%

All aspects of Priority One which have not been achieved will be continue in the Priorities for 2026/2027

Quality Priority Two:
Improve the recognition and management of end of life patients, ensuring advance care planning

<table>
<tr><th>Measure</th><th>Description</th><th>Achievement</th></tr>
<tr><td rowspan="2">1</td><td colspan="2">75% of admitted patients who die in hospital will be recognised as being in the last days of life at least 96 hours before death and have a comfort care plan initiated
How this is measured: SEOLC Comfort care dashboard [power BI]</td></tr>
<tr><td colspan="2">Narrative:
<table>
<tr><th colspan="3">Q1</th><th colspan="3">Q2</th><th colspan="3">Q3</th><th colspan="3">Q4</th></tr>
<tr><th>Apr</th><th>May</th><th>Jun</th><th>July</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td colspan="3">76%</td><td colspan="3">77.1%</td><td colspan="3">75.7%</td><td colspan="3">73.9%</td></tr>
</table></td></tr>
<tr><td rowspan="2">2</td><td colspan="2">90% of these patients will have anticipatory medications prescribed
How this was measured: SPCT Quality Sample: SeeCare [comfort care dashboard]
End of Q2 registering at 98.2% from SeeCare Audit [Quality Sample]</td></tr>
<tr><td colspan="2">Narrative:
<table>
<tr><th colspan="3">Q1</th><th colspan="3">Q2</th><th colspan="3">Q3</th><th colspan="3">Q4</th></tr>
<tr><th>Apr</th><th>May</th><th>Jun</th><th>July</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td colspan="3">98%</td><td colspan="3">98.2%</td><td colspan="3">98%</td><td colspan="3">98%</td></tr>
</table></td></tr>
<tr><td rowspan="2">3</td><td colspan="2">90% of families/relatives of patients on comfort care plans will be formally informed and involved in care discussions
How this was measured: SPCT Quality Sample: SeeCare [comfort care dashboard].</td></tr>
<tr><td colspan="2">Narrative:
<table>
<tr><th colspan="3">Q1</th><th colspan="3">Q2</th><th colspan="3">Q3</th><th colspan="3">Q4</th></tr>
<tr><th>Apr</th><th>May</th><th>Jun</th><th>July</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td colspan="3">96%</td><td colspan="3">96.5%</td><td colspan="3">96.5%</td><td colspan="3">96.5%</td></tr>
</table></td></tr>
<tr><td rowspan="2">4</td><td colspan="2">75% of admitted patients will have a documented comfort care assessment and evaluation completed and recorded in PatientTrac
How this was measured: SEOLC Comfort care dashboard [power BI]</td></tr>
<tr><td colspan="2">Narrative:
<table>
<tr><th colspan="3">Q1</th><th colspan="3">Q2</th><th colspan="3">Q3</th><th colspan="3">Q4</th></tr>
<tr><th>Apr</th><th>May</th><th>Jun</th><th>July</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td colspan="3">55%</td><td colspan="3">46%</td><td colspan="3">55%</td><td colspan="3">50%</td></tr>
</table>
A new section has been added to the End of Life Care (EOLC) Study day around patient trac and completion of said assessments and evaluations and this forms part of the EOLC Education Strategy 2025-27. We are determining if this is a data collection issue, as does not reflect the SeeCare Quality Sample of: 54%, the new Comfort Care Nursing project will target EOLC assessments</td></tr>
<tr><td colspan="3">Those elements not achieved will continue to be monitored through regular reporting to the Quality Governance Steering Group & Board Patient & Quality Committee</td></tr>
</table>

Quality Priority Three:
Improved performance and outcomes for Fractured neck of femur patients

Measure	Description	Achievement
1	**Completion of A3 thinking* and development of an improvement action plan to address route causes** How this is measured: Development of A3 thinking for presentation *a quality improvement methodology using a structured process to understand problems/issues by breaking them down on a page into known facts, root causes, solutions and actions	
	Narrative: A3 Thinking was presented to the NOF/HIP Fracture working Group chaired by the Chief Medical Officer on 11 July 2025.	
2	**Development of a documented pathway for fractured neck of femur pathways across UHSussex** How this was measured: Approved Trust wide pathway in place	
	Narrative: A Trust wide pathway was developed in Q4. Having been out for consultation it is being presented for approval to the NOF/HIP Fracture Working Group chaired by the Chief Medical Officer in May 2026.	
3	**Reduce National Hip Fracture database Crude & Case Mixed 30-day mortality rate to at or below national average** How this was measured: Data published on the NHFD demonstrating mortality metrics	
	Narrative:	

KPI	Q4			Q1			Q2			Q3			Q4		
	PRH	SRH	WGH	PRH	SRH	WGH	PRH	SRH	WGH	PRH	SRH	WGH	PRH	SRH	WGH
Crude Mortality	2.4	5.1	6.5	3.0	6.7	5.0	3.3	8.3	5.3	3.4	8.1	3.8	3.7	7.6	4.5
Casemix adjusted mortality	2.6	4.2	7.9	3.4	5.5	6.1	3.8	6.6	6.6	4.0	6.6	4.3	4.3	6.1	5.1
Casemix adjusted National Average	5.3			5.1			5.1			5.0			5.0		

PRH remains lower than national average and within control limits but has increased slightly, whilst WGH has improved and is now below average and within control limits, SRH position has deteriorated, remains above national average and above control limits for crude mortality, monthly mortality meetings have been taking place to review related deaths.

4

Improve National Hip Fracture Database KPI performance

How this was measured: Metrics seeing an improvement over the 12-month period, with all remaining above national average. NA = data publication lad by NHFD - please note KPI averages change with each data set publication and are graded at the time of publication.

KPI		Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Admission to specialist ward % National Average: 10%	PRH	9.7	10.4	11.7	13.6	15.0	15.4	16.4	18.0	18.8	18.9	18.8	18.8
	SRH	3.2	3.5	3.9	3.2	3.6	3.8	3.5	3.5	4.8	4.9	4.5	4.2
	WGH	7.6	7.6	8.8	9.6	10.0	9.8	9.7	11.0	11.8	12.4	12.3	12.5
Prompt Orthogeriatric review % National Average: 89%	PRH	91.6	91.7	91.5	92.1	91.7	91.9	93.1	93.3	94.1	93.5	93.3	92.3
	SRH	89.4	91.1	91.3	90.5	89.8	91.5	90.4	88.8	93.3	93.4	92.1	89.2
	WGH	99.2	99.4	99.6	99.6	99.6	99.6	99.4	99.4	99.6	99.3	99.6	99.6
Prompt surgery % National Average: 57%	PRH	74.3	74.4	75.4	76.4	77.0	77.9	77.9	78.9	79.1	79.4	78.4	77.8
	SRH	63.8	63.6	61.2	63.3	66.0	66.5	63.9	64.8	66.3	68.7	67.5	66.2
	WGH	53.3	52.9	52.6	53.3	52.8	54.7	53.2	55.3	56.1	57.6	55.2	56.5
NICE compliant surgery % National Average: 71%	PRH	84	83.6	84.3	84.3	84.7	85.3	84.2	85.5	83.9	84	83.8	83.3
	SRH	76.7	75.8	74.6	72.7	72.8	74.5	74.3	73.0	74.1	73.4	72.1	72.1
	WGH	53.1	51.9	50.7	49.6	48.0	47.9	49.9	51.7	53.9	54	54.1	54.5
Promptly out of bed % National Average: 82%	PRH	81	80.3	79.3	79.3	79.0	78.4	77.9	78.4	78.4	78.5	78.4	77.2
	SRH	80.5	81.6	80.9	80.8	80.3	82.0	81.2	78.5	81.7	81.7	82.9	79.4
	WGH	79.1	78.6	78.9	79.9	80.4	81.4	83.3	83.3	83.1	84.4	85	85.5
Not delirious post op % National Average: 67%	PRH	76.8	76.9	76.9	76.8	76.8	77.3	77.9	77.7	77.2	77.2	76.3	75.5
	SRH	69.4	70.6	71.3	70.9	70.4	72.1	71.9	70.6	73.1	73.9	73.4	69.8
	WGH	76.3	76.9	77.6	77.8	77.5	77.1	77.3	76.9	76.8	76.7	76.4	75.2
Return to original residence % National Average: 75%	PRH	65.0	64	64.0	63.3	64.2	64.0	64.5	65.6	66.2	67.7	NA	NA
	SRH	73.7	73.1	72.9	72.7	72.0	70.1	70.3	70.3	71	71.7	NA	NA
	WGH	62.2	62.9	64.0	64.2	65.4	66.9	66.7	65.9	65.1	66	NA	NA
Bone protection medication % National Average: 61%	PRH	63.9	64.7	64.0	63.0	64.4	62.8	63.0	64.7	64.6	64.1	NA	NA
	SRH	85.7	85.2	84.4	84.0	83.6	82.2	82.7	84.6	85.5	85.4	NA	NA
	WGH	78.3	80.2	83.5	86.8	87.9	88.4	88.9	88.4	88.2	87.8	NA	NA

Those elements not achieved will continue to be monitored through regular reporting to the Quality Governance Steering Group & Board Patient & Quality Committee

The Trust recognises the areas for improvement and as such are developing a standardised fractured neck of femur and lower limb injury pathway across all UHSx sites through the delivery of Non-Ambulatory Fragility Centres, which once implemented will deliver improved compliance against the National Hip Fracture Database; however, the following areas are currently highlighted as under-performing;

Admission to specialist ward
Whilst improvements have been made across the year, St Richard's Hospital consistently falls below the average for this KPI due to a limited bed base within a dedicated ortho-geriatric ward leading to many patients being admitted to the emergency floor prior to surgery.

Prompt surgery
Whilst improvements have been made across the year Worthing General Hospital has consistently fallen below national average for this KPI due to theatre scheduling/availability to managed NOF and Major Trauma demand, hip surgeon rota cover, image intensifier availability within theatres and reduced theatre sessions over weekends and bank holidays.

NICE compliant surgery
Worthing General Hospital consistently falls below the national average for this KPI, due to the delays in time to theatre/prompt theatre.

Promptly out of bed
Whilst there has been improvement at Worthing General Hospital over the year as a result of Physiotherapy having undertaking improvement audits. St Richards Hospital and Princess Royal Hospital consistently fall below the national average for this KPI due to capacity within the Physiotherapy teams, a need to review and implement post operative analgesic protocols to support mobilisation and training to support nursing staff to mobile patients unable to be seen by physiotherapists.

Return to original residence
All hospital sites consistently fall below the national average for this KPI due to the frail and elderly population served by UHSx, where many patients require a rehabilitation placement following admission.

2.2.2 Quality Priorities 2026/27

The Quality Account Priorit for 2026/27 will build on the work completed in 2025/26 to further improve the timeliness of observations, identification and management of deteriorating patients, including preventing sepsis in adults and paediatrics as part of a three-year improvement plan.

The following measures will be carried over;

- 95% of NEWS2 admitted adult patient observations completed within agreed timeframe
- 75% of admitted adult patients have a Trust wide Treatment Escalation Plan (TEP) completed
- 100% of patients deemed as high risk received the Sepsis Six Bundle within 1 hour.
- 100% of patients deemed as moderate risk received the Sepsis Six Bundle within 3 hours.
- Completion of the Trust wide In-Patient Sepsis Audit

In addition, the following new measure will be introduced for 2026/2027;

Description	How we will measure success
Improve training compliance to support the identification and management of deteriorating patients (including sepsis)	90% of staff (where required by role) have completed Adult Basic Life Support training
	90% of staff (where required by role) have completed Paediatric Basic Life Support training
	90% of staff (where required by role) have completed Newborn Life Support training
Improve the use of Martha's rule	Understand and analyse the data collected to inform the effectiveness of Martha's Rule Implementation; • % of wards with visible Martha's Rule information (posters, leaflets, bedside prompts) • Number of Martha's Rule calls per 1,000 admissions • Proportion of calls initiated by patients/families vs staff • % of calls that correctly identify acute deterioration • % of deterioration-related incidents where Martha's Rule was used appropriately To support the development of an improvement plan as required

Deteriorating Patients & Sepsis

The recognition and management of the deteriorating patient remains a key patient safety priority for UHSussex. Patient safety incident reviews continue to identify delayed recognition and escalation of deterioration as a recurrent theme across a range of services, reinforcing this as a Trust-wide clinical risk. In response, the Deteriorating Patient Group has led a comprehensive improvement programme focused on strengthening clinical capability, standardising practice and improving patient outcomes. This has included the introduction of a dedicated Sepsis training module on IRIS, Trust-wide Sepsis Six education, and targeted support to improve the use of Patientrack and escalation of patients with NEWS2 scores greater than five.

These interventions have contributed to sustained improvement in sepsis bundle timeliness, with performance increasing from the mid-30% range at the start of the year to a stable position in the low-to-mid 50% range by year end. Alongside workforce development, the Trust continues to advance its digital patient safety agenda through the integration of Mindray observation devices with Patientrack, enabling real-time recording of observations and more reliable escalation of deteriorating patients. This work will be fully embedded across inpatient areas by September 2026, supporting earlier recognition of deterioration, improved compliance with evidence-based care bundles and safer patient care.

Martha's Rule

During 2025/26, UHSussex successfully implemented Martha's Rule across all acute hospital sites, strengthening the role of patients and families in the recognition and escalation of deterioration. The service is now fully operational across the Royal Sussex County Hospital, Princess Royal Hospital, Worthing Hospital and St Richard's Hospital and is supported by the Patient Wellness Questionnaire (PWQ) embedded within Patientrack. UHSussex has been recognised as a national exemplar site for implementation, reflecting its commitment to embedding patient voice within clinical decision-making and safety processes.

During the reporting period, Martha's Rule provided an additional safety net for patients and families, with most calls relating to communication, clinical management and concerns about care rather than acute deterioration. PWQ compliance remained high at 89%, with more than 259,000 assessments completed, demonstrating strong engagement across inpatient areas. Following the success of implementation in adult services, Martha's Rule has now been extended into paediatric services, with further rollout planned within maternity services during 2026/27, ensuring more patients and families can benefit from this important patient safety initiative.

Ward Accreditation Programme

In May 2026, UHSussex launched its Ward Accreditation Programme, a Trust-wide quality assurance and improvement framework designed to recognise excellence, reduce unwarranted variation and provide robust assurance regarding the quality and safety of care delivered across inpatient services. The programme aligns with the Trust's Fundamental Standards of Care and combines clinical outcomes, patient and staff feedback, performance metrics and peer review to provide a comprehensive assessment of ward performance.

The programme has made a strong start, with the first three accreditation visits completed and all participating wards achieving a rating of Great. This demonstrates the commitment of frontline teams to delivering safe, compassionate and high-quality care while embracing a culture of continuous improvement. As the programme expands across UHSussex, it will continue to strengthen ward-to-board assurance, support harm prevention and promote consistent standards of excellence for patients across all hospital sites.

2.3 Clinical Effectiveness & Assurance

2.3.1 Participation in National Clinical Audits (NCA) and National Confidential Enquiries into Patient Outcomes and Death (NCEPOD)

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex fully participated in 86% of eligible audits across all sites. There were an additional 6 audits (8%) where there was partial participation (one or more eligible site) within the Trust. Annual participation checks are now taking place and systems are in place to review national reports and embed recommendations. To reach assurance an improvement in participation, reduction of outlier status, and improvements in the incorporation of National recommendations is required.			

The Trust's participation in National Clinical Audits and National Confidential Enquiries into Patient Outcome and Death enables us to benchmark the quality of the services that we provide against other NHS Trusts. It also highlights best practice in providing high quality patient care and drives continuous improvement across our services.

During 2025/26 the Trust fully participated in 65 out of 75 national clinical audits, achieving 88% participation in eligible audits as outlined in the NHS England Quality Account List. The Trust partially participated in a further 6 audits, resulting in a combined participation status (fully and partial) of 93%. UHSussex did not participate in the following 4 audits at any of it sites:

- National Cardiac Arrest Audit (NCAA)
- Age-related Macular Degeneration Audit (AMD) - National Ophthalmology Database Audit (NOD)
- National Cataract Audit - National Ophthalmology Database Audit (NOD)
- Fracture Liaison Service Database-

Rationale for non participation includes challenges with IT compatibility re the National Audit upload requirements and workforce capacity.

The national audit programme has driven a number of quality improvements within the Trust, these are overseen by the Trust Clinical Outcomes and Effectiveness Group and respective divisional quality and safety groups. Annex 2 contains a summary of some of the key audit achievements and planned actions for improvement.

UHSussex received outlier status for the following audits, throughout 26/27.

- National Vascular Registry (NVR) 27/10/2025

- National Early Inflammatory Arthritis audit (NEIAA) 19/6/25
- National Respiratory Audit Programme - COPD Secondary Care at PRH 17/4/25
- National Respiratory Audit - Adult Asthma at PRH 17/4/25
- National Hip Fracture database 08/09/26
- NJR DQA Historical audit year at SRH 06/01/26
- NJR SOTC Hip Revision alert letter received 19/01/26
- Fracture Liaison Service Database (FLS-DB) 26/01/26

Upon receipt of the outlier status the data is reviewed, validated and a plan for quality improvement implemented. Actions for improvement are overseen at The Trust Clinical Outcomes and Effectiveness Committee and divisional quality and safety meetings.

Throughout 2025/2026 the Trust commenced participation in three new confidential enquiries, and completed submission for four ongoing enquiries from 24/25. The percentage submitted for each study are detailed in the table below. Some areas have been marked as 'in progress' which means that the data is still being collated for the 2025/26 reporting period.

2.3.2 Local Audits

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex continues high levels of activity with clinical audit and local service evaluations. Systems and processes are now in place to follow up every audit registered including re-audits.			

Clinical Audit, including service evaluation drives improvement through a cycle of service reviews against recognised standards and then provides a baseline for implementing change as required. We also use audit to benchmark our care against local and national guidelines so we can put resources into areas requiring improvement; this is part of our commitment to ensuring the best treatment and care for our patients.
Local audits are registered via divisions throughout the course of the year and are undertaken in response to local patient safety, quality, clinical effectiveness concerns or on

areas of clinical interest. Audits were undertaken across all the Trust Divisions, overseen by the Clinical Outcomes and Effectiveness Team.

Year	Local Audits/Service Evaluations				
	No registered	No. in progress	No. Completed	No. not completed	No. shown at conference / published
2025/26	498 registered	541	231 (46.38%)	96 (19.27%)	24
2024/25	345 registered	343	189 (54.78%)	88 (25.50%)	9
2023/24	238	NA	91	NA	NA

2.3.3 NICE (National Institute for Health & Care Excellence) Guidance

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Following the review of NICE processes in 24/25, there has been a significant improvement in the timely review of NICE Baselines across the organisation. To reach Assurance compliance needs to improve (currently 68%) due to the development and implementation of improvement plans.			

NICE Guidelines, Clinical Guidelines, and Quality Standards are evidence-based recommendations for health and care in England. Whilst guidance published by NICE is not statutory, healthcare organisations are expected to take into account recommendations from NICE when developing and delivering services.

Following an internal review of NICE processes in 2024/2025, there has been significant improvement with NICE activity across the Trust. The review included adjustments to processes relating to the receipt, dissemination, implementation and reporting of NICE guidance. As a result of these improvements;

- The backlog of overdue baseline assessments has been cleared (inclusive of baselines >12 months- Post Merger)
- All NICE Guidance has a named lead
- The percentage of completed baselines has remained above 95% throughout the year, achieving up to a 100% for a 6-month period

A further break down of compliance via division is provided in Annex 2.

New Local Quality Metrics were agreed which have helped to maintain Trust and divisional oversite of NICE activity. These LQR's are visible via the COEG Dashboard which is

accessible by all members of staff, and reported monthly to the Clinical Divisions and Trust Wide Governance Meetings.

NICE Technology Appraisals (TAs) are statutory guidance for which NHS healthcare services must make funding available and implement within three months from their date of issue. The formulary status for TAs is reviewed at the Medicine, Safety and Governance Group monthly.

During 2025/26 NICE published 108 TA's all of these TA's have been reviewed in accordance with the Sussex Health and Care Partnership Area Prescribing Committee guidelines. Of the 108**,** 80 have been reviewed and 25 are in progress.
Of the 80 reviewed;

- 49 have been approved for prescribing, supply and monitoring only in specialist care settings,
- 2 have been approved as suitable for prescribing in any setting
- 2 have specialist recommendation status with ongoing prescribing and monitoring in any setting
- 26 have been assessed as Non formulary and are therefore not suitable for prescribing in any setting**,** and three have been superseded
- 1 TA was assessed as not relevant for example when UHSussex is not commissioned to provide a specific service

2.3.4 Patient led assessment in the care environment (PLACE) audit

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	The majority of UHSussex average scores have declined since the previous year and remain lower than national and peer average scores			

The Trust undertook its annual PLACE assessments between September and November 2025, with the PLACE average audit compliance scores for all inpatient Hospital sites within the Trust demonstrating an improvement in scores for 7/8 of the domains when compared to the previous year:

Domain	UHSussex Average Score 2025	UHSussex Average Score 2024	National Average Score 2025	Peer Average Score 2025
Cleanliness	98%	94%	98%	98%
Combined Food	91%	90%	92%	92%
Organisation Food	98%	98%	92%	91%
Ward Food	89%	88%	92%	93%
Privacy, Dignity, and Wellbeing	91%	87%	89%	90%
Condition, Appearance & Maintenance	96%	92%	97%	97%
Dementia	90%	76%	85%	87%
Disability	92%	79%	87%	87%

The Trust now scores higher or equal in 5 of the 8 domains (62.5%) when compared to both the national average and peer average scores. An action improvement plan is provided in Annex 2.

2.3.5 Getting it Right First Time (GIRFT)

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is progressing with the delivery of Further Faster Actions and is the reviewing the systems and processes in place to improve the implementation and oversight of GIRFT Programmes			

Getting It Right First Time (GIRFT) is a national programme designed to enhance the treatment and care of patients through comprehensive reviews of services, benchmarking, and presenting a data-driven evidence base to support change.

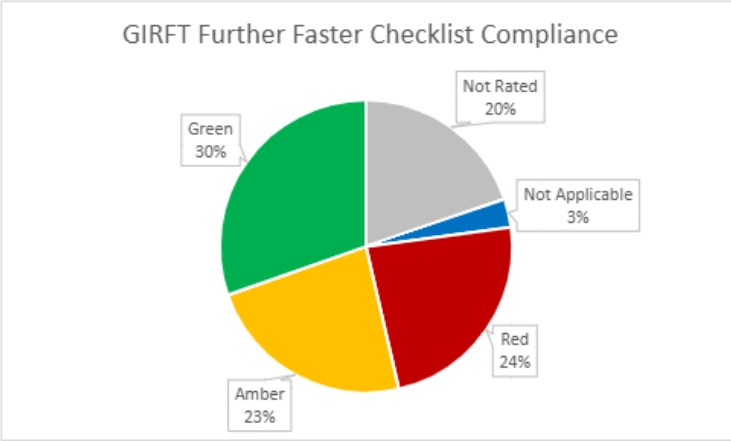
During 2025/26, UHSussex participated in six GIRFT system and peer reviews including:

- Chronic pain Sussex ICS Gateway Review
- Diabetes Childre and Young Adults Sussex ICS Gateway Review
- General Surgery: Deep Dive
- ENT: Deep Dive
- Ophthalmology Deep Dive
- Pancreatic oncology Deep Dive

These programmes are supported by the respective speciality leads and clinical directors. The GIRFT workstream, and supporting governance processes, are currently under

review. The review will ensure there is centralised oversight of the GIRFT work programme, co-ordinated by the Clinical Outcomes and Effectiveness Team. Part of this work will re-address legacy national and local GIRFT recommendations, and ensure, where appropriate improvement action is taken.

Due to competing organisational priorities, the current focus has been directed to Trust participation the GIRFT Further Faster programme cohort, which aims to reduce the number of patients waiting 52 weeks or more. There are currently 23 Further Faster checklists which are applicable to the Trust, which equates to 1560 recommendations, rated as;



Over the next financial year UHSussex is reviewing the systems and processes in place to improve the implementation and oversight of GIRFT Programmes.

2.3.6 Reporting to Secondary Uses Services (SUS)

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	SUS Data submission included the required information in over 99% of records			

The Secondary Uses Services (SUS) is designed to provide anonymous patient-based data for purposes others than direct clinical care such as health planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

UHSussex submitted records during 2025/26 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data (April 2025 - March 2026), which included the patient's valid NHS number was:

- 99.8% for admitted patient care:
- 100% for outpatient care and
- 99% for accident and emergency care

The percentage of records in the published data (April 2025 - March 2026), which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care; and
- 100% for accident and emergency care

2.3.7 Data Security and Protection Toolkit Attainment Levels

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	The Trust expects to attain full compliance to the National Cyber Assessment Framework once submitted			

The Data Security and Protection Toolkit (DSPT) enables the Trusts to measure its compliance against legislation, and central guidance to assess whether information is being handled correctly and protected from unauthorised access, loss, damage and or destruction.

In 2023 NHS England realigned the DSPT to the national Cyber Assessment Framework (CAF) which encourage organisations to promote a culture of continual improvement requiring organisations to proactively monitor emerging security threat landscape and. security risk

The Trust's full response for 2025/26 has yet to be submitted as the deadline is 30 June 2026. However, the Trust expects to attain full compliance.

2.3.8 Clinical Coding Error Rate

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	In 2025-26 the Trust Met expectations across all areas, improving against previous scores for Primary Diagnosis and Secondary Diagnosis			

University Hospitals Sussex NHS Foundation Trust was not subject to an Audit Commission Payment by Results clinical coding audit during 2025-26. However, a local DSPT clinical coding audit has been undertaken on 200 patients discharged between February 2024 and November 2025. In addition, Clinical Coding audit and quality assurance checks have been carried out monthly by an NHS Digital Approved Clinical Coding Auditor.

Episodes from Worthing Hospital and St Richards Hospital were audited from information available on the Evolve electronic document management system (eDMS) and episodes from Sussex Eye Hospital, Princess Royal Hospital and Royal Sussex County Hospital were audited from the Mediviewer eDMS.

There has been a significant investment in trainees to cover the increase in consultant episodes and additional quality assurance staff have been recruited this year, including:

- 5.0 WTE Trainee Clinical Coders
- 2.0 Clinical Coding Auditors
- Trainee Clinical Coding Trainer
- Outpatient Clinical Coding Lead.

	% of Correct Codes 25/26	Toolkit Rating	% of Correct Codes 24/25
Primary Diagnosis	96.00	Met Expectations	94.50
Secondary Diagnosis	93.16	Met Expectations	91.92
Primary Procedure	95.00	Met Expectations	99.50
Secondary Procedure	95.25	Met Expectations	96.44

As a result of undertaking the audit the Clinical Coding Manager will:

- Ensure that the Clinical Coding audit, recommendations and summary of changes document are shared with the Clinical Coders and issue guidance where errors or omissions have occurred.
- Ensure that the Clinical Coding team at all sites are recording all comorbidities documented within an admitted care episode whether they are from the mandatory list or not.
- Arrange training sessions for coders to cover cardiothoracic surgery, ophthalmology and pain management procedures.
- Arrange a training session to cover the importance of capturing multiple injuries with the impact on HRGs. The session should give examples of documentation sources
- Ensure that a centralised guide to assign drug allergy codes, particularly for antibiotics is created and shared with the Clinical Coding team.
- Ensures that all coders are updating histology results by the SUS freeze deadline and put in place a central check to give assurance that this is being completed

2.3.9 Patient Reported Outcome Measures

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex scores have declined since the previous year and are below the national average			

Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves for the following procedures:

- Hip replacement surgery;
- Knee replacement surgery

A higher score indicates better health and/or greater improvement in function following an operation.

Indicator	**Patient Reported Outcome Measures EQ 5D Index (casemix adjusted health gain)**					
Domain	Helping people to recover from episodes of ill health or following injury					
Type of Surgery	UHSussex 2025-26	England 2025-26	Best performing Trust 2025-26	Worst performing Trust 2025-26	UHSussex 2024-25	UHSussex 2023-24
Hip replacement	0.423	0.447	0.598	0.367	0.455	0.437
Knee replacement	0.302	0.447	0.537	0.268	0.322	0.295
Data Source	NHS England PROMs publications - https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/final-2024-25-data					

The table is based on the adjusted average health gain figures for the EQ5D outcome measures. *Prior to 2023/24 the last published reporting was 2021.

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reason: it has been taken from a national data set and the Trust's participation rate is high improving the reliability of the data.

2.3.10 Patients readmitted to a hospital

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Re-admission rates have increased compared to previous years and remain above the national average			

The percentage of patients aged:

- 0 to 15; and
- 16 or over

readmitted to a hospital which forms part of the trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period.

Indicator Domain	**Crude Readmission Rate for patients readmitted to a hospital within 30 days of being discharged** Helping people to recover from episodes of ill health or following injury					
Age Group	UHSussex 2025-26	National average 2025-26	Best performing Trust 2025-26	Worst performing Trust 2025-26	UHSussex 2024-25	UHSussex 2023-24
Patients aged 0 to 16 years	11.30%	10.61%	4.13%	21.56%	10.90%	10.21%
Patients aged 17+ years	8.98%	8.55%	4.06%	14.31%	8.64%	9.03%
Data Source	Activity and Readmission Data produced using Healthcare Evaluation Data (HED)					

Table based on latest available data (January 2025 - December 2025)

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reasons: it is taken from a national provider.

Reducing 30 day readmissions to hospital is an important national indicator across the NHS. Improved discharge processes are key to ensuring patients are discharged to the right place and at the appropriate time in order to prevent the costly effects of re-admitting patients.

2.4 Regulatory Compliance

2.4.1 Care Quality Commissioner (CQC) Inspections & Ratings

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is rated as Requires Improvement overall.			

Since the Trust was established in April 2021 the CQC have undertaken multiple inspections. Since June 2024, the Trust has been inspected on nine occasions, with the most recent inspections of our hospitals as follows:

- 2025 Royal Sussex County Hospital Maternity Services (report received 12th December 2025)
- 2025 Worthing Hospital Maternity Services (report received 7th February 2026)
- 2025 Urgent and Emergency Care (UEC) (report received 12th December 2025)
- 2025 Well-led (draft report received in April 2026)
- 2025 Worthing and St Richards Children and Young People's Services (draft report received in April 2026)

As a result of the comprehensive inspection in August 2023 each hospital was rated as "*requires improvement*" as was the Trust overall. The previous inspections did not change hospital ratings from those inherited from Western Sussex Hospitals Foundation NHS Trust and Brighton and Sussex University Hospitals NHS Trust.

The CQC reports include numerous positive comments in respect of good care and treatment, kind and compassionate staff, teams working well together, patients being respected and involved with their care and patients being supported to lead healthier lives and good local leadership. Of note was the latest inspection of maternity services at Worthing Hospital which resulted in a 'good' rating.

In February 2024, CQC published their new assessment framework which applies to providers, local authorities, and integrated care systems. Their five key questions and ratings (outstanding, good, requires improvement and inadequate) are still central to their inspection assessment approach but their reporting no longer provides the MUST DO and SHOULD DO actions from previous inspection reports.

However, CQC do identify opportunities for improvement. Some of these are practical, such as improving observations and medication management, whereas others are require major programmes of work to address the estate and flow through the hospitals.

To ensure that the Trust is consistent with the principles of regulation and the Fundamental Standards of Care established by the Care Quality Commission (CQC) under the Health and Social Care Act 2008 (Regulated Activities) Regulations (Part 3) and CQC (Registration) Regulations 2009 (Part 4), thus maintaining and ensuring continuous improvement in the

quality and safety of our services, the Trust implemented a monthly CQC Improvement Steering Group. The aim is to ensure 'recommendations from the CQC inspection reports are assured, evidenced and closed.

All required actions are monitored using a bespoke tracker, including where breaches of regulation are identified.

Following a Trust-wide Well-Led review in March 2025, a report was provided in June 2025 prior to a CQC Well-led inspection in July 2025. The Trust engages with the CQC monthly to ensure an understanding of our services and provision of insights for continued improvement.

2.5 Mortality & Learning from Deaths

2.5.1 Summary Hospital-Level Mortality Indicator

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex SHMI is as expected			

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England. SHMI is the ratio between the actual number of patients who died following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

The expected number of deaths is calculated from statistical models derived to estimate the risk of mortality based on the characteristics of the patients (including the condition the patient is in hospital for, other underlying conditions the patient suffers from, age, gender and method of admission to hospital).

SHMI gives an indication for each non-specialist acute NHS trust in England on whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected', 'as expected' or 'lower than expected' when compared to the national baseline.

Indicator Domain	**Summary Hospital-level Mortality Indicator** Preventing people from dying prematurely				
UHSussex 2025	National average 2025	Best performing Trust 2025	Worst performing Trust 2025	UHSussex 2024	UHSussex 2023
100.83 *As expected*	100.22	70.84	141.36	104.74 *As expected*	104.88 *As expected*
Data Source	Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset – data produced using Healthcare Evaluation Database				

Table based on latest available data (January 2025 - December 2025)

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reason that it is taken from a well-established national source.

Palliative care indicators are included below to assist in the interpretation of SHMI by providing a summary of the varying levels of palliative care coding across non-specialist acute providers.

Indicator Domain	Percentage of patient admissions with palliative care coded at either diagnosis or specialty level Preventing people from dying prematurely				
UHSussex 2025	National average 2025	Best performing Trust 2025	Worst performing Trust 2025	UHSussex 2024	UHSussex 2023
2.42%	2.09%	4.52%	0.87%	2.47%	2.45%
Data Source	Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset				

Table based on latest available data (January 2025 - December 2025)

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reason that it is taken from a well-established national source.

2.5.2 Hospital Standardised Mortality Ratio (HSMR)

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex HSMR is as expected			

The HSMR is a ratio of the observed number of in-hospital deaths at the end of an inpatient admission to the expected number of in-hospital deaths (multiplied by 100) for 56 specific diagnostic (CCS) groups which account for 80% of in-hospital deaths. The expected deaths are calculated from logistic regression models with a case-mix adjustment that accounts for the patients age, sex, deprivation, admission method, the presence of palliative care, etc.

Care is needed when interpreting HSMR. Although a score of 100 indicates that the observed number of deaths matched the expected number in order to identify if variation from this is significant confidence intervals are calculated. A Poisson distribution model is used to calculate 95% and 99.9% confidence intervals and only when these have been crossed is performance classed as higher or lower than expected.

Indicator Domain	Hospital Standardised Mortality Ratio Preventing people from dying prematurely				
UHSussex 2025	National average 2025	Best performing Trust 2025	Worst performing Trust 2025	UHSussex 2024	UHSussex 2023
93.33 *As expected*	99.64	69.20	141.24	96.42 *As expected*	99.12 *As expected*
Data Source	Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset – HSMR data produced using Healthcare Evaluation Database				

Table based on latest available data (January 2025 - December 2025)

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reason that it is taken from a well-established national source.

2.5.3 Learning from Deaths

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Structured Judgement Reviews are consistently completed within 60 days, providing assurance of timely and effective scrutiny. The Mortality & Morbidity Surveillance Group (MMSG) is embedded within Trust governance arrangements, ensuring robust oversight and a strong focus on learning and improvement from all mortality reviews, including outcomes from Mortality & Morbidity (M&M) meetings.			

Learning from Deaths Referral Screening

In line with the University Hospitals Sussex NHS Foundation Trust Learning from Deaths Policy, a weekly SJR Screening Panel is convened, comprising the Trust Mortality Lead, the Mortality & Learning from Deaths Lead, and senior SJR reviewers. The SJR Screening Panel reviews all SJR referrals and determines whether cases should progress to a Structured Judgement Review or be referred to clinical teams for review and discussion through Mortality & Morbidity (M&M) meetings.

Learning from Deaths Reports

During 2025/26, Mortality & Learning from Death reporting was further developed to include a breakdown of adult deaths by ethnicity. Quarterly reporting has also been strengthened to capture onward referrals from the Mortality Panel to local Mortality & Morbidity (M&M) meetings for review and discussion.

Adult Deaths

During 2025/26 3757 adults died under the care of the University Hospitals Sussex NHS Foundation Trust, with:

- 3398 adult deaths recorded as inpatient deaths and
- 359 adult deaths recorded in the Emergency Department.

The table below provides a breakdown of adult deaths per quarter, including those with known Learning Disability (LD) and/or Severe Mental Health (SMH) illness.

UHSx Acute Adult Deaths	Q1	Q2	Q3	Q4	2025/26 Total
No. **acute** adult deaths recorded	930	834	981	1012	**3757**
No. of **acute** adult patients that died registered as having a Learning Disability (LD)	3	5	9	6	**23**
No. of **acute** adult patients that died known to have Severe Mental Health illness (SMH)	7	6	4	9	**26**

The Index of Multiple Deprivation (IMD) datasets are small area measures of relative deprivation. Postcode areas are ranked from the most deprived (D1) to least deprived (D10.) The table below provides a breakdown of adult deaths by IMD postcode areas.

Demographics for 25/26 Adult Deaths	No. of Adult Deaths	Underlying Population	Deaths per 1000
1	103	30919	3.33
2	168	43807	3.84
3	297	68282	4.35
4	172	54516	3.16
5	358	93678	3.82
6	468	122144	3.83
7	414	113860	3.64
8	355	99685	3.56
9	356	104283	3.41
10	288	110984	2.59
UHSussex Total	**2979**	**842158**	**3.54**
No. in most deprived postcodes (D1-4)	**740**	**197524**	**3.75**
% in most deprived postcodes (D1-4)	**24.8%**	**23.5%**	

Deaths by Index of Multiple Deprivation (IMD) Decile (1=most,10=least deprived) Further information can be found at https://data.cdrc.ac.uk/dataset/index-multiple-deprivation-imd Note: Horsham, Crawley and East Sussex Local Authorities excluded as UHSussex do not serve the whole of the population and less than 2 deaths per 1000 population.

- 24.8% of adult deaths at UHSussex were within the most deprived postcodes (D1-4), compared to 47.4% of adult deaths which related to those within the least deprived postcodes (D7-10.)
- D3 postcodes accounted for 10% of adult deaths but had the highest number of deaths per 1000 population.
- 5.6% of adult deaths at UHSussex related to D2 postcodes, with the second highest number of adult deaths per 1000 population.

2.5.4 Medical Examiner Scrutiny and Coroner Referrals

The Medical Examiner Service was introduced at University Hospitals Sussex NHS Foundation Trust in 2020 to provide independent scrutiny of all inpatient and Emergency Department deaths.

Adult Deaths

- 18.3% of all adult deaths at UHSussex were referred to the Coroner with
- 10.5% of all adult deaths at UHSussex were investigated by the Coroner.

Community Deaths

New Medical Examiner regulations came into force in England and Wales on 9 September 2024, extending Medical Examiner scrutiny to community deaths and requiring Medical Examiners to countersign death certificates.

Community deaths were consistently higher in West Sussex than in Brighton & Mid Sussex across all quarters, at almost three times the level. West Sussex showed a clear increase in community deaths in Q3 and Q4, whereas Brighton & Mid Sussex remained relatively stable from Q2 onwards, with no sustained upward trend.

The table below provides a breakdown of adult deaths that occurred in the community per quarter.

Table: 2025/26 Adult deaths in West Sussex and Brighton & Mid Sussex by quarter

24/25 Adult deaths (community)	Q1	Q2	Q3	Q4	Total
Brighton & Mid Sussex		181	298	405	**884**
West Sussex		689	907	1047	**2643**

25/26 Adult Deaths (Community)	Q1	Q2	Q3	Q4	2025/26 Total
Brighton & Mid Sussex	279	373	358	371	**1381**
West Sussex	839	873	962	968	**3642**

Coronial Inquests

Through 2025/26 more than 200 coronial inquests have taken place relating to UHSx patients. In one of these cases, in April 2025, a regulation 28 'Prevention of Future Deaths' notice was issued, relating to the care of a patient in the emergency department (ED) corridor at the Royal Sussex County Hospital (RSCH). The case was subject to an internal local learning review, which provided the action plan for HM Coroner.

The patient experienced an extended length of stay in the ED corridor for 16-17 hours. During the patient's stay, a number of factors were identified that contributed to poor experiences. There were no healthcare assistants in the corridor, due to a high demand of patients who required 1:1 observation in the department. Shifts had been advertised via the temporary staffing office but remained unfilled. Shortages were escalated during the shift to the clinical site team, who were unable to find any additional support for the department

The patient's extended stay in the corridor was as a result of demands within the hospital resulting in limited patient flow. The risks of flow (the movement of patients throughout the hospital from admission to discharge) is well recognised, and is scored at the highest level, 25, on the Trust risk register, which means that there is continued executive oversight of the issues.

As the department was operating at significantly above maximum capacity and staffing was below the required levels, care was compromised. A chest x-ray was requested wasn't undertaken that evening. Expected practice would be for the doctor to chase this if not done when expected, and to handover to the night doctor if still not done.

In addition, there is no documentation on the Radiology CRIS system (patient management system) indicating why the x-ray wasn't done. It is considered it was likely due to the high volume of patients awaiting x-rays, also that as the patient was receiving oxygen therapy and requiring a nurse escort, it may have been difficult to identify an available nurse at the time the porters arrived. Portable suction was not easily accessible due to the patient not being in the vicinity and in a non-clinical area.

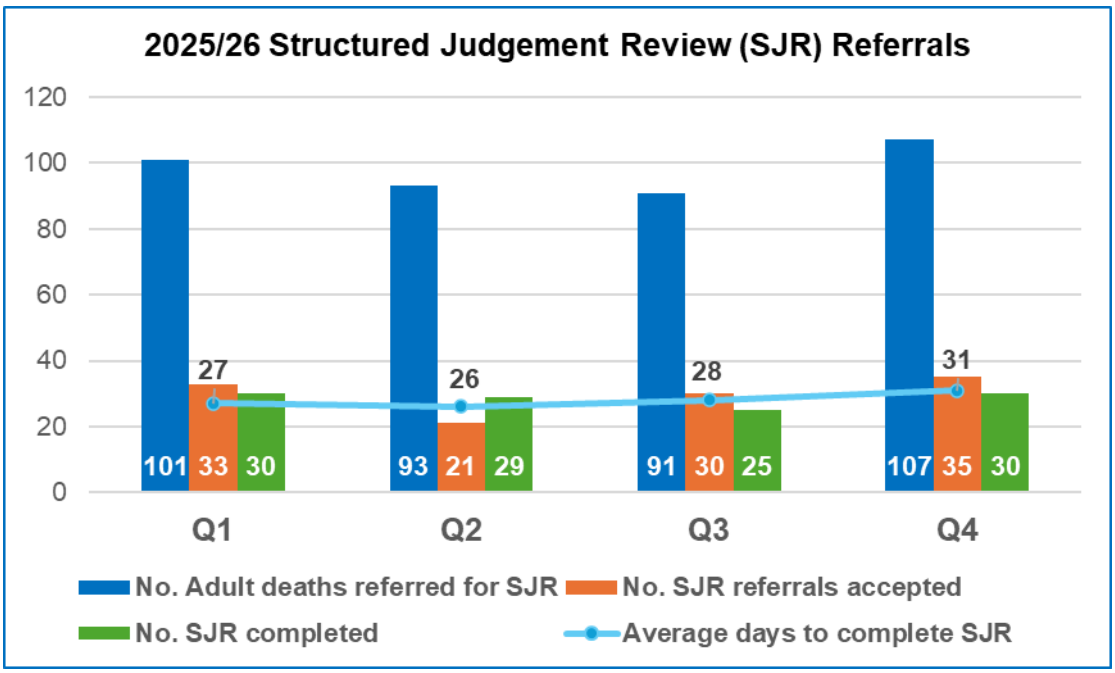
There was also a delay in communication with the patient's family.

A number of learning points were identified and were included in the action plan for HM Coroner. This included the sharing of this as a case study at governance days and team safety huddles, and to respond in a meeting with the patient's family. All actions were completed and confirmed with HM Coroner by the end of June 2025.

2.5.5 Mortality Reviews

The majority of referrals for Structured Judgement Review (SJR) were received through the Medical Examiner Service. A small number were received from the Patient Safety Team, Clinical Divisions and other Trust services such as Patient Experience Teams.

During 2025/26, 392 adult deaths (10.4%) were referred for independent Structured Judgement Review. Of these, 119 referrals were accepted, and 114 reviews were completed by 31 March 2026.



- 30% of SJR referrals were accepted
- Average SJR completion time per quarter ranged from 26 to 31 days
- 5 SJRs remained outstanding as of 31 March 2026; however, none exceeded 60 days from the date of referral
- 92 SJRs were reviewed at the Trust Mortality Panel.

25/26 Structured Judgement Reviews discussed at Mortality Panel	Q1	Q2	Q3	Q4	2025/26 Total
No. SJR reviewed at Mortality Panel	32	23	17	20	**92**

An SJR is completed for every patient with a Learning Disability and is shared with the Learning from Life and Death Review (LeDeR) Team. An SJR is completed for every patient with Severe Mental Health illness.

Structured Judgement Reviews are carried out by trained SJR Reviewers. To successfully complete SJR Reviewer training, Trainee Reviewers are required to complete a minimum of 4 SJRs under the supervision of a Senior SJR Reviewer.

2.5.6 Learning from case record reviews (SJRs) and investigations

Structured Judgement Reviews provide a rich source of opportunities to learn from deaths. All reviews are shared with divisions to discuss and identify opportunities for learning and improvement.

- 15.2% of Structured Judgement Reviews discussed at Mortality Panel identified "good" or "excellent" quality of care.

Structured Judgement Reviews that identified the quality of care as "poor" or "very poor" produced learning themes around:

- absence of community end of life care planning resulting in missed opportunities to avoid admission into hospital when a person was recognised to be nearing or at the end of their natural life
- delays to implementing Packages of Care that would enable a person nearing the end of their natural life to return home or to their chosen place
- delays in recognising a patient was nearing the end of their natural life
- opportunities for learning and improvement around ceilings of care discussions, and in decision making/discussions with patients and their families regarding Do Not Attempt Cardiopulmonary Resuscitation (DNACPR.)

Measurable Improvements

Learning identified from Structured Judgement Reviews resulted in:

- implementation of new documentation/resources to improve patient outcomes
- promotion of processes/policies through team huddles, "Theme of the Week" etc.
- provision/revision of training
- updated protocols/Standard Operating Procedures relating to patient pathways

Mortality & Morbidity Surveillance Group (MMSG)

The Mortality & Morbidity Surveillance Group (MMSG) meets quarterly to provide Trust-level oversight of learning themes arising from Mortality Reviews and Mortality & Morbidity meetings, ensuring that identified themes are translated into clear actions to improve patient safety, quality of care, and outcomes.

2.5.7 Patient deaths judged to be more likely than not to have been due to problems in care during the previous reporting period

A standardised Royal College of Physicians scoring system is used to assess whether deaths reviewed through Structured Judgement Review are more likely than not to have

resulted from problems in care, supporting identification of learning and potential contributory factors.

The Mortality Panel identified 1 case where the death may have been avoidable. Where concerns about care were identified, findings were fed back to the relevant clinical teams following case review to support learning and service improvement.

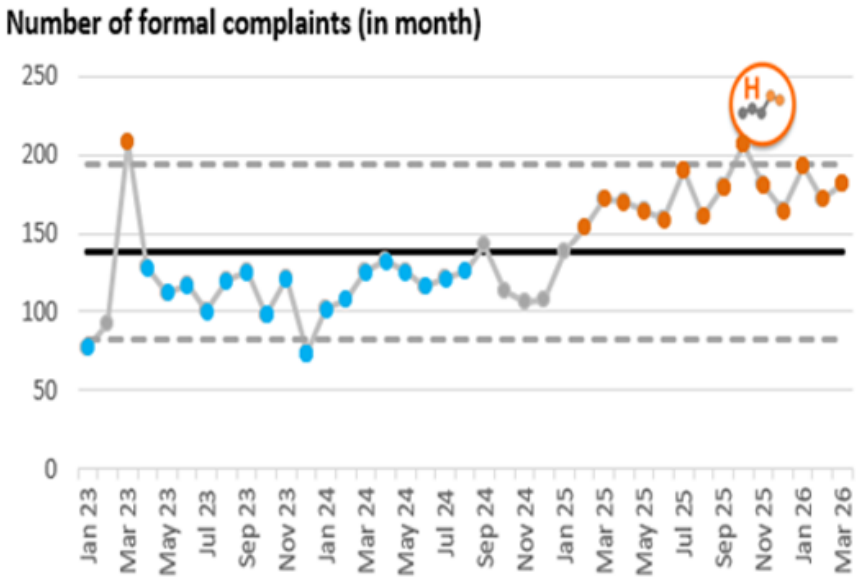
2.6 Patient Experience

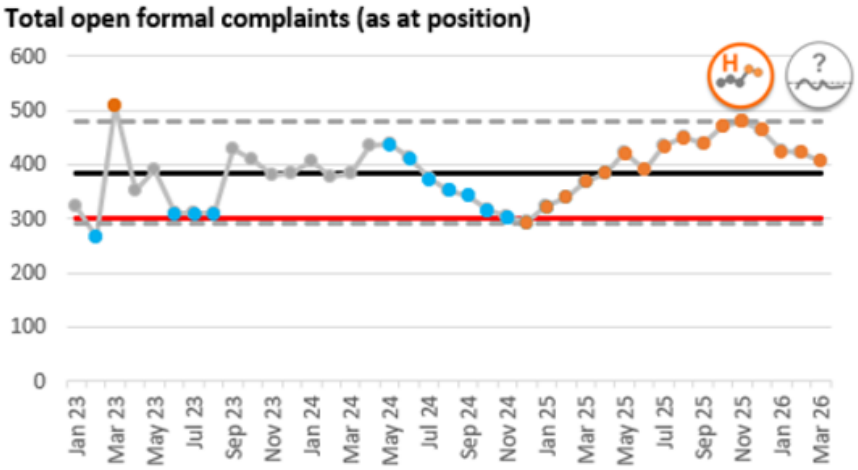
Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Whilst performance against Trust and national standards, such as timeliness and quality of responses, has improved, an increasing number of complaints and concerns received has placed pressure on the patient experience system, and Trust standards were not met.			

Further details are provided in the UHSussex Patient Experience Annual Report.

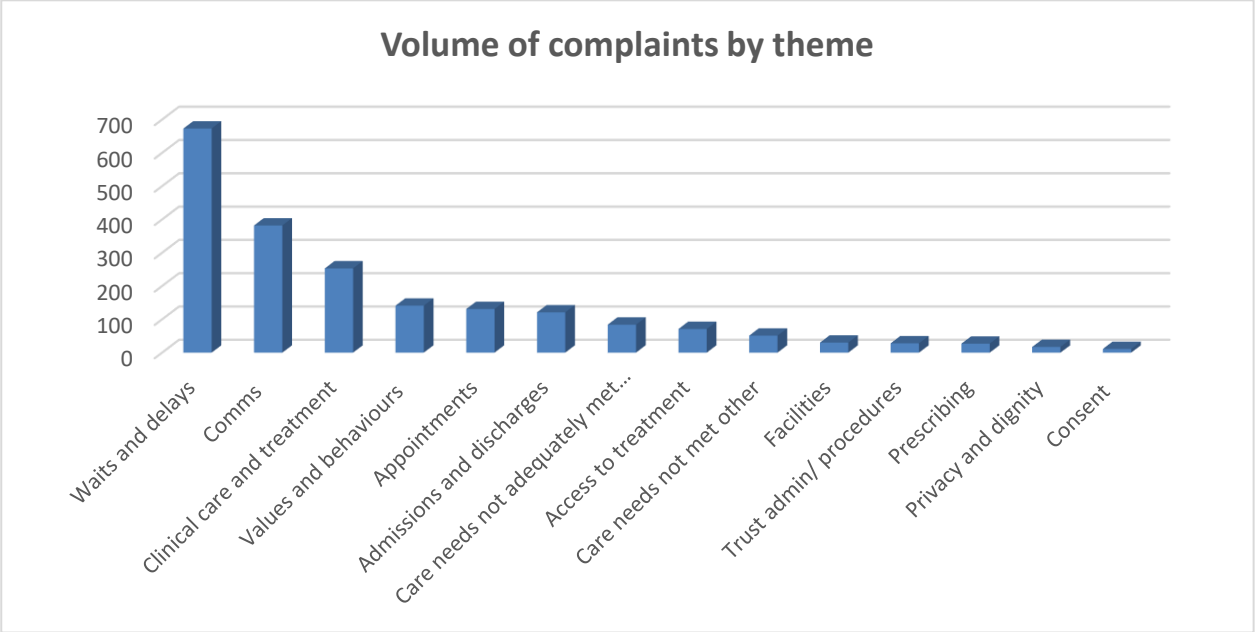
2.6.1 Complaints and Concerns

Throughout 2025/26 the Trust has continued to receive increasing numbers of complaints – 2176 -, with a 78% increase on 2023/24. However there has been an improvement in performance with the volume of re-opened complaints below 2% of the total, and reduced from 25 re-opened in April 2025, to zero in March 2026. In other positive progress, complaints open longer than a year have been eradicated, and only 1% of complaints are open longer than six months, down from 7% in April 2025.

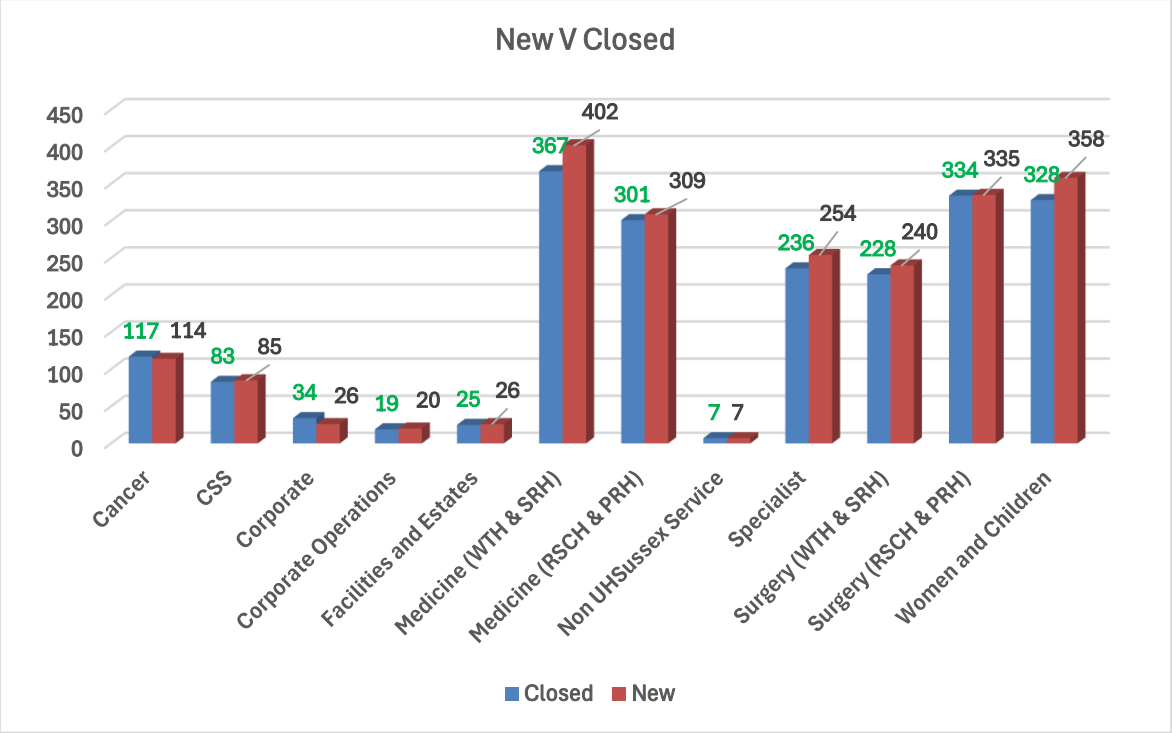




The most prevalent theme in complaints was clinical treatment followed by delays in appointments and diagnoses, ED waits and care, surgery waits and cancellations, doctor attitude and behaviour and communications. A number of improvement actions are underway to address the drivers of increasing complaints.



The number of complaints varies by division, and more complaints were closed in 2025/6 than were opened resulting in a reduced overall number of open complaints, despite the increase in complaints received.



2.6.2 Parliamentary & Health Service Ombudsman Complaints

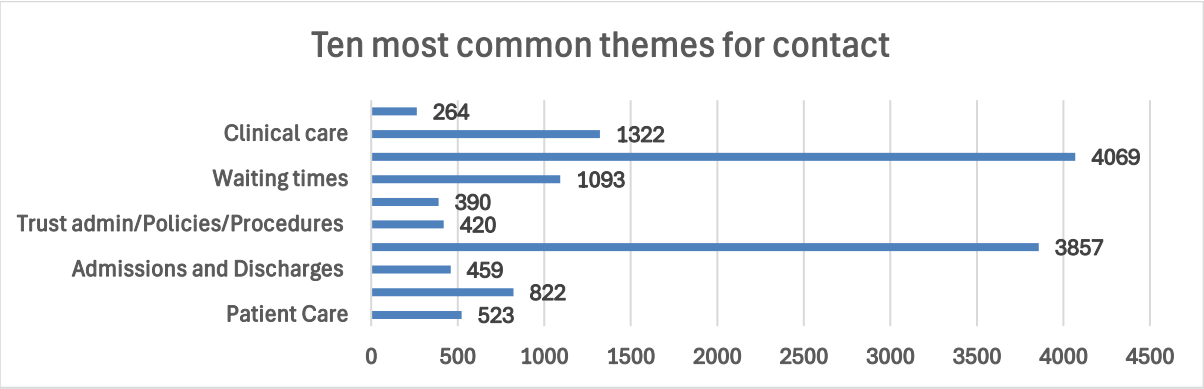
Between 1 April 2025 and 31 March 2026 the equivalent of 0.2% (n=4) of complaints received were accepted by the PHSO for investigation.

Of the four accepted for investigation, none have been concluded. The low % of cases accepted for investigation by the PHSO indicates that despite the challenges in managing the volume of complaints the quality of investigations and responses remains high.

2.6.3 Patient Advice & Liaison Service

The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters to patients and their families and provides a 'much needed point of contact for patients, their families and their carers' (NHS.UK 2018).

During the year, the numbers of PALS concerns received has increased, with 15568 contacts in 2025/26 compared to 13763 concerns received in 2024/25, 12,165 in 2023/24 and 11,616 in 2022/23 - an increase of 34% over four years. Increasingly patients are concerned about accessing results, appointments and dates for surgery, along with concerns that they have been unable to access the service they are seeking information from by phone or email.



2.6.4 National Patient Surveys

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	National patient survey results publish in 2024/25 identify a mixed picture of assurance relating to the patient experience. Maternity service users identify improvements in their care and experience since previous years, and some improvements are noted for inpatients and urgent treatment centre patients. However, there remain issues for patients using emergency departments including the length of waiting times and overall experience.			

The National Patient Survey Programme (NPSP) is commissioned by the Care Quality Commission (CQC), the independent regulator of health and adult social care in England. UHSussex commissions Picker to administer the surveys.

2.6.5 Inpatient Survey

Commissioned by the CQC, the survey was undertaken in Autumn 2024 and results published in 2025, with 40% of patients approached responding. Declines were noted in previous years in a number of areas, in particular waiting for an admission, information whilst waiting, support after leaving hospital and sleeping at night. This resulted in a deterioration in the overall position to 43rd (from the survey provider group) from 41st in 2023.

Improvements on previous years were noted in access to food and medication and some aspects of communication, including in planning for discharge. Declining and poorer scores were noted on waiting for admission and a bed and noise at night.

UHSx in top 5 and most improved questions	Bottom 5 and most declined scores
► Able to get food outside of mealtimes ► Able to take medication when needed to, and given information about medication ► Staff explaining reasons for changing wards at night ► Staff discussing need for equipment at home at discharge, and what they should do after leaving hospital ► Involving family and carers in discussion about leaving hospital	► Minding how long they waited for an admission, and also for a bed on a ward ► Quality of information whilst waiting ► Sleeping at night ► Staff contradicting each other about treatment ► Leaving hospital – support after leaving hospital ► Rated overall experience as 7/10 or more

Insights from the inpatient survey inform commitments to improvements which are detailed in an improvement tracker and overseen via the Patient Experience and engagement group.

Improvements from the 2023 survey included access to food, discharge engagement, asking patients to give views on the quality of care and involvement in decisions about care and treatment. These actions resulted in improved scores in the 2024 survey for access to food, kindness and compassion, and being able to share their views on treatment.

Where inpatient experience is good, and improvements are noted. Particularly positive feedback and scores are noted with:

- Cleanliness
- Taking own medication
- Access to food outside of mealtimes
- Treated with kindness and compassion
- Being treated with respect and dignity

However, the overall patient experience score was lower than the previous year. This is due to the lower scores in the following areas which require improvement action to raise overall positive experience score, and to improve the Trusts position in the cohort:

- Waiting time for admissions
- Information provided whilst on the waiting list
- Waiting for a bed
- Reducing disturbance at night
- Staff contradicting each other
- Information about condition or treatment

Indicator Domain	**Overall experience - NHS Adult Inpatient Survey** Ensuring people have a positive experience of care				
UHSussex 2024	National average 2024	Best performing Trust 2024	Worst performing Trust 2024	UHSussex 2023	UHSussex 2022
8.00	8.18	9.44	7.38	8.07	7.97
Data Source	CQC adult inpatient survey Q48 – Overall, how was your experience while you were in the hospital? Please give your answer on a scale of 0 to 10, where 0 means you had a very poor experience and 10 means you had a very good experience.				

2.6.6 Urgent & Emergency Care Survey

Commissioned by CQC, the urgent and emergency care survey is produced in two parts: type 1 (relating to accident and emergency services) and type 3 relating to urgent treatment centres. 35% of patients invited to complete the survey responded in 2024, with the results published in 2025.

Although the Trust performed in the middle of the pack for type 1 services, UHSx has deteriorated more than most other Trusts since the 2022 survey was undertaken. Particular improvement opportunities are identified for UHSx with:

- Patients receiving the necessary help from 111
- Spending less than 12 hours in A&E – including creating more time with Drs and nurses (RSCH)
- Confidence and trust in the Drs and nurses (all sites)
- Privacy during examinations (SRH and RSCH)
- Improving communication at SRH
- Improving access to food and drink at WGH
- Safety and security in the waiting room

Positive experiences are identified in understanding why tests are needed, knowing who to contact when worried and giving information on medications

For type 3 services, overall scores and position in the pack much improved on the previous survey in 2022. Improvement opportunities include:

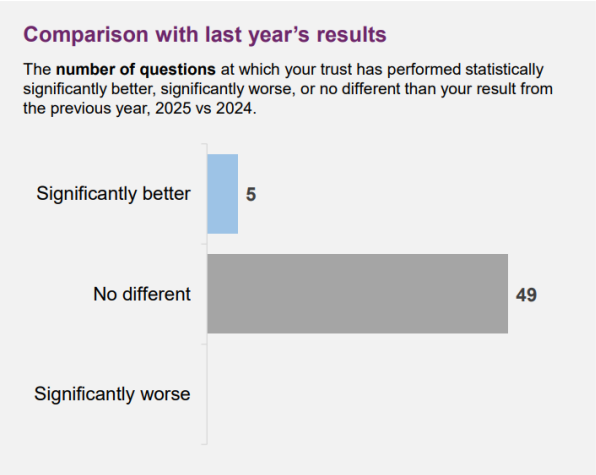
- 4 hour waits
- Keeping patients informed during the wait
- Security in the RSCH waiting room

2.6.7 National Maternity Survey

The national maternity survey was undertaken in 2025 as part of the annual programme, with all eligible organisations in England are required to conduct the survey.

261 (42%) of patients completed the survey in 2025 which was above the national average of 39%.

When compared with the national profile of responses, University Hospitals Sussex was average in terms of performance across most questions, but with a noted improvement in the number of questions where performance was significantly better than the previous year, and better than expected when compared to other trusts.



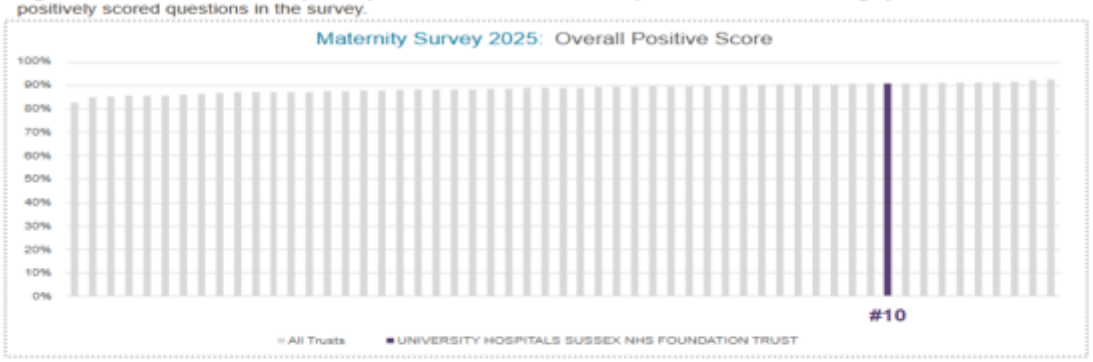
The top five scores, compared with the national average were:

- Antenatal care
- Care in the ward
- Triage
- Labour and birth (advice and support when contacting the hospital)
- Post natal care - support and advice at evenings and weekends

When compared to the comparator group, UHSussex ranked more highly in 2025 than in 2024.

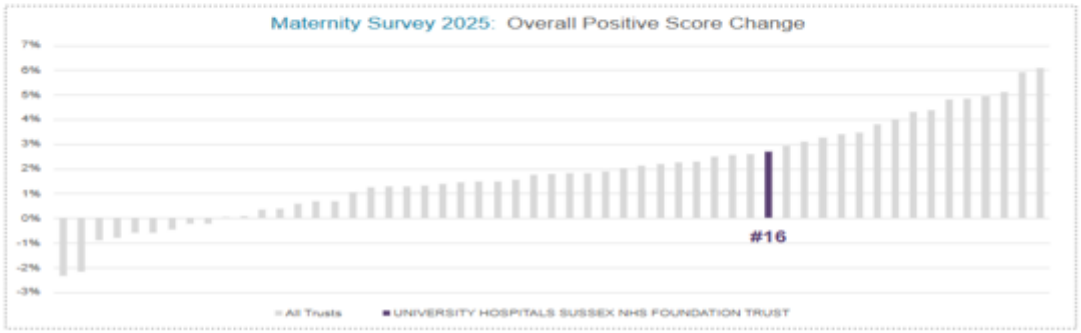
League table: overall positive score

The league table shows your overall positive score's ranking in comparison to the overall positive score of every other organisation that ran the Maternity Survey 2025 with Picker. The overall positive score is the average positive score for all positively scored questions in the survey.



League table: historic positive score

The historical league table shows how your overall positive score change from the previous survey, and how this change compares to other organisations who ran the Maternity Survey 2025 with Picker.



The survey demonstrates the exceptional progress made in supporting partners to stay with the birthing person.

2.6.8 Friends & Family Test (FFT)

Staff who would recommend the trust to their family or friends

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	The UHSussex score has increased on the previous year but remains below national average			

Indicator Domain	**Percentage of staff who would recommend the Trust as a provider of care to their family or friends** Ensuring people have a positive experience of care				
UHSussex 2025	National Median 2025	Best performing Trust 2025	Worst performing Trust 2025	UHSussex 2024	UHSussex 2023
57.2%	60.8%	88.4%	34.7%	54.8%	59.5%
Data Source	NHS NHS Staff Survey Results – NHS Staff Survey Results NHS Staff Survey dashboard (nhssurveys.co.uk)				

Table based on latest available data (NHS Staff Survey 2025)

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reasons it is produced by the Picker Institute in accordance with strict criteria.

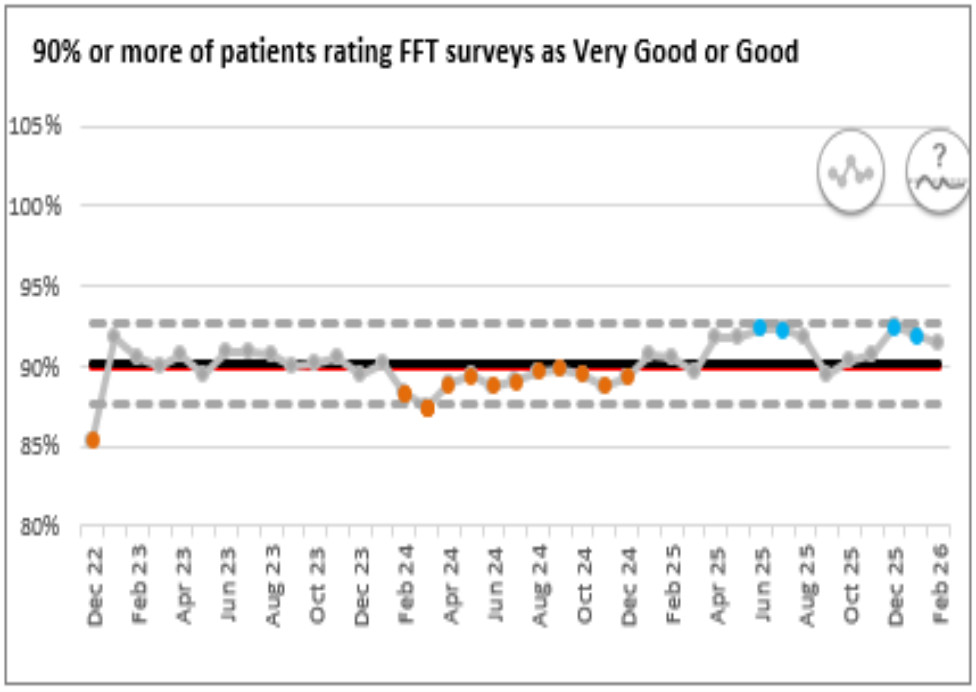
The University Hospitals Sussex NHS Foundation Trust is continuing to focus on staff engagement as part of the Leadership, Culture & Workforce programme with the overall aim of improving staff engagement across the Trust.

2.6.9 Patients rating their care as good or very good (FFT)

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	FFT data indicates that the Trust target of 90% of patients reporting their care as good or very good has been met. Although there is variability between touchpoints, there is improvement identified in each.			

The friends and family test (FFT) asks patients to rate their experience of care on a scale of 1 to 5 (where 1 is very good and 5 is very poor), and then to explain the reason for the rating. The Trust target is for 90% of patients to rate their care as good or very good, and this was achieved in the final quarter of 2024/25.

Each month, the Trust receives approximately 10,000 survey responses with an average response rate of 24% - an improvement on the previous year. The data is reported as a whole Trust, and also by the following touchpoints: emergency departments, inpatient, outpatient, and maternity. During 2025/26, an overall increasing trajectory of patient reported experience is noted.



Inpatient reported positivity remained largely consistent in year, with the significant majority of patients describing their care as good or very good. However, at an average of 92%, this is below the national average. This is due to the local configuration of the data, which includes some part of the emergency floor where waits for care result in lower positivity scores.

Indicator Domain	Percentage of inpatients rating their care as good or very good Ensuring people have a positive experience of care				
UHSussex 2025-26	National average 2025-26	Best performing Trust 2025-26	Worst performing Trust 2025-26	UHSussex 2024-25	UHSussex 2023-24
92.5%	95%	100%	88%	92%	92%
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (February 2026)

The main contributor to positive reviews was excellent care by the clinical staff, with negative reviews relating to waiting, pain management, clinical care and staff behaviour.

Indicator Domain	Percentage of A&E patients rating their care as good or very good Ensuring people have a positive experience of care				
UHSussex 2025-26	National average 2025-26	Best performing Trust 2025-26	Worst performing Trust 2025-26	UHSussex 2024-25	UHSussex 2023-24
82%	79%	95%	63%	80.7%	79.5%
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (February 2026)

Indicator Domain	Percentage of Outpatients rating their care as good or very good Ensuring people have a positive experience of care				
UHSussex 2025-26	National average 2025-26	Best performing Trust 2025-26	Worst performing Trust 2025-26	UHSussex 2024-25	UHSussex 2023-24
96.5%	95%	100%	88%	96%	94.5%
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (January 2025)

Outpatient reported at 96.5% on average positivity remained in line or above national average of 95% throughout the year.

Indicator Domain	Percentage of Maternity (birth) rating their care as good or very good Ensuring people have a positive experience of care				
UHSussex 2025-26	National average 2025-26	Best performing Trust 2025-26	Worst performing Trust 2025-26	UHSussex 2024-25	UHSussex 2023-24
94.%	93%	100%	79%	94%	*
Data Source	NHS England NHS England » Friends and Family Test data				

Table based on latest available data (January 2025) *No data collected during this period

Maternity patient reported experience is the most changeable, due to the smaller numbers of patients.

Patients report a positive experience of the staff, but that they found there to be fewer staff to care from them than they would have preferred.

2.6.10 Improving how we deliver our patient experience functions

During 2025/26 a review of complaints letters by Healthwatch has been undertaken, identifying high levels of compassion and compliance with standards but the opportunity to improve the clarity clinical explanations in some cases.

A review of the complaints process has also been initiated.

Embedding increasingly efficient processes for management of concerns and complaints, in response to increasing demand from patients as a result of growing numbers of complaints and concerns received - this has resulted in fewer complaints open for longer.

2.7 Patient Safety

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex has a lower rate of reporting than the national average from the National Reporting & Learning System (NRLs) 2022 baseline. NHSE Learning from Patient Safety Events (LfPSE) has not yet set a national baseline for reporting			

2.7.1 Implementation of the Patient Safety Incident Response Framework (PSIRF)

The NHSE Patient Safety Incident Response Framework (PSIRF) shapes Trusts approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

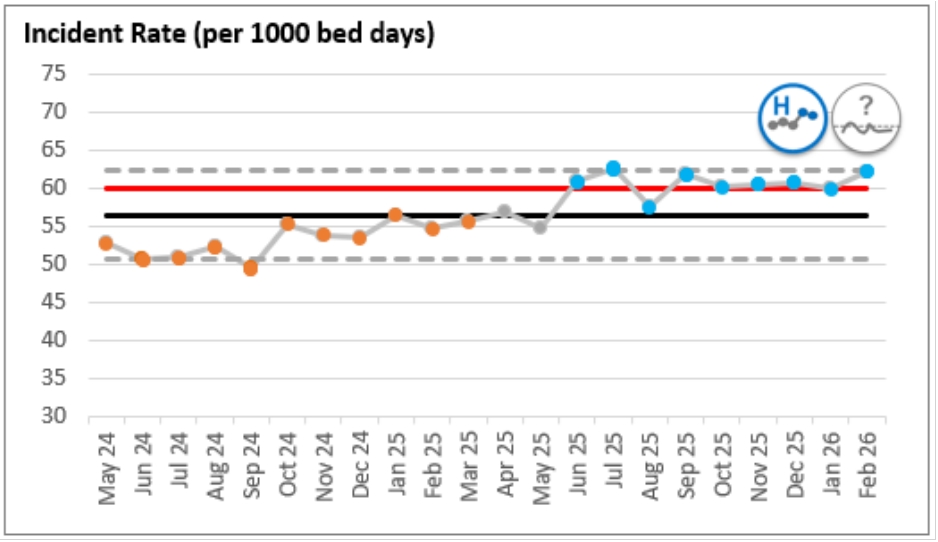
All incidents graded as near miss, moderate/severe harm and death are reviewed by a senior panel on a weekly basis at the Patient Safety Incident Response Group (PSIRG). Following the methodology of the new NHSE Patient Safety Incident Response Framework the level of harm, patient/family engagement and investigation is decided.

2.7.2 Patient safety incidents resulting in Severe Harm or Death as reported to the Learning from Patient Safety Events (LfPSE) Service (From 2024)

The Trust Strategy - Excellent Care Everywhere - identifies that real progress has been made in improving the quality and safety of hospital services in recent years. Trust-wide, it is expected that patients do not suffer harm whilst in our care. However, it is recognised that there are patients who suffer new harm which is acquired during their time in hospital. This has a significant impact on patients, families, carers and staff and within the wider organisation.

The Trust encourages all healthcare professionals to report incidents as soon as they occur to ensure timely investigation and outcomes, which are shared to support learning that is reflective of a positive safety culture. The UHSussex Trust target is a reporting rate of 60 per 1000 bed-days.

Following the implementation of a new Trustwide incident reporting system (DCIQ) in March 2024, the Trust has seen a rise in the rate of reporting to 59.1 (per 1000 bed days), almost meeting the Trust target.



Indicator Domain	**Patient safety incidents and the percentage that resulted in severe harm or death** Treating and caring for people in a safe environment and protecting them from avoidable harm					
	UHSussex 2025-26	National average 2024-25	Highest 2024-25	Lowest 2024-25	UHSussex 2024- 25	UHSussex 2023-24
I) rate of incidents reported per 1000 bed days	59.1	Data is not available			52.87	48.76
ii) rate of incidents that resulted in severe harm or death per 1000 bed days	0.27	Data is not available			0.32	0.19
iii) Number of incidents resulting in severe harm or death	191	Data is not available			176	130
iv) % of severe harm or death over number of reported incidents	0.62%	Data is not available			0.60%	1.32%
Data Source	NHS England: National patient Safety Incident Reports					

2.7.3 Patient Safety Incident Investigations (PSII)

The Trust's records all patient safety and staffing incidents on the electronic incident reporting system (DCIQ). Incidents recorded range in harm levels from near misses, low, moderate severe harm and death.

A revised harm category of psychological harm has recently been added/updated by NHSE and is highlighted as an example for when patients have delayed surgery or mental health patients awaiting specialist treatment. This harm level may be downgraded when incidents have been fully investigated or via the mortality and morbidity (M&M) divisional governance review process.

From April 2025 to March 26, in line with PSIRF, the Trust reported 39 Patient Safety Incident Investigations (PSII), with the following themes;

Incident category	Total
Maternity	11
Never events	5
Bloods, Assessments, Diagnosis, Tests	4
Slip Trip or Fall	4
Cardiac arrest	3
Treatment / Procedure	2
Medication	2
Patient Monitoring	1
Communications	21
Documentation	1
Discharge	1
End of Life Care	1
VTE	1
IPC	1
Appointments	1
Total	39

Moderate/severe harm incidents are investigated via early learning and local learning reviews, with the following themes identified from PSII;

The Trust is committed to being open and honest with our patients. Undertaking Duty of Candour is a legal requirement for all safety incidents recorded as causing moderate harm, severe harm or death where we will formally apologise to the patient and/or family

involved and undertake an investigation into their care. Duty of candour was 98% compliant with the requirements in 2025/26.

We will feedback in writing the findings of our review and any actions we are taking to prevent a similar incident from happening again.

2.7.4 Never Events

There have been nine never events reported in 2025/26.

- Retained foreign object post procedure - 4
- Wrong site surgery - 2
- Overdose of insulin due to abbreviations or incorrect device - 1
- Unintentional connection of a patient requiring oxygen to an airflow meter -1
- Wrong implant/prosthesis - 1

2.7.6 Maternity and Newborn Safety Investigations (MNSI)

The following cases met criteria for investigation by MNSI:

Severity	Incident headline
Moderate	MNSI - Baby transferred for therapeutic cooling
Moderate	MNSI - Baby transferred for therapeutic cooling
Moderate	MNSI - Baby transferred for therapeutic cooling
Moderate	MNSI - Baby transferred for therapeutic cooling
Moderate	MNSI - Intrapartum Stillbirth
Severe	MNSI - Baby transferred for therapeutic cooling
Severe	MNSI - Baby transferred for therapeutic cooling
Severe	MNSI - Shoulder Dystocia & therapeutic cooling
Severe	MNSI - Baby transferred for therapeutic cooling

2.7.7 Regulation 20: Duty of Candour

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex improved compliance with Duty of Candor Regulations to 98% compared to 92.5% the previous year			

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Regulation 20 Duty of Candour ensures that healthcare providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The Trust audits 3 components of the Regulation 20 Duty of Candour.

- Compliance with initial Duty of Candour conversation/apology
- Compliance with initial Duty of Candour letter: follow up from meeting/conversation
- Compliance with investigations/ review findings shared with patients / families

The average compliance with duty of candour at the end of 2025/26 was 98% with the timescales.

The central patient safety team has undertaken two Duty of Candour letter quality audits of letters to identify whether the Duty of Candour criteria was met by these documents and to provide peer feedback on the quality of the letters. 90% of the letters included a clear apology and 97% clearly described the safety incident.

2.7.8 Patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	There has been a small decline in assessments compared to previous years, whilst performance remains below the national average			

Indicator Domain	**The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism** Treating and caring for people in a safe environment and protecting them from avoidable harm				
UHSussex 2025-26	National average 2025-26	Best performing Trust 2025-26	Worst performing Trust 2025-26	UHSussex 2024-25	UHSussex 2023-24
89.6%	91.4%	100%	14.9%	90.75	*
Data Source	NHS Digital NHS England » Venous thromboembolism (VTE) risk assessment 2025/26				

Table based on latest available data (April 2025 to December 2025) * The VTE data collection and publication was suspended after December 2020, and recommenced in Q1 of 2024.

3.7.9 Rate of C.difficile infection

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	The Trust had a higher than anticipated rate of CDI in 2025-26. With rates above regional level but below the aggregate London rate. There was a reduction in cases in Q4 which is encouraging as this was at a time of high sampling due to the presence of Norovirus			

During 2025/26 the Trust recorded 166 CDI cases (ambition 152), equivalent to 23.43 per 100,000 occupied bed days which is 57 cases above trajectory but a reduction in rate from 32.7 last year.

No definite outbreaks or cross transmission events were confirmed, although site level data show month to month variability, with community onset healthcare associated (COHA) cases contributing approximately 40% of the total.

A thematic summary of the PSRIF DATIX risk factor data analysis is as follows;

- 85% of CDI samples were taken in a timely manner.
- 11.3% of patients were on laxatives at the time of sampling, with 34% on proton-pump inhibitors.
- Data shows that 60% of patients were isolated within 4 hours of a sample being sent. However, in the remaining 40% of cases, timely isolation was not achieved, with the lack of available side rooms being the primary reason cited.
- Almost 50% of patients were on antibiotics at the time they were confirmed as *C. difficile* positive, the vast majority in line with EOLAS guidance.
- 11.4% of patients confirmed as *C. difficile* positive were previously positive.

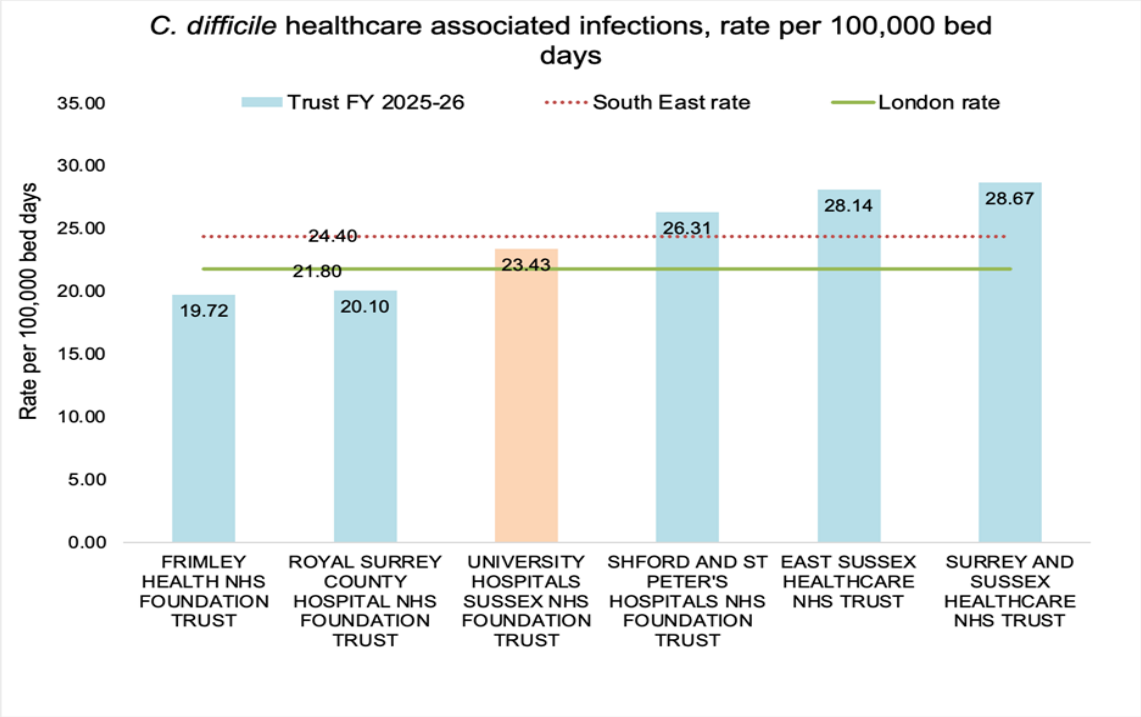
The *C. difficile* Trust-wide action plan interventions updates are as follows;

- We continue with our monthly MDT meeting to discuss key themes driving *C. difficile* cases.
- We continue to drive targeted training at ward level; this includes IPC spot checks as part of the audit agenda and a focus on commode cleaning. These metrics are presented at IPOG.
- Driving *C. difficile* agenda via the Antimicrobial Stewardship Group (ASG) – looking at prescribing among other factors and promoting audit and peer-reviews to drive Trust wide learning and consistency of clinical approach.
- Work continues to focus on identifying gaps in environmental cleaning processes and ensuring consistent adherence to the correct cleaning products, concentrations, and required contact times.
- The adult mattress audit and replacement programme has now become standard practice.

- Timely closure of DATIX reports for CDI positive samples has been raised and is being considered by IPC.
- IPC Link Champions act as conduits for rapid dissemination of learning and good practice across wards and services.

Indicator	**The rate per 100,000 bed days of trust apportioned cases of C. difficile infection that have occurred within the Trust amongst patients aged 2 or over**				
Domain	Treating and caring for people in a safe environment and protecting them from avoidable harm				
UHSussex 2025-26	National average 2025-26	Best performing Trust 2025-26	Worst performing Trust 2025-26	UHSussex 2024-25	UHSussex 2023-24
23.43	Data not published/available			32.7	13.93
Data Source	https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure				

Table based on latest available data April 2025 to March 2026



2.7.10 Sepsis

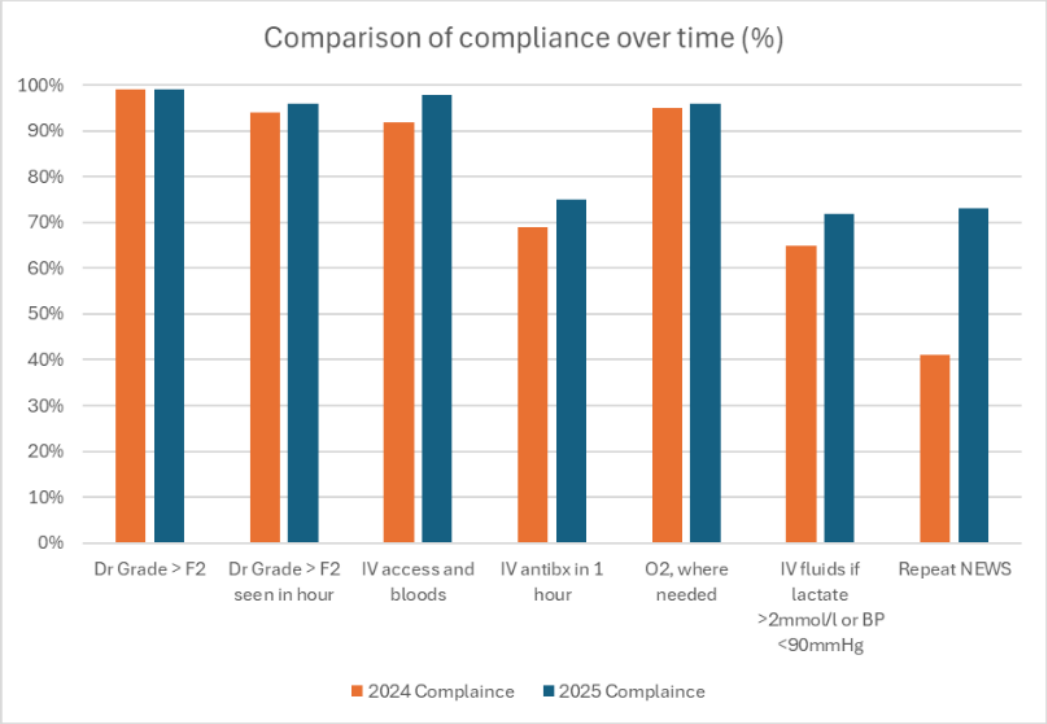
Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex SHMI for sepsis suggests that mortality for this condition is within the expected range, with a lower number of observed deaths against the number of expected deaths and an overall reduction in comparison with the previous year. Audit results have shown an increase in compliance with NICE guidance relating to the management of sepsis.			

Metric	Jan 25 - Dec 25	Jan 24 - Dec 24
SHMI	88.18	98.7
SHMI 95%CI Lower	77.79	88.18
SHMI 95%CI Upper	99.58	110.12
Expected number of deaths	294.85	324.23
Number of patients discharged who died in hospital or within 30 days	260	320
Number of mortalities occurring in the hospital	225	263
Number of provider spells	1233	1409
Number of mortalities occurring out of hospital	35	57
Data Source: SHMI Module in HED (Jan 25 - Dec 25) filtering for the SHMI diagnostic group of sepsis		

2.7.10.1 Trust Wide Emergency Department Sepsis Audit

A Trust Wide Sepsis Audit was undertaken throughout Q3 25/26. The Audit assessed compliance with NICE Guidance NG253 - the recognition, assessment and early management of suspected sepsis in people 16 and over. The audit was carried out across all the Trust Emergency Departments.

The outcomes of the 25/26 audit showed an improvement with standards being met compared to the previous year's results. Most improvement was seen in the timeliness of the repeat in NEWS2 assessment (41% to 73%), and prescription of antibiotics within an hour (69% to 75%). The Figure below provides a summary of compliance with the sepsis care bundle 25/25 compared to 25/26



To support compliance, an audit on Sepsis has been added to the Nursing assessment compliance dashboard. This is an interactive platform where staff can evaluate compliance with different nursing assessments, including compliance with sepsis 6 bundle. Data is available at Trust Wide and Site level.

Part 3: Other Quality Information

3.1 Guardian of Safer Working Annual Report

Rota Gaps & Plans for Improvement

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex has implemented Exception reporting reforms as part of the updated Resident doctors contract from 4.2.2026. The Guardian of safe working (GOSW) reports to People Committee a sub-committee Trust Board with key data (**Exception report ER** trends / work schedule reviews / immediate safety concerns and GOSW fines). GOSW report includes a workforce report of rota gaps and clear evidence of recruitment plan / backfill strategy (Appendix 1) ER data has been presented at LFG meetings (local faculty group meetings). Discussion is focused on ER themes, trends and impact on training. Data presented is within contractual rules which ensure individual doctors cannot be identified from ER data (incurring data breach). The GOSW attends Medical Educational management group meetings (MEMG) and the Joint Local Negotiating Committee (JLNC) providing key updates and New educational supervisor courses. The Resident doctors Forum (RDF) is monthly and rotates between sites. It includes senior leadership speakers, RDF/GOSW fine bids and updates on delivering the NHS England 10-point plan, with GOSW, medical workforce, wellbeing, educational and trainee RD peer representation.			

In 25/26 there has been an overall sustained increase in Exception Reporting (ER) with 2006 in total compared to 1785 in 24/25 and 1394 in 23/24. In comparison to 24/25 this constitutes an 11% increase overall.

ER reforms ensure Resident Doctor's (RDs) ER is processed within 7 days. Data breach rules protect the confidentiality of the reporting doctor. The Trust asks that reporting RDs provide a probity statement with each ER (in lieu of geo-location proof of hours worked). ERs <2hrs are reviewed and approved by medical workforce officers. ERs > 2hrs / immediate safety concerns (ISCs) and ERs incurring a Guardian of Safer Worker (GOSW) fine (penalty) are escalated for review by the GOSW. ISCs are escalated to Chief of Service for immediate actions and a summary of remedial actions is included in GOSW reports.

Site	Exception Reports 25/26	Exception Reports 2024/25	2025/26 Hotspots
Worthing General Hospital & Southlands Hospital (WGH)	552 (Up 16%)	461	Acute Medicine (19%) Elderly Medicine (15%)
Royal Sussex County Hospital, Royal Alexandra Children's Hospital, Brighton General Hospital, Sussex Eye Hospital (RSCH)	1003 (Up 21%)	795	Elderly Medicine (13%) Emergency Medicine (11%)
Princess Royal Hospital & Hurstwood Park Neurosurgical Centre (PRH)	131 (Up 47%)	69	Elderly Medicine (53%)
St Richards Hospital (SRH)	380 (Down 21%)	460	Acute Medicine (21%) Respiratory (14%)

ER reforms have been implemented at UHSussex from 4.2.26, early indicators suggest an **increase in overall ER** and more RDs requesting payment over time-off-in-lieu (TOIL) for additional hours worked (97% for payment since ER reforms were implemented, by RD choice). Other early trends include an increase in exception reporting among Higher Specialty Trainees and those on 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. It is likely that this reflects doctors previously under reporting despite this occurring on a regular basis. Under reporting may have been through fear of detriment - a perception by the RD that a supervisor (closing the ER) that ER demonstrated a lack of competence, professionalism, or poor time management. ER behaviours have changed post reform with a greater willingness to submit ER and submitting ERs for shorter time durations.

24 immediate safety concerns (ISCs) have been upheld during 25/26. ISCs were submitted in high volume (12) by RSCH F1s in Surgery (June - July 2025). These have been thoroughly investigated by senior clinical and educational leads resulting in positive changes in working practices for newly appointed RDs with no further ISCs. An emerging theme among ISCs is same day sickness resulting in rota gaps for out of hours shifts (specifically in acute medical specialties / EF on call) leading to actions to ensure rota resilience and adequate staffing.

187 Guardian fines have been levied for 25/26 (WGH;49, SRH;29, RSCH;100 PRH;9). The majority of these relate to RDs shift exceeding 13hrs in length.

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 return travel home. The GOSW and Trainee peer representative continue to contribute to workstreams to implement the NHS England 10 point plan, a communication **Teams channel** has been launched to give RDs and LEDs access to key policies, user guides and contacts within

the organisation (including exception reporting enquiries, payroll and rota compliance teams).

In 25/26 the RD forum has dispersed fines to project agreed by RD representatives including winter safety equipment (bike lights, ice scrapers, personal safety alarms and high visibility vests), rest space equipment and well-being events / social activities.

From August 2026 ER will expand to **Locally employed doctors at UHSussex**. This will have a positive impact on the working lives of local employed doctors with parity of safe working practices and remuneration for additional hours worked. With expansion of the number of reporting doctors in 26/27 UHSx will appoint additional GOSW support. This will ensure clear oversight of ER data across sites and allow GOSWs to meet additional responsibilities (LFG fora, educational involvement, responding to GMC reports, chairing RDF and advising on relevant aspects of 10 point plan). This will ensure the GOSW can be responsive, and use ER data as a mechanism to deliver changes to rota patterns and support safe working practices.

3.2 Health Inequalities

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	The Trust is not able to report against all applicable items outlined in NHS England's statement on information on health inequalities; however this has improved significantly over the year, with outstanding items have been logged on a data quality improvement plan			

UHSussex is committed to offering services that are equitable and provide equality of access. As part of this commitment the Trust within its service change and business case process undertakes a review on the equality and equity of access as part of the needs assessment and associated service configuration processes.

The Trust has established a Clinical Outcomes & Health Inequalities Group (COHIG). This is integral to the delivery of our Integrated Care System's (ICS) CORE20 plus 5 programme which aims to reduce health inequalities. This programme works with those who are within the 20% most deprived of our national population and allows the ICS to target five additional patient groups who experience poorer health outcomes. As part of the work relating to the five additional patient groups, the Trust particularly focusses on health inequalities relating to maternity care, chronic respiratory disease and early cancer diagnosis.

Under the purview of COHIG, we have developed a Health Inequalities Improvement Plan, which is supporting delivery of the Trust 5 Year Strategy and to review equity of access by geographic and demographic profile of the Trust catchment populations, with the aim to build stronger and more collaborative strategies to address health inequalities.

Hearing and responding to the voice of our patients is integral to how we make improvements and pathway changes to our services. Patient feedback from a range of sources such as the Friends and Family Test, compliments and complaints provide a wealth of information that gives us insight into what is important to our patients. We draw on this when undertaking continuous improvement as well as engaging directly with key patient and stakeholders where this is indicated.

The plethora of patient surveys undertaken, including national patient surveys and friends and family test, provide insights into the priorities for local people, including those with protected characteristics which shape the Trust's work on inequalities.

Health inequalities is an on-going focus for the Trust. Inequalities in health are the systematic, avoidable and unfair differences in health arising from multiple factors including the social and economic environments in which we live and influenced by the decisions we make for ourselves and our families.

People living in more deprived areas are more likely to experience poor health, shorter life expectancy and less good access to health and care services due in part to poor housing, lower incomes, and lower health literacy (knowing how to understand and navigate the

health and care system). Despite being a relatively affluent county, within Sussex there are pockets of significant social deprivation, notably along the coastal strip in Hastings, Brighton and Hove and Littlehampton, which rank within the most deprived areas in England.

Our population is ageing but those from more deprived neighbourhoods are spending increasingly more time in ill health and people are developing multiple long-term conditions at younger ages than before. Whilst there is a stark difference in life expectancy between the most and least disadvantaged men and women.

The table below summarises population differences between Brighton and Hove, East Sussex and West Sussex.

	Brighton & Hove	East Sussex	West Sussex
Population Size	283,870	563,200	882,400
Aging Population	Median Age 38 14.1% of residents are aged 65+	Median Age 48 26.1% of residents are aged 65+	Median Age 44 23% of residents are aged 65+
Difference in life expectancy most and least deprived - Men	9.9 years	11 years	14 years
Difference in life expectancy most and least deprived - Women	7.7 years	10 years	14 years

People from Black and Asian Minority Ethnic (BAME) communities are also more likely to experience poor health and barriers to services as are those with learning disabilities or mental ill health.

The NHS Long Term Plan (2019) has highlighted the need to take a concerted and systematic approach to reducing health inequalities and addressing the unwarranted variations in care that arise. The Covid-19 pandemic acutely highlighted how marginalised groups were adversely impacted and the Equality, Diversity & Inclusion agenda is of great importance to the Trust.

Progress has been made this year in understanding and addressing inequalities in access and outcomes for our patients. This includes:

- Analysing our waiting list population and stratifying patients according to characteristics such as deprivation and ethnicity to understand what inequalities are evident, under the oversight of the Health Inequalities Strategic Oversight Group.
- Connecting as an active partner in the Sussex Health and Care Partnership's population health management work and delivery of the national 'Core 20 plus 5' programme to reduce inequalities.
- Quarterly patient experience reports which include a review of patient feedback and how this has enabled improvements for those who may face inequalities in access and outcomes, with the resulting actions taken being reported to the appropriate Trust committees.
- Access to patient feedback via the Friends and Family Test system, with a word and comment search function so that all service areas can understand what patients have to say about their experience, including those for whom their experience was perceived to have been influenced by a characteristic such as disability or gender.
- Close work continues with local Healthwatch organisations, including hearing the voice of less heard groups.

- Hundreds of patient information leaflets have been produced about specific conditions which are fully accessible and published on the Trust website, which is available in multiple languages and formats.

Inclusion is one of the Trust's values and UHSussex has a number of services and functions with a health inequalities focus, with Trust-wide strategic responsibility under the Chief Medical Officer. There is an Equality, Diversity and Inclusion team within the People Services and the Patient Experience teams in the Chief Nurse services include a focus on engagement with an inequalities lens.

Taking opportunities to engage with patients during hospital visits to address health promotion such as stopping smoking, weight loss and alcohol management (Making Every Contact Count) also contributes to reducing inequalities in our local population. Ensuring clinical teams are enabled to confidently deliver such messaging is an important part of embedding a collaborative approach to tackling health inequalities in a hospital setting.

The Trust is committed to delivering NHS England's approach to reducing adult health inequalities through the Core20PLUS5 programme.

The Trust is cognisant of NHS England's statement on Information on Health Inequalities (duty under Section13SA of the National Health Service Act 2006). Through the development of the Trust 5 Year Strategy, it is working to fully meet all of the requirements set out in the statement, with the following key areas of activity having taken place over 2025/26.

3.2.1 Smoking Cessation

Over the course of 2025/26 the Trust fully recruited to its Tobacco Dependency Advisors (TDA) to enable the delivery of the inpatient smoking pathway, and continuation of the Smoke Free Pregnancy Service. The following data excludes March 2026.

Inpatient Smoking Cessation Service

The aim is for all patients to have their smoking status recorded at the time of admission to enable referral to a Trust TDA. As of Q4 the Trust achieved a recorded smoking status for 82.9% of patients. Where a patient wants to make a quit attempt with a Trust TDA, they are referred on discharge to community pharmacy stop smoking services, local authority stop smoking services and the national Swap2Stop vape replacement scheme. Over the course of the year the Trust TDAs made the following numbers of referrals to these services;

- 99 to community pharmacy stop smoking services
- 331 to local authority stop smoking services
- 98 to Swap2Stop incentive scheme

The majority of 2025/26 Local Quality Requirements for Inpatient Smoking Cessation Service were met or exceeded, however due to capacity within the smoking cessation team it was not possible to see 70% of referrals to the service.

70% of referrals receive a TDT consultation (excluding inappropriate referrals and those received and discharged outside of service operating hours Monday to Friday 0900-1700)

	Q1	Q2	Q3	Q4
Achievement	Change to reporting metric	52.2%	45.3%	61.1%

40% of referrals receiving a TDT consultation which subsequently undertook a quit attempt

	Q1	Q2	Q3	Q4
Achievement	42%	43.9%	43.2%	42.3%

25% of those undertaking a quit attempt reporting as smoke free (CO2 or self-reported) at 28 days

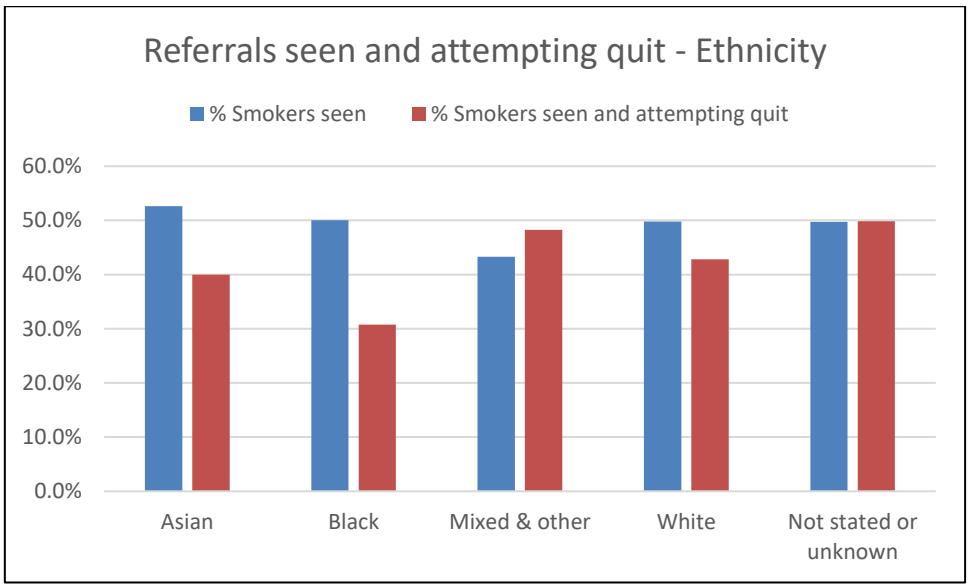
Performance	Q1	Q2	Q3	Q4
Achievement	28.1%	24.9%	28.1%	32.6%

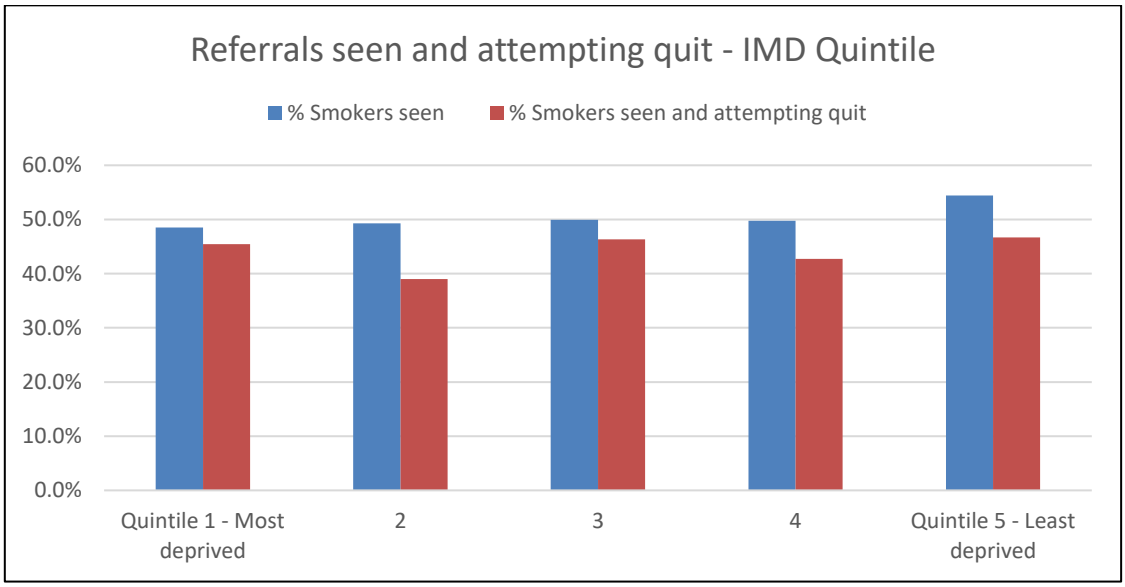
Inpatients undertaking a supported quit attempt

UHSussex have improved the percentage and national ranking of inpatient undertaking a supported quit attempt and remain above the national average.

Indicator	**% of people who are seen by an in-house tobacco dependence treatment service that are provided with care plans to support a quit attempt (T.061.032)**			
UHsussex (Feb 25 - Jan 26)	National Value (Feb 25 - Jan 26)	Lowest provider (Feb 25 - Jan 26)	Highest provider (Feb 25 - Jan 26)	UHsussex (Feb 24 - Jan 25)
43.1% (Rank 45/121)	38.5%	0%	100%	34.3% (Rank 58/121)
Data Source	Tobacco Dependence Services Dashboard (based on monthly tobacco dependence submissions)			

Looking at local data by ethnicity, 40-50% of smokers referred are seen by the service, across all ethnic groups. However, there is variance of 20% in the proportion of patients seen that opt to undertake a supported quit attempt by ethnicity. Whilst there is a marginal variance in referral and uptake across deprivation scores.



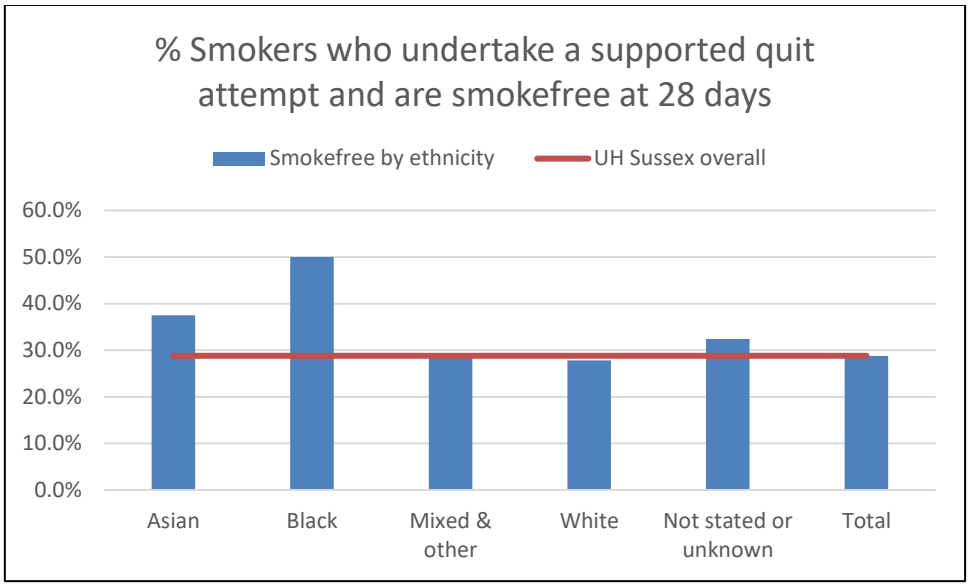


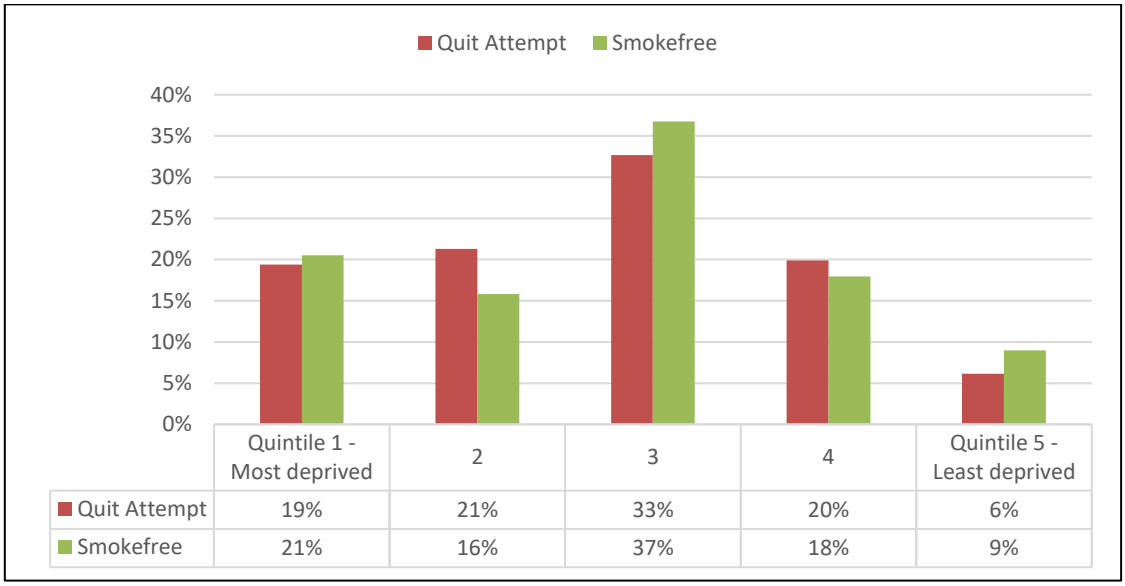
Inpatient Successful Quits

UHSussex have improved the percentage and national ranking of inpatients successfully quitting and remain above the national average.

Indicator	**% of people provided with care plans to support a quit attempt that are recorded as having quit smoking (O.284.061)**			
UHsussex (Feb 25 - Jan 26)	National Value (Feb 25 - Jan 26)	Lowest provider (Feb 25 - Jan 26)	Highest provider (Feb25 – Jan 26)	UHsussex (Feb24 – Jan 25)
24.8% (Rank 48/110)	17.2%	0%	85.7%	8.33% (Rank 68/110)
Data Source	Tobacco Dependence Services Dashboard (based on monthly tobacco dependence submissions)			

Looking at local data, there is variation in quit rates by ethnicity. Whilst black smokers have the lowest uptake of a quit attempt, this group see the highest success rate in becoming smoke free.





	Quintile 1 - Most deprived	2	3	4	Quintile 5 - Least deprived
Quit Attempt	19%	21%	33%	20%	6%
Smokefree	21%	16%	37%	18%	9%

Future Service Developments

In order to improve service delivery and smoke free outcomes for patients over the coming year the following service improvements are planned;

- Automated follow up via Netcall of discharged patients with a planned quit attempt
  - 7-14 day check in, offer support and onward referral if required
  - 28 day check of smoke free status and onward referral if required

Whilst reducing administrative burden on TDAs to enable them to undertake more face to face meetings with inpatients, it is expected that this intervention will enable better support to those attempting a quit, improve engagement and reduce the number of patients lost to follow up (because they don't respond) resulting in better outcomes data and improved

successful quit attempts. It will also enable earlier intervention for those requiring additional support to sustain their quit attempt.

- Automated follow up via Netcall of patients admitted/referred/discharged outside of service operational hours (Monday to Friday 0900-1700)

Due to funding constraints, it is not possible to deliver the service across 7 days and as such a number of patients are not provided with access to smoking cessation support. The use of automated follow up will enable those patients to be offered referral to community pharmacy and local authority stop smoking services should they wish.

Smoke Free Pregnancy Service

In addition to in house smoke free pregnancy services the Trust delivered the National Maternity Incentives scheme and Swap2Stop Vape scheme. The Trust also continued the use of novel Technologies such as iCO remote monitors and Attend Anywhere for virtual appointments to increase engagement with rural and harder to reach patients.

As a result the Trust registered 99 patients who set a quit date on the National Maternity Incentives Scheme and of those 67.68% were smoke free at 4 weeks. The Trust provided 314 Swap2Stop voucher codes to pregnant patients and their partners to support smoke free homes.

All of the 2025/26 Local Quality Requirements for Smoke Free Pregnancy Service were met and exceeded. The following data excludes March 2026.

30% quit rate - Smoker at time of booking who engages with the service and are smoke free at delivery (CO2 or self reported)

	Q1	Q2	Q3	Q4
Achievement	38.3%	39.4%	52%	42%

Percentage of pregnant smokers (Smoking at Time of Booking (SATOB) Vs Smoking at time of delivery (SATOD))

There is a national target for smokers at time of delivery to be less than 6%

	Q1	Q2	Q3	Q4
SATOB	5.91%	6.14%	6.32%	6.32%
SATOD	4.12%	4.24%	3.93%	3.18%

Using the most available data (2024/25) UHSussex has seen a small reduction in successful maternity quit rates and ranking since last year and remains around the national average.

Indicator	% of pregnant women identified as smoking at antenatal booking who are identified as not smoking at delivery (O.332.023)			
UHsussex (Aug 24 - Jul 25)	National Value (Aug24 - Jul25)	Lowest provider (Aug24 - Jul25)	Highest provider (Aug24 - Jul25)	UHsussex (Aug23 - Jul24)
40.6% (rank 21/117)	40.7%	0%	100%	42.96% (rank 17/117)
Data Source	Tobacco Dependence Services Dashboard (based on monthly tobacco dependence submissions)			

However, data shows that of those who do undertake a supported quit attempt, over 70% are successful and are smokefree at delivery, which is well above the national value of 29.2%.

Indicator	% of pregnant women identified as smoking at antenatal booking who are identified as not smoking at delivery (O.332.023)			
UHsussex (Aug24 - Jul25)	National Value (Aug24 - Jul25)	Lowest provider (Aug24 - Jul25)	Highest provider (Aug24 - Jul25)	UHsussex (Aug23 - Jul24)
73.33% (rank 3/106)	29.2%	0%	100%	72.92% (rank 2/106)
Data Source	Tobacco Dependence Services Dashboard (based on monthly tobacco dependence submissions)			

Future Service Developments

In order to improve service delivery and smoke free outcomes for patients over the coming year the following service improvements are planned;

- Automated postnatal follow up via Netcall for those patients smoke free at time of delivery to check in, offer support and onward referral if required.

This service is not currently offered and will provide additional post-natal support to sustain a quit attempt or seek onward referral for those who have lapsed to help deliver smoke free homes for children across Sussex.

Peri-Operative Swap2Stop Scheme

During 2025/26 the Trust has been developing a PreOptimisation service to support patients to wait well and to optimise them for surgery, providing links to information and guidance regarding healthy lifestyles. Initially there was a focus on supporting patients to undertake a quit attempt through referral to the National Swap2Stop incentive.

This involved a large aspect of practitioner training to empower conversations around stopping smoking and provision of very brief smoking cessation advice. During the year:

- 322 patients were registered for Swap2Stop
    - 188 patients via face to face pre-operative clinics
    - 100 patients vis the NHS App
    - 2 patients via face to face surgical outpatient appointments
    - 32 patients via the PreOptimisation website

Outcome data from 109 patients shows that 65% made a quit attempt preoperatively with 45% of those quit attempts self-reporting as having successfully quit.

During the later part of the year the PreOptimisation service has expanded to provide guided exercise classes in conjunction with the University of Brighton. Further service improvements are planned for the forthcoming year, adopting the making Every Contact Count methodology with a wider focus on nutrition, healthy weight, alcohol and substance misuse, smoking cessation and exercise.

3.2.2 Hepatitis C, HIV & Liver Fibrosis

Hepatitis C Prison Micro-elimination

- HMP Ford 100% reception testing and treatment initiation, with 82% 12-month population testing for Hep C.
- HMP Lewes: 98% reception testing coverage, 100% treatment initiation, and 90% 12-month population testing for Hep C

Community Liver Health Checks

- 1,153 people had a Fibroscan via a Community Liver Health Check with
    - 135 high risk patients of liver cancer identified

HIV & Hep C

- 32,388 people were tested for HIV & HEP C via ED opt out services at RSCH
    - 28 Positive Hep C RNA tests and 12 New Diagnoses
    - 160 Positive HIV Tests and 6 New Diagnoses
- 114 patients have started on treatment for HEP C following testing with
    - 75.9% starting treatment within 4 weeks (against a target of 75%)
    - 194 patients achieved sustained virologic response

Over the coming months work is taking place to establish HEP B testing at RSCH, whilst HIV opt out testing is being rolled out across WGH.

3.2.3 Early Diagnosis of Cancer

NHS England's approach aims to ensure 75% of cases are diagnosed at stage 1 or 2 by 2028.

Year	% patients discussed within a Trust MDT with a stage recorded	% patients diagnosed with early stage cancer
2022	84.7	57.2%
2023	86.0	58.9%
2024	89.2	58.4%
2025	87.9	58.8%

3.2.4 Recording of Health Inequalities Data Including Ethnicity

UHSussex is committed to ensuring that it holds data which enables us to understand the impact our services and care has on ethnically minoritised groups, and those most at risk of health inequalities.

UHSussex recognise it can be difficult for staff to ask patients questions relating to their protected characteristics. During Q4 face to face training and materials were provided to support staff to feel confident to ask those questions, with patient facing leaflets and posters also provided to key areas such as receptions to inform patients why such data collect is important. Whilst performance for completeness of data has reduced slightly in comparison to the previous year, the Trust remains significantly within the national threshold of 60% completeness.

Data Set	YTD	National	UHSx 24/25	UHSx 23/24
Outpatients	84.8%	77.1%	84.30%	84.60%
In-Patient Discharges	86.8%	86.1%	86.50%	86.90%
Emergency Department Attendance	80.9%	84.3%	82.00%	80.70%

Maternity Ethnicity Completeness

Uhsussex has seen a slight deterioration since previous years, but has a high competition of ethnicity completeness with only 2% recorded as not known or not stated

Indicator	Ethnicity completeness % Ethnicity recorded as 'not known' or 'not stated'			
Uhsussex (2025-26)	Highest provider (2025-26)	Lowest provider (2025-26)	Uhsussex (2024-25)	Uhsussex (2023-24)
2%	34%	0%	1%	1%
Data Source	Data source: National Maternity Dashboard (taken from Maternity services dataset)			

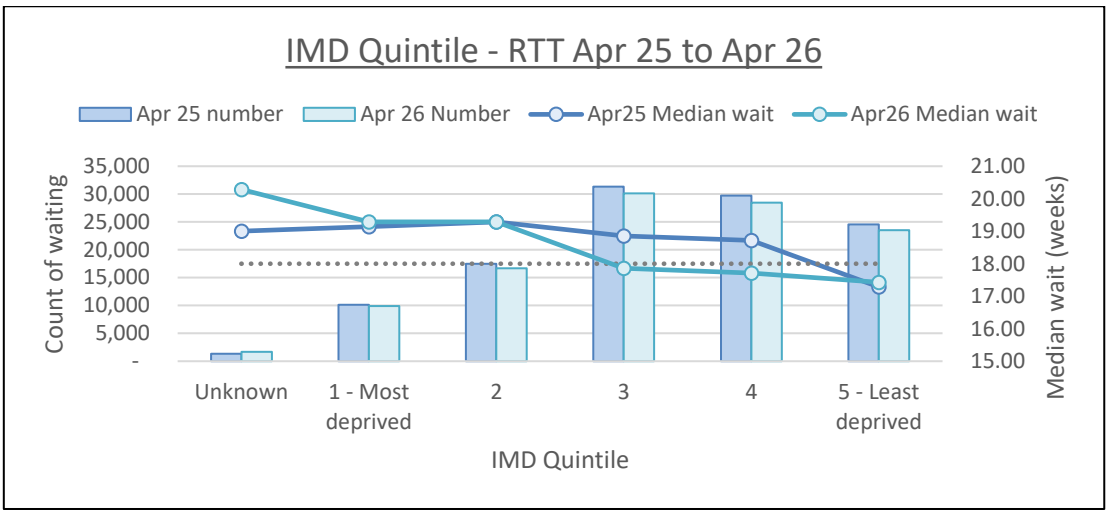
National Cancer Audit Collaborating Centre (NATCAN) Ethnicity Completeness

UHSussex is below the national average for data completeness across all NATCAN audits;

Audit	Uhsussex %	Uhsussex Cases submitted (n)	Uhsussex Rank	National Median	Lowest provider % (N)	Highest provider % (N)	Data source and period covered
National Lung Cancer audit	95%	582	101/123	98%	86.6% (531)	100% (402)	NATCAN NLCA Dashboard (01/07/24 to 30/06/25)
National Kidney Cancer audit	92%	585	102/123	96%	78% (87)	100% (589)	NATCAN NKCA Dashboard (01/10/22 to 30/09/25)
National Bowel Cancer audit	86%	261	98/118	93%	73% (459)	100% (377)	NATCAN NBOCA Dashboard (01/10/24 to 30/09/25)
National Non-Hodgkin Lymphoma audit	92%	279	78/129	94%	72.8% (92)	100% (150)	NATCAN NNHLA Dashboard (01/10/24 to 30/09/25)
National Oesophago-Gastric Cancer audit	90%	197	101/118	96%	67% (6)	100% (105)	NATCAN NOGCA Dashboard (01/10/24 to 30/09/25)
National Prostate Cancer audit	89%	3455	96/118	95%	78.1% (2238)	100% (1285)	NATCAN NPCA Dashboard (01/10/22 to 30/09/25)
National Pancreatic Cancer audit	91%	187	91/119	96%	77.4% (62)	100% (72)	NATCAN NPaCa Dashboard (01/10/24 to 30/09/25)
National Ovarian Cancer audit	92%	131	31/39	96%	85.8% (106)	100% (204)	NATCAN NOCA Dashboard (01/10/23 to 30/09/24)

3.2.5 Referral to Treatment Waiting Times

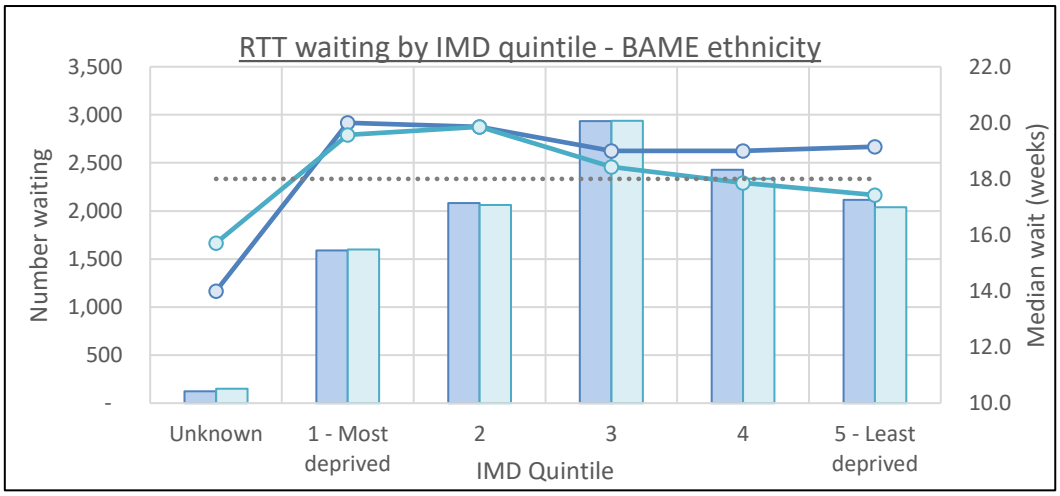
Over the last 12 months total number waiting for treatment has decreased by 3.7%. This reduction varied across IMD declines, with the smallest reduction of 2.6% in the most deprived group (IMD quintile 1). This reduction also varied by ethnicity, where White British waiting reduced by 4.8% but BAME patients reduced by 1.3% in size. There was an increase in the waiting list size for those with unknown IMD quintile.



The most deprived patients (IMD quintile 1) saw an increase of 0.7% in median weeks waiting. Those with unknown IMD quintile saw an increase in median weeks waiting of 6.8% from 19 weeks to 20.29 in Apr 2026. Unknown IMD and IMD quintiles 1 & 2 have a median wait above the national target of 18 weeks.

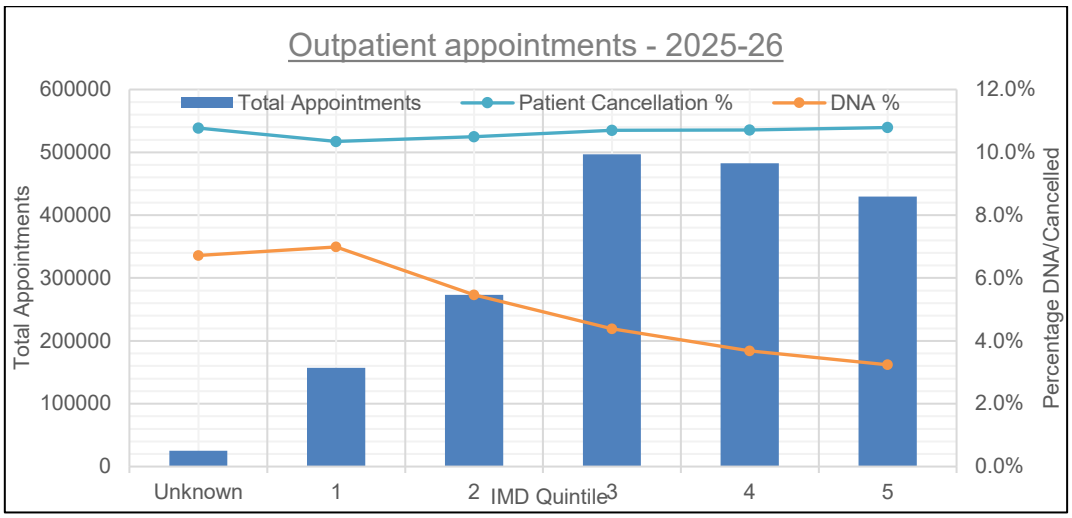
White British patients follow the same trend, with small increases in median weeks waiting for the most and least deprived patients, and reductions in waiting times in quintiles 2-4.

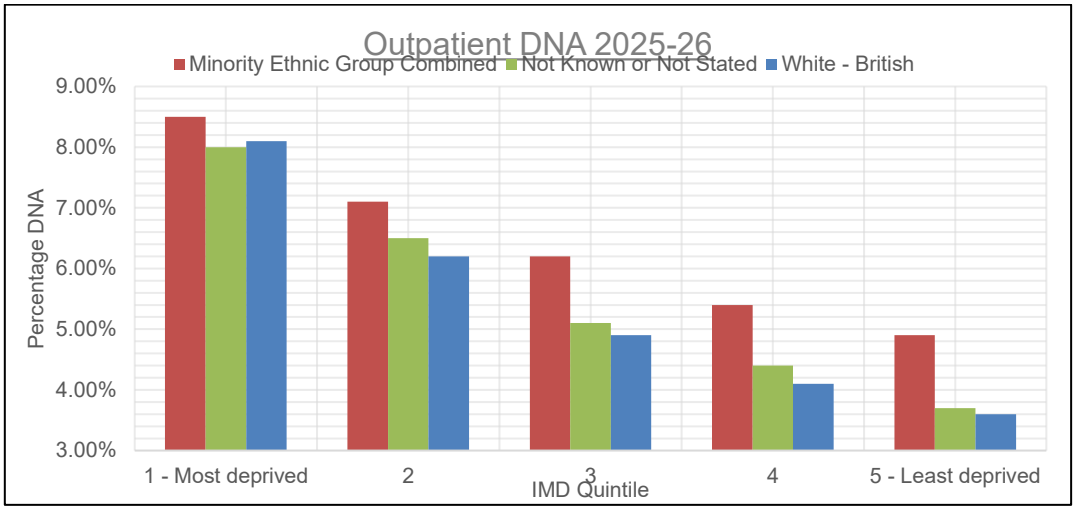
BAME patients however did see a reduction in median weeks waiting across all IMD quintiles except for unknown IMD. The reduction was most pronounced in the least deprived quintiles (IMD 4&5) which now sit below the 18 week target. This has widened the disparity between most and least deprived BAME patients.



DNA and cancellation

Analysis of patient cancellations and DNA (Did not attend) appointments shows that as deprivation increases, so too does percentage of DNAs. This trend is seen across White British, BAME and unknown ethnicity groups. BAME patients have higher percentage of DNA's than White British and unknown ethnicity across all IMD quintiles.

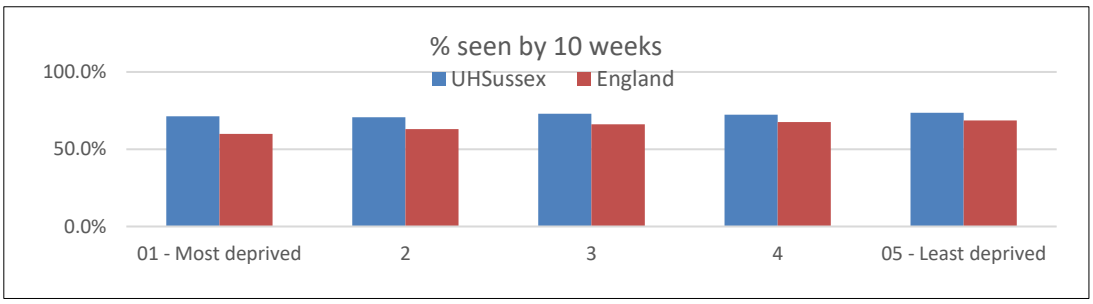




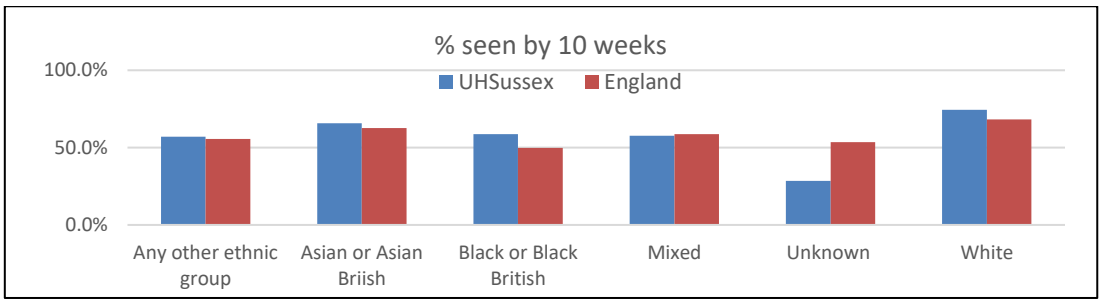
3.2.6 Maternity Services

Gestation at booking

Data is submitted monthly in the Maternity services Dataset (MSDS). This data is processed and published in the Maternity and Neonatal Equalities Dashboard. Analysis of this data shows that across all deprivation quintiles, we are seeing a higher percentage of patients within 10 weeks of gestation compared to England figures.

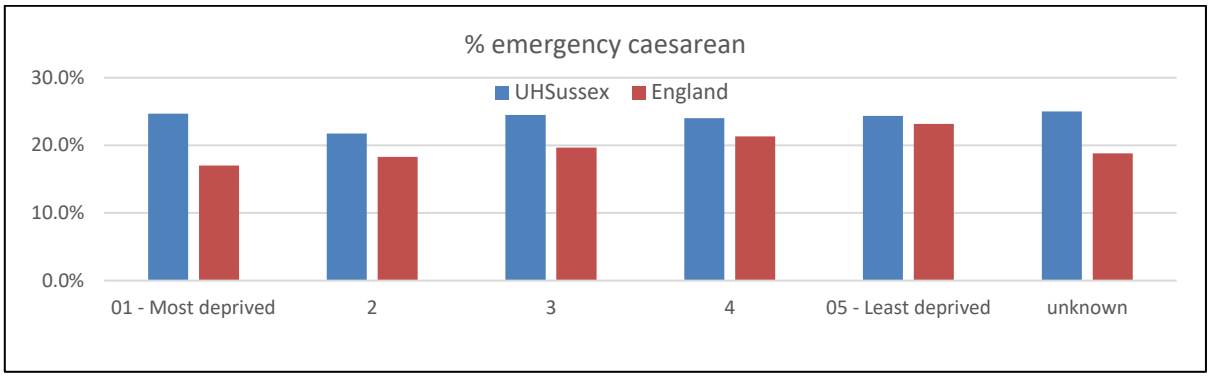


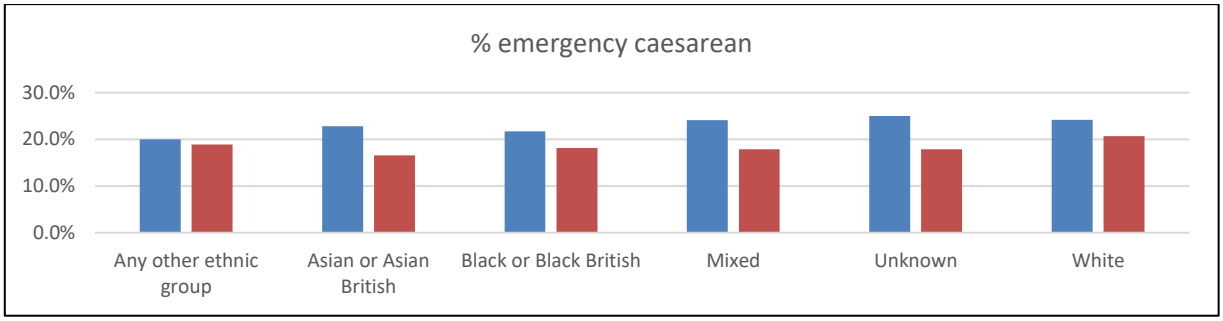
However, this does not transfer across to ethnicity where patients from 'Mixed' and 'Unknown' ethnicity groups are seen later in pregnancy, with the percentage seen within 10 weeks gestation being lower for these ethnicity groups than national figures.
Note: Low numbers of patients have Unknown ethnicity.



Mode of delivery

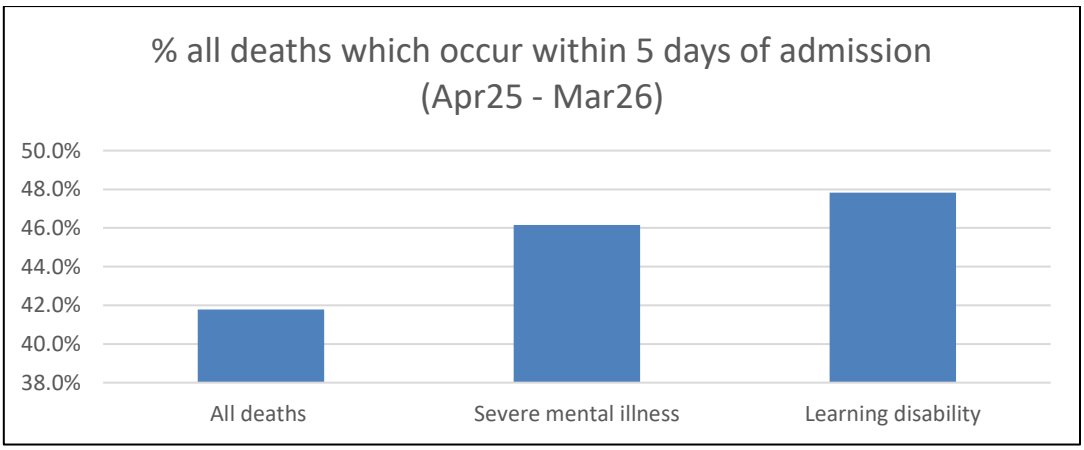
Analysis of mode of delivery shows that across all deprivation quintiles and all ethnic groups, UHsussex is seeing higher percentages of emergency caesareans than national figures. This is most pronounced in the most deprived quintile. Further analysis is required to understand this and develop an improvement plan as required.



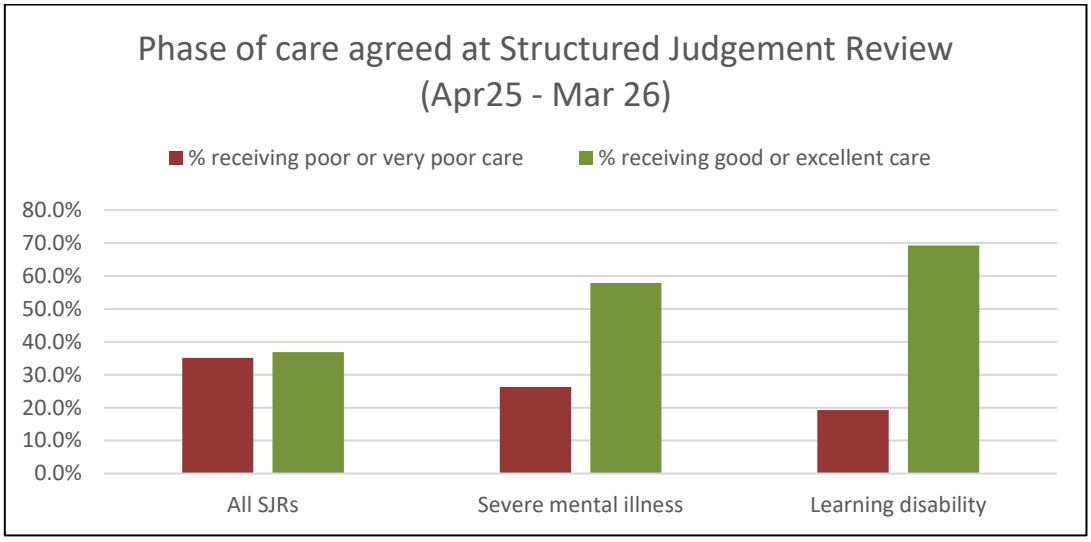


3.2.7 Mortality for people with severe mental illness/ learning disability

Looking at all deaths at UHsussex sites, patients admitted with Severe mental illness (SMI) and Learning disabilities(LD) die within 5 days of admission at higher rates.



However, Phase of care agreed at Structured Judgement Review (SJR) suggests that care provided is of higher quality for patients presenting with SMI and LD.



Length of stay for people with learning disability

Length of stay is longer for those patients with Learning disability or autism, however this has reduced compared to the previous year.

Average Length of stay Data source: UHsussex Careflow data		
	2024/25	2025/26
All patients	3.51	3.21
Patients with LD/Autism	8.71	6.36

3.3 NHS Staff Survey

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	Overall, the NHS Staff Survey has been assessed as 'Significant Assurance'. This is based on three criteria: • **Response rate**: 8,358 (46.5%) UHSussex staff responded to the 2025 Staff Survey. Although the response rate fell slightly from 2024 (47.0%), it was the largest number of individual responses in any year since the Trust was established in 2021. The Trust was slightly below the national survey response rate for benchmarked Trusts (47%), which fell by 1.19% in 2025. The Survey reflects a high degree of engagement that provides reliable (statistically significant) data across almost all scores, and remains the Trust's single largest staff engagement activity. • **Process**: Results were analysed and reported to key stakeholders and committees rapidly, and data made available to managers and staff via an interactive digital dashboard that enables local analysis of results, benchmarking against Trust and NHS scores. Results are used to update Divisional and local tailored Action Plans. The c. 1,900 free text comments have also been analysed and are informing action planning and the continuing development of the Trusts five-year Strategy 'Excellent Care Everywhere'. • **Overall results**: For substantive staff, overall 83% of question scores improved compared with 2024, with no statistically significant deterioration. 47% of questions now score above the NHS average, with the Trust closing the gap in ~73% of areas where scores remain below average. All nine NHS People Promise / Theme scores improved in 2025, with eight of nine showing statistically significant improvement. By contrast, comparator Trusts showed flat or declining performance compared to 2024. Engagement and Morale Theme scores are broadly in line with the NHS average, with stronger performance in Involvement and Morale indicators (including reduced intention to leave), although advocacy (of the Trust) and work pressure remain comparatively weaker.			

The NHS Staff Survey is one of the largest workforce surveys in the world. It gives people working in the NHS the opportunity to share their views and experiences about work, leadership, wellbeing and inclusion. The results provide a vital source of feedback for Trust Boards, regulators and the public - and play a central role in improving the quality of care. There is strong research evidence that positive staff experience is linked to safe, effective, compassionate care for patients.

At UHSussex, 8,358 colleagues completed the 2025 NHS Staff Survey representing 46.5% of the workforce. The results are benchmarked nationally against other comparable NHS organisations, helping us understand how our staff experience compares with the wider NHS.

Involving our staff

Staff are involved in shaping the direction of the Trust through a range of formal and informal channels. Alongside the national programmes of the NHS annual Staff Survey, Bank only Survey and Quarterly Pulse Survey (undertaken three times per year), ongoing opportunities for staff involvement are solicited. These include our inclusion Staff Networks for lived experience, Divisional, local listening events and engagement forums, Monthly Pulse Survey (as part of annual STAM), Trust Ambassadors programme, and participation in strategy development. In late 2023, we launched a new Culture Programme, alongside our 'Big Conversation' to inform our new Trust Strategy, which have engaged extensively with staff across all sites and staff groups, ongoing feedback is monitored to ensure engagement and assurance that our Strategy addresses the issues that most matter to staff.

Staff experience survey data is complemented by other sources of workforce intelligence – such as Freedom to Speak Up Guardian themes, Employee Relations case patterns, Occupational Health and Staff Psychological Support Service insights.

Quarterly meetings with relevant stakeholders are held to ensure triangulation, interpretation and identification of emerging themes and early warning signals relevant to Well-Led oversight.

In addition, the results of the NHS Staff Survey are shared via an interactive dashboard accessible to all Divisional and Corporate leadership teams and departments, enabling local analysis and action planning tailored to each area's specific priorities.

What our staff told us

The survey asks questions structured around the NHS People Promise, which sets out what people working in the NHS should experience every day, to feel recognised, supported, included, and empowered to speak up and develop.

After mixed results in 2024, 2025 scores showed a marked improvement in staff experience in key areas:

- The largest improvements were seen in teamworking, development and learning, flexible working, wellbeing, line management support, and equality and inclusion, with several of these now performing above the NHS average.
- Development, learning, flexible working and work-life balance all score above the NHS average, in contrast to national trends where these areas have declined.
- Teamworking improved across nine of 11 measures, with most scores now above NHS average.

- Morale indicators improved, including reductions in staff considering leaving and improvements in stress-related measures, now better than NHS average across all three related questions.
- Engagement items show consistent improvement, particularly in staff involvement, although advocacy remains below NHS average.

However, areas for improvement remain:

- Speaking up measures improved but remain below NHS average, including, confidence to speak up; confidence that concerns will be acted on. Two new local questions on Freedom to Speak Up Guardians (FSUG) highlighted that overall awareness of the independent service is relatively strong (72.2%). The FSUG programme of in-reach to teams with lowest awareness scores will continue in 2026/27.
- Safety culture improved (10/12 measures), including raising clinical concerns and feedback following incidents, but all remain below NHS benchmark levels.
- Harassment, abuse, violence and discrimination from patients and the public increased, consistent with national trends but remaining higher (worse) locally than benchmark averages.
- Bullying, harassment and unwanted sexual behaviour from colleagues reduced, but remain above NHS average. Bullying, harassment and abuse from managers increased slightly (by 0.16% points) to 10.1%. This is now above the NHS average, which fell (positively) in 2025.

How we are responding

Local review and action planning are underway. Each Division are developing a tailored Staff Survey Action Plan for implementation in 2026/27, which will be aligned with the new Trust Operating Model launch in April 2026.

Several cross-cutting improvement themes have already emerged:

- Speaking up and psychological safety - making it easier and safer for staff to raise concerns and be heard
- Violence prevention and reduction, including a focus on sexual misconduct

These plans form part of our wider commitment to delivering the NHS People Promise, improving staff experience, and ensuring UHSussex is a place where people feel proud to work.

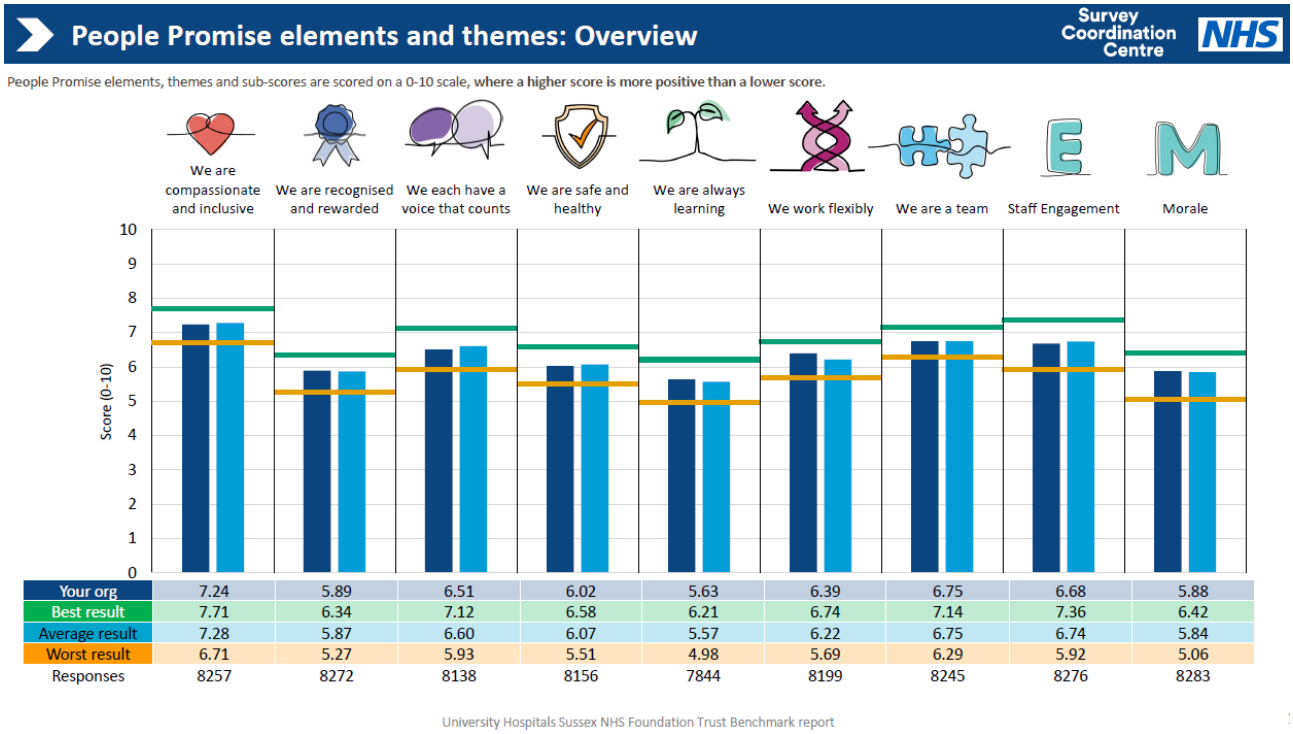
Our commitment

We are grateful to every colleague who took part in the 2025 survey. Staff experience is central to quality, safety, and compassionate care – and we remain committed to listening, learning, and acting on what our people tell us.

For more information

National and local results of the NHS Staff Survey, and survey documents, are available via the interactive NHS Staff Survey Dashboard.

University Hospitals Sussex NHS Foundation Trust: 2025 NHS Staff Survey results summary (People Promise/Themes)



3.4 Operation Performance Relevant to Quality of Care

3.4.1 Emergency Department Performance

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is not meeting the required standard of 78% of patients seen, treated and admitted/discharged within 4 hours, and has seen a 2.6% deterioration in performance compared to the previous year, in comparison to a 2.1% improvement nationally.			

The Trust has improved several of it's UEC measures across 25/26 when compared with 24/25 but some key metrics have deteriorated over the Winter. These include the percentage of patients seen and treated/discharged in 4 and 12 hours in all Emergency Departments.

Our bed occupancy across the Trust continues to be higher than planned, due to discharge delay numbers. The number of patients with a long length of stay (>21 days) is materially unchanged although the number of patients who are discharge-ready (DRD) is much higher in March '26 than in March '25 (these are patients who are ready to leave hospital but require input from another provider). This creates back-up, and thus corridor care in our EDs as we have delayed patients in our beds who are waiting for services or beds outside of our hospitals to be provided by our Community, Social Care and Mental Health partner organisations.

UHSussex is not meeting the required standard of 78% of patients seen, treated and admitted/discharged within 4 hours, having achieved just under 70% for the year. The UEC Improvement programme continues and will be delivered in partnership with an external company this year with the intention to improve our 4hr and 12hr performance, reduce and eradicate corridor care in ED, and shorten our LOS (length of stay) in every hospital. Further information with regards to the metrics are in the tables below:

A&E4hr	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
UHS<4hr %	71.5%	72.1%	72.9%	72.8%	72.9%	69.9%	68.9%	70.3%	70.4%	67.6%	67.0%	66.1%	68.9%
RSCH	59.6%	58.2%	60.2%	59.6%	59.2%	58.0%	57.4%	63.2%	59.9%	56.1%	57.5%	59.3%	63.4%
PRH	66.8%	67.6%	70.5%	69.5%	69.2%	68.4%	64.6%	65.6%	67.0%	60.9%	60.3%	57.3%	58.8%
RACH	90.6%	91.8%	92.4%	95.0%	95.1%	94.8%	91.9%	90.4%	86.8%	83.6%	89.3%	91.3%	90.0%
Worthing	61.9%	68.1%	67.1%	65.8%	66.3%	57.9%	57.4%	59.1%	60.2%	54.6%	56.1%	54.1%	59.6%
SRH	65.1%	63.0%	65.5%	66.5%	67.2%	67.0%	64.0%	62.1%	64.9%	67.1%	59.6%	54.9%	57.6%

A&E4hr	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Trend
UHS<4hr %	71.5%	72.1%	72.9%	72.8%	72.9%	69.9%	68.9%	70.3%	70.4%	67.6%	67.0%	66.1%	68.9%	
National	75.0%	74.8%	75.4%	75.5%	76.4%	75.9%	75.0%	74.1%	74.2%	73.8%	72.5%	74.1%	77.1%	
A&E 12 hours in department	2,662	2,448	2,240	2,088	1,765	2,443	2,823	3,007	2,641	2,793	3,560	2,890	3,052	
A&E Attendances	37,888	36,483	38,342	37,228	38,746	37,446	36,455	38,471	37,096	36,827	37,241	33,159	38,471	
Time to Triage	21	17	17	18	18	16	17	19	18	19	20	21	23	
Time to Treatment	127	125	130	124	126	137	137	141	133	140	141	142	146	
Mean Waiting Time	315	302	294	288	272	306	345	327	316	329	370	362	345	
Ambulance Handovers	7,017	7,022	7,316	7,169	7,540	7,556	7,256	7,576	7,350	7,583	7,717	6,697	7,407	
Ambulance Handover <15 minutes	52.7%	55.8%	59.0%	59.3%	64.0%	58.0%	55.8%	52.5%	55.6%	53.3%	45.7%	52.6%	50.1%	
Ambulance Handover >45 minutes	8.3%	7.0%	6.2%	5.0%	2.6%	8.8%	7.3%	9.0%	7.4%	8.9%	11.4%	8.4%	8.8%	
Ambulance Handovers > 60 minutes	2.4%	2.1%	2.0%	1.5%	0.6%	1.4%	2.6%	3.5%	2.1%	2.8%	3.6%	2.8%	2.5%	
Emergency Admissions > 1 LOS	5639	5621	5848	5606	6147	5655	5703	5941	5565	6055	5847	5155	5765	
Bed Occupancy	93.6%	93.5%	93.1%	92.4%	92.6%	94.2%	94.4%	94.5%	94.5%	94.7%	95.8%	95.4%	95.1%	
Average LOS (Excl LOS 0)	10.20	9.60	9.70	10.30	9.10	9.10	10.10	9.70	9.90	9.60	11.90	10.80	10.50	
>= 7 day LOS Patients	1,052	1,050	1,021	994	926	990	990	959	995	951	1,050	1,068	1,063	
>=21 day LOS Patients	475	476	460	432	397	447	433	459	434	401	437	478	477	
Ave. DRD per day	346	361	378	357	335	360	352	353	354	306	375	391	403	

Patients seen within four hours

The Trust achieved 68.9% in March 26. This is a 2.6% deterioration from March 25. The national average improved by 2.1% over the same period, UHSussex intends to utilise joint working with an external partner to it's fullest benefit to improve performance and thus safety for our UEC patients.

Patients waiting for more than twelve hours

This metric has improved for March '26 when compared to a high in January 26, but it continues to be variable by site. With regards >12hrs stay in ED, we improved from a peak of 9.5% in January to 7.9% at year end, which is still too high and is an overall yearly increase from March '25 to March '26 of 15%.

Ambulance handover > 60 mins

We have stayed static overall for the year with our >60min ambulance handover performance, with January seeing higher numbers of handover delays. The March performance has improved significantly since Jan 26 moved from 3.6% to 2.5% of our ambulances taking more than 60 mins to be handed over. Thia is an overall yearly improvement on last year - UHSussex achieved the initial target of less than 4% of ambulances taking more than 60 mins to offload.

Long length of stay

These metrics are slightly improved on March 25 but are not significantly better. However, the number of medically ready for discharge (DRD) patients is much higher in March 26 than March 25. This group of patients will be impacting the over 21-day metric as the medically ready cohort of patients have a longer length of stay, pushing them into the over 21-day bracket.

24/25 UEC Improvement Programme Objectives

The UEC Improvement Plan, aims to deliver against the following four key NHSE standards and operational targets for each of the five main hospital sites within UHSussex:

- 78% of patients in ED seen, treated, admitted or discharged within 4 hours by March 2025
- Reduce the number of patients waiting over 12 hours from arrival in ED to 10%
- Achieve 0% 60 mins handover delays
- 10% reduction in number of patients with a Length of Stay of over 7 days

The UEC Improvement Plan is comprised of:

- Divisional/site level priority projects: addressing local improvement needs.
- Trust level programmes: bringing together common improvement themes from across the organisation.
- Regulatory and NHSE guided improvement requirements.
- Quality/best practice recommendations from bodies such as GIRFT, ECIST, NHS Impact and most recently NPIP (National Programme for Provider Improvement)
- Partnership working with an external partner

The Year 3 Improvement Programme is:

- Alignment to Trust Strategy.
- Delivery Roadmap at project level agreed to meet National Standards requirements in partnership with our System and external partners.
- Improved data driven decision making to address unwarranted variation.

3.4.2 Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex continues to improve the number of patients waiting over 18 weeks, but remains below the national average			

The NHS constitution sets a standard that 92 per cent of people waiting for elective (non-urgent) treatment, for example, cataract surgery or a knee replacement, should wait no longer than 18 weeks from their referral to their first treatment.

Indicator	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway				
UHSussex 2025-26	National 2025-26 (to Feb-26)	Best performing 2025-26 (to Feb-26)	Worst performing 2025-26 (to Feb-26)	UHSussex 2024-25	UHSussex 2023-24
55.1%	62.5%	100.0%	38.2%	48.9%	41.4%
Data Source	NHS England Consultant-led Referral to Treatment Waiting Times Data 2025-6				

Table based on patients waiting to receive treatment at the end of February 2025

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reasons data is taken direct from the internal clinical system(s) and is validated by the appropriate service.

3.4.3 Maximum six-week wait for diagnostic procedures

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex has improved the number of patients waiting over 6 weeks for diagnostic procedures, and is below the national average			

Diagnostic waiting times are now part of the NHS Constitution, which pledges that patients should wait less than 6 weeks for a diagnostic test from the time that the request has been sent.

Indicator	Percentage of patients waiting more than six-week wait for diagnostic procedures				
UHSussex 2025-26	National average 2025-26	Best performing Trust 2025-26	Worst performing Trust 2025-26	UHSussex 2024-25	UHSussex 2023-24
11.6%	20.2%	0.0%	48.0%	14.3%	30.0%
Data Source	NHS England Monthly Diagnostics Data 2025-26				

Table based on latest available data (February 2025)

The University Hospitals Sussex NHS Foundation Trust considers that this data is as described for the following reasons data is taken direct from the internal clinical system(s) and is validated by the appropriate service.

3.5 Participation in Clinical Research

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex has placed Research and Innovation at the heart of its new Strategy, patient access to research has been widened by broadening the research portfolio and increasing the number of participants recruited to research studies. The Trust has established a NIHR Commercial Research Delivery Centre for Sussex. The Trust has initiated a major capital project to relocate and upgrade its Clinical Research Facilities.			

Research and innovation are central to delivering high quality, forward-looking healthcare. They enable patients to benefit from the latest medical advances and ensure that treatments are both clinically effective and financially sustainable. Their impact extends far beyond those who take part in studies: a strong research culture consistently drives up the quality of care across entire services, strengthens community engagement, and supports the long-term resilience of the health and care system. It also enriches the working environment for staff, offering unique opportunities for development and helping organisations attract and retain talented, motivated teams.

For these reasons, University Hospitals Sussex NHS Foundation Trust (UHSussex) has placed Research and Innovation at the heart of its strategic ambitions. As one of England's largest teaching hospital trusts, we are proud of our deep commitment to collaboration across the local health and care system to improve outcomes through high-quality research. This shared mission is reflected in the work of the Sussex Health and Care Research Partnership (SHCRP), which last year, together with the Sussex Integrated Care Board and other key stakeholders, launched the NHS Sussex research strategy *Improving Lives Together through Research*. This five-year strategy sets out a collective vision for how research across Sussex will advance prevention, diagnosis, treatment, and recovery, ultimately contributing to better health, improved care, and more responsive services for our communities.

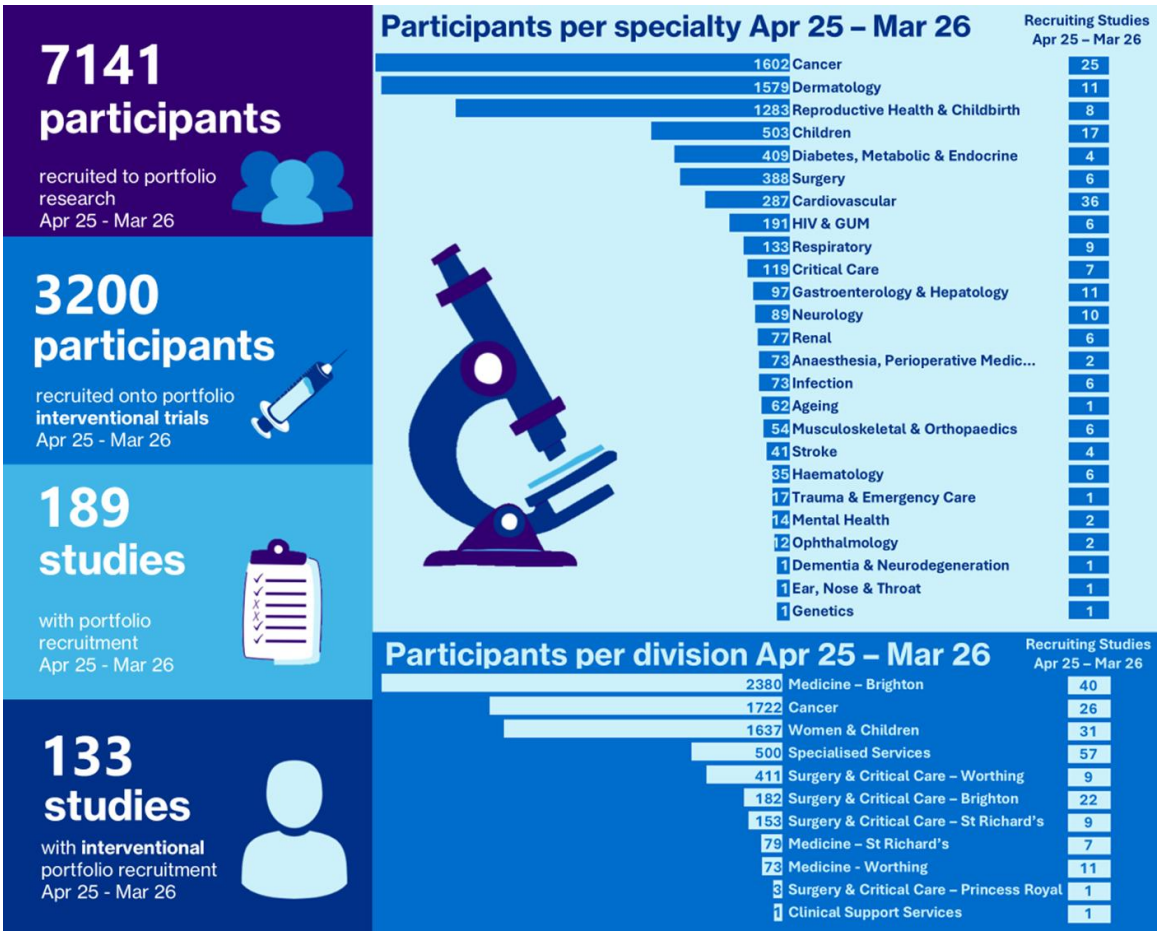
Leading Regional Research

Health research transforms care by giving patients access to the latest innovations in treatment, diagnostics and condition management, and helps staff develop new skills and expertise. Staff and patients have told us they want more opportunities to take part in innovative healthcare research. The Trust's strategy makes five commitments to enable this.

1. Giving every patient access to research

We aim to give all patients access to research. We will do this by improving access to studies and expanding our clinical research facilities. We aim to be in the top 10% of trusts for patient participation, ensuring the Sussex population has fair access to health research.

Access to research



Caption: Graphic showing statistical information about research studies open and number of participants in research studies at UHSussex between April 2025 and March 2026.

This year 7,141 patients have participated in research at UHSx, compared to 5,148 in 2024/25. This represents a substantial 38% increase in participation for 2025/26.

3,050 patients participated in interventional studies in 2025-26 as compared to 1,990 the previous year. Interventional studies are those that offer patients the potential to directly benefit from new treatments, operations, tests or procedures.

The Trust benchmarks in the top 20% of NHS acute hospitals for patients enrolled in research this year.

In 2025/26 we have had 189 recruiting studies and 280 studies that are treating or following up patients. The Trust benchmarks in the top 20 % of NHS acute hospitals for number of studies recruiting in year.

Opportunities for patients to benefit from participating in research have widened. We now have studies running across all core hospital specialities. Our most research active specialties are Cancer, Cardiology, Paediatrics, Reproductive Health & Childbirth, Infectious Diseases, Critical Care, Dermatology and Neurology.

2. Providing faster access to healthcare innovations

We aim to provide patients with faster access to healthcare innovations. We will do this by expanding our portfolio of earlier-phase trials and interventional studies. New facilities and stronger links to our clinical services will improve access to innovative treatments, while community engagement and inclusivity will make sure our research programmes reflect the needs of our population.

Expanding clinical research facilities

The Trust has secured £1.3 million in funding from the National Institute for Health and Care Research (NIHR) to expand and enhance clinical research facilities across its hospitals over the next two years. A major capital project will see the relocation and upgrade of the main Clinical Research Facility at Royal Sussex County Hospital in Brighton, providing modern, patient-focused space within the Louisa Martindale Building. This will support the delivery of more complex and early-phase clinical trials requiring close clinical monitoring.

Investment will also establish and strengthen research bases at Princess Royal Hospital, Haywards Heath, and Worthing Hospital, improving access to research opportunities for local communities. The Princess Royal site will play a key role in specialist areas such as mental health and dementia research through the NIHR Commercial Research Delivery Centre (CRDC) Sussex partnership.

Overall, the programme will broaden the Trust's clinical research portfolio, support new collaborations with industry and life sciences organisations, and increase patient participation in research across hospital and community settings.

Research engagement and inclusion

The Trust is expanding opportunities for Sussex communities to play an active role in research, aiming to increase awareness, improve engagement with underserved groups, and ensure studies reflect local needs. The Research Engagement Group, made up of staff and public representatives, has led initiatives including public events, science cafés, integration of research into patient information, and support for national campaigns. Patient Research Champions have also helped reach underrepresented communities and encourage wider participation.

A strong focus has been placed on improving inclusion in research, particularly for minoritised groups and people living in deprived areas, ensuring equitable access to the benefits of advances in care and treatment. This includes addressing barriers to participation and ensuring research better represents the diversity of the population.

Partnership working has been central to this effort, particularly with the Sussex Research Engagement Network (REN) and the NIHR Commercial Research Delivery Centre (CRDC): Sussex. Since its launch in 2023, the REN has strengthened community involvement by training Community Researchers, supporting organisations to engage in research, and gathering lived experience insights to inform service improvements. Its work has contributed to more inclusive research practices, influenced local service design, supported successful funding bids, and gained national recognition as a leading model for community-led research.

Overall, these initiatives are helping to build a more inclusive, community-driven research environment across Sussex, ensuring that innovation benefits all populations.

3. Offering colleagues more opportunities to get involved in research

The Trust is committed to offering our workforce opportunities to get involved in clinical research. We will do this by integrating research as a key part of job planning for clinical staff; expanding the number and variety of research roles for nurses, midwives, and allied health professionals; and strengthening our partnership with Brighton and Sussex Medical School (BSMS) to support career development and improve service quality by increasing joint academic appointments.

The Trust continues to strengthen research capability across its workforce, supporting staff to confidently contribute to research as part of routine clinical practice. This progress is reflected in the annual staff survey, with the proportion of colleagues reporting opportunities to engage in research increasing from 24% in 2023 to 42% in 2025.

A key priority within the refreshed Research Delivery Plan is building staff confidence to discuss research with patients and participate in study delivery. Initiatives such as the My Charity UHSussex Research Fellowships, expanded education and training via the IRIS platform, and regular drop-ins, mentoring, and career development support have enhanced accessibility and engagement.

The Trust has introduced Research Link Nurses and implemented phased job-planned research time for consultants and specialist practitioners, alongside exploring rotational secondments to broaden experience. Medical research capacity has also grown, with increased job-planned time and pump-priming support for Principal Investigators. In 2025–26, the Trust supported 238 active PIs (up from 211), alongside a significant rise in participation in the NIHR Associate PI Scheme, with 105 Associate PIs contributing to research delivery.

Overall, these initiatives are embedding a stronger research culture and building workforce capability to support high-quality, research-led care.

Growing Research Excellence

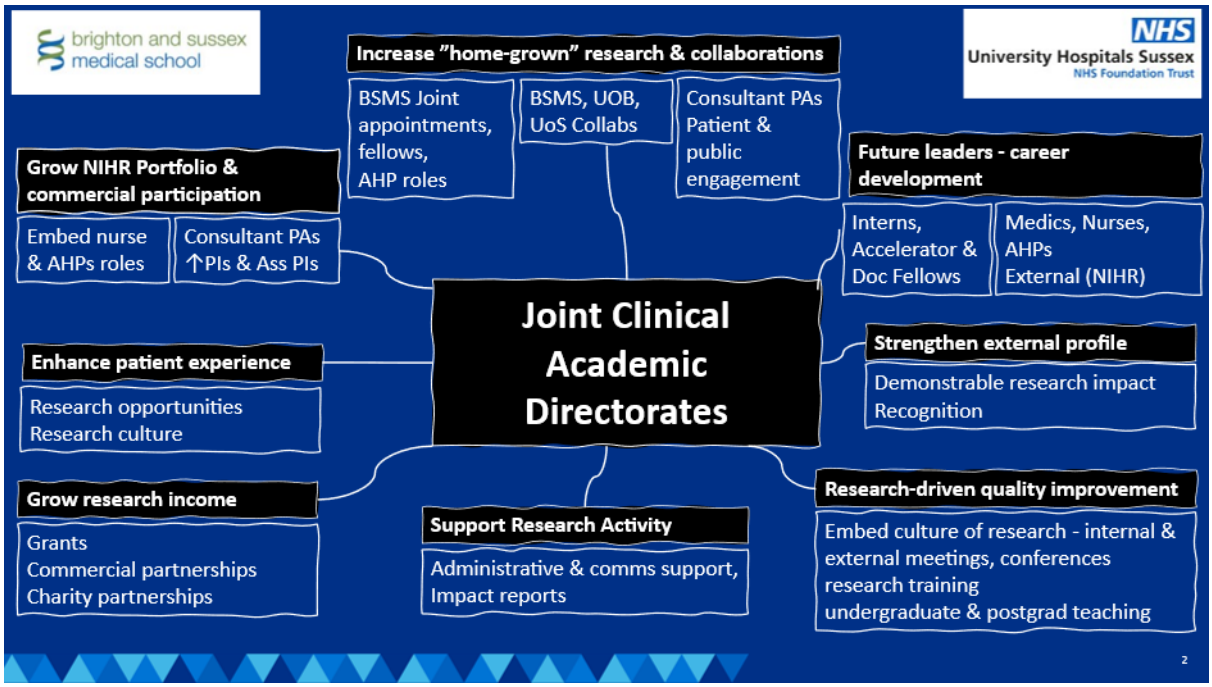
Driving research excellence at UHSussex is underpinned by strong collaboration across clinical, academic and community partners. In 2026, the Trust will launch its first Joint Clinical Academic Directorate (JCAD), focused on Critical Care and Peri Operative

Medicine, bringing together multidisciplinary expertise to accelerate research and innovation.

Over the following year, five initial JCADs will be established in Cardiology, Critical Care & Peri Operative Medicine, Cancer, Infection and Paediatrics. These will 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.

To support this programme, the Trust is investing in joint academic appointments, career development awards, consultant-level research time, and funded research roles, including rotational posts and research practitioners.

The JCADs will act as flagship centres for research within each division, uniting clinicians, researchers and patients to strengthen clinical academic partnerships. By fostering collaboration across disciplines and organisations, they will support the development of innovative treatments, improve patient recovery, and deliver better long-term outcomes for local communities.



Graphic showing Joint Clinical Academic Directorate function

Developing research leaders

UHSussex continues to invest in developing research leaders through research-led improvement fellowships funded by My Charity UHSussex. These programmes support doctors, nurses, midwives and allied health professionals to build research expertise, advance their careers, and lead studies focused on the needs of Sussex communities.

The My Charity UHSussex Research Fellowship programme offers three pathways—Internship, Accelerator and Doctoral—supporting staff at all stages of their research

journey. The Internship Fellowship remains highly popular, attracting around 34 applications per round. In response to identified barriers, particularly for internationally educated staff, the Trust introduced targeted webinars, outreach and Q&A sessions, resulting in improved application quality, broader professional representation and increased success among these groups.

Fellows have become strong research ambassadors, helping to build a positive research culture across the Trust. They are leading journal clubs, networks and events, mentoring colleagues, and supporting increased patient access to national clinical trials. Their work is delivering tangible benefits, improving patient care locally while contributing to national research through publications, conference presentations, and input into clinical guidelines and policy.

This year saw strong progress in supporting UHSussex staff to secure competitive national research funding. These achievements reflect the growing strength of the Trust's research development pathways, alongside increasing confidence and capability among staff to compete successfully for national awards.

Over the past two years, in addition to My Charity-funded fellowships, the Trust has secured more than £795,000 in external investment to support research career development, further strengthening its research capacity and future pipeline of clinical academics.

The Sussex Research Training Hub continues to play a key role in strengthening research capacity and supporting a growing community of emerging researchers across the region.

This year, the Hub launched a new programme of accessible online training events, broadening access to research skills development. It also established the Sussex Nurses Research Network, now with over 100 members and regular events showcasing expertise from across Sussex.

The third annual Sussex Clinical Academic Conference attracted 150 attendees, with a focus on pathways into research careers. Expanded careers support included additional advisory appointments and a monthly Integrated Academic Training drop-in session.

The Hub also supported a successful Brighton and Sussex Medical School bid to the NIHR Integrated Academic Training Programme, securing five Academic Clinical Fellowships and three Clinical Lecturer posts for 2025–26. In addition, it contributed to a regional bid for the NIHR Health & Care Professionals Internship Programme, securing 24 internships annually for three years.

Through strengthened partnerships across health, social care and public health, the Hub continues to widen participation and access to research opportunities, helping to build a skilled, diverse and confident workforce to drive innovation and improve care across Sussex.

4. Collaborating more closely with our research partners

We have been funded by the National Institute for Health and Care Research (NIHR) to establish a Commercial Research Delivery Centre, which will enhance the speed and efficiency of commercial clinical research in the UK. By expanding our research leadership and working with partners, we will increase opportunities for Sussex, bring new funding into the organisation, and support future research leaders.

Accelerating Commercial Research in Sussex

This year marked the launch of the NIHR Commercial Research Delivery Centre – Sussex (CRDC), hosted by UHSussex as part of a national network to accelerate commercial clinical research. Launched at the Sussex Health and Care Research Partnership Conference, the CRDC brings together partners from across the Sussex Integrated Care System, including researchers, clinicians, academics and members of the public.

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.

Early impact has been significant. The setup process for industry-sponsored trials has been streamlined, with median setup times reduced from 161 days to 47 days over the year, and all commercial studies now consistently set up within 60 days. Recruitment has also improved, with the “first patient recruited within 30 days” metric embedded into routine practice.

Commercial research activity is growing, with 47 industry-sponsored studies active by March 2026, including new partnerships with sponsors not previously working in the region. Collaboration with Sussex Partnership NHS Foundation Trust is also expanding opportunities in mental health and dementia research.

A strong focus on inclusion underpins this work. A CRDC Patient and Public Stakeholder Group has been established, alongside a public involvement and engagement plan, ensuring research is accessible and representative. This complements ongoing collaboration with the Sussex Research Engagement Network to increase diversity in clinical trial participation and ensure equitable access to innovative treatments.

5. Using research to get better value for money

We focus on exploring new technologies that can reduce costs and streamline workflows; conducting research programmes to improve service efficiency; exploring the use of AI and digital tools; and using the new Health Data Research Service (HDRS) to support evidence-based innovation.

Significant progress has been made in improving the efficiency of clinical trial delivery. Additional NIHR-funded posts have been secured to accelerate commercial trial setup and support the digitisation of participant identification in partnership with primary care. Investment in digital systems, including electronic trial master files, is streamlining workflows, improving quality, and supporting more sustainable research practices.

Sustainability is a key priority, with research aligned to the Trust's Green Plan. Training in low-carbon research design is being embedded into fellowship programmes, encouraging approaches such as reducing waste, minimising unnecessary patient visits, and increasing remote monitoring. Research delivery is also being redesigned to reduce travel by expanding community-based clinics, aligning research with routine care, and offering access across multiple sites.

The Trust is digitising core research processes, including regulatory and documentation systems, to reduce waste and improve efficiency. These efforts are helping to embed research as a driver of service improvement and sustainability across clinical services.

Attracting inward investment

In 2025/26, the Trust secured £9 million in external investment to support its research programme. This includes around £3 million from the NIHR Kent, Surrey and Sussex Research Delivery Network to deliver national portfolio studies, and £1.4 million in direct grant funding for Trust-led research. Notable awards include NIHR Research for Patient Benefit funding for a paediatric asthma trial exploring early use of high-flow oxygen therapy.

Further investment includes £3 million over seven years to establish the NIHR Sussex Commercial Research Delivery Centre, alongside additional funding to develop a regional research support hub. Commercial research activity also contributes significantly, generating 30% of research income through partnerships with life sciences companies, supporting staff costs and consultant time.

In addition, £1.3 million in capital funding from the National Institute for Health and Care Research has been secured to expand clinical research facilities across UHSussex hospitals, further strengthening research capacity and impact.

3.6 Voluntary Services

Assurance Self-Assessment 25/26	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Assurance Self-Assessment 24/25	Limited Assurance	Partial Assurance	Assurance	Significant Assurance
Self-Assessment Statement	UHSussex is making good use of its volunteers			

At the end of the financial year of 2025/26, UHSussex had 620 registered volunteers who had contributed their time throughout the year to support and deliver various functions and activities across the Trust, with 11% of the total number being inactive or unable to volunteer.

This is a decrease from the previous financial year due to the cleansing of data and updating of application processes within the department, using Assemble the internal Volunteer Management System

Each registered volunteer for the Trust fulfils a role that impacts both patient and staff experience and the experience of visitors, relatives, and carers.

Service delivery: volunteer activities support therapeutic interventions and access to services.

Operational support: carrying out tasks that enable efficiency and effectiveness in the delivery of services and the involvement and improvement of services through lived experiences.

There are a variety of roles currently being fulfilled across the seven hospitals of the Trust in Brighton, Worthing, Shoreham and Chichester, including:

- A&E and all Emergency floors
- Activities for patients
- Administration and Reception across various departments within the Trust
- Auxiliary Services
- Chaplaincy
- Clinic Support across various departments within the Trust
- Complimentary Therapists
- Counselling
- Crisis Response
- Dementia Support
- Dining Support
- Gardening
- Libraries across the Trust
- Patient Support
- Pharmacy
- Portering
- Wayfinding
- Ward Support

As part of the new 5-year strategic framework, we will be looking at introducing a micro-volunteering offer and a Trust-wide corporate volunteering offer.

Current partnerships with voluntary and charitable organisations also contribute to the on-going effort including those who volunteer for the Leagues of Friends across all sites. Macmillan Cancer Support, Sussex Cancer Fund, Cancer United, Carers Support West Sussex, Hospital radio stations across all sites, Pets as Therapy Dogs and countless other local community organisations provide volunteers whose contributions are vital to supporting the delivery of services in the region.

A new 5-year strategy and operational plan is now being implemented, putting into action the Trust's support of the NHS Long-term plan and enabling the delivery of the recommendations of the NHS Volunteering Taskforce as effectively as possible.

Excitingly, we are a part of a new project working in partnership with the charity Helpforce, NHS Sussex and the East Sussex Healthcare Trust on their "Back to Health Sussex" project. This has the aim of improving discharge and patient flow with the input of volunteering roles within the Trust and in improved relationships with our partners in the communities in which the Trust is based.

The importance of the role of volunteers within the NHS has never been more important than in the current financial climate as financial and health pressures continue to grow and increase pressures on already existing demands. A clear, effective and impactful Voluntary Services strategy will enable the Trust to move forward to deliver the Communities element of itsnew strategy, which volunteers have helped to create - ensuring that the very best care is always offered to those who receive it.

Annex 1: Assurance Report on Quality

There is no requirement for a foundation trust to commission external assurance on its quality report for 2023/24; however the Trust has undertaken its own internal review to provide assurance that the required elements are met;

Description of prescribed Information	Areas applicable to UHSussex Foundation Trust	National Average	UHSussex Performance	page number
(a) The value and banding of the hospital-level mortality indicator ('SHMI') for the trust for the reporting period; and	Inpatient Care – all sites	100.22	100.83	Page 34
(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	Inpatient Care – all sites	2.09%	2.42%	Page 35
The Trust's patient reported outcome measures (PROMs) Scores for: (i) Groin hernia surgery (ii) Varicose vein surgery (iii) Hip replacement surgery (iv) Knee replacement surgery Reported during the period	Elective orthopaedic surgery	(i) NA (ii) NA (iii) 0.447 (iv) 0.447	(i) NA (ii) NA (iii) 0.423 (iv) 0.302	Page 30

Description of prescribed Information	Areas applicable to UHSussex Foundation Trust	National Average	UHSussex Performance	page number
The percentage of patients aged (i) 0 to 15 and (ii) 16 or over Readmitted to a hospital which forms of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	Inpatient Care – all sites	10.06% 8.42%	12.14% 8.93%	Page 31
The Trust's responsiveness to the personal needs of its patients during the reporting period	Data not nationally available			
The percentage of staff employed by or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	Staff employed by, or under contract to the Trust	60.8%	57.2%	Page 51
Friends and Family Test - Patient. The data made available by National Health Service Trust or NHS Foundation Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients	Adult inpatients	95.0%	92.5%	Page 52
Patients discharged from Accident and Emergency (types 1 and 2)	ED attendees	79%	82%	

Description of prescribed Information	Areas applicable to UHSussex Foundation Trust	National Average	UHSussex Performance	page number
The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	Inpatients across all sites	South East Region Average 24.40	23.43	Page 60
The number and where available rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death	Reporting across all sites	Not published	0.27	Page 56

Annex 2: Additional Data Sets

A2.1 Participation status for 2025-26 National Audit Programme

Programme	Description	2025/26 Participation status across eligible sites
Emergency Medicine QIPs	Adolescent mental health - Emergency Medicine QIPs RCEM	Full participation
Emergency Medicine QIPs	Care of Older People (Year 3)	Full participation
Emergency Medicine QIPs	Mental Health (Self- Harm) Year 3 - Emergency Medicine QIPs RCEM	Full participation
Emergency Medicine QIPs	Time Critical Medications (RCEM) Year 2	Partial participation
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls (NAIF) (FFFAP)	Full participation
National Respiratory Audit Programme (NRAP)	Pulmonary Rehabilitation (NRAP)	Full participation
BAUS Data & Audit Programme	British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG) - BAUS	Full participation
BAUS Data & Audit Programme	Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST) - BAUS	Full participation
NHS England Outcomes Registries Programme	Breast and Cosmetic Implant Registry - Outcome Registries Platform	Full participation
Case Mix Programme (CMP)	Case Mix Programme (CMP) - ICNARC	Full participation
National Acute Kidney Injury Audit	UK Renal Registry National Acute Kidney Injury Audit	Full participation
National Audit of Cardiac Rehabilitation	National Audit of Cardiac Rehabilitation	Full participation
National Audit of Care at the End of Life (NACEL)	National Audit of Care at the End of Life (NACEL)	Full participation
National Cancer Audit Collaborating Centre (NATCAN)	Breast Cancer, Metastatic (NAoMe) (NATCAN)	Full participation
National Cancer Audit Collaborating Centre (NATCAN)	Breast Cancer, Primary (NAoPri) (NATCAN)	Full participation
National Cancer Audit Collaborating Centre (NATCAN)	Kidney Cancer (NKCA) (NATCAN)	Full participation
National Cancer Audit Collaborating Centre (NATCAN)	National Bowel Cancer Audit (NBOCA) (NATCAN)	Full participation
National Cancer Audit Collaborating Centre (NATCAN)	National Lung Cancer Audit (NLCA) (NATCAN)	Full participation
National Cancer Audit Collaborating Centre (NATCAN)	National Oesophagogastric Cancer Audit (NOGCA) (NATCAN)	Full participation
National Cancer Audit Collaborating Centre (NATCAN)	National Prostate Cancer Audit (NPCA) (NATCAN)	Full participation
National Cancer Audit Collaborating Centre (NATCAN)	Non-Hodgkin Lymphoma (NNHLA) (NATCAN)	Full participation
National Cancer Audit Collaborating Centre (NATCAN)	Ovarian Cancer (NOCA) (NATCAN)	Full participation
National Cancer Audit Collaborating Centre (NATCAN)	Pancreatic Cancer (NPaCA) (NATCAN)	Full participation

National Cardiac Arrest Audit (NCAA)	National Cardiac Arrest Audit (NCAA)	Not participating
National Cardiac Audit Programme (NCAP)	Left Atrial Appendage Occlusion (LAAO) (NCAP - NICOR)	Full participation
National Cardiac Audit Programme	Myocardial Ischaemia National Audit Project (MINAP)	Full participation
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit (NACSA) (NCAP - NICOR)	Full participation
National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management (CRM) - National Cardiac Audit Programme (NCAP)	Full participation
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (NAPCI) (NCAP - NICOR)	Full participation
National Cardiac Audit Programme (NCAP)	National Congenital Heart Disease Audit (NCHDA) (NCAP - NICOR)	Full participation
National Cardiac Audit Programme	National Heart Failure Audit (NHFA) (NCAP - NICOR)	Full participation
National Cardiac Audit Programme (NCAP)	Percutaneous Foramen Ovale Closure (PFOC) (NCAP - NICOR)	Full participation
National Cardiac Audit Programme (NCAP)	Transcatheter Mitral and Tricuspid Valve Procedure (TMTV) (NCAP - NICOR)	Full participation
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Cohort 7 National Clinical Audit of Seizures and Epilepsies for Children and Young People	Full participation
National Diabetes Audit (adults) (NDA)	National Core Diabetes Audit (NDA)	Full participation
National Diabetes Audit (adults) (NDA)	National Diabetes Foot Care Audit (NDFA) (NDA)	Full participation
National Diabetes Audit (adults) (NDA)	National Diabetes Inpatient Safety Audit (NDISA) (NDA)	Full participation
National Diabetes Audit (adults) (NDA)	National Pregnancy in Diabetes Audit (NPID) (NDA)	Full participation
National Diabetes Audit (adults) (NDA)	Transition (Adolescents and Young Adults) and Young Type 2 Audit (NDA)	Full participation
National Early Inflammatory Arthritis Audit (NEIAA)	National Early Inflammatory Arthritis Audit (NEIAA)	Full participation
Falls and Fragility Fracture Audit Programme (FFFAP)	National Hip Fracture Database (NHFD) - FFFAP	Full participation
National Joint Registry (NJR)	National Joint Registry (NJR)	Full participation
NHS England Outcomes Registries Programme	National Major Trauma Registry (NMTR)	Full participation
National Maternity and Perinatal Audit (NMPA)	National Maternity and Perinatal Audit (NMPA)	Full participation
National Neonatal Audit Programme (NNAP)	National Neonatal Audit Programme (NNAP)	Full participation
National Ophthalmology Database (NOD) Audit	Age-related Macular Degeneration Audit (AMD) - National Ophthalmology Database Audit (NOD)	Not participating
National Ophthalmology Database (NOD) Audit	National Cataract Audit - National Ophthalmology Database Audit (NOD)	Not participating
National Paediatric Diabetes Audit (NPDA)	National Paediatric Diabetes Audit (NPDA)	Full participation
National Respiratory Audit Programme (NRAP)	Adult Asthma Secondary Care (NRAP)	Partial participation
National Respiratory Audit Programme (NRAP)	Children and Young People Asthma (NRAP)	Full participation
National Respiratory Audit Programme (NRAP)	COPD Secondary Care (NRAP)	Partial participation
National Vascular Registry (NVR)	National Vascular Registry	Partial Participation

Paediatric Intensive Care Audit Network (PICANet)	Paediatric Intensive Care Audit Network (PICANet)	Full participation
Perioperative Quality Improvement Programme (PQIP)	Perioperative Quality Improvement Programme (PQIP)	Full participation
Sentinel Stroke National Audit Programme (SSNAP)	Sentinel Stroke National Audit Programme (SSNAP)	Full participation
UK Cystic Fibrosis Registry	UK Cystic Fibrosis Registry	Full participation
UK Parkinson's Audit: Transforming Care	UK Parkinson's Audit	Full participation
UK Renal Registry Chronic Kidney Disease Audit	UK Renal Registry Chronic Kidney Disease Audit	Full participation
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal mortality surveillance- (MBRRACE)	Full participation
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance (MBRRACE) UK perinatal deaths of babies born in 2023	Full participation
National Emergency Laparotomy Audit (NELA)	National Emergency Laparotomy Audit (NELA 12)	Full participation
British Spine Registry	British Spine Registry	Partial Participation
LeDeR - Learning from Lives and Deaths of People with a Learning Disability and Autistic People	LeDeR - Learning from Lives and Deaths of People with a Learning Disability and Autistic People	Full participation
National Bariatric Surgery Registry (NBSR)	National Bariatric Surgery Registry (NBSR)	Full participation
National Comparative Audit of Blood Transfusion	2025 Major Haemorrhage Audit	Full participation
Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database	Not participating
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Full participation
National Cardiac Audit Programme (NCAP)	Transcatheter Aortic Valve Implantation (TAVI) (NCAP - NICOR)	Full participation
National Audit of Dementia (NAD)	National Audit of Dementia - Service Mapping Exercise	Full participation
National Perinatal Mortality Review Tool (PMRT)	National Perinatal Mortality Review Tool (PMRT)	Full participation
National Emergency Laparotomy Audit (NELA)	No Laparotomy (NoLap) (NELA 2)	Partial participation

A2.2 Actions planned or undertaken as a result of participation in the National Audit Programme

National Hip Fracture Database	Process map pathways at sites against best practice: Expanded the footprint of the #NOF unit from 27 to 33 beds, with the target of one always ringfenced for new admissions (targeting lower outlier status / delays to being on the ward) Development of Cross site pan UHS #NOF quality clinical group to disseminate learning from adverse events in NOF care linking in with newly formed divisional Continued working with A&E and Anaesthetics to improve access to Fascia Iliaca Block (FIB) blocks
National Early Inflammatory Arthritis Audit (NEIAA)	Review of referral pathway and establishment of dedicated EIA (and systemic autoimmune disease) Clinics at Worthing Hospital, Southlands and St Richards Hospital. Review of booking processes to ensure individuals are referred into dedicated EIA clinics. Where clinically appropriate, patients are now started on DMARDS at the first visit. This is to improve the Trust's ability to meet the 6 week standard of starting DMARDS within 6 weeks of referral.
Fracture Liaison Service Database	A Sussex wide osteoporosis review is under way to support this workstream and involvement in the FLS audit. An internal review of the care pathway across all four UHsussex is currently underway to support this programme of work.
National Audit of Inpatient Falls	Clinical lead for Falls has been appointed to. This is ontop of previous actions taken to support the use of 4AT screening tool across A&E sites and increasing number of staff trained in Fascia Iliaca Block (FIB) blocks to improve pain management for #NOF.

A2.3 Participation status for 2025-26 National Confidential Enquiries Programme

National confidential enquiries	Report published	Eligible	Percentage submitted (Clinical Questionnaire)
Stabilisation of the Critically Ill Child	Expected December 2027	Yes	82%
Pleural Procedures	Expected April 2027	Yes	In progress
Rib Fractures	Expected May 2027	Yes	In progress
Data Collection carried over from 24/25			
Emergency (no elective) procedures in children and young adults	December 2025	Yes	76%
Blood Sodium	October 2025	Yes	86%
Acute Limb Ischaemia	November 2025	Yes	100%
Acute illness in people with a learning disability 24/25	Expected July 2026	Yes	57%

A2.4 Actions planned or undertaken as a result of participation in the local Audit Programme

Speciality	Project Title	Actions to improve the quality of care
Care of the Elderly	Assessment of Cancer Recognition and Referral in Inpatients (Medicine-Care of the Elderly)	Implementation of new trust processes to support the early identification of suspicious skin lesions. Actions include implementation of multidisciplinary opportunistic screening approach, targeting resident doctors with an educational intervention on a baseline knowledge assessment, using s structure skin cancer assessment sticker to support and normalise opportunistic skin assessments.
Cardiology	Improving educational opportunities for Trainee in Cardiology ward	A fully operational shadowing programme has been successfully built into the Cardiology rota for senior trainees (SHOs) rotating through Cardiology. Shadowing shifts demonstrated to be beneficial for reducing workload burden of the Cardiology registrar and supporting further learning opportunities for SHOs. Mondays and Wednesdays provide an SHO a full working day pursuing educational opportunities in addition to their existing clinical time without compromising ward commitments or safe staffing levels. This has facilitated time in the Cath labs, time shadowing the registrar, time in extra Cardiology clinics supporting the service.
Stroke	Review of stroke discharge summaries on Botolphs Ward	Review and adjustments to careflow discharge summary form, to facilitate improved quality and more consistent discharge paperwork Inclusion of historic discharge summary info (as in old template) into new Care flow discharge form. Change of discharge summary format to make more operationally friendly, and improve quality of paperwork Developed a discharge summary help sheet, made available on each computer to support Resident Doctors with completion of paperwork.
Rheumatology	treatment timeline analysis for DMARD (Disease Modifying Activity Drugs) initiation and dose escalation in EIA (Early Inflammatory Arthritis) patients at *RSCH (Royal Sussex County Hospital)*	Actions are all related to increasing EIA clinic capacity at RSCH and to have equitable capacity between RSCH and PRH.
Surgery	Audit of short-acting opioid prescriptions for inpatients	Mandated explicit opioid review/cessation plan in EPMA/TTO text Agreed default short-course quantities for discharge strong opioids Education on Opioids Aware & Surgery and Opioids 2021

A2.5 NICE Guidance Data

Compliance with NICE guidance received in last 12 months as of March 2026

1 *guidelines may be applicable to more than one division*

	Metric	Cancer	Corporate	CSS	Medicine	Specialist	Surgery	W&CH
March 2026	**% assessed as fully complaint**	40%	58%	56%	60%	71%	53%	73%
	% assessed as partially compliant	40%	16%	25%	28%	8%	18%	13%
	% assessed as not compliant	20%	26%	19%	12%	21%	29%	14%
	% baseline assessment overdue (published in last 12 months)	2	1	2	1	3	0	0
	Baseline assessment backlog (published >12 months ago)	0	0	0	0	0	0	0

A2.7 PLACE High Level Improvement Plan

Activity	Action	Start	End	Owner	Status
Mealtimes (Ward Food)	Once action plan has been devised by Senior Nursing and F&E, it will be implemented	Apr 26		Nursing	To be transferred
Dementia artwork	Charity halted the project as they wanted to review all artwork across the Trust	Jan 25	Nov 25	Charity	Awaiting outcome of review
CAM - Chairs	Different styles for patient types required.	Apr 26		Nursing/ procurement	To be confirmed
CAM - Flooring	Flooring list compiled, TBA how much Capital sits with site directors	Apr 26	Mar 27	Hospital Directors	In progress
Disability - Hearing Loops	Review Hearing Loop availability across sites	TBC		IT/Estates	To be confirmed
Disability - Lift audible and visual announcements	Ensure added as part of lift replacement programme	Apr 26		Estates	Ongoing
Disability - MUST audits	Review to understand drop in timeliness from 23/24	TBC		Nursing	To be transferred

Annex 3: Statements from Stakeholders

Annex 3.1 Statement from Sussex Integrated Care Board

NHS
Surrey and Sussex

Maggie Davies
Chief Nursing Officer
University Hospitals Sussex NHS
Foundation Trust
Sent via email

Horizon House
28 Upper High Street
Epsom
Surrey
KT17 4QJ
Website: surreysussex.icb.nhs.uk

08/06/2026

Dear Maggie,

NHS University Hospitals Sussex NHS Foundation Trust Quality Account 2025/2026

Thank you for giving NHS Surrey and Sussex ICB the opportunity to comment on the University Hospitals Sussex Quality Account for 2025/26. We appreciate the continued collaborative working and open communication with Trust colleagues, particularly through Quality Review Meetings (QRM) and wider system forums.

NHS Surrey and Sussex ICB note the Trust's ongoing work to respond to Care Quality Commission findings, with established oversight arrangements to drive improvement following the "Requires Improvement" rating and subsequent site visits.

The ICB recognises that 2025/26 has been a challenging year, particularly in relation to delivering urgent and emergency care performance, reducing waiting times and variable patient experience, which reflect wider local and national system pressures.

The ICB acknowledges the positive progress made by the Trust in 2025/2026 in driving quality improvement via various service transformation programmes and the "Excellent Care Everywhere" strategy. The Trust has achieved several successes during this year, including:

1. Investment in the Sussex Cancer Centre new build,
2. Opening of St Richards Same Day Emergency Care Unit, and Acute Medical Unit in Brighton
3. End of Life care pathway development and
4. Good Patient Led Assessments of the Care Environment (PLACE) scores.

Certain clinical performance indicators, patient outcomes and safety metrics were below expected standards. These include an increase in complaints, hip and knee surgery outcomes performance below the national average, and lower-than-target compliance with NEWS/PEWS and sepsis management. These challenges are acknowledged by the Trust, with targeted actions linked to improvement programme activity, for 2026/2027.

NHS
Surrey and Sussex

The Trust's priorities for the year ahead include improving access & flow, reducing variation, strengthening workforce engagement & culture, addressing health inequalities, and digital transformation, supported by a new Trust Operating Model, signalling a commitment to positive change, in line with system ambitions.

The ICB looks forward to continuing to work collaboratively with the Trust over the coming year.

Yours sincerely,

Allison Cannon
Chief Nursing Officer

On behalf of NHS Surrey and Sussex

Annex 3.2 Statement from Trust Lead Governor

This report makes very reassuring reading as the future of this Trust has been built on a very sound strategy through the implementation of a five year plan that has been put forward under the leadership of the CEO, Chair and Board.

The Trust's Strategy is dynamic yet achievable as it has been thought through from ground level upwards, setting out five ambitions and has the population it serves at the heart of its operational delivery plan structure.

The quality report has evaluated standards, performance and health of the service the Trust provides, and has assessed how standards are being met via risk assessment and making informed decisions. It clearly demonstrates through a high level overview of critical attention to current performance status and key recommendations and openly acknowledges the on going challenges.

The Trust's new operating model and associated leadership structure has been designed to carry through the strategy set out in the five year plan. Thus, through open and honest dialogue the quality of these plans will define the future of this Trust to enable this Trust to provide *Excellent Care Everywhere.*

Lindy Tomsett, Lead Govenor

Annex 4: Statement of Directors' responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual and supporting guidance detailed requirements for quality reports
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2025 to March 2026
    - papers relating to quality reported to the board over the period April 2025 to March 2026
    - feedback from commissioners dated 8 June 2026
    - the trust's 2025-26 complaints report for the period April 2025 to March 2026 published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the national patient survey results published between April 2025 to March 2026
    - the 2025 national staff survey
    - CQC inspection reports published between April 2025 to March 2026
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality

accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board:

Philippa Slinger	**Dr. Andy Heeps**
Chair, University Hospitals Sussex NHS Foundation Trust	Chief Executive Officer, University Hospitals Sussex NHS Foundation Trust
Date: 25 June 2026	Date: 25 June 2026

Annex 5: Glossary of Terms and Acronyms

Care Quality Commission (CQC) An independent regulator responsible for monitoring and performance measuring all health and social care services in England.

Clinical Audit The process by which clinical staff measure how well the Trust performs against agreed standards. Action plans for improvement are often based on the findings of an audit.

***Clostridium Difficile* (C.Diff)** A form of bacteria that is present naturally in the gut of around 2/3s of children and 3% of adults. On their own they are harmless, but under the presence of some antibiotics they will multiply and produce toxins (poisons) which cause illness such as diarrhoea and fever. At this point, a person is said to be infected with C. difficile.

Datix/RLDatix A web-based clinical incident reporting and risk management software for healthcare and social care organisations.

Friends and Family Test (FFT) The FFT is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Governance The systems and processes by which health bodies lead, direct and control their functions in order to achieve organisational objectives and by which they relate to their partners and wider community.

Healthrota Digital rostering platform for managing doctors roistering

Information Governance (IG) Information Governance allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

IG Toolkit The Information Governance Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information, Governance policies and standards. It also allows members of the public to view information of participating organisations.

IRIS The Trusts e-learning site

LFPSE - Learn from Patient Safety Events The Learn from Patient Safety Events service is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare.

Mortality Review A process in which the circumstances surrounding the care of a patient who died during hospitalisation are systematically examined to establish whether the clinical care the patient received was appropriate, provide assurance on the quality of care and identify learning, plans for improvement and pathway redesign where required.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) NCEPOD assists in maintaining and improving standards of healthcare for adults and children by reviewing the management of patients and by undertaking confidential surveys and research.

National Early Warning Score (NEWS) NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. NEWS2 is the updated version of this tool.

National Institute for Health and Clinical Excellence (NICE) The National Institute for Health and Clinical Excellence provides independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.

Structured Judgement Mortality Review The SJR methodology has been validated and used in practice within a large NHS region. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.