University Hospitals Sussex
NHS Foundation Trust

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Annual Report and Accounts 2025 / 26

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Annual Report 2025-26

1. Performance Report

This section of the Annual Report is to provide a summary of the purpose and activities of University Hospitals Sussex NHS Foundation Trust the Trust's priorities and objectives for 2025/26, the key risks to achieving these objectives and how we have performed in relation to these during the year.

1.1 Welcome from the Chair and Chief Executive

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.

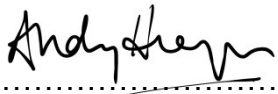
Openness also means being willing to accept external judgement and use it to direct our improvement efforts. It was in this spirit that we published in July the findings of the Developmental Well-led Review we commissioned from the independent evaluator Niche. We were not obliged to do so, but we wanted 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**.



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Dr Andy Heeps
Chief Executive
25 June 2026

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Philippa Slinger
Chair
25 June 2026

1.2 About the Trust

About the Trust

University Hospitals Sussex NHS Foundation Trust (UHSussex) is one of the largest organisations in the NHS. We employ nearly 20,000 staff, serve a population of around 1.8 million people and have an annual operating budget of around £1.7 billion.

The Trust provides all district general hospital services for Brighton and Hove, West and Mid Sussex and parts of East Sussex. We also provide specialist services for patients from across the wider South East. These include:

- neuroscience,
- arterial vascular surgery,
- neonatology, and
- specialised paediatric, cardiac, cancer, renal, infectious disease and HIV medicine services.

The Trust runs seven hospitals in Brighton and West Sussex:

- Princess Royal Hospital in Haywards Heath
- Royal Alexandra Children's Hospital in Brighton

- Royal Sussex County Hospital in Brighton
- St Richard's Hospital in Chichester
- Southlands Hospital in Shoreham-by-Sea
- Sussex Eye Hospital in Brighton
- Worthing Hospital in Worthing

Our Royal Sussex County, Worthing, St Richard's and Princess Royal hospitals all have 24-hour accident and emergency units. Maternity services are available at all four hospitals. The County is also our centre for major trauma and tertiary specialist services. We provide children's services at the Royal Alexandra, St Richard's and Worthing hospitals. Eye care is based at the Sussex Eye Hospital and at Southlands, which also specialises in day-case procedures, diagnostics and outpatient clinics.

We also provide services at GP surgeries, health clinics and other hospitals. These include:

- Bognor War Memorial Hospital,
- Brighton General Hospital,
- Crawley Hospital,
- Hove Polyclinic,
- Lewes Victoria Hospital,
- the Park Centre for Breast Care, and
- sexual health clinics across the county.

Our status as a University Hospital Trust is helping us develop as an academic centre. We offer high-quality medical teaching and contribute to cutting-edge research and innovation. To do this, we work closely with our partners at:

- the Brighton and Sussex Medical School,
- Health Education England,
- Kent, Surrey and Sussex Postgraduate Deanery, and
- the Universities of Brighton, Chichester and Sussex.

Trust Strategy

We were proud to launch our new Trust Strategy for 2025-2030 Excellent Care Everywhere in October - a major step forward in how we deliver care and unlock our full potential as one of the country's largest NHS Trusts. (For more details visit: https://heyzine.com/flip-book/18eff8d5f7.html#page/1)

The strategy sets out our bold, shared vision of Excellent Care Everywhere, developed with our patients, partners and staff. Their insights, experiences, and honest feedback directly shaped our plans and the five core ambitions at the centre:

Our five core ambitions:

- 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 standards we all want to see, helping us to think, organise, and work differently to improve.

UHSussex was created to help our hospitals achieve together what they would not be able to do alone and unlocking that potential by uniting our organisation will be vital in the years ahead.

Over the next five years we will standardise patient pathways, harmonise staff terms and conditions, and simplify our digital and governance systems. We will also invest in leadership, culture, and communication to ensure everyone feels connected and empowered to live our values to be Compassionate, Inclusive and Respectful in all they do.

Co-produced with staff and patients, these values reflect what matters to us most. Over the next five years, we will embed our values into every aspect of our work – from recruitment and development to leadership and decision-making.

This work is already underway with the development, and imminent launch of our new behavioural compass.

More than 28,000 staff, patients and local people are members of the Foundation Trust. Our members help shape our future plans and priorities. They also elect our Council of Governors. Our governors represent the views of our community and act as a “critical friend” to the Trust. This means they keep an eye on our performance and hold the organisation to account.
In 2025/26:

- We continued to hold more than 1.36 million outpatient appointments *(2024/25 1.36 million)*
- We received more than 612,000 referrals for care *(2024/25 620,000)*
- We saw more than 445,000 people in our emergency departments *(2024/25 432,000)*
- We admitted more than 135,000 patients to our wards *(2024/25 134,000)*
- We performed more than 156,000 in patient operations and day case procedures *(2024/25 152,000)*
- We delivered more than 8,676 babies *(2024/25 8,566)*
- More than 7,000 people started cancer treatment *(2024/25 6,500)*

More information about the Trust’s operational and financial performance is available in Section 1.4 of this report.

The headquarters of the Foundation Trust are:

Chief Executive’s Office
Worthing Hospital, Lyndhurst Road, Worthing, West Sussex, BN11 2DH

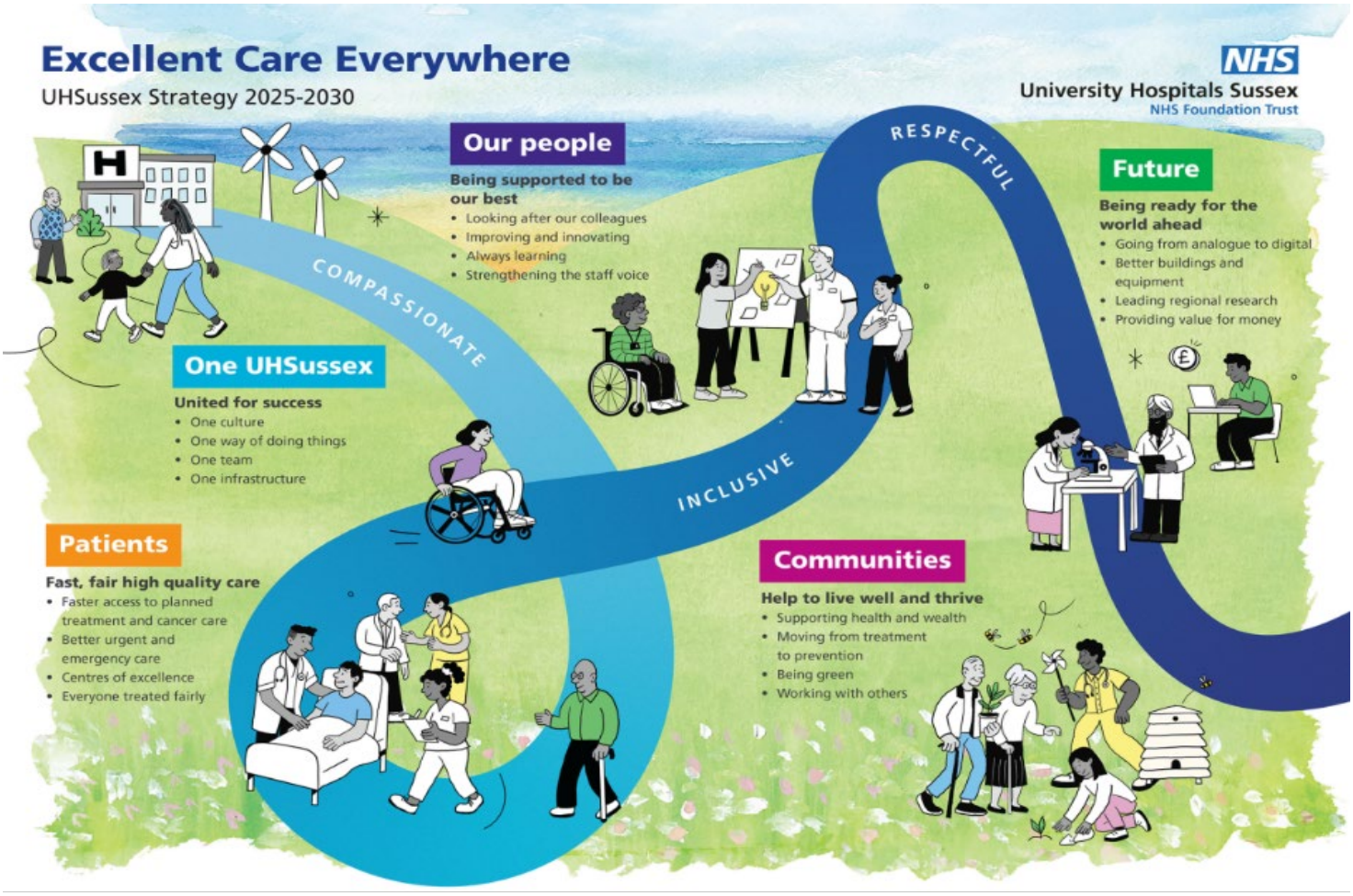
1.3 The Trust's Strategic Ambitions

1.3.1 *Excellent Care Everywhere*

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 (shown below). To deliver the ambitions and priorities set out in our strategy, we have introduced a new strategy and its 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.



Infographic - Excellent Care Everywhere

1.3.2 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:

- We are working 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 effectively 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

1.3.3 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 new employer brand **'excellent care starts with you'** has been launched and will provide the foundation for our recruitment strategy over the next five years.

1.3.4 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

1.3.5 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)

1.3.6 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)

1.3.7 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.

1.3.8 Strategic Risk Management

The Trust has an established risk management framework. The pinnacle of the framework is the Board Assurance Framework (BAF) which is used to record and track the management of the Trust's strategic risks against each of the Trust's true north objectives which carried forward to 2025/26. Each strategic risk has an executive lead and is overseen by a specific Committee of the Board. Throughout the year regular reporting of these risks has been provided through the Board Committees to the Board and at each Board meeting the Board confirmed the Board Assurance Framework fairly represented the Trust's strategic risks.

The Board utilised the Trust's risk appetite statements when determining the strategic risks respective risk's target scores. During the year the BAF records how the Trust has been managing its 11 strategic risks. Across 2025/26 the Trust had seen a number of these risks remain rated as significant meaning at the year end seven of these key risks exceeded their determined target score and seven of these risks were rated as significant.

Below is a summary of the Trust's strategic risks as monitored through the Trust's BAF

Strategic Risk	***Committee Oversight***
Risk 1 - We are unable to maintain safe effective and compliant care.	***Oversight provided by the Patient and Quality Assurance Committee***
Risk 2 - We do not develop a culture that supports the delivery of the Trust's mission of excellent care everywhere.	***Oversight provided by the People and Culture Assurance Committee***
Risk 3 - We do not attract, develop and retain enough people with the right skills, values and behaviours to deliver our ambitions.	
Risk 4 - We are unable to progress towards medium-term financial sustainability, driven by a failure to deliver the in-year financial plan and/or actions to return to a break-even run rate by M12	

Strategic Risk	*Committee Oversight*
2026/27 along with national funding realignment away from Sussex ICB.	***Oversight provided by the Finance and Performance Assurance Committee***
Risk 5 - We are unable to maintain the condition of our non digital infrastructure or support the required capital investments to deliver our strategic ambitions.	
Risk 6 - We are unable to configure our services and sites to enable us to deliver the Trust's annual performance plan leading to patients having a poor experience and increased safety risks due to extended waits for their treatment**.**	
Risk 7 - We are unable to realise the benefits of transformation via research and innovation integration programs.	***Oversight provided by the Research, Innovation and Digital Strategy Assurance Committee***
Risk 8 - Our digital immaturity in our infrastructure, skill and technology threaten our cyber security, operational and clinical performance**.**	
Risk 9 - We are unable to capitalise the use of digital as a key driver for transformational improvement at the Trust.	
Risk 10 - We are unable to successfully develop and deliver our plans which configure our sites and services in a way that aligns with system partners and the ICS strategy.	***Oversight provided by the Strategy and Major Projects Committee***
Risk 11 - We are unable to support, guide and deliver the level of change required to successfully deliver the strategy**.**	

For each of these strategic risks there was a detailed series of mitigations which will continue to be implemented throughout 2026/27 where they align to the 2026/27 revised strategic risks.

The delivery of the designed mitigations and their impact on the risks is monitored through the allocated lead oversight committee of the Board.

The work of the Patient and Quality Assurance Committee provides assurance to the Board in respect of the Trust's action to manage patient experience and quality risks, During the year the Committee received assurance over actions being taken to enhance the Trust's systems of internal control in respect of patient safety and experience. Whilst various actions were taken as planned the Committee's recommendations to the Board support the executives view that the overall risk score should not yet be reduced and therefore this remained one of the four significantly scored risks as the year end. This risk score reflects that whilst patients experience quality

services there are extended waits for patients to access Trust services and for some there are extended waits within the patient pathways. The Trust's developed Strategy brings a focus to the further actions to bring an improvement to these key risks over the next year.

The Finance and Performance Assurance Committee maintained a focus on the management of the Trust's financial sustainability risks and those relating to the Trust's non digital infrastructure as well as its performance risks. The Trust took action during the year in respect of performance improvement plans which has seen the planned improvement to RTT, Cancer and Diagnosis performance and whilst this has seen the risk reduce, this is reduction was only marginal as Urgent and Emergency Care performance has not improved at the pace the Trust planned. The Trust in developing its 2025/26 annual plan recognised that it contained a significant degree of risk and whilst the Trust has worked hard to achieve its plan, the degree of risk remained high and thus this risk did not reduce.

The Finance and Performance Assurance Committee also received assurance in respect of its developed non digital improvement plan which saw this risk reduce marginally by the year end. The oversight of the delivery of this plan remains central to the work plan of the Patient and Quality Assurance Committee to secure assurance that this work is improving the Trust's facilities and thus their ability to improve the waiting times of patients.

The People and Culture Assurance Committee has enabled the Board to track the formulation and delivery of plans to manage its key people and culture risks alongside receiving direct information from staff feedback / surveys on the efficacy of the wellbeing programmes developed to support the Trust's staff. The People & Culture Assurance Committee has also received information from the Trust Freedom to Speak up Guardian and the Guardian of Safe Working on both their activities but also on the programme of work supporting staff to be able to raise matters where improvements can be made. The Committee has also supported the Board in its oversight of the developed cultural improvement programme including engaging with the Trust's values and behavioural framework. This element of the Committee's work programme enabled it to recommend to the Board a marginal reduction in the cultural strategic risk.

The Research, Innovation and Digital Strategy Assurance Committee maintained a focus on the action taken to deliver the Trust's Research and Innovation Strategy and through the assurance received the Committee recommended to the Board a marginal reduction in that strategic risk. This Committee received various reports on the work the Trust has been undertaking to improve its digital infrastructure and whilst a lot of work is being undertaking In readiness for the Trust's EPR launch in 2027 the Trust's digital maturity assessment confirmed there remained much work yet to complete and therefore the risk remained significantly scored at the year end as well as needing more work to ensure that digital supports the Trust's transformational aspirations.

The Audit Committee has maintained a review of the Trust's Board Assurance Framework underlying processes complementing the specific oversight

provided by the respective Board Committees. In the last quarter of 2025/26 the Audit Committee commenced its planned series of complementary risk deep dives to provide wider assurance to the Board over the Trust's risk management processes especially those supporting the Trust's Board Assurance Framework.

The Trust has recognised that there is work to be undertaken to improve its overall risk management processes and supported by an external diagnosis review has developed an improvement plan, The Trust's Interim Chief Corporate Affairs Officer is overseeing this work through an improvement sprint. In support of the oversight of the Trust's risk management processes and especially the highest scored risks an Executive Risk and Governance Group has been established.

Further detail in respect of the Trust's risk management framework can be found in the Trust's annual governance statement which is at section 2.7 of this report.

1.4 Performance Analysis

1.4.1 Performance Framework

University Hospitals Sussex NHS Foundation Trust utilises a Performance Framework to ensure sustained delivery of key measures based on the principles of the Balanced Scorecard. This framework ensures scrutiny, assurance, and where necessary, remedial actions and follow through to compliance recovery. This dovetails against the National Performance Assessment Framework. The layering of this framework ensures oversight occurs through:-

- Divisional Management Board review of associated Directorates
- Regular performance review by the relevant Board Committees of Finance and Performance, People, Patient and Quality which support the review at Trust Board of the Trust's integrated performance report.
- There are additionally, UEC improvement and planned care boards, and weekly performance review
- The Trust also has fortnightly review with NHSE regarding key constitutional standards

Each layer of review and action considers both the key targets and outcomes / objectives used to assess operational performance alongside a wider set of balanced scorecard indicators that have been selected to provide a more complete view of operational risks and interdependencies. The review process is underpinned by a suite of business intelligence tools designed to show outcomes, but also the drivers of potential compliance risks such as changing demand profiles.

1.4.2 Operational performance

The operational performance of UHSussex is measured against key access targets and outcomes objectives set out in the NHS Operating Framework by the NHS England (NHSE). For operational performance these are:

- A&E maximum waiting time of 4 hours from arrival to admission/transfer/ discharge. National Target of >78% by March 2026 and 82% by March 2027
- RTT patients on an incomplete pathway, 60% patients waiting under 18 weeks by March 2026 (the Trust committed to 55% performance), and a reduction to 1% of the total waiting list size for 52 weeks (the Trust has committed to 3%). For 2027, the national ambition is to 65% <18 Weeks, whilst the Trust has committed to 60% performance
- Cancer:
  - 28 day Faster Diagnosis Standard > 80% March 2026, and maintained 2026/7
  - 94% performance for 31 day treatment standard
  - 80% performance for 62 day target.
- Maximum 6-week wait for diagnostic procedures, no greater than 5% waiting over 6 weeks by March 2026. This has changed to improvement of 3% improvement, or <20% whichever is greater. The Trust has committed to a 3% improvement in 2026/27.

A&E

tables showing A&E performance over 2025/26

A&E4hr	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
UHS<4hr %	72.1%	72.9%	72.8%	72.9%	69.9%	68.9%
National	74.8%	75.4%	75.5%	76.4%	75.9%	75.0%
A&E 12 hours in department	2,448	2,240	2,088	1,765	2,443	2,823
A&E Attendances	36,483	38,342	37,228	38,746	37,446	36,455
Time to Triage	17	17	18	18	16	17
Time to Treatment	125	130	124	126	137	137
Mean Waiting Time	302	294	288	272	306	345
Ambulance Handovers	7,022	7,316	7,169	7,540	7,556	7,256
Ambulance Handover <15 minutes	55.8%	59.0%	59.3%	64.0%	58.0%	55.8%
Ambulance Handover >45 minutes	7.0%	6.2%	5.0%	2.6%	8.8%	7.3%
Ambulance Handovers > 60 minutes	2.1%	2.0%	1.5%	0.6%	1.4%	2.6%
Emergency Admissions > 1 LOS	5621	5848	5606	6147	5655	5703
Bed Occupancy	93.5%	93.1%	92.4%	92.6%	94.2%	94.4%
Average LOS (Excl LOS 0)	9.60	9.70	10.30	9.10	9.10	10.10
>= 7 day LOS Patients	1,050	1,021	994	926	990	990
>=21 day LOS Patients	476	460	432	397	447	433
Ave. DRD per day	361	378	357	335	360	352

A&E4hr	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	24/25	25/26
UHS<4hr %	70.3%	70.4%	67.6%	67.0%	66.1%	68.9%	70.3%	70.0%
National	74.1%	74.2%	73.8%	72.5%	74.1%	77.1%	73.9%	74.9%
A&E 12 hours in department	3,007	2,641	2,793	3,560	2,890	3,052	35609	31750
A&E Attendances	38,471	37,096	36,827	37,241	33,159	38,471	432378	445965
Time to Triage	19	18	19	20	21	23	20.1	18.6
Time to Treatment	141	133	140	141	142	146	135.0	135.1
Mean Waiting Time	327	316	329	370	362	345	338.9	321.3
Ambulance Handovers	7,576	7,350	7,583	7,717	6,697	7,407	84113	88189
Ambulance Handover <15 minutes	52.5%	55.6%	53.3%	45.7%	52.6%	50.1%	50.3%	55.1%
Ambulance Handover >45 minutes	9.0%	7.4%	8.9%	11.4%	8.4%	8.8%	12.7%	7.6%
Ambulance Handovers > 60 minutes	3.5%	2.1%	2.8%	3.6%	2.8%	2.5%	5.8%	2.3%
Emergency Admissions > 1 LOS	5941	5565	6055	5847	5155	5765	67161	68908
Bed Occupancy	94.5%	94.5%	94.7%	95.8%	95.4%	95.1%	95.1%	94.2%
Average LOS (Excl LOS 0)	9.70	9.90	9.60	11.90	10.80	10.50	10.2	10.0
>= 7 day LOS Patients	959	995	951	1,050	1,068	1,063	1040	1005
>=21 day LOS Patients	459	434	401	437	478	477	476	444
Ave. DRD per day	353	354	306	375	391	403	318	360

Trust performance for the year was 70.0%, below the National target of 78%, which was 4.9% below the National average of 74.9%, and a 0.3% deterioration from the Trust's performance in the preceding year. There has been a 3.1% increase in attendances, and 4.8% increase in ambulance handovers in 2025/26.

The Trust has continued its programme of work to improve performance and has seen progress with other key emergency care indicators, such as 12 hour waits (which have improved by 11%), and 60 minute handovers (which have more than halved this year compared to last). The Trust is continuing to focus its improvement work to reduce congestion at the front end of the patient pathway, by improving alternatives to A&E, such as utilising Urgent Treatment Centres (UTC), and Same Day Emergency Care (SDEC), to reduce patients Length of Stay and expedite earlier discharges to free up beds for A&E demand to reduce delays within the department.

Additionally, the Trust has continued to engage, and co-ordinate aligned resilience plans in the wider Local Health Economy, through the Sussex ICB, and wider regional acute partners for escalation to target reducing long staying patients, to free up bed capacity and enhance patient flow. Despite this, Discharge Ready Patients (DRDs), have increased by 14% this year on average per day than 2024/25. Continued focus to expedite discharge to a more appropriate setting for patients who are medically ready to be discharged will contribute to improving flow for patients who require acute care.

Referral To Treatment (RTT)

tables showing RTT performance over 2025/26

RTT Elective Care	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
RTT 18 Week Performance	50.3%	50.9%	51.3%	51.4%	50.8%	51.6%
RTT 18 Week Performance National	*59.7%*	*60.9%*	*61.5%*	*61.3%*	*61.0%*	*61.8%*
Waiting List Size	115,225	112,989	113,130	114,891	114,712	113,266
<18 Weeks	57921	57534	58034	59024	58275	58388
>=18 weeks	57,304	55,455	55,096	55,867	56,437	54,878
>= 52 Weeks	6,925	6,826	5,860	5,884	5,629	4,977
>=65 Weeks	590	795	580	642	693	491
>=78 Weeks	97	44	20	24	27	18
Clock Starts	21,230	20,604	22,184	23,462	19,386	21,150
Clock Stops	20,413	21,484	22,881	21,885	19,312	22,285

RTT Elective Care	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	24/25	25/26
RTT 18 Week Performance	52.3%	51.8%	51.1%	50.7%	52.2%	55.1%	48.92%	55.10%
RTT 18 Week Performance National	*61.7%*	*61.8%*	*61.5%*	*61.4%*	*62.6%*			
Waiting List Size	116,149	115,993	116,319	116,190	114,061	*112,535*	114,132	112,535
<18 Weeks	60738	60111	59488	58856	59530	*62009*	55,834	62,009
>=18 weeks	55,411	55,882	56,831	57,334	54,531	*50,526*	58,298	50,526
>= 52 Weeks	5,007	4,855	4,730	4,961	4,753	*3,580*	6,923	3,580
>=65 Weeks	354	314	187	349	394	*52*	377	52
>=78 Weeks	22	7	3	0	1	1	119	1
Clock Starts	22,487	20,958	19,836	21,445	20,884	24,609	19,665	21,520
Clock Stops	24,061	21,347	19,637	21,664	21,464	23,059	22,530	21,624

The Trust's under 18-week RTT performance has improved across the year with a reported performance of 55.1% March 2026. This was 7.5% below the national average position in February 2026 (62.6%) (*latest information available at the year end*).

The Trust has maintained a focus on treating the very long waits, those waiting over 52 week and 65 weeks in 2025/26 despite significant emergency, urgent elective related pressure (in terms of demand and staff and patient restricted availability). The Trust reduced 65 weeks to 52 patients March 2026 and 52 weeks from 6923 Mar 2025 to 3580 March 2026.

Waiting List Size growth

The Trust saw a 1.4% reduction in its elective RTT waiting list size in 2025/26 to 112,535 patients waiting by March 2026. This is less of a reduction than planned due to higher demand than anticipated.

The Trust has plans to tackle this by increasing capacity by 5% in 2026/7 and plans to mitigate demand with support from system partners. Plans to increase capacity and reduce demand include:

- increased productivity for theatre and outpatient utilisation rates and reduction of DNAs (patients who do not attend) as part of the Trust's productivity and efficiency programme.
- Outpatient transformation of pathways, including increased patient initiated follow ups, and advice and guidance

Cancer 62-day Performance

tables showing cancer performance over 2025/26

Cancer	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
62 Day Performance	60.6%	68.9%	63.8%	61.2%	60.1%	62.7%	60.4%
62 Day Performance (National)	67.0%	71.4%	69.9%	67.8%	67.1%	69.2%	69.1%
31 Day performance	80.5%	74.4%	75.2%	76.0%	77.0%	78.9%	78.2%
31 Day National	91.8%	91.4%	91.3%	91.0%	91.7%	92.4%	91.6%
FDS 28 day Performance	81.58%	79.99%	76.4%	74.7%	78.0%	74.3%	72.6%
FDS National	80.20%	78.93%	76.7%	74.8%	76.8%	76.6%	74.6%
>62 Day prospective waits*	288	278	334	415	332	389	487
>104 Day prospective waits*	66	74	73	85	81	99	91

Cancer	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	24/25	25/26
62 Day Performance	59.6%	61.8%	66.8%	70.0%	63.3%	62.9%		59.5%	63.0%
62 Day Performance (National)	67.9%	68.8%	70.2%	71.9%	68.4%	68.6%		68.0%	69.0%
31 Day performance	76.4%	81.2%	79.7%	84.2%	75.6%	82.7%		80.6%	78.6%
31 Day National	91.2%	92.5%	91.7%	92.5%	89.8%	93.0%		91.0%	91.7%
FDS 28 day Performance	72.1%	75.5%	78.3%	77.8%	74.3%	80.9%		69.6%	75.9%
FDS National	73.9%	76.1%	76.5%	77.4%	72.8%	80.5%		76.3%	76.1%
>62 Day prospective waits*	543	447	390	444	423	338	338	278	338
>104 Day prospective waits*	88	97	100	113	122	102	88	74	88

Cancer 62-day performance was 63%, to February 2025 (the latest data available for this indicator) compared to 59.5% the preceding year.

Over 62 Day prospective waits increased to 338 March-26 from 278 March 2025.

The Trust achieved 80.9% February 2026 (the latest data available for this indicator) for the Faster Day 28 Day Standard.

A continued focus on improving the waiting times for diagnostics, in a safe environment, and optimised pathways will contribute to the improvement in this standard.

Diagnostic 6-week waiters

tables showing diagnostic performance over 2025/26

Diagnostics	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
6 Week Performance UHS	13.6%	14.4%	13.5%	12.1%	12.4%	15.0%	14.0%
6 Week Performance England	*18.4%*	*21.2%*	*22.0%*	*21.3%*	*21.9%*	*24.0%*	*22.5%*
6 week backlog	2,539	2,612	2,388	2,231	2,182	2,560	2,503
Waiting List size	18,702	18,093	18,507	18,451	17,560	17,072	17,842
Activity	40,740	38,443	40,150	41,347	42,377	37,412	40,967

Diagnostics	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	24/25	25/26
6 Week Performance UHS	12.2%	12.6%	15.3%	15.0%	11.4%	11.6%	13.6%	11.6%
6 Week Performance England	*21.3%*	*21.7%*	*24.8%*	*24.7%*	*20.2%*		17.5%	
6 week backlog	2,087	2,230	2,836	2,844	2,243	2,411	2539	2411
Waiting List size	17,108	17,696	18,567	18,908	19,724	20,816	18702	20816
Activity	42,775	38,491	37,591	40,383	38,154	41,015	467777	479105

Trust performance for patients waiting more than 6 weeks for a diagnostic test improved in 2025/26 from 13.6% March 2025 to 11.6% March 2026. This is 8.6% better than the National average of 20.2% in February 2026. There have been particular challenges with endoscopy and audiology modalities with targeted improvement plans to mitigate this risk.

The Trust undertook 11,328 more tests than in 2025/256 (an increase of 2.4%).

The waiting list for diagnostic tests increased by 2114 (11.3%) from March 2025 to March 2026, which means that capacity was higher than demand.

The Trust will continue to work closely with most challenged modalities in 2026/27 to improve performance to operating framework aims of achieving less than 11% waiting over 6 weeks by March 2027.

Improving Data Quality

The Trust has continued to develop its performance reporting suite to enable near real time reporting and provide greater visibility to empirically support decision making and provide greater systematic rigour supporting our drive for enhanced data accuracy. This has been supplemented by re-introduction of kite mark measures to provide further data quality assurance as part of the integrated performance report, and with statistical process control charts to target sustainable and specific cause variation where meaningful. These will continue to be developed in 2026/27

1.4.3 Quality (Safe Care)

Quality Performance is reported to the Board through the Patient and Quality Committee through a high level Quality Scorecard summarised overleaf.

UHSussex Quality Scorecard		Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
CLINICAL OUTCOME & EFFECTIVENESS								
E04	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	104.3	103.0	102.7	102.6	103.0	102.6	101.7
PATIENT SAFETY								
	Clinical incidents							
S02	NEVER events	2	1	0	2	1	0	1
S04	Incident Rate per 1000 bed days)	55.6	56.9	54.8	60.9	62.5	57.5	61.8
FSoC (Fundamental Standards of Care)								
	Falls							
S13	Falls resulting in harm	96	95	75	88	87	99	80
	Pressure Ulcers							
S15	Grade 2+ pressure ulcers	185	178	153	139	138	152	149
	Safer staffing							
S18	Safer Staffing: Average fill rate - registered nurses/ midwives (day shifts)	89.6%	90.4%	90.7%	92.7%	92.5%	91.6%	90.9%
S19	Safer Staffing: Average fill rate - registered nurses/ midwives (night shifts)	93.4%	93.1%	92.8%	93.5%	94.0%	94.1%	94.4%
IPC (infection prevention and control)								
	Healthcare acquired infections							
S24	Number of hospital attributable MRSA cases (HOHA/COHA)	0	0	0	1	0	0	0
S25	Number of hospital attributable C.diff cases (HOHA/COHA)	15	11	14	20	11	21	13
S26	Number of hospital attributable MSSA bacteraemia cases (HOHA/COHA)	12	7	4	7	8	8	6
S27	Number of hospital attributable E.coli cases (HOHA/COHA)	22	14	20	21	28	15	16
S28	Number of hospital attributable Pseudomonas cases (HOHA/COHA)	4	6	5	4	3	4	2
S29	Number of hospital attributable Klebsiella species cases (HOHA/COHA)	3	5	5	8	3	13	5
S30	Surgical Site Infection Surveillance (compliance is below National average)					16.7%		
PATIENT EXPERIENCE								
	Friends and Family Test							
X01	90% or more of patients rating FFT surveys as Very Good or Good	89.7%	91.8%	91.8%	92.3%	92.3%	91.7%	89.4%

UHSussex Quality Scorecard		Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD Actual	Target	Trend
CLINICAL OUTCOME & EFFECTIVENESS										
E04	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	100.8	101.3	100.8	*lag*	*lag*	*lag*	100.8	100	
PATIENT SAFETY										
	Clinical incidents									
S02	NEVER events	1	1	1	0	1	0	9		
S04	Incident Rate per 1000 bed days)	60.1	60.5	60.7	59.9	62.2	58.9	59.7	60.0	
FSoC (Fundamental Standards of Care)										
	Falls									
S13	Falls resulting in harm	79	88	67	64	78	88	988		
	Pressure Ulcers									
S15	Grade 2+ pressure ulcers	132	159	137	158	162	139	1796		
	Safer staffing									
S18	Safer Staffing: Average fill rate - registered nurses/ midwives (day shifts)	91.8%	93.5%	92.2%	92.6%	93.4%	93.4%	91.9%	95%	
S19	Safer Staffing: Average fill rate - registered nurses/ midwives (night shifts)	94.4%	95.0%	94.5%	95.0%	96.1%	96.4%	94.1%	95%	
IPC (infection prevention and control)										
	Healthcare acquired infections									
S24	Number of hospital attributable MRSA cases (HOHA/COHA)	0	1	1	0	1	1	5	0	
S25	Number of hospital attributable C.diff cases (HOHA/COHA)	17	14	10	10	12	13	166	152	
S26	Number of hospital attributable MSSA bacteraemia cases (HOHA/COHA)	10	9	6	5	6	14	90		
S27	Number of hospital attributable E.coli cases (HOHA/COHA)	22	18	21	21	13	25	234	208	
S28	Number of hospital attributable Pseudomonas cases (HOHA/COHA)	5	6	4	3	1	2	45	36	
S29	Number of hospital attributable Klebsiella species cases (HOHA/COHA)	11	3	4	1	10	3	71	67	
S30	Surgical Site Infection Surveillance (compliance is below National average)		56.6%			44.4%			variable	
PATIENT EXPERIENCE										
	Friends and Family Test									
X01	90% or more of patients rating FFT surveys as Very Good or Good	90.4%	90.7%	92.5%	91.9%	91.5%	91.7%	91.5%	90%	

Note that the national mortality data issued to March 2025 only covers the period to December 2024

Clinical Outcomes and Effectiveness

Mortality

Mortality in UHSussex is monitored through the use of standardised mortality rates and the calculation of a crude mortality rate for the Trust.

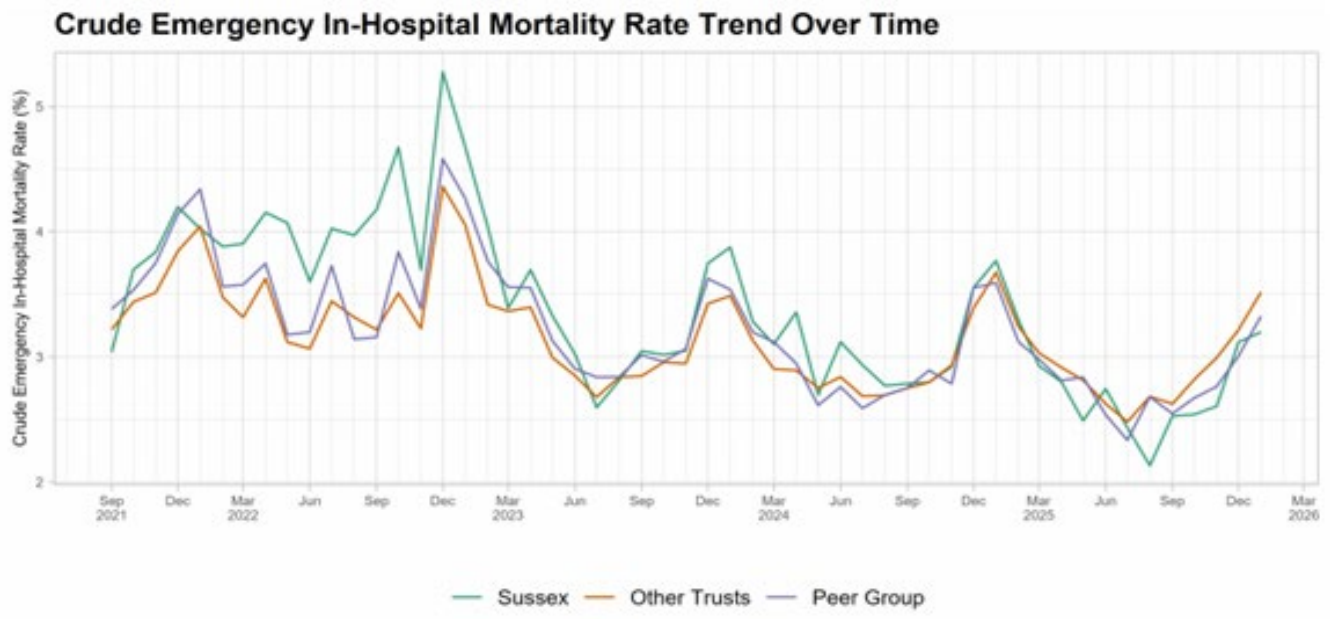
Standardised or risk-adjusted mortality rates are calculated by comparing the number of deaths expected in a particular hospital with how many patients actually died. Two risk adjusted methodologies are used in this process; the first is the Hospital Standardised Mortality Ratio (HSMR).

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 all patients that are coded to one of 56 diagnostic groups. This cohort of patients accounts for approximately 80% of all hospital deaths. The expected number of deaths is calculated from logistic regression models that adjusts for case mix and the different characteristics of the patients being treated such as the patient's age, sex, deprivation, co-morbidities, admission method, source of admission and the presence of palliative care coding.

The other standardised mortality ratio that the Trust utilises is the Summary Hospital-level Mortality Indicator (SHMI). The SHMI is calculated in a similar way to HSMR with two key differences in that it includes all hospital inpatients and deaths within 30 days of discharge. The most recent SHMI data covers the period January 2025 to December 2025.

The calculation of HSMR and SHMI is undertaken by an external company, Healthcare Evaluation Data (HED) who provide the Trust with an online benchmarking database developed by University Hospitals Birmingham NHS Foundation Trust.

Over 2025/26 the Trust's Crude mortality continued fall from 2.60 to 2.30 (when calculated as an average across all four hospitals). The Trust's peer group contains 5 other Trusts, against which UHSussex has a higher in hospital crude mortality.

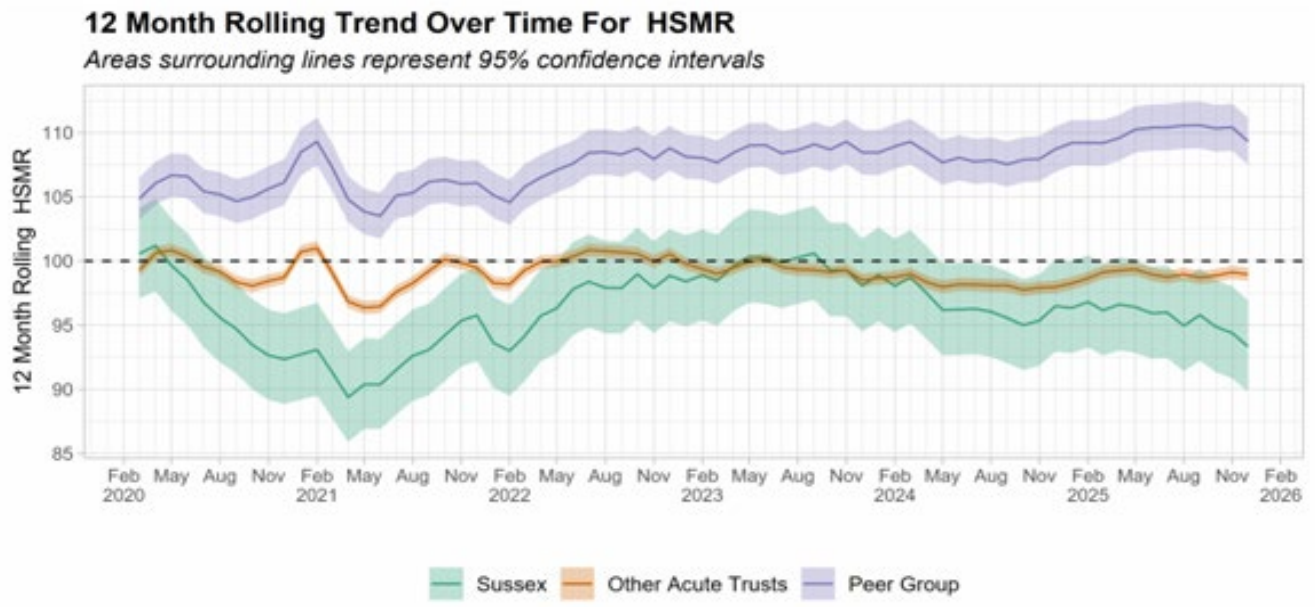


Whilst Crude Mortality Rate is a useful way to track basic trends in mortality, it does not take into account case-mix, and as such UHSussex has continued to monitor complementary mortality ratios, these being the Hospital Standardised Mortality Ratio (HSMR) and the Standardised Hospital-Level Mortality Index (SHMI).

UHSussex's HSMR is within expected range, but is considered a low value outlier using the 95% Poisson method.

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				

UHSussex's 12 month rolling trend over time for HSMR remains low (with observed deaths below expected deaths) and is lower than other acute Trusts, however it should be noted that most of those Trusts in the peer group are high outliers.

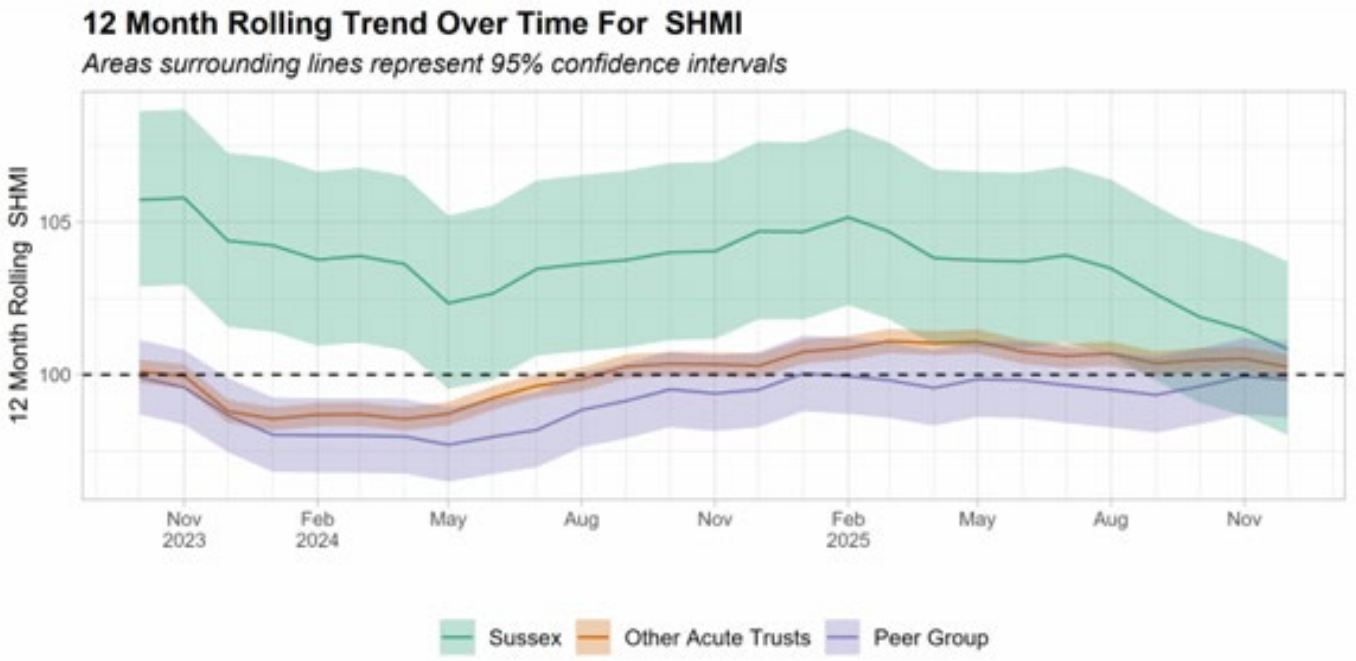


Both Weekday and Weekend HSMR are below the expected range of 100, however weekend HSMR is higher than weekday HSMR.

UHSussex's SHMI is within expected range and is not considered an outlier against either the 95% over-dispersed funnel plot limit or stricter 95% Poisson method.

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				

UHSussex's 12 month rolling trend over time for SHMI has improved. This is due to the number of observed deaths reducing over the rolling 12 month period, resulting in closer alignment of observed vs expected deaths.



However, there is statistically significant variance between 12 month rolling weekday and weekend SHMI trends, where Weekend SHMI for Sussex remains statistically significantly higher than expected and the Trust is using this analysis to determine actions it can take.

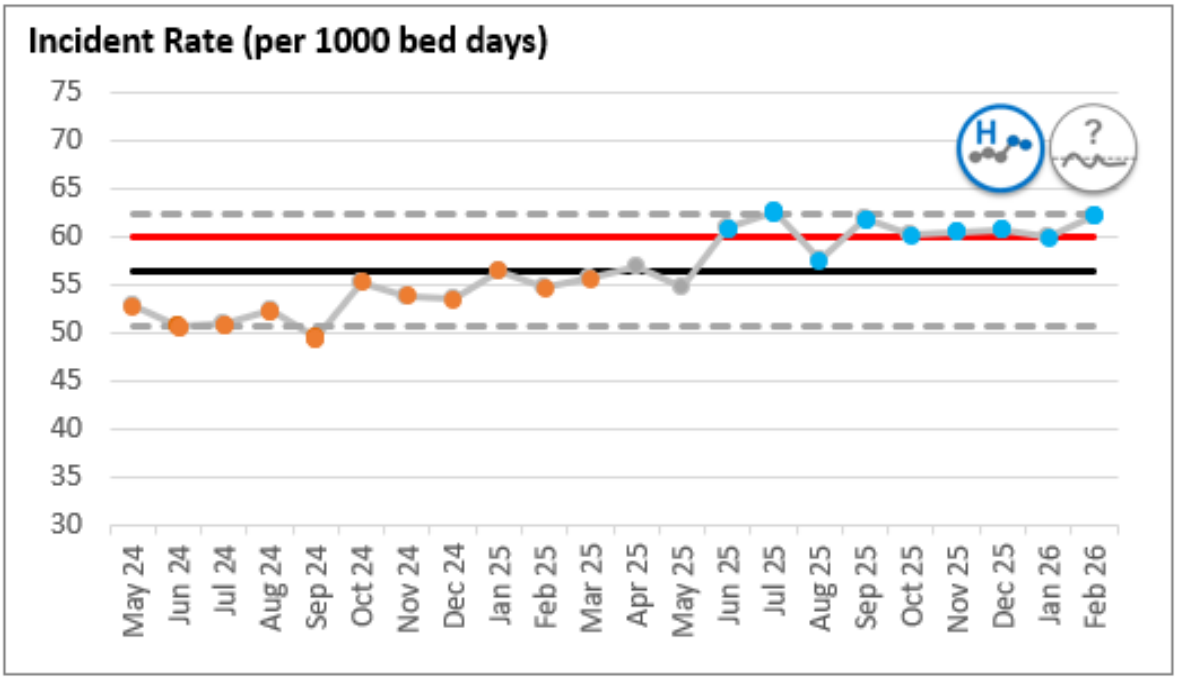
Patient Safety

Incidents including never events

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 Trust-wide 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).



The Trust 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.

Through 2025/26 UHSussex has continued to implement the NHSE Patient Safety Incident Response Framework (PSIRF). 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.

From April 2025 to March 2026 the Trust reported 191 fatal or severe patient safety incidents, equivalent to 0.27% of all harms reported.

Nine never events were reported in this period, four of which were graded as moderate, two were low harm and three were no harm.

Moderate/severe harm incidents are investigated via early learning and local learning reviews. All incidents graded near miss, moderate, severe harm or death are reviewed weekly at the Patient Safety Incident Response Group (PSIRG). This senior multidisciplinary panel meets weekly to review the incidents within the Trust that have been reported on Datix in the previous week. PSIRG's primary purpose is to agree the incident

response/investigation level, harm level and investigation governance including the duty of candour.

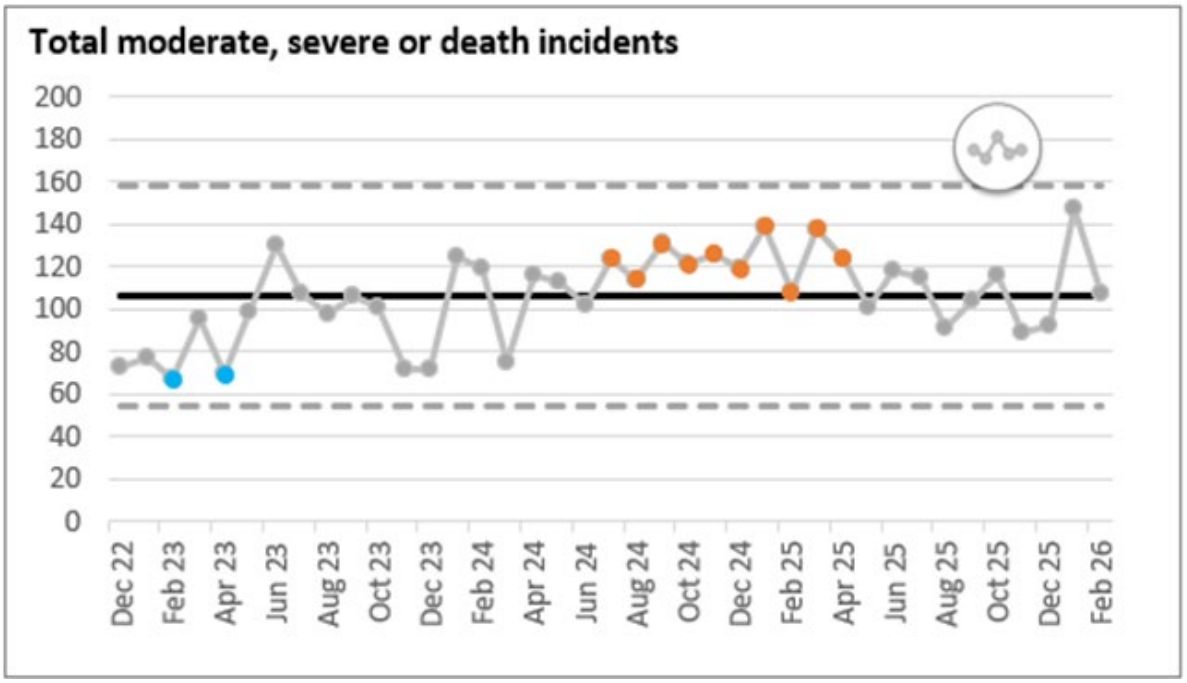


Chart showing reporting incidents over time, showing for 2025/26 this is within normal variation

Emergent themes within the moderate and severe harm/death categories remain patients lost/ delayed to follow-up/referral to treatment and harm free care, including falls and pressure damage, within acute care settings.

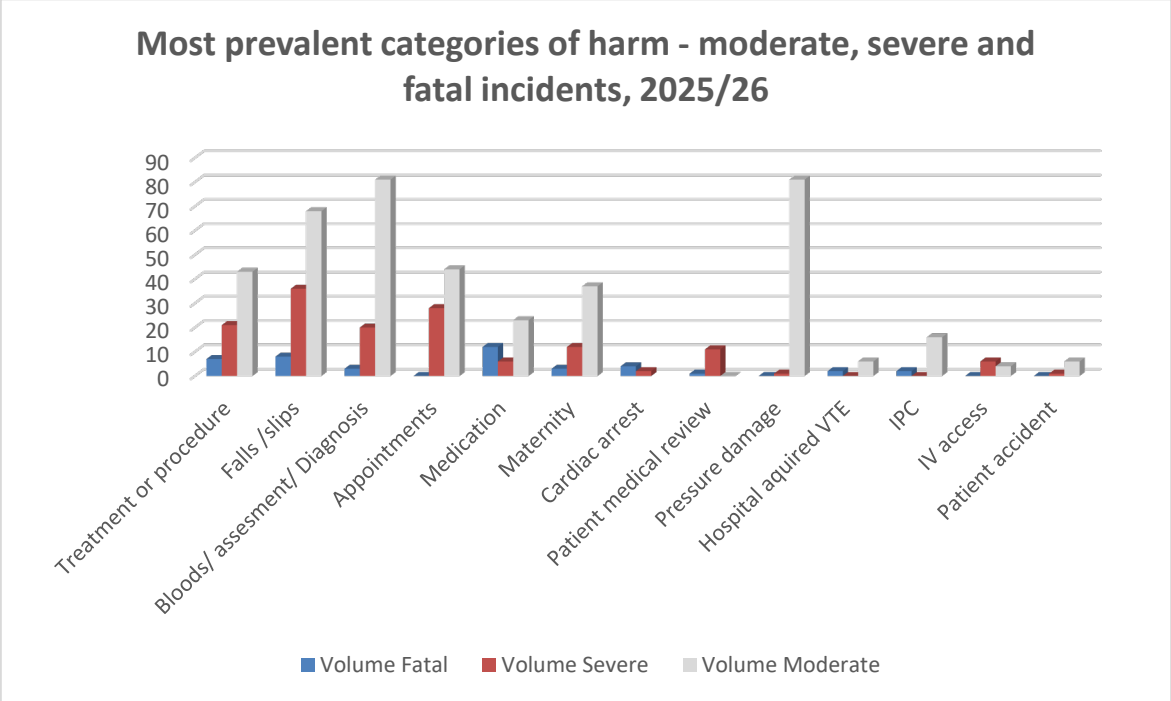


Chart showing primary reported categories of incidents

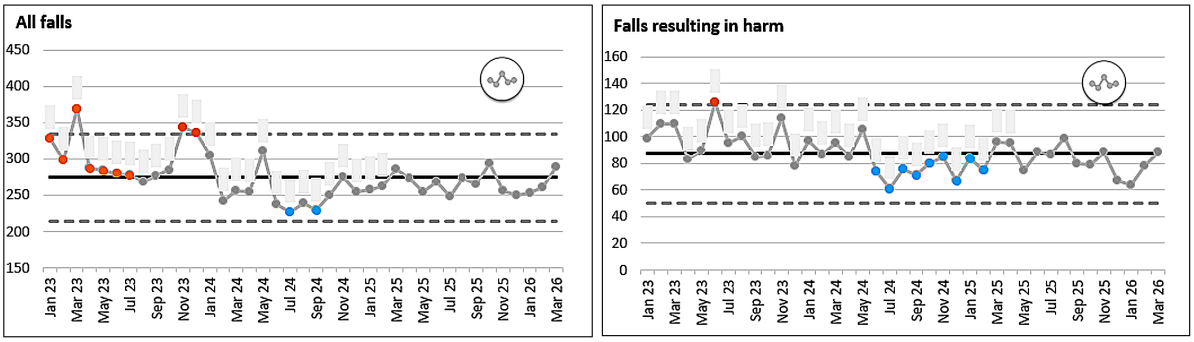
Fundamental Standards of Care

During 2025/26, the Trust has continued to strengthen the delivery of safe, effective and person-centred care, with the Fundamental Standards of Care (FSoC) embedded as the foundation for clinical practice, improvement and assurance.

This progress reflects delivery against the Trust's Strategy of "Excellent Care Everywhere", with increasing evidence of more consistent, compassionate and high-quality care across clinical areas.

Whilst there is clear evidence of improvement across several core standards, this has been achieved in the context of sustained operational pressure, increasing patient acuity and ongoing system demand. Variation remains across key indicators, and improvement is not yet consistently embedded at a level that provides full organisational assurance.

Falls and Falls Resulting in Harm



Charts showing falls over time both showing the events are within the normal range

Falls have remained broadly stable over the year, with no sustained increase (4.48 compared to 4.36 in 2024/25).

Encouragingly, falls resulting in harm have reduced, indicating that interventions to minimise injury are having a positive impact.

However, the overall number of falls has not significantly reduced, and variation persists. Falls therefore remain a key patient safety priority, with continued focus required on both prevention and harm reduction.

Pressure Damage Category Two and Above per 1000 bed days.

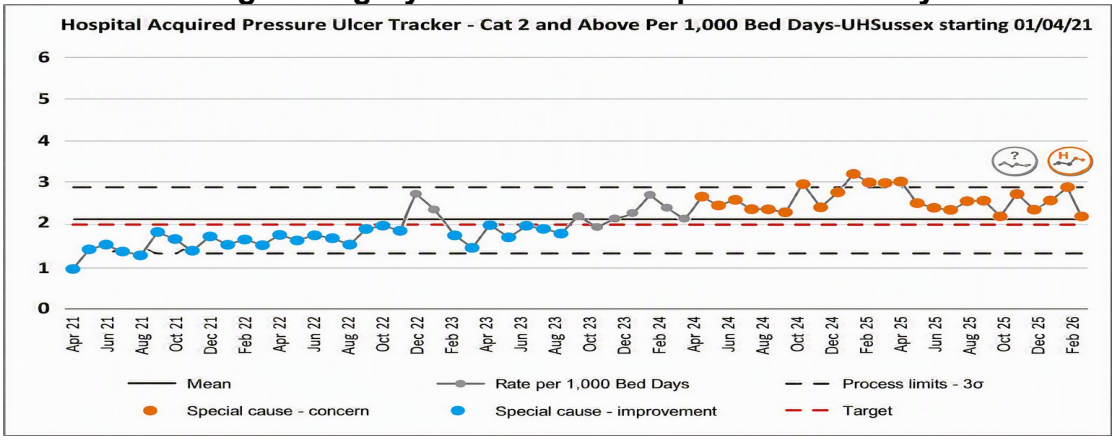


Chart showing hospital acquired pressure ulcers over time showing a statistical variance since 2024.

There has been an overall reduction in pressure ulcers compared to previous years, reflecting improvements in prevention, risk assessment and care planning.

Performance was stable for a period, indicating that interventions were becoming embedded. However, more recent data shows increased variation and a slight rise in average rates, suggesting that improvements are not yet consistently sustained.

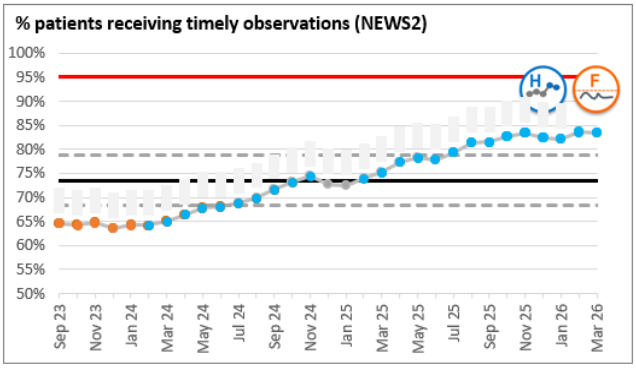
While performance remains close to target, this variation presents a risk to maintaining progress. This may be associated with increased patient complexity, workforce pressures and variability in adherence to prevention protocols.

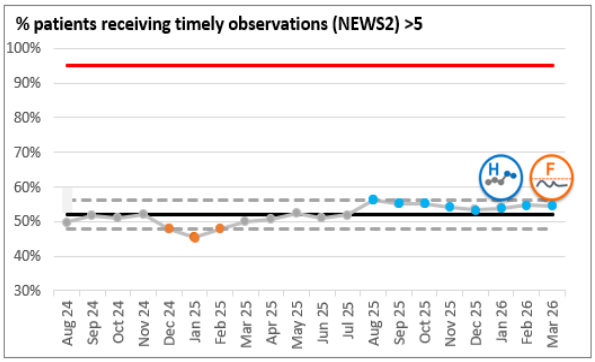
Focus remains on strengthening prevention measures, improving consistency in practice and ensuring early identification and response to risk.

Recognition and Response to the Deteriorating Patient

In support of improving the Trust's fundamental standards of care for our Patients over 2025/26 work has been undertaken to focus and improve the Trust's processes to recognise and respond to deteriorating patients.

Timeliness of Observations (NEWS2)





Charts previously overleaf showing timeliness of observations showing a statistical improvement for the year.

Performance in the timeliness of observations has improved, with a sustained upward trend demonstrating that improvement actions are having an impact. However, compliance remains below the required standard and has not been consistently achieved. Performance for patients with NEWS2 greater than 5 remains lower and more variable than the overall cohort.

This represents a significant patient safety concern, as timely recognition and escalation of deterioration is critical to safe care. The variation observed indicates that processes are not yet sufficiently reliable, particularly under operational pressure.

Further focused action is required to ensure consistent delivery, particularly for high-acuity patients.

VTE compliance

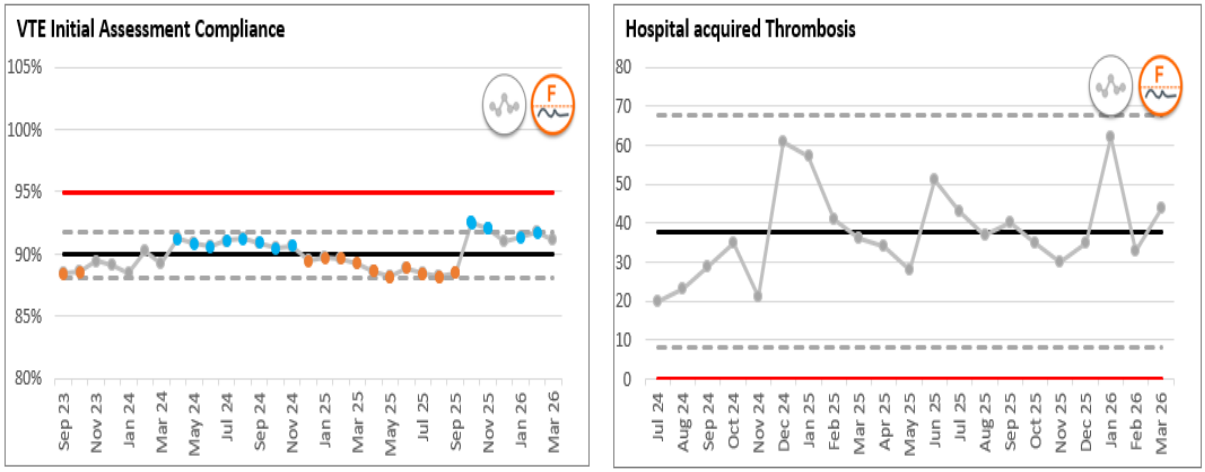


Chart showing VET over time showing over the later half of the year a statistical improvement has been made.

VTE compliance has improved from 88.4% to over 91%, indicating strengthening clinical processes. Continued focus is required to achieve and sustain expected standards.

Eliminating Mixed Sex Accommodation

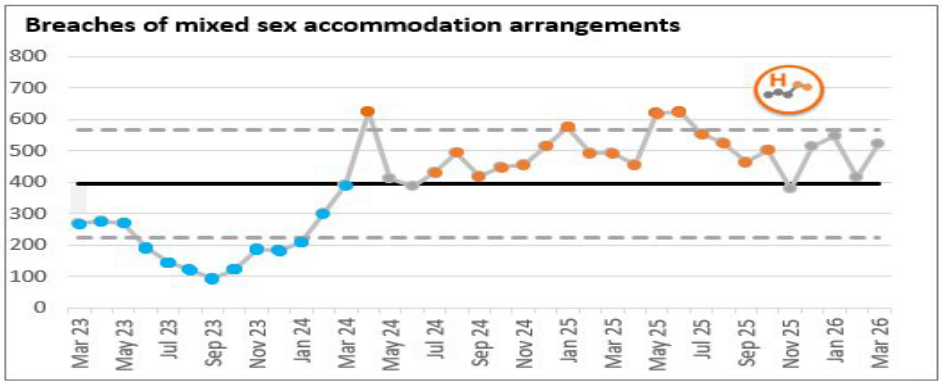


Chart showing mixed sex breaches over time showing a statistical rise since 2024.

The Trust has an up-to-date policy and a clear validation process to review and confirm breaches.

However, breach rates remain significantly higher than peer organisations at 15.6, with the majority occurring at the RSCH site.

Standards relating to nutrition, hydration, dignity and personal care are increasingly consistent, reflecting improved reliability in the delivery of fundamental care. These improvements indicate progress towards a more patient-centred and consistent model of care delivery.

Innovation and Improvement

There has been progress in the recognition and management of deteriorating patients, supported by:

- Embedding of the Daily Management System
- Increasing clinical ownership of deterioration pathways
- Early adoption of digital solutions to support observation and escalation

These developments align with the strategic ambition to use innovation and improvement methodology to enhance patient safety.

However, variation remains, particularly in escalation processes for higher NEWS scores and sepsis compliance. This continues to represent a priority area for improvement.

Leadership, Culture and Consistency

Progress has been supported by strengthening clinical leadership, shared accountability and a more consistent approach to care delivery.

This includes improved ward and divisional leadership, wider adoption of the Daily Management System and more mature governance processes enabling earlier identification and management of risk.

Whilst this provides a stronger foundation for improvement, consistent translation into measurable outcomes across all areas is not yet fully achieved.

Workforce and Capability

Improvements in quality and safety have been supported by improved workforce stability, strong fill rates and low turnover, alongside continued investment in leadership and professional development.

Strengthening ward-level capability and accountability remains central to delivering consistent, high-quality care.

Martha's Rule

The introduction of Martha's Rule and the Patient Wellness Questionnaire has strengthened the ability to identify concerns early and incorporate the patient voice into safety systems.

Themes from escalations highlight the importance of communication, clarity of care plans and responsiveness to concerns. Further work is required to demonstrate how patient feedback is consistently translated into measurable improvements in care.

Clinical Accreditation Programme

The Clinical Accreditation Programme represents the next phase of the FSoC programme and will launch in May 2026.

This will provide a consistent and transparent framework for assessing quality at ward and service level, supporting standardisation, reducing variation and recognising excellence.

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Priorities for improving standards of care 2026/27

The Trust will focus on:

- Delivering sustained reductions in falls and pressure damage
- Reducing variation in deterioration pathways, particularly NEWS and sepsis compliance
- Improving reliability of care for high-acuity patients
- Reducing Mixed Sex Accommodation breaches
- Strengthening communication and patient involvement in care
- Embedding the Clinical Accreditation Programme
- Continuing to develop clinical leadership, workforce capability and innovation

Safer Staffing

Safer staffing levels continue to be monitored using the Care Hours per Patient Day (CHPPD) metric, reported monthly through the Unify return. SaferCare, within the Allocate platform, remains the primary tool for workforce redeployment across UHSussex and supports daily staffing huddles, enabling teams to respond dynamically to changes in patient acuity and service demand.

As of February 2026, the average fill rate for registered staff is 93% during the day and 96% at night. For Healthcare Assistants (Band 2/3), the fill rate is 84% during the day and 93% at night.

During November and December 2025, nursing establishment reviews (NER) and roster reviews were undertaken across all inpatient areas to ensure workforce deployment aligned with the budgeted Whole Time Equivalent (WTE). These reviews were informed by the Safer Nursing Care Tool (SNCT), an evidence-based methodology used to determine appropriate nursing workforce requirements. The review process also triangulated workforce data, including fundamentals of care indicators, sickness absence, annual leave utilisation, vacancies and staff turnover.

The Trust has also undertaken a review of maternity staffing using the Birthrate Plus® (BRP) methodology, a nationally recognised workforce planning tool specifically designed for maternity services. BRP provides an evidence-based approach to determining safe and effective midwifery staffing establishments by analysing the complexity of care required for women and

babies across maternity pathways. The methodology considers a range of factors including birth numbers, case mix, clinical interventions and care requirements, enabling organisations to determine the appropriate number of midwives required to deliver safe, high-quality maternity care. As part of the review process, data collection was undertaken in real time within clinical areas, rather than retrospectively. This approach increases the reliability and accuracy of the data, ensuring that the assessment reflects the actual workload and acuity experienced by maternity teams during routine service delivery.

The findings from the BRP review are currently under consideration, with further analysis being undertaken to fully understand the workforce implications. The outcomes of BRP and NER are presented to the Trust Board as part of the annual safe staffing paper. This will enable the organisation to ensure that staffing establishments remain aligned with national best practice and support the delivery of safe, high-quality care.

Recruitment

Recruitment activity during 2025 has been highly successful, with 568 internal & external offers made to Band 5 nurses. A strong collaborative approach with partner universities resulted in 82% of qualifying students accepting positions within the Trust. As a result, the nursing vacancy rate has reduced significantly from 13.4% to 7.7% over the past six months. Our retention of band 5 staff continues to remain low at 3.7%.

Similar progress has been achieved in Healthcare Assistant recruitment, with 304 candidates appointed, reducing the vacancy rate from 17% to 11.6%. The re-banding of Band 2 Healthcare Assistants to Band 3 roles has also contributed positively to retention, with turnover currently at 6.9%.

The Trust also continues to support internationally educated nurses through the Objective Structured Clinical Examination (OSCE) programme. During the past year, 19 candidates completed the programme (16 internal and 3 external), all of whom secured roles within the Trust. For the coming year, four cohorts are planned with capacity for up to 15 candidates per cohort, although current cohort sizes average approximately seven. As more internationally educated nurses join the Trust as Healthcare Support Workers and become eligible for the programme after one year, cohort numbers are expected to increase.

Since October 2025, based on current templates, all midwifery posts are fully recruited to, compared to a regional and national vacancy rate of 3.2%. This is in part due to a strategy of offering all 3rd year students an automatic offer of employment (subject to checks) in 2024 and 2025. Whilst this initiative has been incredibly successful and was recognised nationally with a nomination at the Nursing Times Workforce Awards in 2025, it is not a sustainable recruitment model. Instead, this year maternity intends to offer fixed term Band 5 Preceptorship contracts to 3rd year students who have completed their training at UHSussex, with competitive interview for available Band 6 roles on completion of competencies (subject to financial approval). Registered nursing roles on postnatal wards initiated in 2022 to support

significant workforce gaps have now been disestablished with nurses redeployed to alternative roles trust wide. Agency use has completely ceased since November 2025. There still remains very high rates of parental leave at some sites (peaking at 9% at both Royal Sussex County Hospital and St Richards Hospital in 2025) remain a challenge, however fixed term cover is actively sought to fill these gaps.

Retention

The Professional Nurse Advocate (PNA) programme continues to develop across University Hospitals Sussex, with progress being made against the Trust's milestone plan. The current baseline number of PNAs has increased from 46 to 50 across the Trust, improving the staff-to-PNA ratio and supporting progress toward the national ambition of 1 PNA per 20 registered nurses. Recruitment activity has also progressed, with 21 staff recruited through the NHS England funded PNA course, with training running from December 2025 to March 2026.

Analysis of current provision highlights variation in PNA coverage across sites. The data shows the largest gaps at RSCH and Worthing Hospital, reflecting the higher number of registered nurses within these locations. Overall, there are currently 49 trained PNAs across the Trust, with additional trainees in progress which will further strengthen provision. The programme continues to focus on prioritising areas with the greatest workforce need and ensuring equitable access to restorative clinical supervision.

Governance arrangements for the PNA role are now embedded within the Trust structure, with supervision processes established and over 170 logged restorative supervision session reaching almost 2000 staff. Systems have also been introduced to record PNA activity and measure impact, including a central database and feedback mechanisms.

Over the next period, the focus will be on expanding training capacity, supporting newly trained PNAs into role, and strengthening monitoring of activity and outcomes to demonstrate impact on staff wellbeing, retention and patient safety.

The Maternity department currently has 29 sessional Professional Midwifery Advocates working across all four maternity sites, each allocated 7.5 hours per month within their substantive role. They support a caseload of 20–25 midwives, providing Restorative Clinical Supervision (RCS), career conversations, staff support, quality improvement, and education in line with the A-EQUIP model. A full-time PMA Lead has been in place across all four sites since September 2025.

As part of the Trust's agency exit programme, the use of Registered Nurse and Registered Midwife agency staff ceased across non-specialist services from 12 January 2026, with a small number of clinically critical areas temporarily exempt while substantive workforce plans are implemented. Agency usage in these areas is subject to weekly review through the Agency Control Meeting, with the aim of achieving a full exit in non-specialist areas by

the end of the financial year. As demonstrated in the chart, there has been a sustained reduction in weekly RN agency shifts since mid-2025.

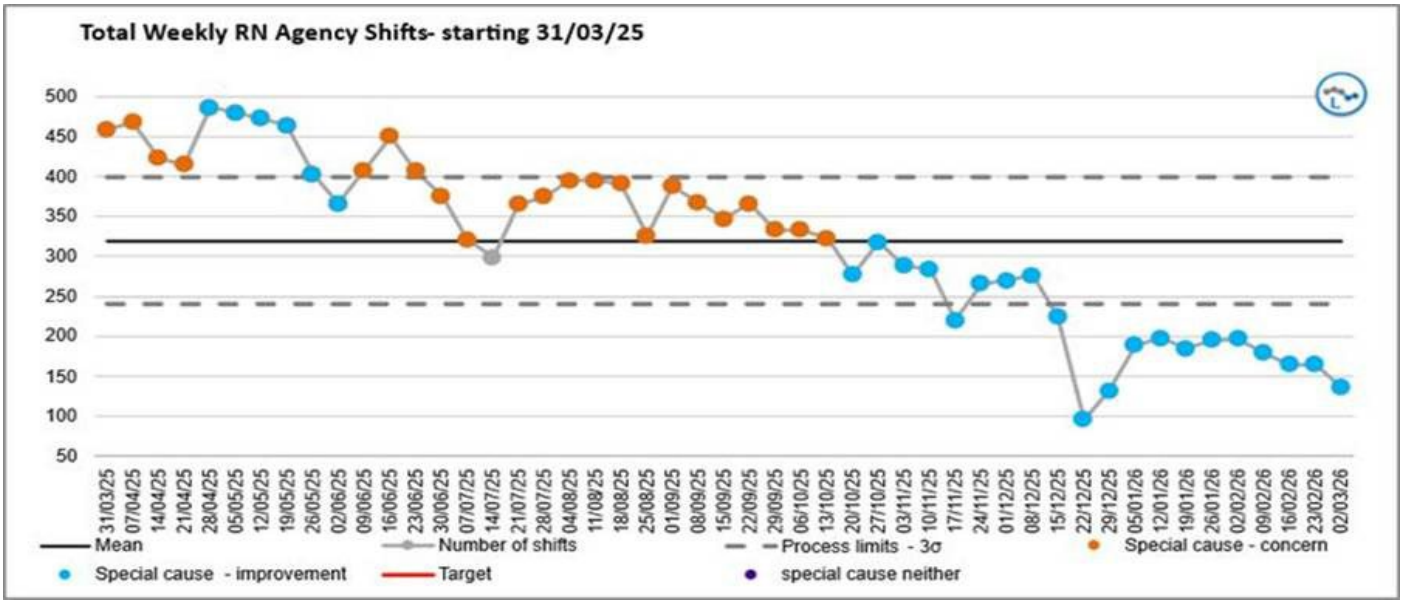


Chart showing reduction in agency over time showing a statistical sustained improvement from March 2025

Strict governance controls have been introduced to ensure agency use is only authorised where necessary for patient safety. All agency shifts require Divisional Director of Nursing (DDoN), Director of Midwifery (DoM), or an approved deputy sign-off. Where agency is required as a break-glass safety measure in areas where agency is otherwise prohibited, approval must be obtained from the Deputy Chief Nurse (DCN), DDoN, DoM, or their nominated deputy, with Director on Call approval required out of hours. Access to create agency shifts on HealthRoster has also been restricted to authorised approvers only, supported by the Temporary Staffing Office (TSO), strengthening oversight and supporting the Trust's ambition to become agency-free wherever possible.

Education and Workforce Development

The Trust continues to provide Preceptorship programmes for all Nurses, Nurse Associates, Midwives and Allied Health Professionals. The programme has been awarded the NHSE National Multi-Professional Preceptorship Quality Mark, recognising the exceptional quality of support provided to newly qualified professionals. This gold standard accreditation benchmarks NHS trusts against national best practice and reflects the organisation's commitment to supporting and retaining its workforce.

This achievement demonstrates the dedication of teams across the Trust to nurturing staff through high-quality support and professional development. In turn, this contributes to improved recruitment, retention and patient outcomes by ensuring a confident, well-supported workforce delivering safe and compassionate care.

Workforce Pathways and Future Talent

The Nursing, Midwifery and Allied Health Professional (NMAHP) Education Team continues to support workforce development, including the transition of Healthcare Assistants from Band 2 to Band 3 roles. This has involved extending clinical skills in practice and formalising development pathways, strengthening both the role profile and capability of the HCA workforce.
The team is also working collaboratively with the Chichester College Group to support the development of T Level placements. Joint planning has focused on governance, high-quality placement experiences and clear career pathways into the Trust.

T Level learners, aged 16–21, complete a curriculum equivalent to three A Levels and spend 20% of their programme in clinical placement. The knowledge, skills and behaviours gained through the Health T Level pathway align closely with the Band 3 Healthcare Assistant role, providing UHSussex with a strong future pipeline of staff while supporting local workforce development and reinforcing the Trust's role as an anchor institution.

Building on progress over the past year, the NMAHP Education Teams have continued to develop comprehensive career pathways across UHSussex. These pathways support progression from Healthcare Support Worker to Registered Nurse, Midwife or Allied Health Professional, and onwards into advanced practice roles, underpinned by continuing professional development.

Continuous Professional Development (CPD)

In relation to continuous professional development, the Trust has entered into an academic partnership with the University of Chichester, which will:

- Provide academically accredited training opportunities
- Support career development and workforce retention
- Offer staff access to university facilities, resources and research-led teaching

This partnership represents a significant step forward in strengthening staff development and supports delivery of the UHSussex Trust Strategy 2030 and the Trust Education Plan.

During 2025/26, £1.9 million was invested in CPD for Nurses, Midwives and Allied Health Professionals, with 60% of training delivered in-house. A range of clinical modules has been developed to support leadership, clinical skills and specialist knowledge. Alongside this, the Trust has launched a new clinical skills competency platform, providing standardisation and a comprehensive record of competency assessment for nursing and midwifery staff.

Infection Prevention and Control

Mandatory Surveillance data

Metrics for C.difficile, E.coli, Pseudomonas aeruginosa, Klebsiella species, MRSA and MSSA blood cultures are all reported to the national 'data capture system' (DCS) and are subject to specific targets.

All positive cases are assigned as follows:

- Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission
- Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks. Please note these cases include GP samples where the patient has had a hospital contact in the previous 28 days
- Community onset indeterminate association (COIA)
- Community onset community associated (COCA)

HOHA and COHA cases are deemed to be Trust attributable.

The Trust did not meet the required thresholds as per the table below which depicts the Trust level data for 2025/26, however there was a reduction in numbers from the previous year in *C.difficile*, MSSA, MRSA (HOHA), and *E.coli*.

Benchmark data against other organisations in the Southeast and London using the rate per 100,000 bed days (which gives a reflection against acuity) shows that while numeric numbers are exceeded, the rate of MRSA is only 40% of that in London and just over half of that in the Southeast; *E.coli. Pseudomonas* and *Klebsiella* rates are all below both London and Southeast rates, and *C.difficile* while remaining slightly above regional level is below the aggregate London rate.

Mandatory reportable infections	Annual total figures	UKHSA Annual threshold 25/26
Meticillin-resistant *Staphylococcus aureus* (MRSA) BSI	5	0
Meticillin-sensitive *Staphylococcus aureus* (MSSA) BSI	90	No threshold
Escherichia coli (E. coli) BSI	234	208
Klebsiella species BSI	71	67
Pseudomonas aeruginosa (P. aeruginosa) BSI	45	36
Clostridioides difficile (C. difficile) infection	166	152

Table showing summary of mandatory reportable healthcare-associated infections at UHSussex for the year

The Trust has developed a series of improvement actions which will delivered across 2026/27.

2025/26 has been a challenging year, particularly due to winter pressures from influenza and norovirus, despite this, the Infection Prevention and Control (IPC) team has made meaningful progress against several key objectives from its prior year improvements:

- Enhanced Data Systems:
  PowerBI is now actively used for clinical case reviews.
- the Patient Safety Incident Response Framework (PSIRF), is being used to enhance understanding of *Clostridioides difficile* (C. difficile) infections.
- Improved Data Interpretation:
  With support from the IPC epidemiologist, the team has streamlined data collection and analysis processes, allowing for more targeted allocation of resources.
- Improving mandatory surveillance metrics
  Improvement actions were put in place for IV devices and C.difficile with a reduction in numbers from the previous year in *C.difficile*, MSSA, MRSA (HOHA), and *E.coli*.
- IPC Auditing:
  Routine audits continue via the electronic Tendable platform, covering hand hygiene, commode cleanliness, and environmental checks. Where issues are identified, local improvement work is implemented with staff.
- Surgical Site Surveillance:
  Surveillance has been rolled out trust-wide, covering orthopaedics, breast, and cardiac surgery. Further work was undertaken to include cranial and spinal neurosurgery. All results are reviewed by a specialist panel and improvement actions initiated as required.
- Capital Projects and Ventilation:
  IPC input has been embedded in major building developments, including the 3Ts Stage 2 Cancer Centre, Royal Sussex County Hospital Acute Floor reconfiguration, Worthing Urgent Treatment Centre and St Richard's Same Day Emergency Care unit. Capital funding has been secured for improvements to critical ventilation across the Trust. Work is underway to install temporary operating Theatres which will enable work to be decanted and allow the refurbishment to progress.

Patient Experience

Friends and Family Test

The Trust receives approximately 11,000 friends and family test (FFT) survey responses each month. The percentage of respondents rating their care as good or very good averaged 92% throughout the 2025/6 year, which is an increase on 2024/25 which achieved 89.5%. The Trust overall response rate was 24%, slightly higher than the prior year, and represents approximately 122,000 patient responses. Outpatient, maternity and emergency care performance remained above or in line with national averages and inpatient performance slightly below this average. FFT data and patient voice is available by division, site, clinical area and specialty and enables the experience of patients to inform how services improve.

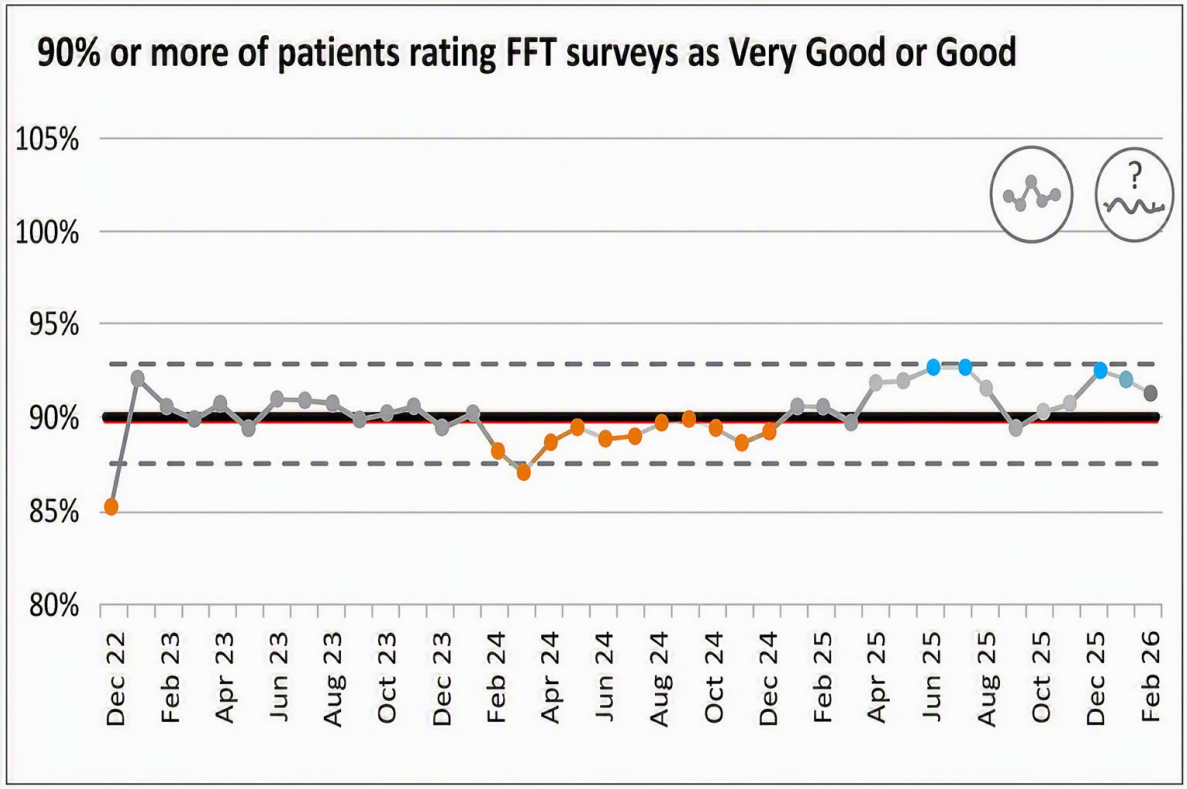


Chart showing statistical improvement for 2025/26

Consistent with the national position for the NHS, patient experience is most positive in outpatient, inpatient and maternity services and least positive in emergency departments (EDs). Compared to national average, University Hospitals Sussex patients' reported experience is more positive for maternity (94% compared to monthly averages of 93% nationally), outpatients (97% locally and 95% nationally), emergency departments (82% locally compared to monthly averages of 79% nationally), but less positive for inpatient care (92.5% locally compared to 95% nationally). This is due to the inclusion of the emergency floor within inpatient calculations which reduces the overall positive rating. Each of the Trust's eight clinical divisions had an average annual patient reported positive experience rate of 93% or higher.

Each month, the Trust receives approximately 11,000 surveys from patients rating their experience of their care, with approximately 8,000 patients leaving comments. Through the commissioned Friends and Family Test system, these comments can be analysed by theme, site, ward, speciality and clinical division to identify strengths and opportunities for improving patient experience.

The FFT feedback from patients demonstrates consistent themes relating to patient experience being negatively impacted by longer waits and staff behaviours but with more positive feedback about the staff and quality of care just one example is given below.

> "Staff were very caring and patient. They were informative and concerned to carry out the procedure but friendly and supportive. All were very professional but in a kind and relaxed way. They delivered a gold service." *Patient, May 2025.*

These themes are also reflected in feedback obtained from patients' complaints, with up to 200 new complaints raised each month, in addition to concerns raised via Patient Advice and Liaison Service and from national patient surveys. Prevalent causes of concern include: delays to appointments, follow up actions, surgery, diagnosis and cancellations; staff behaviour; and communications, all of which have been subject to improvement work in 2025/26.

The 'Welcome Standards' programme focused on improving the experience of greeting and entrance to the Trust has continued its implementation in year, with measurable improvements in patient reported experience. A new programme has been initiated to support improved communication skills for doctors. Service transformation for specialties with higher risk and waiting times has been underway, including for ophthalmology, alongside risk stratifying waiting lists and creating single pathways of care (GIRFT) to mitigate the risk of longer waits for follow ups.

The 'Welcome Standards' programme focused on improving the experience of greeting and entrance to the Trust has continued its implementation in year, with measurable improvements in patient reported experience. A new programme has been initiated to support improved communication skills for doctors. Service transformation for specialties with higher risk and waiting times has been underway, including for ophthalmology, alongside risk stratifying waiting lists and creating single pathways of care (GIRFT) to mitigate the risk of longer waits for follow ups.

The Trust also supports completion of the national patient surveys commissioned by the CQC every year for hospital admissions where feedback is taken from a representative sample of patients. This is designed to be a one-off snapshot of experience or views that can be compared with other Trusts and is based on a lengthy structured questionnaire.

The annual inpatient survey was published in 2025. 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.

The national patient survey for maternity 2025 was published this year. This presents a picture of improvement and positive patient experience, with the overall positive score position improving on the previous year. Particular improvements were noted in partners being able to stay as long as they wished, support and advice about feeding, advice about mental health and support from health professionals.

The urgent and emergency care survey also published this year. The Trust performed in the middle of the pack for accident and emergency services, but had deteriorated more than most other Trusts since the 2022 survey was

undertaken. Particular improvement opportunities are identified for UHSussex with in reducing the number of patients pending less than 12 hours in A&E, privacy during examinations (SRH and RSCH) and safety and security in the waiting room. For urgent treatment centres, overall scores and position in the pack much improved on the previous survey.

Other means of monitoring experience included feedback from complaints and PALS enquiries, patient engagement activities, PLACE audits, governor committees, comments placed on social media and the NHS Choices website, Healthwatch reports and patient feedback submitted to Healthwatch.

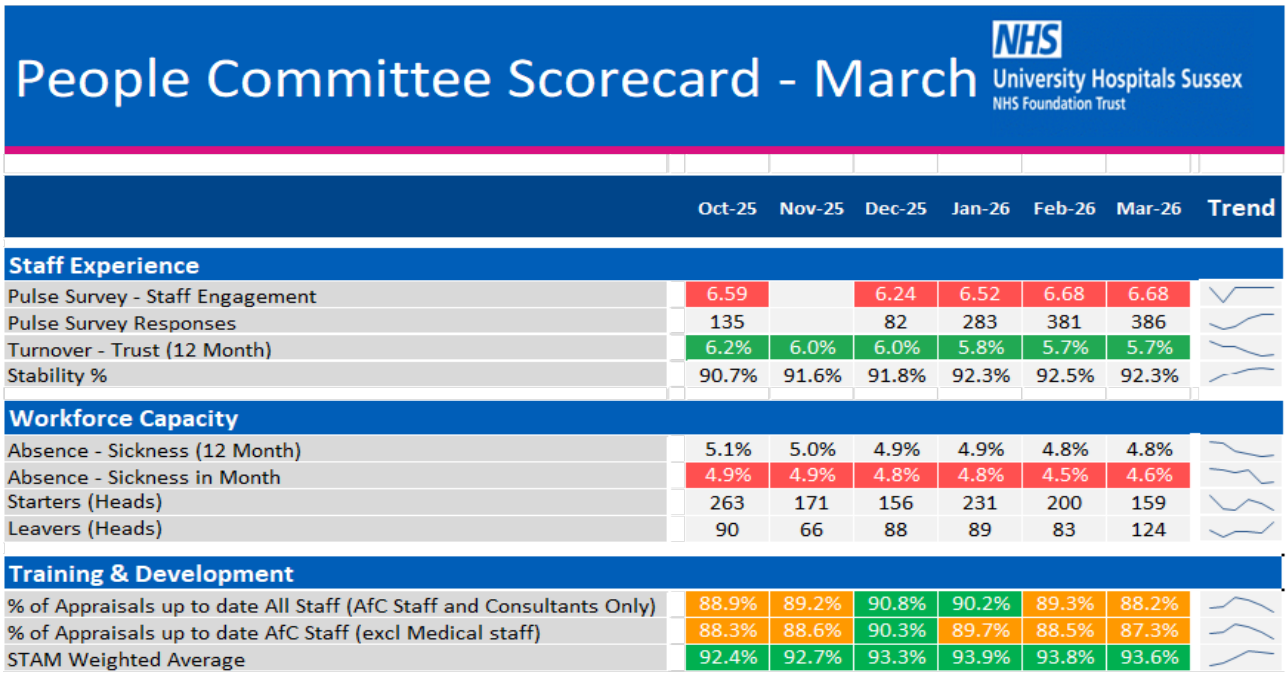
Further information on quality performance can be found in sections 1.4.11 - 1.4.13 of this report and within the Trust's Quality Account which can be found on the Trust's website.

1.4.4 Workforce

Workforce performance is reported to the Board through the People & Culture Assurance Committee supported by a high-level people scorecard. A summary of this is provided here:

People Committee Scorecard - March 2026

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Staff Experience							
Pulse Survey - Staff Engagement	6.42	6.41	6.43	6.23	6.25	6.36	6.21
Pulse Survey Responses	692	561	531	460	172	230	294
Turnover - Trust (12 Month)	6.7%	6.7%	6.6%	6.5%	6.4%	6.4%	6.3%
Stability %	89.2%	89.3%	89.5%	89.4%	89.9%	90.1%	90.6%
Workforce Capacity							
Absence - Sickness (12 Month)	5.4%	5.3%	5.3%	5.2%	5.1%	5.1%	5.1%
Absence - Sickness in Month	4.9%	4.6%	4.2%	4.5%	4.5%	4.6%	4.8%
Starters (Heads)	165	198	133	153	155	502	263
Leavers (Heads)	113	82	71	78	95	283	125
Training & Development							
% of Appraisals up to date All Staff (AfC Staff and Consultants Only)	83.3%	83.5%	82.4%	82.7%	87.2%	88.1%	87.8%
% of Appraisals up to date AfC Staff (excl Medical staff)	83.0%	82.3%	81.1%	81.4%	86.2%	87.3%	87.1%
STAM Weighted Average	91.2%	91.8%	90.8%	91.7%	93.0%	92.7%	92.7%



People Committee Scorecard - March

NHS University Hospitals Sussex NHS Foundation Trust

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Trend
Staff Experience							
Pulse Survey - Staff Engagement	6.59		6.24	6.52	6.68	6.68	
Pulse Survey Responses	135		82	283	381	386	
Turnover - Trust (12 Month)	6.2%	6.0%	6.0%	5.8%	5.7%	5.7%	
Stability %	90.7%	91.6%	91.8%	92.3%	92.5%	92.3%	
Workforce Capacity							
Absence - Sickness (12 Month)	5.1%	5.0%	4.9%	4.9%	4.8%	4.8%	
Absence - Sickness in Month	4.9%	4.9%	4.8%	4.8%	4.5%	4.6%	
Starters (Heads)	263	171	156	231	200	159	
Leavers (Heads)	90	66	88	89	83	124	
Training & Development							
% of Appraisals up to date All Staff (AfC Staff and Consultants Only)	88.9%	89.2%	90.8%	90.2%	89.3%	88.2%	
% of Appraisals up to date AfC Staff (excl Medical staff)	88.3%	88.6%	90.3%	89.7%	88.5%	87.3%	
STAM Weighted Average	92.4%	92.7%	93.3%	93.9%	93.8%	93.6%	

Summary extract from people performance scorecard

Staff Experience

Staff experience is tracked through a number of metrics, a high level these are through a pulse survey and turnover but also through the annual staff survey.

Pulse Survey

The Trust Pulse Survey remained broadly stable in the first half of the year, dipping slightly over summer (6.23-6.36 out of 10), before improving notably from October onwards, reaching a peak of 6.68 in February-March 2026. This suggests a stronger staff sentiment in the latter part of the year.

Turnover

Staff turnover has shown a positive downward trend (improvement) over 2025/26, reducing from 6.7% in March 2025 to 5.7% in March 2026. This rate remains comfortably below the Trust's target of 9.0% and represents the lowest level since the Trust was formed in 2021.

Turnover remains particularly low within certain staff groups including Nursing & Midwifery (3.6%) and Medical & Dental (6.1%) but is seeing higher levels within Administrative & Clerical (7.7%), and particularly within Scientific, Therapeutic & Technical (5.9%) and Support Staffing (6.2%).

The Trust's Nursing & Midwifery Workforce Steering Group continues to support a range of initiatives aimed at improving retention and reducing turnover among registered and unregistered nursing and midwifery staff. Central to this is the 'First 100 Golden Days: Thrive and Grow Programme', which provides a structured and supportive framework for staff in their first three months. In parallel, career progression pathways have been developed, and the professional nurse advocate scheme has been implemented.

Workforce Capacity

Workforce capacity is tracked at a high level through the metrics of sickness absence and number of starters and leavers.

Sickness absence

Sickness absence continued to be closely monitored and actively managed throughout the year, with progress demonstrated in reducing absence levels. Monthly absence data is reported both as a percentage for each individual month and as a 12-month rolling average. This dual approach helps capture short-term seasonal fluctuations while also providing a broader view of long-term trends.

At the beginning of 2025/26, the 12-month rolling sickness absence rate stood at 5.3%. By February 2026, this had reduced to 4.8%, its lowest level since 2023. This indicates a gradual downward trend over the past 12 months. The rate also is below the average rates for the Sussex ICB (5.5%) and the NHS South East Region (5.2%).

The percentage of short-term absence was 2.4% in month in February 2026, compared to 2.8% in February 2025, whilst long-term absence was at 2.1% in February 2026 compared to 2.2% at February 2025. Both metrics therefore indicate notable and sustained improvement.

The HR Employee Relations team support the management of short and long-term sickness, with proactive assistance to managers and individual support for staff to return to work. During this year over 255 supervisors and managers have received additional training in absence management.

Preventing ill health remains a priority in 2026/27, reflected in the Health & Wellbeing Plan. Work is continuing to target support in identified 'hotspot' teams – to ensure continual improvement in the sickness absence support that is offered to staff. This is complemented by a new Trust-wide in house Occupational Health service, which will start on 1 April 2026.

The Trust's sickness absence data can always be found on NHS Digital's publication series on NHS Sickness Absence Rates https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Starters & Leavers

Workforce flow (starters and leavers) shows significant variation, particularly in August where there is a sharp increase in starters (502 people) and leavers (283 people) due to the annual medical and dental staff intake. Apart from this, starters and leavers are relatively balanced, although March 2026 shows a relatively higher number of leavers (124), which may warrant attention and will be kept under review.

Training & Development

Within this element the Trust monitors this through two key metrics, appraisals and statutory and mandatory training

Appraisals

There is an established relationship between effective appraisal and patient care and outcomes, as well as staff experience. We value regular, meaningful conversations about performance, development and career goals.

In 2025/26, appraisal coverage remained high, with 88.2% of all staff up-to-date as at end of March 2026, including 100% of Medical Consultants and 87.3% of Agenda for Change staff (up from 83.0% in March 2025).

The 2025 National Staff Survey also showed encouraging signs:

- The proportion of all staff reporting that they had had an Appraisal or Development Review in the previous 12 months (87.4%) was notably higher than the NHS benchmark median (85.9%).
- The proportion of staff reporting that their appraisal helped them do their job has improved since 2024 and is better than the NHS benchmark median.
- The proportions of staff reporting that their appraisal helped them agree clear objectives for their work, and that their appraisal left them feeling their work was valued by the organisation, were slightly lower than the NHS benchmark median, but both notably improved from 2024 and the gap to the NHS benchmark scores has narrowed.

In the latest Trust Appraisee Feedback Survey, 92% of non-medical appraisees reported that their appraisal was a positive experience overall, with 91% reporting that they had covered all the topics they wanted to, 90% reporting that they felt safe to talk about personal issues, and 87% reporting that the feedback they received was useful.

A new Appraisal Policy for Non-Medical Staff was approved during 2025/26, and new Appraisal process and documentation introduced to continue to support managers and appraisees and strengthen the quality and impact of appraisals. During 2026/27, a new national NHS approach to appraisal is expected to be introduced.

Statutory and Mandatory Training (STAM)

The Trust's Statutory & Mandatory training compliance rate continues to perform strongly, with a year-end rate of 93.6%. Rates have remained over 90% since April 2024.

This has been achieved while introducing new mandatory programmes, including Prevent and Cyber Awareness. The Oliver McGowan Mandatory Training Part Two on Autism and Learning Disabilities is now live, and the Trust has commenced delivery in line with national requirements.

Engagement & Morale

Staff Engagement is a key measure of overall staff satisfaction and is strongly associated with a range of positive individual, organisational and patient outcomes.

The annual NHS Staff Survey measures three aspects of engagement: Motivation, Involvement and Advocacy. The results of the 2025 Staff Survey (conducted in Autumn 2025) showed an improvement in the overall Staff Engagement score (to 6.68/10.00). This is slightly below the NHS benchmark average, but the gap has been narrowing steadily since 2022, indicating a faster rate of improvement than for the NHS benchmark group. Within the Staff Engagement score, Motivation increased considerably in 2025 and is now level with the NHS benchmark average.

Morale is also measured through the NHS Staff Survey. The Trust's score has increased steadily year-on-year since 2022 and is now higher (better than) the NHS average. The Morale score measures three aspects: Thinking about leaving, Work pressure and Stressors. Scores have improved consistently since 2021, with Stressors and Thinking about leaving now better than the NHS average, and the score for Work pressure improving steadily since 2024.

For more information on the NHS Staff Survey see section 2.3.6.

1.4.5 Financial Performance

The Trust's Financial Performance is measured through the metric of delivering the Trust's Financial Plan. The delivery of the Trust's financial plan is measured through:

- I&E Performance: achieving the agreed Income & Expenditure surplus;
- Capital: delivering the agreed capital programme; and
- Efficiency: achieving a performance higher than forecast.

The key highlights for the Trust's financial performance for the financial period ended 31 March 2026 were:

- Against a challenging operating environment, the Trust reported a surplus of £4.9m, consistent with the agreed financial position with the Sussex Integrated Care Board.
- The Trust delivered £96.8m of efficiencies, against a planned target of £109.0m through streamlining processes and improving productivity, smarter procurement, and reducing waste.
- The 2025/26 capital expenditure of £146.4m, was delivered through £137.2m on intangible assets, property, plant and equipment and received £9.2m from cash donations and capital grants. The Trust acquired £1.2m of Right of Use assets during the year in the form of new lease agreements. The capital programme was supported by the Trust's dedicated hospital charity, My University Hospitals Sussex Charitable fund, as well as our partner charities, including the League of Friends.

As at the end of March 2026, the Trust is reporting a surplus of £4.9m after adjustment for impairments and donated assets as summarised in the table below:

Adjusted financial performance (control total basis):	*2025/26 £'000*
Deficit for the period	(220,010)
Remove impact of consolidating NHS charitable fund	3,131
Remove net impairments not scoring to the Departmental expenditure limit	232,241
Remove I&E impact of capital grants and donations	(7,472)
Remove PFI revenue costs on an IFRS 16 basis	4,605
Add back PFI revenue costs on a UK GAAP basis	(7,577)
Adjusted financial performance surplus for the purpose of system achievement	4,918

Long-term liabilities

The affordability of long-term loans is considered by the Trust Board prior to approval. The largest balance is attributed to lease liabilities arose from the implementation of IFRS 16 from 1 April 2022 recognising Right of Use assets. This was subsequently followed by accounting changes to Public Finance Initiatives in 2023-24. Further information on the Trust's long-term borrowings is available within Note 31.1 to the accounts.

Financial outlook

The Trust submitted a breakeven plan for 2026/27 to NHS England in March 2026. Included in this plan is an efficiency requirement of £128.61m. The plan will need to be updated for pay awards, pending confirmation of the final settlement. Additional activity is included in the plan to improve the Trust's Referral to Treatment (RTT) performance. The plan assumes that the additional activity for these pathways will be funded at national tariff.

Going concern

The annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

The future cashflow projection of My University Hospitals Charity provides the corporate trustee with a reasonable expectation that the charitable activity will continue for the foreseeable future. The Charity has investments it can readily

drawdown if required. For this reason, the corporate trustee has adopted the going concern basis in preparing the accounts.

Pharm@Sea Limited remained operational throughout the year. The financial year 2025/26 has seen the volume of patients and prescriptions increase week on week as well as the expansion of the drugs dispensing service within Sussex. This remains closely monitored and supply chains planned accordingly. The company has been profitable throughout the year. The Board of directors have a reasonable expectation that the services provided by the company will continue to be provided for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts.

Other financial information

Accounting policies for pensions and other retirement benefits are set out in Note 1.6 Employee Benefits.

Details of senior employees' remuneration can be found within the Remuneration Report, at section 2.4.

There have been **no** Post balance sheet events.

The Trust **NIL** on external consultancy services in 2025/26.

Note 40 to the accounts sets out, in relation to the financial instruments, an indication of the financial risk management objectives and policies of the Trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash flow risk, where material for the assessment of the assets, liabilities, financial position and results of the Trust.

1.4.6 Efficiency programme delivery

Quality-led improvement is a key priority for University Hospitals Sussex, supporting the NHS 10-year Plan to develop workforce, technology and digitally enabled efficiencies. Improvements to patient experience, including safety and effectiveness, mean we can deliver consistent high-quality care in more cost-effective ways, improving the flow of patients through our hospitals.

The Trust efficiency requirement in 2025/26 was significantly larger than in previous years, with a plan to deliver £109m in savings and productivity improvements.

Overall, the Trust delivered £96.8m against this plan. This included £50.2m delivery against the Trust's core divisional efficiency plan, £18.5m productivity improvements with the balance from other schemes such as asset disposals.

The year end position includes £29.8m of non-recurrent delivery, encompassing £14m of benefit relating to the WOS. This is £6.2m above the planned value and reflects the largely non-recurrent nature of the divisional mitigations and the H2 stretch delivery.

The largest delivery challenges related to full achievement of the additional schemes in the Trust's recovery plan, and under-delivery against corporate savings targets. This included plans such as establishment growth removal, and tightening cost controls across a range of areas including staffing rotas and rate card optimisation, and reductions in medical pay rates for additional work.

Key successes across the Trust's divisions in 2025/26 include delivery of:

- Productivity improvements (greater delivery of work within normal time within theatres and outpatient) and improved coding and capture of activity across all clinical divisions
- Nursing pay savings of £7.3m through reduced use of agency and improvements to shift planning, and reduced reliance on RMN capacity
- Additional pay savings of £17.7m across other clinical and non-clinical professions
- Procurement-led savings of £6.5m.

During 2026/27, the Trust plans to deliver an Efficiency Programme of £140m. This year's plan will focus largely on cost reduction, which in turn will drive improvements to service productivity and performance. This will include renewed focus on corporate cost reductions to maximise the funds available to clinical services and control of workforce numbers.

There will be particular focus on bringing services together in the new operating model, which enables pathway optimisation, an Urgent and Emergency Care improvement plan to close beds and end corridor care, and improvements to Outpatients productivity with more patients being seen.

This will be supported by a Trust-wide estates improvement plan, to maximise service availability and enable delivery of improved theatres including having temporary theatres to enable overhaul of the ventilation systems.

The Trust will continue to develop opportunities arising from an increased scale of working at University Hospitals Sussex level, working practices, purchasing decisions and contract management across sites and specialties.

All improvement schemes are subject to rigorous quality and safety checks to ensure quality standards are maintained or improved. Equality and Quality impact assessments for each scheme are developed by staff working in the relevant areas and signed off by the Division's Managing Director before implementation (a small number of schemes with higher risk scores will be further escalated to the Chief Medical Officer and Chief Nurse for review).

1.4.7 Our Capital Plan

The planning and prioritisation that goes into agreeing the Trust's annual capital investment programme follows an extensive engagement process with clinical divisions and corporate Directorates. Development of the plan is overseen by the Executive led Capital Investment Group (CIG). CIG makes a recommendation to Trust and Finance and Performance Boards for approval at the start of each financial year.

This year the capital plan represented a significant programme of investments in a wide range of areas including in our clinical priorities, major medical equipment, other medical devices, backlog maintenance in our hospital estate and implementation of our digital strategy as well as other IM&T infrastructure and systems upgrades. Working with our system partners at the ICB, NHS England, and other funding providers, we have ensured that major projects are earmarked and have taken place at all our hospital sites, with every clinical division and staff from across the Trust benefiting from the investments made.

Sussex Cancer Centre

Stage 2 of the 3Ts Redevelopment will be built on the site of the demolished Barry Building and replace the current cancer centre building with a new state of the art Sussex Cancer Centre, centralising all non-surgical haematology and oncology services on the Royal Sussex County Hospital site. The Sussex Cancer Centre is a once in a lifetime opportunity to transform cancer care. The transformation is wide-ranging, and will deliver benefits through three key themes:

- Transforming treatment – enabling best-practice care
- Transforming experience – providing a healing place
- Transforming research – improving outcomes

During 2024/25, the clearance of the site was completed whilst the design development was underway. The planning amendment application was submitted to Brighton & Hove City Council in November 2024, and a full market-testing exercise was completed in December 2024.

The New Hospital Programme has closely collaborated with the Trust's project team to advance the project and demonstrated strong support. This included approving an additional £17m enabling works package to progress on site whilst the Full Business Case was submitted and approved, instructed in February 2025. In March 2025, NHP and NHSE responded positively to the project's cost plan update, advising the Trust of their desire to look at accelerating the FBC submission and approval.

These positive developments have solidified the project's timeline, with the main construction works due to take place 2026-2028 and the building opening to patients in 2029.

Wider capital investments

By the end of 2025/26, five hundred and forty-one (541) investments. A significant achievement given the ongoing operational challenges. The 2025/26 capital expenditure of £146.4m, was delivered through £137.2m on intangible assets, property, plant and equipment and received £9.2 from cash donations and capital grants. The Trust acquired £1.2m of Right of Use assets during the year in the form of new lease agreements. The capital programme was supported by the Trust's dedicated hospital charity, My University Hospitals Sussex Charitable fund, as well as our partner charities, including the League of Friends.

The 2025/26 capital programme was divided into two elements. Strategic capital associated with preparation of the site of the former Barry and other buildings at the Royal Sussex County Hospital for the development of our new Cancer Centre. This, together with a new materials management and logistics yard, completes the 3T's programme which is a key element of the governments New Hospitals Programme (NHP) initiative.

In addition, operational capital investments and nationally-funded projects have also been made across our hospitals and sites. These investments include:

- A new Ambulatory Medical Unit, incorporating a new SDEC, in Millenium Wing at Royal Sussex County Hospital SDEC was completed. This was phase 2 of the emergency department and acute floor redevelopment project at the Royal Sussex County Hospital (£65m over 4 years). This converted a previous area into a new 33 trolley areas and is expected to see 500 patients per week. The space is far larger with modern clinical areas and is designed to enhance privacy, dignity and infection control.
- A new £6m Urgent Treatment Centre was constructed at Worthing Hospital, which opened in September 2025. This was funded through the Return to Constitutional Standards programme. This will further reduce the 4hr wait target for Emergency care. It is in a newly built extension to the existing ED at Worthing.
- A new £6m Same Day Emergency Care unit was opened at St. Richard's Hospital. This was also funded through the Return to Constitutional Standards programme. This provides a superb and light environment for patients. Lead consultant and acute physician, Dr Neal Gent, described its introduction as a "game-changer" for patient care.
- Investments in our digital strategy, including electronic patient records, and other IM&T infrastructure, equipment, and systems (£10.0m); A further £3m was invested in the Electronic Patient Record (EPR) programme, with numerous benefits for patients and staff.
- Major medical equipment purchases include a new £1.5m MRI, which has been installed at Southlands hospital, as part of the NHSE Community Diagnostic Centre programme. This is the second MRI to be delivered at the site. Also, replacement X-Ray systems were installed at SRH and at the RACH at RSCH. These were £0.5m each.
- Investments were made in removing Reenforced Autoclaved Aerated Concrete (RAAC) from our sites. This comprised of creating a new Mortuary and purchasing four body storage units for the site. The RAAC containing building is now ready to be demolished and will be undertaken next financial year. This was a £3m investment.
- Further investments in RAAC remediation measures at SRH were £1m in RAAC safety measures to ensure the building is safe for its current occupants. More work will be carried out in the next year. Also work progressed on developing the Diagnostic block RAAC remediation business case to remediate the circa 2,000m² of RAAC which is present there. All the RAAC schemes are funded by NHSE's RAAC Remediation programme.

- Four new temporary theatres were procured in the year. These have been sited at PRH and SRH hospitals and represent a £13m investment. They are being commissioned and put into use in the new financial year. These provide decant theatres, to enable the existing theatre stock to be taken out of service and have upgrades to their critical ventilation systems. They will maintain the same amount of theatre availability as the Trust has to reduce waiting lists. Ultimately this is to improve theatre reliability, avoiding cancelled lists, and will provide the right environment to provide care to patients.
- Infrastructure investments include replacing ventilation for an MRI at Worthing hospital, heating system at PRH, and further work on the Energy Centre at RSCH. Public toilets were also expanded and fully refurbished at PRH. Finally, work was undertaken to Thomas Kemp Tower windows to enable the Helideck, which sits upon it, to be put into use.
- As part of a large investment in the Trust's Stroke services a new Acute Stroke Centre has commenced construction at SRH. In the year the enabling works commenced with ground being made ready to receive the new 1,000m² extension to the hospital. This will be progressed in the new financial year to date £2.9m was spent in the financial year. It will complete in Autumn 2027.
- Feasibility studies were worked up in the period for future schemes. This included a new UTC at PRH, further RAAC removal at Worthing Hospital, and a new Theatre block extension at Southlands Hospital. All these schemes are being worked up with business cases being prepared for approval in the next financial year. All these schemes are NHSE funded through relevant funding streams.
- Replacement of more than 100 items of critical medical equipment (£7.5m);
- The Trust demonstrated its commitment to becoming more sustainable through the procurement and installation of £2.6m's worth of Solar Panels at SRH, Southlands and PRH hospitals. This is expected to continue in the future with other sustainable measures. This particularly investment was funded through Great British Energy and the Department for Energy Security and Net Zero. It is estimated it will save the Trust £0.36m/year in energy costs.
- Backlog maintenance improvements in the Trusts estate has also been prioritised (£5.0m).

The Trusts own charity and partner charities have also made a significant contribution, funding 49 separate investments in medical equipment and small improvement works in staff facilities totalling £2.0m. Many of the schemes listed above have charity elements for either staff or patient space enhancements or individual pieces of equipment. The Trust is very grateful to MyUHSussex Charity and our partner charities for their generosity in supporting these investments.

1.4.8 Environmental Sustainability

University Hospitals Sussex NHS Foundation Trust (UHSussex) remains firmly committed to embedding environmental sustainability across all aspects of our organisation. We recognise the clear and growing connection between

environmental impact, population health, service resilience and the long-term sustainability of the NHS. As one of the largest Trusts in England, we play a critical role in supporting the national ambition to become the world's first net zero health system.

Our Trust Strategy, Excellent Care Everywhere, places Being Green at the heart of how we deliver care. It sets out our ambition to become one of the greenest trusts in the country and highlights the importance of environmental stewardship for our patients, communities and staff. Sustainability is not treated as a standalone programme; it is a core enabler of high-quality, equitable and financially responsible care.

Our refreshed Green Plan builds on the progress made through our previous Patient First, Planet First Green Plan (2022–2025) and reflects the priorities identified by our Buildings & Utilities Working Group, Sustainable Travel Group and Green Ambassador network. The 2026–2030 plan focuses on areas where the Trust can make the greatest impact—both in reducing emissions we directly control (the NHS Carbon Footprint) and in influencing emissions across our wider system and supply chain (the NHS Carbon Footprint Plus). It reinforces the importance of leadership, partnership and system working in achieving lasting change.

The plan is fully aligned with the NHS Sussex Together to Zero Green Plan and national Greener NHS guidance, ensuring a coherent system-wide approach to net zero and climate resilience. As the NHS continues to evolve following the establishment of NHS Surrey and Sussex Integrated Care Board, we will continue to align our approach with emerging system-level sustainability priorities.

This refresh has strengthened our approach across key areas including estates decarbonisation, sustainable models of care, travel and transport, procurement, and climate adaptation. It introduces clearer governance, more robust delivery plans and improved performance monitoring to support implementation.

Since our last plan, we have completed 95 key actions, with a further 60 in progress and 9 not yet started due to dependencies on other workstreams. Eight actions have been superseded by updated national guidance or are now being delivered at a national level.

We continue to make progress in reducing our environmental impact, building on a long-term downward trend in emissions since our baseline year. This has been achieved through a combination of infrastructure investment, operational improvements and clinical engagement. Based on NHS England's published data, our reported emissions for 2024/25 were 37,528 tCO_2e, against a 2032 target of 20,937 tCO_2e. We estimate that our 2025/26 footprint will reduce to approximately 36,000 tCO_2e.

Green Plan Refresh: Strengthening Delivery

During 2025/26, we completed a full refresh of our Green Plan. This process has:

- Updated emissions baselines and trajectories in line with national expectations
- Strengthened governance and accountability structures
- Identified priority actions in high-impact areas such as energy, clinical practice, and supply chain
- Integrated climate adaptation and resilience into strategic planning
- Improved alignment with Integrated Care System (ICS) priorities

The refreshed Green Plan provides a clear and deliverable roadmap, with defined workstreams, measurable outcomes, and enhanced reporting mechanisms.

Task Force on Climate-related Financial Disclosures (TCFD)

NHS England's NHS foundation trust annual reporting manual adopted a phased approach to incorporate the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures are as interpreted and adapted for the public sector by HM Treasury. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

UHSussex has complied with the TCFD disclosure requirements for 2025/26. Scope 1, 2 and 3 emissions are not reported within this section, as these are calculated nationally by NHS England.

Governance

The Trust Board maintains oversight of climate-related issues through its committee structure, with sustainability embedded within strategic planning, capital investment decisions, and performance monitoring.

The Finance and Performance Assurance Committee receives regular updates on Green Plan delivery, including progress against targets, key risks, and investment requirements. Sustainability is considered as part of wider discussions on operational performance, estate strategy, and financial planning.

Progress against sustainability objectives is monitored through established governance processes, ensuring alignment with the Trust's strategic priorities. Executive responsibility for sustainability is held by the Chief Strategy Officer, supported by the Director of Facilities and Estates as Senior Responsible Officer.

Delivery is coordinated through the Environmental Sustainability Steering Group (ESSG), which brings together clinical, operational, and corporate leads. The ESSG oversees implementation of the Green Plan, monitors performance, and manages risks.

The group is supported by workstreams covering areas such as estates, travel, waste, and sustainable clinical practice. These groups are responsible

for delivering specific actions and reporting progress through established governance routes.

Strategy

The Trust has identified a range of climate-related risks and opportunities across short, medium, and long-term time horizons:

- **Short-term (0–3 years):**
  Rising energy costs, infrastructure constraints, and increasing regulatory requirements.
- **Medium-term (3–10 years):**
  Transition risks associated with decarbonising heat, fleet, and supply chain, alongside the need for significant capital investment.
- **Long-term (10+ years):**
  Physical risks including extreme weather events, overheating of buildings, and impacts on service delivery and patient outcomes.

Opportunities include improved energy efficiency, access to external funding, innovation in clinical practice, research and development and enhanced resilience of infrastructure.

Our five-year Trust Strategy, *Excellent Care Everywhere*, identifies Being Green as a key priority under *Excellent Care in Our Communities*. Commitments include expanding on-site renewables, embedding reuse by default, providing low-carbon transport options and developing a green innovation test bed.

Climate-related risks and opportunities are increasingly influencing organisational decision-making. Investment in low-carbon infrastructure, such as heat decarbonisation and renewable energy, requires significant capital but delivers long-term cost savings and resilience benefits. Service delivery models are also evolving, with increased use of digital pathways and reduced reliance on high-carbon clinical practices.

Under a global warming pathway of 2°C or lower, the Trust anticipates increased demand for resilient infrastructure, greater regulatory and financial pressure to decarbonise and a need to prioritise investment in high-impact areas.

Risk Management

Climate-related risks are identified through existing risk management processes, including the corporate risk register and divisional risk reviews. These include both physical risks (e.g. flooding, heatwaves) and transition risks (e.g. policy, technology, and financial changes).

The Trust has committed under the new Green Plan to utilise national guidance, including NHS climate risk tools, to inform its assessment.

Mitigation measures include:

- Investment in infrastructure upgrades and resilience measures
- Development of Heat Decarbonisation Plans

- Integration of sustainability into procurement and business case processes and decisions
- Adoption of the Sustainable Healthcare Impact Assessment (as per ICB Green Plan)

Climate-related risks are fully integrated into the Trust's overall risk management framework and are reported through divisional and corporate governance processes. Where material, these risks are escalated and managed alongside other principal risks.

Metrics

The Trust uses a range of metrics to assess performance, including:

- Energy consumption and associated carbon emissions (reported via Estates Returns)
- Progress on fleet electrification, Reuse by default and On site Renewable expansion (reported through Trust Strategy)
- Waste segregation performance (reported via Estates Returns)
- Delivery of Green Plan actions and milestones

Under our new Green Plan all focus area workstreams will develop new KPIs and interim targets which will be reported and monitored internally through the ESSG and governance structures.

Targets and Performance

The Trust is aligned with NHS net zero targets:

- Net zero for directly controlled emissions by 2040 (ambition of 80% by 2032)
- Net zero for wider emissions by 2045

Supporting targets include:

- Interim carbon reduction milestones
- Transition to zero-emission vehicles by 2027
- Waste segregation targets aligned to the NHS 20:20:60 model

Our Carbon Footprint Plus baseline is 185,667 tCO_2e, which reduced to 175,472 tCO_2e in 2024/2025. We expect this to decrease as our supplier's progress on their journeys toward Net Zero. To support this, our procurement team has implemented a sustainable procurement policy aimed at meeting the reduction targets outlined above.

1.4.9 Statement on equality and equity of access

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.

1.4.10 Health Equalities

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 overleaf 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.

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.

Below is a high level summary of the Trust's performance over the 2025/26 year

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

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

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
    - 21 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%	3.76%

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.

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 Royal Sussex County Hospital, whilst HIV opt out testing is being rolled out across Worthing Hospital.

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 recognises 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.

Area	2025/26	National comparator 2025/26	2024/25	2023/24
Outpatient Attendances	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%

Table showing level of data set completeness

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.

1.4.11 Patient Care and learning

Care Quality Commission standards.

The CQC has continued to undertake further inspections across Trust in the last year. This includes 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 the CQC has yet to undertake a further comprehensive inspection, their ratings from the August 2023 remain which saw the Trust and each main hospital rated as "*requires improvement"*, and good or outstanding for caring.

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.

The inspection in 2023 of General Surgery at the Royal Sussex County Hospital resulted in the Trust receiving an enforcement notice in relation to Upper GI Cancer Surgery. As a result, the Trust does not undertake these surgical procedures with these patients being treated at neighbouring Trusts and is therefore compliant with the registration requirements of the Care Quality Commission.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period. However, the Trust has continued to engage with the CQC has sought to understand our services and provide insights for improvement.

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 required major programmes of work to address the estate and flow through the hospitals.

How we learn

We have robust systems in place for reviewing incidents, complaints, mortality reviews and inquests within our clinical divisions. Each clinical division has a

clinical governance lead, called a Divisional Quality and Safety Manager, to coordinate this activity and help the divisions to track and complete the actions arising out of each of these areas. The divisions also use safety huddles, the “Theme of The Week”, Patient Story newsletters and staff meetings to help communicate changes made in response to learning.

The weekly Patient Safety Incident Review Response Group (PSIRG) reviews all reported unexpected deaths and new incidents (graded moderate/severe harm and/or near miss on RL DATIX IQ).

The group also reviews newly reported high-grade complaints, findings from SJR’s and safeguarding alerts to ascertain whether they require conversion to incident investigation. Using a senior multidisciplinary approach, the panel/group agree the appropriate level/grading of harm and the appropriate investigation/escalation level.

The group also makes a decision regarding Duty of Candour, and provides direction to the divisions to ensure we do not delay verbal and written Duty of Candour. When harm occurs, talking to the person affected or their family/carer provides crucial context to any investigation. We continue to develop and encourage an open and honest approach to supporting patients who have been harmed, or their families, as candour and transparency are our core values.

The Trust investigates all patient safety incidents, reported on our incident reporting system, DCIQ. The organisation has a Patient Safety Incident Response Plan (PSIRP) which identifies the different ‘levels’ of investigation and when they should be used. These include Early Learning Reviews, Local Learning Reviews, Patient Safety Incident Investigation (PSII), Thematic Reviews, and Rapid Reviews are the Trust’s agreed learning responses.

At the weekly Patient Safety Incident Review Response Group (PSIRG), all incidents that are reviewed are given direction as to which ‘level’ of investigation they need (this includes never events). The organisation uses systems thinking methodology (for example, System Engineering Initiative for Patient Safety) to understand the complexity of the incidents and the organisation has moved away from reductionist methodologies that were used under the Serious Incident (SI) framework.

Learning from incidents

The Trust utilises reported incidents to learn and apply this learning to improve our processes, these include

- The utilisation of the Patient Safety Incident Response Framework (PSIRF)
- The utilisation of the Patient Safety Incident Monitoring (PSIM), which involves tracking weekly Duty of Candour compliance and bi-weekly tracking of incident investigation progress within the patient safety team.
- Harm free care (falls/pressure damage/VTE) is monitored through the structured process reporting within the Fundamental Standards of Care work programme

- Divisional thematic reviews focusing on: Harm reviews from cancelled surgery: vascular, ortho, trauma, surgery, cancer. RTT follow up ophthalmology
- Continuing with the training of clinical staff through the in-house patient safety training programme which covers theoretical and practical applications of systems thinking and investigatory science
- The use of the Duty of Candour training package on Trust's central IRIS training system.

Responding to Complaints

Our Patient Advice and Liaison Services (PALS) are usually the first port of call for anyone who has a problem they need the Trust to look into or resolve. PALS staff are able to offer advice on how and where to complain, investigate concerns and help bring resolution if things have gone wrong. Our complaints managers investigate more complex concerns that require a formal investigation about past events.

Throughout 2025/6, the Trust received 2,176 new complaints for investigation – this is an increase from 1,589 in 2024/25 1,221 in 2023/24, a 78% increase over the two years. Fewer than 0.5% of all complaints' responses were accepted for investigation by the independent Parliamentary Health Service Ombudsman, which indicates the high quality of complaint responses and investigations. At the end of 2025/26, there are also fewer complaints open for longer than six months than at the end of 2024/25, down to 1% of the total caseload.

Prevalent causes of concern include: delays to appointments, treatment and diagnosis delays and cancellations, including follow ups; communication, staff attitude and behaviour; and clinical care. Improvement initiatives, including plans for the EDs, communication training and introduction of new appointment systems have enacted progress against the key themes. The 'Welcome Standards' programme focused on improving the experience of greeting and entrance to the Trust has continued its implemented in year, with measurable improvements in patient reported experience.

During the year, the trajectory for the numbers of PALS concerns received also remained upwards, with increasing numbers of patients concerned about accessing results, appointments and dates for surgery.

1.4.12 Monitoring of Quality Priority Improvements

The Trust has an established Quality Governance Structure which is overseen at Board level by the Patient and Quality Committee and at Executive Level through the Quality Governance Steering Group chaired by the Chief Medical Officer. Reports are presented to the Patient and Quality Assurance Committee and the Trust Board on the delivery of the Trust's Ambitions which are themselves supported by the Trust's delivery of its stated quality improvement priorities.

UHSussex remains fully committed to consistently meeting and exceeding these twelve standards within the Care Quality Commission's Fundamental

Standards of Care framework. These standards provide the baseline expectations for safe, compassionate, and person-centred Care. UHSussex continues demonstrating its commitment to the Fundamental Standards of Care through measurable, multidisciplinary improvement programmes. It remains firmly rooted in a culture of learning, transparency, and evidence-based practice, ensuring the best possible outcomes for patients, their families and the staff caring for them.

The Fundamental Standards of Care programme has seen improvements in all the metrics outlined and the programme has also overseen the launch of Enhanced Care Support Workers.

Enhanced Care Support Worker Programme

UHSussex is an acute care provider and in response to an increase in the number of adults, children and young people attending emergency departments with mental ill health an Enhanced Care Support Worker (ECSW) programme was launched to provide**,** high-quality care for patients requiring enhanced observation and mental health support in an acute setting. This complements the use of Registered Mental Health Nurses (RMNs)

ECSW's provide a range of therapeutic engagement with the people they care for and are supervised by a mentor identified in their clinical area and the Head of Nursing for Mental Health and Dementia. Their use has seen:

- A reduction in complaints from staff, patients and carers
- A reduced Length of Stay Length of Stay for enhanced mental health patients
- An improved working environment for staff with reduction in turnover
- An improved health and safety environment for patients, reducing reliance on security bed watch
- An ability to reduce RMN agency costs within the Trust

1.4.13 Research as a driver for improving the quality of care and patient experience

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.

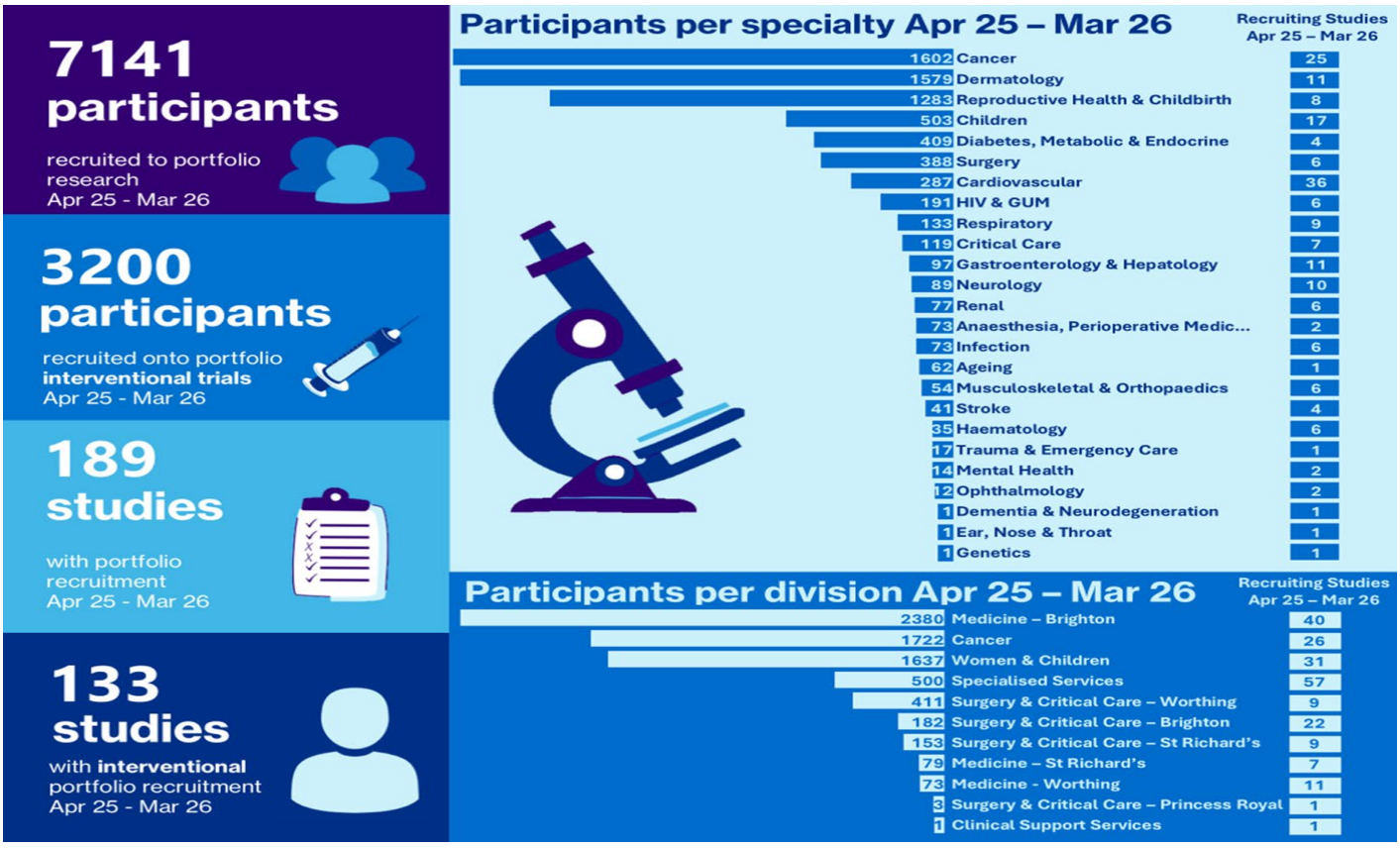
Leading Regional Research

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.

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 UHSussex, 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.

Where specialist clinical care is provided on more than one hospital site, we aim to run studies at each site. This will be dependent on local factors such as availability of clinical support services and workforce capacity. In 2025-26 just under 40% of studies were running across 2 hospital sites at any one time. A further 20% are running across 3 sites. 10 studies were running across all four of our main hospital sites.

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

This year the Trust has established a major capital project to develop the Clinical Research Facilities across the Trust. We have also secured £1.3m funding to support the expansion clinical research at UHSussex hospitals. The funding, secured from the National Institute for Health and Care Research (NIHR), is set to expand and improve clinical research facilities over the next two years at Royal Sussex County Hospital in Brighton, Princess Royal Hospital in Hayward's Heath and Worthing Hospital. This is in addition to ongoing plans to develop the research space at St Richards Hospital, Chichester.

The mainstay of the investment will enable the Trust to relocate and enhance its main clinical research facility at the Royal Sussex County Hospital in Brighton. The new facility, in the hospital's Louisa Martindale Building, will

provide 180m² of patient-facing space for research participation close to key acute services, including the Emergency Department, critical care and new Cancer Centre when this opens. This will allow researchers to deliver larger and more complex trials, including early phase and first-in-human studies, which require closer clinical monitoring.

Alongside the central research facility in Brighton, the funding will support the development of research bases at Princess Royal Hospital and Worthing Hospital. These sites will help bring research opportunities closer to local communities, allowing more patients across Sussex to take part in clinical trials without needing to travel long distances.

The research base at Princess Royal Hospital will also support the delivery of specialist research including mental and dementia studies as part of our NIHR Commercial Research Delivery Centre (CRDC) Sussex, in partnership with Sussex Partnership NHS Foundation Trust.

This investment will also help grow the Trust's research portfolio by broadening the range of clinical trials that are available to patients across our medical and surgical specialties, both within our hospitals and community settings. The new facilities will enable us to grow new industry collaborations and partnerships with life sciences organisations, while improving opportunities for people in local communities to take part in research. The Trust already runs a wide range of clinical studies that offer improved patient care and treatment options through its research facilities.

Research *engagement and inclusion*

We are expanding opportunities for our Sussex communities to be active partners in research, helping shape and support studies across UHSussex. This work aims to increase awareness of health and care research, strengthen engagement among underserved groups, and ensure our research reflects local needs.

Our Research Engagement Group - comprising staff and public representatives - has led a range of initiatives this year, including integrating research into patient information, hosting public science cafés, running Trust wide pop-up events, and supporting the NIHR Be Part of Research campaign. Patient Research Champions have played a vital role in reaching underrepresented communities and encouraging participation.

We are strengthening our commitment to research inclusion by widening participation across all communities we serve, with a particular focus on minoritised groups and people living in areas of deprivation. Our aim is to ensure that everyone can benefit from the advances in care and treatment made possible through research, with no group unfairly excluded.

Many people continue to face barriers that limit their ability to take part in studies, reducing access to research findings and, ultimately, to high quality healthcare. Ensuring our research reflects the full diversity of our population is essential for understanding how medicines, devices and treatments work for different groups.

To address this, we are working closely with the Sussex Research Engagement Network (REN) and the new NIHR Commercial Research Delivery Centre (CRDC): Sussex to increase diversity and inclusivity in clinical trials across the region. These partnerships are helping us build a more representative research environment and ensure that the benefits of innovation reach every part of our community.

The Sussex REN was set up in 2023 to make health and care research more inclusive and to ensure that people from all communities across Sussex can shape the research that affects them. REN achievements include:

- *Strengthening community voices*: REN has trained 25 Community Researchers and delivered research training to 46 people from 30 organisations, helping more communities feel confident taking part in research.
- *Listening to lived experience*: Community researchers carried out over 90 interviews about people's experiences of cancer and mental health services, highlighting barriers and what needs to change.
- *Real improvements to services*: Insights from Cancer REN and Mental Health REN projects have already influenced local service design and improved wellbeing, confidence, and connection for participants.
- *Stronger research system for Sussex*: REN's work has contributed to over £14 million in successful funding bids and strengthened collaboration between the NHS, universities, and the voluntary sector.
- *National recognition*: REN has been highlighted by NHS England as a leading example of community led, equitable research.

REN is helping to reshape how research is done in Sussex - making it more inclusive, more community driven, and more reflective of the people it aims to serve.

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.

We continue to strengthen research capability across our workforce, ensuring staff feel confident and supported to contribute to research as part of everyday clinical practice. Our annual staff survey shows significant progress: the proportion of colleagues who felt they had opportunities to contribute to research rose from 24% in 2023 to 42% in 2025.

Building staff confidence to discuss research with patients and to participate in clinical research delivery is a central priority of our refreshed Research Delivery Plan. The My Charity UHSussex Research Fellowships have demonstrated how structured support can empower staff to champion

research and evidence-based care. We have expanded our research education and training offer, making it more accessible through the IRIS platform, alongside regular research drop-in's, bitesize training, mentoring and career development support.

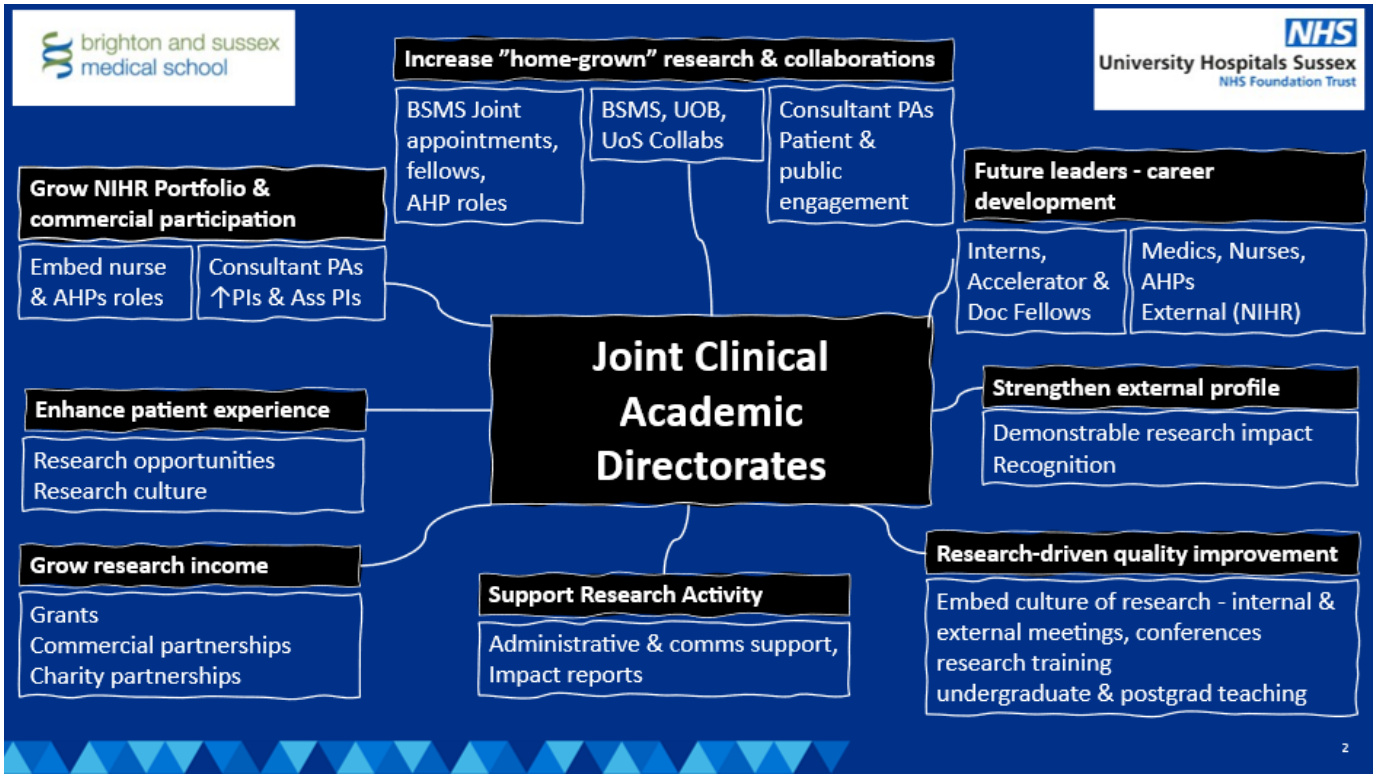
We have also introduced Research Link Nurses within the Trust's established link nurse model and agreed phased job planned research time for consultants and specialist NMAHP practitioners. This commitment is reflected in both our Nursing and Midwifery and Education plans. We are exploring practice development approaches and rotational secondments to help more clinical staff gain the skills and confidence to talk to patients about research and contribute to study delivery across a wide range of clinical settings.

Medical job planned research time has been expanded, and we have provided pump priming support for Principal Investigators (PIs). In 2025–26, there were 238 active PIs across the Trust compared to 211 the previous year. We have also significantly increased participation in the NIHR Associate PI Scheme, which offers six months of accredited, in work research training for staff new to research. This year,105 Associate PIs were supporting research.

Growing **Research** ***Excellence***

Driving research excellence across UHSussex relies on strong collaboration across organisational and disciplinary boundaries. With this in mind, we are preparing for the launch of our first Joint Clinical Academic Directorate (JCAD), focused on Critical Care and Peri Operative Medicine (CPOM), in early 2026. This inaugural JCAD will bring together clinicians from UHSussex with academic and community partners to accelerate research and innovation. Over the next year we will establish five JCADs initially, building on areas of established research strength between the Trust and BSMS, and aligning with the Trust's new operating model so that each clinical division has at least one JCAD to drive research growth. The first JCADs will focus on Cardiology, Critical Care & Peri Operative Medicine, Cancer, Infection and Paediatrics. To support these directorates, we are working with Brighton and Sussex Medical School to develop joint appointments, investing in career development awards, pump priming for consultant level PAs, and funded time for research roles including rotational research posts and research practitioners.

Looking ahead, the emerging JCADs will be the research flagships in each of the Trust's divisions, bringing together doctors, nurses, therapists, researchers and patients to strengthen clinical academic partnerships. By bridging multidisciplinary and organisational boundaries, they will help us develop safer treatments, support better recovery and improve long-term outcomes for our patients and communities.



Graphic showing Joint Clinical Academic Directorate function

Developing research leaders

UHSussex is continuing to invest in its workforce through research-led improvement fellowships funded by the Trust's Charity. These programmes empower doctors, nurses, midwives and other healthcare professionals to develop their research expertise, careers and lead research driven by the needs of people in Sussex.

The MyUHSussex Charity Research Fellowship programme supports staff at every stage of their research journey through three pathways: Internship, Accelerator, and Doctoral Fellowships.

This year the Internship Fellowship has continued to attract strong interest, with around 34 applications per round. Early in 2024 we identified that many applicants - especially internationally educated staff - needed more support to submit competitive applications. In response, we introduced targeted webinars, focused outreach, and Q&A sessions to make the process clearer and more accessible.

These changes have led to more professional groups represented across the Trust, a significant rise in application quality and more internationally educated practitioners being shortlisted and awarded fellowships.

Fellows are now some of our strongest research ambassadors. Their enthusiasm and confidence are inspiring colleagues and strengthening our research culture, by setting up journal clubs, networks, and Trust wide research events, mentoring peers to build research skills, helping to expand patient access to national clinical trials.

Their work is improving patient care locally and contributing nationally through publications, conference presentations, and input into clinical guidelines and policy.

Updated Fellowship Data Summary (2024 - 2027)

Fellowship Category	2024/5	2025/6	2026/7
Internship Fellows	13	14	14
Accelerator Fellows	3	7	—
Doctoral Fellows	0	1	4
Total Fellows	16	22	18

Table shows number of fellows over the years 2024/25 to 2026/27

Increasing success in national research grant awards

This year saw significant progress in supporting UHSussex staff to secure competitive national research funding.

- Internship Fellows have successfully submitted two major NIHR career fellowship applications in 2025: 1 NIHR Doctoral Fellowship and 1 NIHR Postdoctoral Fellowship.
- Three My Charity UHSussex Fellows have successfully secured places on the My Charity UHSussex Doctoral Fellowship programme, beginning in September 2026.
- Accelerator Fellows have also submitted applications for 1 NIHR Doctoral Fellowship and 2 NIHR Post Doctoral Fellowships in 2025/26.
- Internship and accelerator fellows have submitted 4 applications for national research grant programmes (1 successful in 2025, 3 pending in 2026) Eight health and care practitioners have been awarded NIHR Health and Care Professional internships in 2025.
- Five health and care professionals have been awarded NIHR INSIGHT Master of Research (MRes) Fellowships in 2025/26.

These achievements demonstrate the growing strength of our research development pathways and the increasing confidence and capability of UHSussex staff to compete for national funding. In the last two years, in addition to our My Charity funded fellowships we have achieved over £795K inward investment to support research career development.

Year	Fellowship/Programme	Recipients	Profession(s)	Individual Grant Value	Total Value
2025	NIHR Doctoral Fellowship	1	Nurse	£463,402	£463,402
2025	NIHR Pre-Doctoral Fellowship	1	Nurse	£102,479	£102,479
2024/25	NIHR INSIGHT Fellowships	5	3 Nurses, 1 Midwife, 1 Physiotherapist,	£30,000	£150,000

2025/26	NIHR HCP Internships	8	3 Nurses, 1 Midwife, 1 Dietician, 1 Pharmacist, 1 Bio-medical Scientist, 1 Physiotherapist,	£10,000	£80,000
				Total	£795,881

Table showing number of successful fellowship applications by year, programme and professional group with total value of awards.

Sussex Research Training Hub

Our Fellowship programme leadership continues to play a central role in the Sussex Research Training Hub, which this year has focused on strengthening research capacity and supporting a growing community of emerging researchers across the region.

Key achievements include:

- Launching a new research training event series, delivering a successful programme of online sessions to broaden access to research skills.
- Establishing the Sussex Nurses Research Network, now with more than 100 members and bi-monthly events featuring inspiring speakers from across Sussex.
- Delivering the third annual Sussex Clinical Academic Conference, welcoming 150 attendees and focusing on pathways into research careers.
- Expanding the careers advisory service, offering increased appointments and a monthly Integrated Academic Training (IAT) drop-in session.
- Supporting the BSMS submission to the 2025 NIHR IAT Programme, resulting in the award of five Academic Clinical Fellowships and three Clinical Lecturer posts for 2025–26.
- Contributing to a successful regional bid for the NIHR Health & Care Professionals Internship Programme, securing 24 internships per year for three years for nonmedical health and care professionals
- Widening participation by building collaborations across health, social care and public health to reach more people and broaden access to research opportunities.

Together, these initiatives are helping to nurture a skilled, confident and diverse research workforce equipped to drive innovation and improve care across Sussex.

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), unveiled at the Sussex Health and Care Research Partnership Conference at the University of Sussex. Hosted by the Trust, the CRDC forms part of a national NIHR network designed to accelerate commercial clinical research across the UK.

The launch brought together academics, health and care professionals, researchers, members of the public and people with lived experience from across the Sussex Integrated Care System, reflecting the collaborative ambition of the new centre.

CRDC aims:

- Expand access to cutting edge treatments for patients
- Reduce health inequalities through inclusive research participation, building on the work of the Sussex Research Engagement Network
- Strengthen local research infrastructure and support the life sciences sector
- Drive inward investment into Sussex and the wider UK

Early impact in the first year includes:

Improving the speed and efficiency of commercial research

We have redesigned and accelerated the setup process for industry sponsored clinical trials in line with national performance objectives. Median setup timelines reduced from 161 days in Q1 2025/26 to 47 days in Q4, and since January 2026 all commercial studies have consistently been set up within 60 days. The “first recruit within 30 days” metric has also been embedded into routine practice through clearer expectations, improved monitoring and proactive communication at green light.

Increasing opportunities for Sussex

Commercial research activity continues to grow, with 47 industry sponsored studies on the Sussex CRDC portfolio as of 31 March 2026, including new partnerships with sponsors not previously active in the region. We are also working closely with Sussex Partnership NHS Foundation Trust to expand commercial opportunities within mental health and dementia research.

Strengthening research inclusion

We have established a CRDC Patient and Public Stakeholder Group and developed a public involvement and engagement plan. This work compliments our collaboration with the Sussex Research Engagement Network, with a shared focus on increasing the diversity of clinical trial participation and ensuring equitable access to new treatments.

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.

Driving Innovation and Efficiency in Research Delivery

This year we have made significant progress in improving the efficiency of clinical trial setup, ensuring we meet national performance targets for the life sciences industry and accelerate access to new treatments for our patients. We successfully secured NIHR funding for three posts to further speed up commercial trial setup within support departments and to lead the digitisation of participant identification in partnership with primary care. In addition, we have received investment to support the digitisation of clinical trial master files. Together, these developments ensure we are harnessing digital innovation to improve the efficiency, quality and sustainability of clinical research.

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

Building Sustainability into Research Design

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

Reducing Travel and Improving Access

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

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

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

Digitising Research Processes

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

Across the Trust, clinical teams continue to explore how innovation can enhance service quality and sustainability, streamline processes and improve

patient experience. These efforts are helping to embed research as a driver of improvement and efficiency across our clinical services.

Inward investment in Research and Innovation 2025/26

The Trust received £9 million in external investment to support then delivery of its research programme during 2025-26.

Core funding from the NIHR Kent, Surrey and Sussex Research Delivery Network in the region of £3 million was awarded to support the delivery of national portfolio studies. The funding underwrites the core research nursing, pharmacy and support service costs associated with delivery studies funded by bodies such as Cancer Research UK, British Heart Foundation and the Medical Research Council.

Direct grant funding amounted to approximately £1.4 million. This is for projects the Trust runs and has oversight for. Included in this is £498,965 awarded by the NIHR Research for Patient Benefit scheme to Dr Akshat Kapur and Prof Paul Seddon for the project 'High Flow humidified oxygen as an early intervention in children with Acute Severe Asthma: a randomised controlled trial (HOPSA)'

The aim of this project is to find out whether starting HiFlo early on speeds up recovery from a severe asthma attack and reduces the need for unpleasant intravenous therapy. We carried out a small trial which showed that this study is feasible, told us how many children and hospitals will be needed to get a clear answer on whether using early HiFlo is beneficial for children with a severe asthma attack. The trial will involve 218 children (aged 2–18 years) who come to hospital with a severe asthma attack.

The NIHR awarded the Trust £3m over a seven-year period to establish the NIHR Sussex Commercial research Delivery Centre. This was followed by a further £500,00 over 3 years to set up a regional research support hub. The object of this funding being to develop resources and capability to deliver high impact commercial research for patients from across Sussex.

30% of our income is generated from the delivery of commercial trials on behalf of MedTech and pharmaceutical companies. The income earnt pays directly for the salaried of the staff involved in delivering the research. 20% of this supports the time taken by consultants to oversee the care of patients whilst participating in trials.

In addition, this year the Trust has also secured £1.3m of capital funding to support the expansion clinical research at UHSussex hospitals from the National Institute for Health and Care Research (NIHR).

Looking forward

Our key research and innovation ambitions are set out in the Trust strategy and annual research delivery plan. Key deliverables for the next year include:

- **Giving every patient access to clinical research**
  - Further development of a broad portfolio of clinical research opportunities across all of our hospital sites with a goal to open 110 new interventional studies 2026-27.

- **Access to new treatments**
  - Clinical Research Facilities major project delivery
  - CRDC – Increase in the number of new industry sponsored clinical trials offered in Sussex – by 20% on the previous year
  - Targeted research engagement to promote diversity in clinical trial participation

- **Opportunities to get involved in research**
  - Alignment of research delivery with new target operating model
  - Increasing embedded clinical roles with job planned research time
  - Research delivery education and training and secondment opportunities

- **Speed and efficiency of research**
  - Improving the speed and efficiency of commercial clinical research – exceeding DHSC 150-day targets
  - Digital pilots with primary care to optimise study feasibility and participant identification
  - Sustainability training embedded in all research fellowships
  - Digitisation of research trial master files and regulatory archiving processes

- **Research Partnership**
  - Expanding CRDC partnerships – primary care, MH, community pharmacy
  - Five new Joint Clinical Academic Directorates Launched
  - My Charity UHSussex supported annual cohorts of My Charity UHSussex Research Fellowship opportunities
  - Increase in multiprofessional clinical academic roles
  - Research Training hub support and training programme
  - Continued REN partnership, supporting community research engagement

- **Research funding – increasing inward investment**
  - Expanded life science industry partnerships through the CRDC to increase access to new treatments and bring investment
  - Submit MyUHSussex Charity bid to support the research fellowship programme for the next three years
  - Increase in NIHR and other externally funded clinical academic fellowships
  - Increase in externally funded research grants secured through collaborations across the Sussex Health and Care Research Partnership
  - Submit NIHR Capital Funding bid 2026 – to support research pharmacy and laboratory development

1.4.14 The Best of University Hospitals Sussex - Our Year in Review

Looking back, it has been a year of remarkable progress and celebration across our Trust. From national award wins and pioneering clinical research to the development of major new services, the past 12 months has ushered in significant improvements for our patients. These achievements reflect the valued commitment of our clinical teams and highlight the important contributions from our local and national partners. Below is a summary of the innovations, achievements, and successes that defined our year.

April – £62m boost for urgent and emergency care in Brighton
April saw the Trust announce a £62 million transformation programme at Royal Sussex County Hospital to modernise urgent and emergency care in Brighton. The redevelopment will improve patient flow, reduce waiting times and expand capacity through redesigned clinical areas and upgraded facilities, with phased works continuing over the coming years as services remain open.

May – UHSussex Board welcomes public engagement and new MyUHSussex Charity-funded endoscopy care
In May we welcomed members of the public to our first Board meeting of the year at Worthing Hospital, which included a focus on patient stories and clinical service presentations. Chair of the Board, Philippa Slinger, also reinforced the Trust's commitment to transparency by introducing a dedicated time for public questions - ensuring that the voices of our local communities are heard and reflected at the highest level of Trust leadership.

Alongside this, we also celebrated a new Transnasal Endoscopy service at Princess Royal Hospital in May, made possible with thanks to funding from My Charity. The service is improving patient experience during gastroscopy. The less invasive nasal procedure avoids the need for sedation, allowing patients to remain awake and return to normal activities immediately while maintaining the same diagnostic accuracy.

June – A night celebrating staff achievements at the 2025 STAR Awards
We were delighted to honour the incredible achievements of our staff at the annual Patient First STAR Awards in June. With over 1,200 nominations from colleagues and the public, the awards ceremony celebrated the compassion, patient care and professional excellence found in every corner of our Trust. From inspiring clinical teams to our dedicated volunteers, the winners represent the very best of our values.

July – Local partnerships deliver better stop smoking support for patients
In July we announced the expansion of a key service supporting patients to quit smoking. Part of the NHS Long Term Plan towards a smoke-free England by 2030, our tobacco dependency advisor service provides behavioural support and Nicotine Replacement Therapy to patients across all our hospitals, now including Worthing Hospital and Royal Sussex County Hospital.

Alongside this, we continued to see strong uptake of Swap2Stop. This scheme in partnership with West Sussex County Council Public Health supports patients on surgical waiting lists to quit smoking before operations, improving surgical outcomes and reducing the risk of post-operative complications.

August – Charity donation delivers sight-saving equipment at St Richard's

The Trust marked the introduction of new sight-saving equipment at St Richard's Hospital in August. Funded by a £33,000 donation from volunteer-led charity Friends of Chichester Hospitals, it is transforming glaucoma diagnosis and treatment. The equipment enables patients to receive same-day testing and treatment planning in a one-stop clinic, helping to speed up diagnosis, reduce the need for pressure-related surgery and improve outcomes for patients with glaucoma.

September – UHSussex research uncovers hidden heart risks in sepsis survivors

In September we celebrated new research from the Sussex Cardiac Centre in Brighton which uncovered that sepsis survivors may face long-term heart damage. Led by Consultant Cardiologist Dr Alexander Liu, the pioneering study used advanced imaging to identify a link between heart scarring and reduced pumping function, highlighting potential ongoing cardiac risks after recovery from sepsis and informing future patient care.

October – £100m Digital Strategy: "Excellent Care Everywhere"

In October we unveiled our ambitious five-year strategy, 'Excellent Care Everywhere'. Central to this vision is a £100 million investment in digital transformation, including the rollout of a Trust-wide Electronic Patient Record (EPR). This move will unify our hospitals, replacing paper systems and giving staff real-time data to provide the best possible care.

November – UHSussex and NHS partners win national award for Alzheimer's diagnosis research

November saw UHSussex and its research partners recognised at the HSJ Awards for taking a key role in a prestigious national research collaboration investigating earlier and more precise diagnosis of Alzheimer's disease for patients. Working collaboratively with private sector partners and three other NHS trusts (including Oxford, Manchester and Sheffield), this transformative project is helping establish a framework for the use of advanced diagnostic testing within the NHS, enabling earlier detection of the disease. The collaboration was awarded 'Partnership of the Year' at the 2025 HSJ Awards.

The Community Diagnostic Centre at Southlands Hospital celebrated its first anniversary this month after delivering more than 140,000 vital diagnostic tests and significantly reducing waiting times across Sussex.

Through its innovative 'one-stop' model of care, the facility continues to transform patient experiences and bring healthcare closer to the community.

December – Bringing cutting-edge prostate cancer research to Sussex patients
December marked an important milestone for clinical research within the Trust, with a major national clinical trial being extended to patients at Royal Sussex County Hospital. As part of the *STAMPEDE2* clinical trial, Sussex patients have started to access innovative new therapies to treat the disease. These include a combination of hormone therapy with either a radiopharmaceutical drug or a highly targeted form of radiotherapy.

The trial aims to assess whether these therapies can improve survival and disease control, offering new hope to patients and cementing our role as a leader in regional medical research.

January – £250m investment secures new Sussex Cancer Centre
A quarter-of-a-billion-pound investment to deliver a new state-of-the-art Sussex Cancer Centre at the Royal Sussex County Hospital was announced in January. The funding, confirmed by the Government and the New Hospitals Programme, will bring specialist cancer services, diagnostics, treatment and research together under one roof, significantly expanding capacity and improving patient experience across Sussex.

February – University of Brighton partnership supports recovery of Stroke patients
In February a new partnership between UHSussex and the University of Brighton brought sports students onto wards at Royal Sussex County Hospital to help patients recovering from strokes and at risk of deconditioning. Working under the guidance of Trust clinical teams, students helped patients to stay active and rebuild strength through gentle, supervised exercise as part of the Stronger for Life in Hospital programme, helping improve recovery, independence and confidence while also giving students valuable hands-on experience in a real NHS setting.

March – Celebrating a year of 'A Friend In Need' end-of-life volunteer partnership
We closed the year in March by celebrating the first anniversary of ‘A Friend In Need’ - an essential end-of-life volunteer service helping hundreds of patients. The service is a partnership between UHSussex, the Friends of Brighton & Hove Hospitals, and the Anne Robson Trust. In its first year, 17 volunteers provided companionship to nearly 400 patients in their final hours. March also saw the opening of the Douglas Chamberlain Education Centre, a new facility dedicated to training the next generation of healthcare professionals.

And finally, Dr. Nisal Karunaratne, a year one resident doctor, successfully transformed bedside ultrasound imaging at St Richard’s and Worthing hospitals by expanding access to portable, handheld Point of Care Ultrasound (POCUS) devices. This innovative project allows clinicians to make faster, more accurate diagnostic decisions right at the patient's bedside, significantly improving the speed and quality of care.

Stay Updated: These highlights represent just a fraction of the work happening across University Hospitals Sussex. You can find more stories and detailed news updates throughout the year at: www.uhsussex.nhs.uk/news/.

1.4.15 Stakeholder Relations

Collaborative working is key to achieving the ambitions of Our Communities strategic theme, which puts a strong focus on the way we work with our external partners as well as on a multidisciplinary basis within the Trust.

Our approach is, and always has been, based on openness, honesty and a genuine desire to listen to and act on feedback to improve our services and our patients' experience. The Governors' Patient Experience and Wider Engagement Committee exists to seek the views of Foundation Trust members through the governors, and those of the statutory bodies to inform priority work programmes to improve patient experience and influence the strategic direction of patient and public involvement by ensuring a wide range of stakeholder views are gathered and taken into account.

Our partners in our local health economy include GPs, community healthcare providers, NHS Sussex and Sussex Health and Care Partnership members, Healthwatch West Sussex, Brighton & Hove and East Sussex, social care providers, charities, the ambulance service and mental health Trust.

1.4.16 Our dedicated charity "MyUHSussex Charity"

In this past year, MyUHSussex Charity has continued to deliver vital funds to support care, treatment and research across University Hospitals Sussex. My Charity funding provides equipment, enhanced environments and care to improve the hospital experience for patients, families and staff. The charity also plays a key role in the community by mobilising third sector support and acting as a broker and advocate for the Trust across Sussex's vibrant civil society.

The charity, now in the second year of a three-year strategy, secured £1.7m in fundraised and investment income and distributed £4.1m to support a number of programmes and initiatives including:

> Neonatal feeding pumps £348,192 - Funding a new fleet of state-of-the-art feeding and medication pumps for our neonatal units across Sussex. These new pumps ensure that medications are delivered with absolute, microscopic precision giving piece of mind to parents and families.
>
> Small Acts of Friendship £218,800 - This grant allowed our Small Acts of Friendship programme to be implemented across all acute hospitals. This unique programme focuses on patient wellbeing by providing services, therapies and activities that supports patients' emotional state, sense of dignity and self-expression whilst in hospital.
>
> Savi Scout biopsy system £158,800 - This innovative technology uses non-radioactive tags to precisely locate breast cancer before surgery. This upgraded biopsy system will provide a more comfortable patient

experience and improve surgical accuracy, preventing many women from needing a second operation.

Pentacam Camera £51,935 - This vital piece of equipment is used in ophthalmology for the diagnosis of corneal conditions. Providing this equipment at Princess Royal Hospital allows patients to receive the full suite of diagnostic tests in the hospital, removing the need for a second appointment at the Sussex Eye Hospital in Brighton.

Cardiology Ultrasound £38,778 - This new dedicated heart and blood vessel scanner helps prevent dangerous delays during emergencies and high-risk procedures. This equipment will ensure faster, safer treatment and help patients recover and return home sooner by streamlining urgent scans.

Finally, work has progressed on the private phase of a capital fundraising appeal supporting the new Sussex Cancer Centre. Building networks across East and West Sussex, the appeal is reaching out to individuals and organisations who may have an interest in supporting the appeal at a high level. Approaches to prospective donors will continue throughout the 2026/27 financial year and the charity is finalising plans for a public phase of the campaign which is expected to start in 2027/28.

1.4.17 Directors' statement

The Directors are required under the NHS Health Service Act 2006 to prepare accounts for each financial year.

The Directors consider the Annual Report and Accounts, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators, and stakeholders to assess the Trust's performance, business model and strategy.

Each Director of the Trust Board, at the time of approval of the Annual Report and Financial Statements, declares that:

- So far as they are aware, there is no relevant audit information of which the Trust's auditor is unaware; and
- The Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

…… 25 June 2026

Dr Andy Heeps
Chief Executive

2. Accountability Report

2.1 Directors' Report

Our Board of Directors is responsible for the management and performance of the Trust, and for setting its future strategy.

This section of the Annual Report provides an overview of 2025/26 from an operational and strategic standpoint, outlines the in-year development of the Trust's relationships and partnerships with stakeholders, and details its governance and management arrangements from a Board perspective.

2.1.1 Managing the Trust

How the Trust is run

The Trust's Constitution sets out the way in which the Council of Governors and the Board of Directors will operate and work together including their key areas of responsibilities.

The Trust's Scheme of Delegation sets out the responsibilities of the Trust's Board and key Committees.

In the event of dispute between the Council and the Board then the dispute resolution procedure set out in the Constitution shall be followed in order to resolve the matters concerned. This has not been required during the period 1 April 2025 to 31 March 2026.

The Board is responsible for the management of the Trust and for ensuring proper standards of corporate governance are maintained. The Board accounts for the performance of the Trust and consults on its future strategy with its members through the Council of Governors (CoG).

The Board has established a committee structure of five main Committees. The Committees retain their oversight of allocated BAF risks but also have capacity within their respective work programmes to provide enhanced assurance to the Board over the Trust's delivery of its Strategy and Operational plans. The Trust from 1 April 2025 established a Strategy and Major Projects Assurance Committee to provide enhanced oversight and assurance to the Board on the delivery of the many key transformational projects instrumental to the delivery of the Trust's excellent care everywhere strategy.

Our Board of Directors 1 April 2025 to 31 March 2026

NON-EXECUTIVE DIRECTORS

Philippa Slinger, Chair (Term of office 1 July 2024 to 30 June 2027)

Chair of the Executive Appointments and Remuneration Committee
Trust's lead of the Committee in Common

Professor Paul Layzell CBE, Deputy Chair (Term of Office 1 September 2022 to 31 August 2028 noting his second term commenced on 1 September 2025)

Chair of People and Culture Committee and Chair of Strategy and Major Projects Committee.

Lucy Bloem, Senior Independent Director (Term of Office from 1 September 2021 to 30 August 2027, noting her second term commenced on 1 September 2024)

Chair of the Patient and Quality Committee and NED Maternity Safety Champion

David Curley (Term of Office from 1 July 2022 to 30 June 2025)

Chair of the Audit Committee

Mike Driver (Term of Office from 1 August 2025 to 31 July 2028)

Chair of the Audit Committee

Professor Jackie Cassell Term of Office from 1 April 2021 to 31 March 2027, noting her second term commenced on 1 July 2024)

Chair of the Research, Innovation and Digital Committee

Philip Hogan (Term of Office from 1 January 2024 to 31 December 2027)

Chair of Finance and Performance Committee (he was also interim Chair of the Audit Committee from 1 July 2025 to 31 July 2025)

Wayne Orr (Term of Office from 19 February 2024 to 31 January 2026)

Chair of the Charitable Funds Committee

Bindesh Shah (Term of Office from 1 July 2022 to 30 June 2028, noting his second term commenced on 1 July 2025))

Chair of the Charitable Funds Committee from 1 February 2026

Professor Gordon Ferns (Term of Office from 1 August 2024 to 31 July 2027)

Non-Executive Director

Kate Steadman (Term of Office form 1 August 2025 to 31 January 2026)

Non-Executive Director

EXECUTIVE DIRECTORS

Dr George Findlay, *Chief Executive until 31 August 2025*

Dr Andy Heeps, *Chief Executive from 15 December 2025, was Interim Chief Executive from 1 September 2025 to 14 December 2025 and prior to that was Deputy Chief Executive*

Jonathan Reid, *Chief Financial Officer*

Professor Catherine (Katie) Urch, *Chief Medical Officer*

Dr Maggie Davies, *Chief Nurse*

David Grantham, *Chief People Officer until 15 February 2026*

Sarah-Jane Taylor, *Interim Chief People Officer from 16 February 2026*

Roxanne Smith, *Chief Strategy Officer*

Nigel Kee, *Interim Chief Operating Officer*

Michelle Arrowsmith, *Interim Chief Corporate Affairs Officer from 13 October 2025 until 9 January 2026.*

***Helen Brown**, Interim Chief Corporate Affairs Officer from 12 January 2026*

Sandi Drewett, *Chief Culture and Organisational Development Officer until 30 May 2025*

It should be noted that the Chief Cultural and Organisational Development Officer was not a voting member of the Board during this period.

Board of Directors

The Chair and the Non-Executive Directors are appointed by the Council of Governors.

The Board attendance of the Directors of the Trust for the period of this report are shown in the tables later in the report together with their attendance at their allocated Committee meetings for the same period.

All of the Non-Executive Directors are considered to be independent.

The Chair of the Board is also the Chair of the Council of Governors.

Deputy Chair

Good practice suggests that the Trust should have a Deputy Chair to stand in during any period of absence of the Chair. The Trust Constitution makes provision for the appointment of a Deputy Chair and NHS England's guidance states that this should be a Council of Governors appointment, although it

would be expected that the Chair would make a recommendation to Governors.

Professor Paul Layzell CBE, Non-Executive Director, is the Deputy Chair.

Senior Independent Director

The Senior Independent Director is a Non-Executive Director appointed by the Board as a whole in consultation with the Council of Governors. The Senior Independent Director has a key role in supporting the Chair in leading the Board and acting as a sounding board and source of advice for the Chair.

Lucy Bloem, Non-Executive Director, is the Board's Senior Independent Director.

Skills of the Board

The Board undertook a review of its skills as it developed its merger full business case. The Board has used this skills analysis during the recruitment of two new Non-Executive Directors in the summer of 2025 and is utilising this analysis as it has commenced a recruitment campaign for the replacement of the two retiring Non-Executive Directors, Wayne Orr and Kate Streadman. The Trust is also planning to recruit a clinically skilled Non-Executive Director during 2026/27.

Operation of the Board

The Board has agreed a scheme of reservation and delegation which sets out those decisions which must be taken by the Board and those which may be delegated to the Executive or to Board sub-committees.

The Board sets the Trust's strategic aims and provides active leadership of the Trust. It is collectively responsible for the exercise of its powers and the performance of the Trust, for ensuring compliance with the Trust's Provider Licence, relevant statutory requirements and contractual obligations, and for ensuring the quality and safety of services. It does this through the approval of key policies and procedures, the annual plan and budget for the year, and schemes for investment or disinvestment above the level of delegation.

The Non-Executive Directors play a key role in taking a broad, strategic view, ensuring constructive challenge is made and supporting and scrutinising the performance of the Executive Directors, whilst helping to develop proposals on strategy.

Board cycle meetings follows a pattern of one meeting a quarter having a forward, strategic delivery focus and the other meeting in the quarter having a focus on in year performance, these meetings follow a formal agenda which includes a update from the Chief Executive, the Trust's structured integrated performance report that reflects the Trust's performance along with formal assurance reports from each of the Board Committees. With the various, patient experience, quality and workforce annual reports being agreed by the Board prior to this placement on the Trust's website.

The Board during 2023/24 agreed to enter into a series of undertakings with NHS England in respect to improvements required over the Trust's quality governance and operational performance. The Board has undertaken a comprehensive review of its delivery against these and made a formal submission to NHS England requesting they review these against the evidence of delivery provided.

The Board has received a range of information covering the Trust's annual plan, maternity service oversight dashboards, infection prevention and control, safeguarding, the Trust's capital programme, learning from deaths, learning from incidents, various compliance reports, CQC recommendation action delivery, delivery against the Trust's undertakings and the tracking of delivery through the one UHSussex strategic ambition of the well led developmental review recommendations.

Attendance at Board meetings 1 April 2025 to 31 March 2026

	Public Board	Private Board	Corporate Trustee
Total number of meetings in the year	7	14	4
Non-Executive Directors			
Phillipa Slinger, Trust Chair	7 of 7 100%	13 of 14 93%	3 of 4 75%
Lucy Bloem, Non-Executive Director	7 of 7 100%	13 of 14 93%	1 of 4 25%
Professor Jackie Cassell, Non-Executive Director	6 of 7 86%	13 of 14 93%	4 of 4 100%
David Curley, Non-Executive Director *(until 30.06.25)*	0 of 2 0%	2 of 3 67%	1 of 1 100%
Michael Driver CB, Non-Executive Director *(from 01.08.25)*	5 of 5 100%	10 of 11 91%	2 of 3 67%
Professor Gordon Ferns, Non-Executive Director	7 of 7 100%	13 of 14 93%	4 of 4 100%
Philip Hogan, Non-Executive Director	7 of 7 100%	14 of 14 100%	3 of 4 75%
Professor Paul Layzell CBE, Non-Executive Director	6 of 7 86%	11 of 14 79%	3 of 4 75%
Wayne Orr, Non-Executive Director (until 31.01.2026, with sabbatical taken 01.08.25-31.10.25)	1 of 3 33%	4 of 7 57%	1 of 1 100%
Bindesh Shah, Non-Executive Director	5 of 7 71%	10 of 14 71%	3 of 4 75%
Kate Steadman, Non-Executive Director (from 01.08.25 - 31.01.2026)	2 of 3 67%	6 of 7 86%	2 of 2 100%
Executive officers:			
Dr George Findlay Chief Executive (until 31.08.25)	2 of 2 100%	2 of 4 50%	0 of 1 0%

Michelle Arrowsmith, Interim Chief Corporate Affairs Officer (13.10.25 - 09.01.26)	2 of 2 100%	3 of 3 100%	1 of 1 100%
Helen Brown, Interim Chief Corporate Affairs Officer (from 12.01.26)	2 of 2 100%	5 of 5 100%	1 of 1 100%
Dr Maggie Davies, Chief Nurse	6 of 7 86%	10 of 14 71%	1 of 4 25%
*Sandi Drewett, Chief Culture & Organisation Development Officer (until 30.05.25)	1 of 1 100%	2 of 2 100%	0 of 0 n/a
David Grantham, Chief People Officer (until 13.02.26)	6 of 6 100%	11 of 11 100%	3 of 3 100%
Dr Andy Heeps Deputy Chief Executive (01.04.25) Acting Chief Executive (10.07.25 - 31.08.25) Interim Chief Executive (from 01.09.25) Chief Executive (from 15.12.25)	6 of 7 86%	13 of 14 93%	4 of 4 100%
Nigel Kee, Interim Chief Operating Officer	6 of 7 86%	12 of 14 86%	4 of 4 100%
Jonathan Reid, Chief Financial Officer	6 of 7 86%	12 of 14 86%	4 of 4 100%
Sarah-Jane Taylor, Interim Chief People Officer (from 16.02.26)	1 of 1 100%	3 of 3 100%	1 of 1 100%
Roxanne Smith, Chief Strategy Officer	6 of 7 86%	12 of 14 86%	2 of 4 50%
Professor Catherine "Katie" Urch, Chief Medical Officer	7 of 7 100%	14 of 14 100%	3 of 4 75%

*Note * non voting members of the Board*

Board Committees

The Board has established a series of Committees that support the discharging of the Board's responsibilities. Complementing these are five main Committees, along with the Audit Committee, the Appointments and Remuneration Committee and a Charitable Funds Committee noting that these three Committee are mandated. Each of these Committee's is chaired by a Non-Executive Director.

These committees do meet independently of each other but where appropriate operate together (and indeed report to one another) to ensure full coverage and clarity on all areas of Trust activity. The schematic below shows the inter-relationships of the Committees and the Board as at the 31 March 2026.

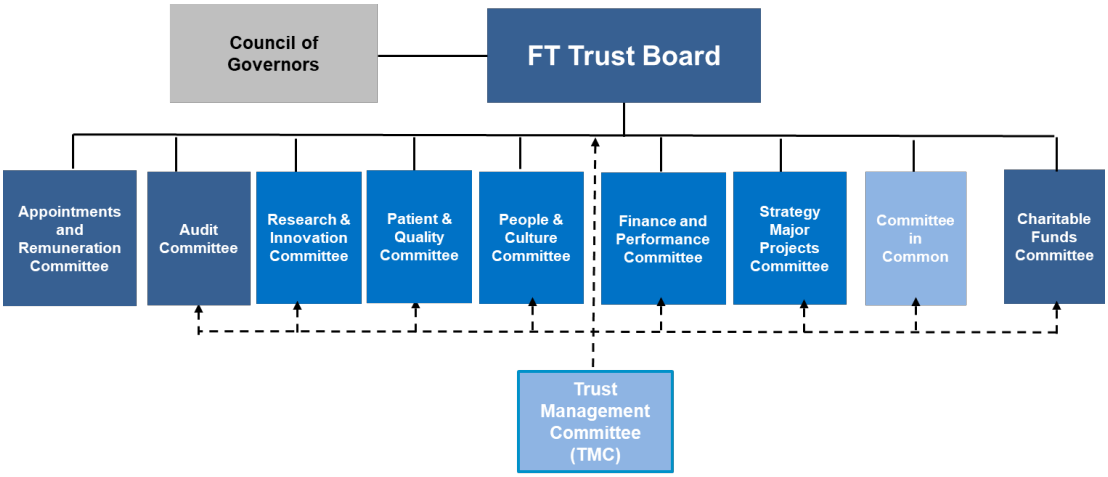
The Trust along with the other Sussex Providers established a Committee in Common to support discussions about the strategic challenges across the system. The Trust Chair and Chief Executive along with another NED were members of this Committee which met at the same time as other Committee's in Common along with NHS Sussex. At the end of 2025/26 it was determined

to dis-establish this Committee as the work was moving to the established provider collaboratives and therefore there were different governance arrangements.

The Trust has a senior management Committees, the Trust Management Committee which reports as required to the Board through the Chief Executive.

The attendance tables shown highlight those Non-Executive Directors and Executive Directors attending as members of the individual Committee or as attending for quoracy purposes, recognising that all Non-Executive Directors and Executive Directors can choose to attend any meeting as they wish.

The Board Committee schematic as at 31 March 2026 is shown below:



Patient and Quality Assurance Committee

The Patient and Quality Assurance Committee supported the Board in ensuring that the Trust's processes take account of patient feedback and that the Trust has sound processes for securing patient engagement where pathway changes are to be considered. The Committee received the action plans developed based on national patient survey feedback including the roll out of the Trust's developed welcome standards.

This Committee also supports the Board in ensuring that the Trust's management of clinical and non-clinical processes and controls are effective in setting and monitoring good standards and continuously improving the quality of services provided by the Trust. The Committee receives structured updates from the divisions through the quality governance steering groups supporting the Committees receipt of operational and management assurance in respect of their systems of patient quality and safety.

People and Culture Assurance Committee

The People and Culture Assurance Committee supports the Board in ensuring that the Trust's processes and controls are effective in setting and monitoring good standards and continuously improving the leadership, development and wellbeing of the Trust's workforce alongside oversight of compliance with the Trust's range of workforce KPIs. The Committee receives reports from the Freedom to Speak up Guardian and Guardian of Safe Working Hours along with the National Staff Survey and GMC survey.

The Committee also supports the Board through the provision of oversight of the Trust's Cultural Development programme and within 2025/26 the revision to the Trust's values and behaviours framework and supporting behavioural compass.

Finance and Performance Assurance Committee

The Finance and Performance Assurance Committee supports the Board to ensure that all appropriate action is taken to achieve the financial objectives of the Trust through regular review of financial strategies and performance, investments, and capital and estates plans and performance. The Committee also has oversight of the Trust's processes for setting and delivering the Trust's environmental sustainability agenda, procurement and major investment business cases. The Committee also supports the Board to ensure that all appropriate action is taken to improve its operational performance along with the Trust's processes for working with the systems and its engagement with ICS. As the Trust remained in Tier One oversight for Cancer and Planned Care (Referral to Treatment) performance with this Committee receiving assurance over the delivery of the specific improvement measures to reduce waits in these areas.

Research, Innovation and Digital Strategy Assurance Committee

The Board agreed to extend the remit of the Research and Innovation Committee from the 1 April 2024, to include oversight of the Trust's digital improvement agenda seeing this Committee renamed the Research, Innovation and Digital Strategy Assurance Committee. This Committee continued to provide assurance to the Board on the Trust's development and successful implementation of its Research and Innovation Strategy along with assurance over research activity over the year. The Committee received routine reports from the Chief Information Officer in respect of the plans to improve the Trust's digital maturity ahead of the implementation of the Electronic Patient Record systems.

Strategy and Major Projects Assurance Committee

The Board continued with a dedicated Committee to oversee the Trust's delivery of its Major Projects that are instrumental to the delivery of its Excellent Car Everywhere Strategy. The Committee also provides oversight of the delivery of the Strategy annual delivery plan milestones. The Committee receives reports from an established Strategy and Major Projects Steering Group which itself is supported by a Clinical Transformation Programme Board whose membership includes all eight of the Chairs of Service.

The table overleaf shows the attendance at each of these Committees

	Finance & Performance	Patient & Quality	People & Culture	Research Innovation & Digital Strategy	Strategy & Major Projects
Total number of meetings in the year	10	8	6	4	4
Non-Executive Directors					
Phillipa Slinger, Trust Chair	1 of 1 100%	n/a	n/a	n/a	n/a
Lucy Bloem, Non-Executive Director	9 of 10 90%	8 of 8 100%	n/a	n/a	4 of 4 100%
Professor Jackie Cassell, Non-Executive Director	1 of 1 100%	2 of 3 67%	3 of 3 100%	4 of 4 100%	n/a
David Curley, Non-Executive Director (until 30.06.25)	n/a	n/a	n/a	n/a	n/a
Michael Driver CB, Non-Executive Director (from 01.08.25)	n/a	1 of 1 100%	n/a	1 of 2 50%	n/a
Professor Gordon Ferns, Non-Executive Director	1 of 1 100%	7 of 8 88%	n/a	3 of 4 75%	n/a
Philip Hogan, Non-Executive Director	8 of 10 80%	n/a	1 of 1 100%	1 of 1 100%	3 of 4 75%
Professor Paul Layzell CBE, Non-Executive Director	8 of 10 80%	n/a	5 of 6 83%	n/a	4 of 4 100%
Wayne Orr, Non-Executive Director (until 31.01.2026, with sabbatical 01.08.25-31.10.25)	n/a	n/a	1 of 4 25%	2 of 4 50%	n/a
Bindesh Shah, Non-Executive Director	2 of 2 100%	n/a	5 of 6 83%	3 of 4 75%	3 of 4 75%
Kate Steadman, Non-Executive Director (from 01.08.25 - 31.01.2026)	n/a	3 of 4 75%	1 of 2 50%	n/a	2 of 2 100%
Executive officers:					
Dr George Findlay, Chief Executive (until 31.08.25)	2 of 2 100%	n/a	2 of 2 100%	n/a	n/a
Michelle Arrowsmith, Interim Chief Corporate Affairs Officer (13.10.25 - 09.01.26)	1 of 1 100%	1 of 1 100%	1 of 1 100%	n/a	1 of 1 100%
Helen Brown, Interim Chief Corporate Affairs Officer (from 12.01.26)	2 of 2 100%	1 of 1 100%	2 of 2 100%	n/a	n/a
Dr Maggie Davies, Chief Nurse	2 of 2 100%	6 of 8 75%	2 of 6 33%	n/a	3 of 4 75%
Sandi Drewett, Chief Culture & Organisation Development Officer (until 30.05.25)	n/a	0 of 1 0%	2 of 2 100%	n/a	1 of 1 100%

David Grantham, Chief People Officer (until 13.02.26)	7 of 8 88%	n/a	5 of 5 100%	4 of 4 100%	4 of 4 100%
Dr Andy Heeps Deputy Chief Executive (01.04.25) Acting Chief Executive (10.07.25 - 31.08.25) Interim Chief Executive (from 01.09.25) Chief Executive (from 15.12.25)	2 of 2 100%	n/a	1 of 1 100%	2 of 2 100%	2 of 2 100%
Nigel Kee, Interim Chief Operating Officer	8 of 10 80%	5 of 8 63%	1 of 1 100%	n/a	3 of 3 100%
Jonathan Reid, Chief Financial Officer	10 of 10 100%	6 of 6 100%	n/a	n/a	4 of 4 100%
Sarah-Jane Taylor, Interim Chief People Officer (from 16.02.26)	2 of 2 100%	1 of 1 100%	1 of 1 100%	n/a	n/a
Roxanne Smith, Chief Strategy Officer	5 of 10 50%	n/a	3 of 6 50%	4 of 4 100%	4 of 4 100%
Professor Catherine "Katie" Urch, Chief Medical Officer	1 of 10 10%	8 of 8 100%	6 of 6 100%	3 of 4 75%	2 of 3 67%

Appointment and Remuneration Committee

The Committee sets the terms and conditions of the Executive Directors. This committee's membership is the Trust Chair and Non-Executive Directors only. In attendance at meetings are the Chief Executive, Chief People Officer and the Company Secretary.

During the period the Committee did not procure any external advice relating to Executive pay.

This meeting met seven times during the year.

Audit Committee

The existence of an independent Audit Committee is the central means by which the Trust Board ensures effective control arrangements are in place. The Committee membership is solely made of Non-Executive Directors in line with the Code of Governance for Foundation Trusts, with each of the Committee NED Chairs being members of the Audit Committee and the Audit Committee chair being independent of other Committee Chair responsibilities.

The Audit Committee independently reviews, monitors and reports to the Board on the attainment of effective internal control systems and financial reporting processes.

The Chief Financial Officer, Interim Chief Corporate Affairs Officer, Director of Operational Finance, Company Secretary, Local Counter Fraud Services, Internal and External Auditors are regular attendees at meetings of the

Committee. The Committee requests other senior Trust officers to attend for specific items.

Also in attendance at the Audit Committee are the Trust's External Auditor, Grant Thornton LLP, the Trust's Internal Auditor which is BDO LLP and the Trust's Local Counter Fraud Service provider RSM UK. In addition to external audit services, Grant Thornton also undertook as non audit services to the Trust, a review of the Trust's contracting, coding and governance processes, for a fee of £45k noting that this was paid for by NHS Sussex ICB. This work was considered by the Audit Committee who agreed undertaking this work did not reflect any conflict.

The Audit Committee agenda is based upon an agreed annual work-plan. In order to maintain independent channels of communication, the members of the Audit Committee hold a private meeting collectively with External Audit, Internal Audit and Counter Fraud at least once a year. This provides all parties the opportunity to raise any issues without the presence of management.

The Audit Committee is responsible to the Board for reviewing the adequacy of the governance, board assurance and risk management and internal control processes within the Trust. In carrying out this work the Audit Committee obtains assurance from the work of the Internal Audit, External Audit and Counter Fraud Services.

The Audit Committee review the financial year-end Annual Report, Annual Accounts and Annual Governance Statement with the External Auditor prior to Board approval and sign off.

The Audit Committee agrees the schedule of Internal Audit reviews at the start of the year and receives the reports of those audits and tracks the implementation of recommendations at each of its meetings.

Charitable Funds Committee

The purpose of the Charitable Funds Committee is to monitor progress and performance against the strategic direction of the Trust's charity fundraising activity as determined by the Board as corporate Trustee; to approve and monitor expenditure of charitable funds in line with specified priority requirements; and to monitor the management of the Trust's investment portfolio ensuring that the Trust at all times adheres to Charity Law and to best practice in governance and fundraising. The Committee meets quarterly but convened four further times to consider funding bids.

The table below overleaf the attendance at each of these Committees

	Appointment & Remuneration	Audit	Charitable Funds
Total number of meetings in the year	7	5	8
Non-Executive Directors			
Phillipa Slinger, Trust Chair	7 of 7 100%	n/a	1 of 1 100%
Lucy Bloem, Non-Executive Director	7 of 7 100%	3 of 5 60%	n/a
Professor Jackie Cassell, Non-Executive Director	7 of 7 100%	4 of 5 80%	n/a
David Curley, Non-Executive Director (until 30.06.25)	0 of 1 0%	2 of 2 100%	n/a
Mike Driver CB, Non-Executive Director (from 01.08.25)	5 of 5 100%	2 of 2 100%	3 of 5 60%
Professor Gordon Ferns, Non-Executive Director	7 of 7 100%	n/a	7 of 8 88%
Philip Hogan, Non-Executive Director	7 of 7 100%	3 of 5 60%	5 of 8 63%
Professor Paul Layzell CBE, Non-Executive Director	6 of 7 86%	5 of 5 100%	1 of 1 100%
Wayne Orr, Non-Executive Director (until 31.01.2026, with sabbatical 01.08.25-31.10.25)	2 of 5 40%	n/a	3 of 5 60%
Bindesh Shah, Non-Executive Director	4 of 7 57%	n/a	2 of 2 100%
Kate Steadman, Non-Executive Director (from 01.08.25 - 31.01.2026)	3 of 4 75%	n/a	n/a
Executive officers:			
Dr George Findlay, Chief Executive (until 31.08.25)	1 of 1 100%	n/a	n/a
Michelle Arrowsmith, Interim Chief Corporate Affairs Officer (13.10.25 - 09.01.26)	n/a	1 of 1 100%	1 of 1 100%
Helen Brown, Interim Chief Corporate Affairs Officer (from 12.01.26)	n/a	1 of 1 100%	2 of 2 100%
Dr Maggie Davies, Chief Nurse	n/a	n/a	2 of 8 25%
Sandi Drewett, Chief Culture & Organisation Development Officer (until 30.05.25)	n/a	n/a	n/a
David Grantham, Chief People Officer (until 13.02.26)	4 of 6 67%	n/a	6 of 7 86%
Dr Andy Heeps Deputy Chief Executive (01.04.25) Acting Chief Executive (10.07.25 - 31.08.25)	4 of 5 80%	1 of 3 33%	n/a

	Appointment & Remuneration	Audit	Charitable Funds
Total number of meetings in the year	7	5	8
Interim Chief Executive (from 01.09.25) Chief Executive (from 15.12.25)			
Nigel Kee, Interim Chief Operating Officer	n/a	1 of 1 100%	4 of 8 50%
Jonathan Reid, Chief Financial Officer	n/a	5 of 5 100%	2 of 2 100%
Sarah-Jane Taylor, Interim Chief People Officer (from 16.02.26)	1 of 1 100%	n/a	1 of 1 100%
Roxanne Smith, Chief Strategy Officer	n/a	1 of 1 100%	1 of 8 13%
Professor Catherine "Katie" Urch, Chief Medical Officer	n/a	n/a	n/a

2.1.2 Executive and NED appointments and appraisal

Recruitment

The Chair, other Non-Executive Directors, and the Chief Executive are responsible for deciding the appointment of Executive Directors.

Non-Executive Directors are appointed by the Council of Governors with the process being led by the Governors Nomination and Remuneration Committee. Non-Executive Directors are appointed for a three-year term in office. A Non-Executive can be re-appointed for up to two further three-year terms in office on an uncontested basis, subject to the recommendation of the Chairman and approval by the Council of Governors.

During the year the Council of Governors were actively involved in the recruitment of the new Non-Executive Directors, their involvement included being part of the review of the role descriptions and the shortlisting and stakeholder panel processes, with the lead governor and a staff governor being an integral part of the interview panel.

During the year the Non-Executives led the appointment of the Trust's Chief Executive, this appointment was considered and approved by the Trust's Appointment and Renumeration Committee. The lead governor and a staff governor were also part of the interview panel for the Chief Executive which supporting the governor agreement to the Chief Executive's appointment.

The Non-Executive Appointment and Renumeration Committee also considered and approved the appointment of three interim executives over the year to 31 March 2026.

Appraisals

The Chief Executive undertakes an appraisal on the performance of the Executive Directors, which are formally reported to the Appointment and Remuneration Committee.

The Chair conducts the Chief Executive's appraisal which is reported in the same way.

The Chair undertakes the appraisal of the Non-Executive Directors, having sought feedback from other Directors. The Senior Independent Director conducted the appraisal of the Chair which included feedback from Directors, Governors and the wider system. The Chair and Non-Executive Directors appraisals were formally reported to the Council of Governors.

All Non-Executive Directors are considered to be independent, and their independence is considered during their annual appraisal and confirmed by the Governors.

2.1.3 Statement of compliance with the Code of Governance for NHS Provider Trusts 2023/24

University Hospitals Sussex NHS Foundation Trust has applied the principles of the Code of Governance of NHS Provider Trusts which follows the 'comply or explain' basis.

The Code requires several disclosures to be made within the Annual Report of NHS Trusts. These are recorded in the table below, noting that for many, there is more detail within other sections of the annual report and where this is the case then a cross reference to those paragraphs has been included.

The Foundation Trust Annual Reporting Manual also requires Foundation Trusts to make further disclosures regarding how the Trust and Governors work, for ease, compliance against these requirements have been included in the table, again where applicable, appropriate cross references have been included to where the detail is contained in other parts of the annual report.

Code section	Summary of requirement	Trust position
A 2.1	The Board of Directors should assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of Directors should ensure the Trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The Trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is	Compliant Further detail is provided within the Strategy section 1.3 the Performance section 1.4 and its various sub sections along with Annual Governance Statement section 2.7

Code section	Summary of requirement	Trust position
	contributing to the delivery of its strategy.	
A 2.3	The Board of Directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the Trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the Trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Compliant. Further detail is provided within the Staff Report section 2.3 and in particular sub section within section 2.3.1 our Culture and People Priorities which covers staff wellbeing.
A 2.8	The Board of Directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the Trust has entered. The board of Directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisations governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Compliant. Further information is provided within the Performance section 1.4 especially in relation to systems and partnerships. Also see sections 1.4.10 and 1.4.15 in respect of work to address equity of access and health inequalities.
B 2.6	The Board of Directors should identify in the annual report each Non-Executive Director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive Director's independence include, but are not limited to, whether a Director: • has been an employee of the Trust within the last two years • has, or has had within the last two years, a material business relationship with the Trust either directly or as a partner, shareholder, Director or senior employee of a body that has such a relationship with the Trust • has received or receives remuneration from the Trust apart from a Director's fee, participates in the Trust's performance-related pay	Compliant. Information in respect of the Board members is provided at section 2.1 Directors report including information on each Board member at section 2.1.1 plus information on the Trust processes for recording and managing and interests is

Code section	Summary of requirement	Trust position
	scheme or is a member of the Trust's pension scheme • has close family ties with any of the Trust's advisers, Directors or senior employees • holds cross-Directorships or has significant links with other Directors through involvement with other companies or bodies • has served on the Trust Board for more than six years from the date of their first appointment • is an appointed representative of the Trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of Directors nonetheless considers that the non-executive Director is independent, it needs to be clearly explained why.	provided at section 2.1.6. Information on Remuneration of each Board members is included in section 2.4 Remuneration Report.
B 2.13	The annual report should give the number of times the board and its committees met, and individual Director attendance.	Compliant This is described in section 2.1 Directors Report, specifically in section 2.1.1 How the Trust is run.
B 2.17	For foundation Trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of Directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the Board of Directors.	Compliant In respect of the Governors this is described in section 2.2 Governor Report specifically in sections 2.2.2 Role of the Governors. In respect of the Board this is described in section 2.1 Directors Report specifically in section 2.1.1 How the Trust is run.
C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the Trust or individual Directors.	There have been no significant external consultancy

Code section	Summary of requirement	Trust position
		engagements this year.
C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive Directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	Compliant This is described in Section 2.2 Governors report specifically within section 2.2.11.
C 4.2	The Board of Directors should include in the annual report a description of each Director's skills, expertise and experience.	Compliant This is included within section 2.1 Directors Report specifically in section 2.1.1 How the Trust is run and 2.1.2 Executive and NED appointments along with 2.2.11 for the Governors appointment process for NEDs.
C 4.7	All Trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the Trust or individual Directors.	Compliant The Trust undertook an external well led developmental review in 2024/25 which reported in July 2025. This work was undertaken independently by NICHE consulting. The CQC also undertook their Well Led review in July 2025 and their report issued in May 2026 reflected an improved judgement of requires improvement. section 2.1.8.

Code section	Summary of requirement	Trust position
C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of Directors and individual Directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to Trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the Trust's workforce and communities served the gender balance of senior management and their direct reports.	Compliant This is included within section 2.1 Directors Report specifically in section 2.1.1 How the Trust is run and 2.1.2 Executive and NED appointments along with 2.2.11 for the Governors appointment process for NEDs. Information in respect of diversity and inclusion including the NHS WRES is included in section 2.3 Staff Report specifically in section 2.3.2.
C 5.15	Foundation Trust governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Compliant Detail is provided within section 2.2 Governors Report and specifically within section 2.2.2 role of the Governors and within the section 2.1.10 membership engagement.
D 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS Trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm,	Compliant This include in section 2.1 Directors report and 2.1.1 how the Trust is Run which provides information on role and operation of the Audit Committee.

Code section	Summary of requirement	Trust position
	when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	The Council of Governors appoint the Trust's external auditors, and the current auditors were appointed through open competition for the 2025/26 year, a review of the external auditors performance was considered by the Governors. The Trust uses BDO to provide Internal Audit Services. The Audit Committee supports the Governors assess the independence of the auditors. The Audit Committee assessed the non audit work delivered in 2025/6 by the External Auditors.
D 2.6	The Directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.	Compliant See the Directors statement at 1.4.17plus the statement of the accounting officer at section 2.6
D 2.7	The Board of Directors should carry out a robust assessment of the Trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Compliant Information the Trust's risk management process and principal risks are included at

Code section	Summary of requirement	Trust position
		section 1.3.8 also information is provided within the Annual Governance Statement at section 2.7.
D 2.8	The Board of Directors should monitor the Trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Compliant Information on this assessment is provided within the Annual Governance Statement at section 2.7.
D 2.9	In the annual accounts, the Board of Directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation Trust annual reporting manual which explain that this assessment should be based on whether a Trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	Compliant A statement is included in section 1.4.5
E 2.3	Where a Trust releases an executive Director, e.g. to serve as a non-executive Director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the Director will retain such earnings.	The Trust does not have any such arrangements
Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Compliant See section 2.2 Governors report.
Appendix B, para 2.14 (not in	The Board of Directors should ensure that the NHS foundation Trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for	Compliant See section 2.2 on the role of Governors

Code section	Summary of requirement	Trust position
Schedule A)	members who wish to communicate with governors and/or Directors should be clear and made available to members on the NHS foundation Trust's website and in the annual report.	specifically in sections 2.2.12 and 2.2.13 relating to the membership strategy and membership engagement.
Appendix B, para 2.15 (not in Schedule A)	The Board of Directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive Directors, develop an understanding of the views of governors and members about the NHS foundation Trust, e.g. through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Compliant See section 2.2.8 on governor engagement.
Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the Directors to attend a governors' meeting for the purpose of obtaining information about the foundation Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the foundation Trust's or Directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	The Governors have not exercised this power during the year.

2.1.4 Statement of compliance with the NHS Constitution

The Board of Directors takes account of the NHS Constitution in its decisions and actions, as they relate to patients, the public and staff and is compliant with the principles, rights and pledges set out in the Constitution. However, the Trust recognises that it has not met all the NHS Constitutional Standards during 2025/26.

2.1.5 Statement on Directors' disclosures

The Annual Report is required to include a statement that for each individual, who is a Director at the time the report is approved, as follows:

- So far as each Director is aware, there is no relevant audit information of the which the (external) auditor is unaware; and
- the Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

The Directors have confirmed the above statement.

2.1.6 Declarations of interest

The Trust holds a register of company Directorships and other significant interests, held by both Directors and governors, which may conflict with their management responsibilities. The Audit Committee receives an Annual Report on Board Declarations and the process to mitigate any potential conflicts. Complementing this the Council of Governors receives an Annual report on Governors Declarations in the public part of its meeting.

No Board Member has declared any significant commitments that require disclosure or any management actions.

The register of these interests is made publicly available on the Trust's public website. The register can be found at https://www.uhsussex.nhs.uk/about/trust/statutory-documents/declarations/

In line with the standard contract for NHS Services each Trust is required to report on the level of staff required to make an annual declaration that have made such a declaration. For 2025/26 1301/1314 of the required staff made their declaration recognising that the majority of staff made a nil return. Of those who did not provide a return none have any budgetary responsibilities.

2.1.7 NHS Oversight Framework

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to a respective 'segment'.

Segmentation indicates performance and whether improvement is required, from high-performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability rating is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

a) Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)
b) considering financial override which may limit a segment to be no better than 3
c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and

d) capability assessments which consider the organisation's leadership and governance.

Segmentation

University Hospitals Sussex NHS Foundation Trust is in Segment 4 and has been assessed as red in its provider capability assessment. Whilst there have been no enforcement actions taken against the Trust the Trust continues with its licence undertakings with NHS England. These undertakings cover an agreement to improve operational performance and make improvements to the Trust's quality governance processes. Operational performance improvements are overseen by both the Board's Finance and Performance Committee and through the Tier 1 (RTT and Cancer) and Teir 2 (UEC) meetings with NHS England and quality governance improvements were overseen by both the Patient and Quality Committee and the Strategy and Major Projects Committee given that these improvements were weaved into the Trust strategic ambitions. The Board received information on the Trust's segmentation within its Integrated Performance Report.

The Trust in March 2026 entered into the National Provider Improvement Programme and has engaged with NHS England through the preparation of an improvement plan aligned to the Trust's strategy delivery plan.

This segmentation information is the trust's position as at quarter 3 (published on 19 March 2026, updated on 1 April 2026). Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/. The trust is included on the acute trust dashboard.

2.1.8 NHS England Well led framework

In 2025 the Board commissioned an external well led development review. This review was undertaken by NICHE consulting limited. The Trust had no relationship with the company or those leading the review. The specification of this review sought input from both NHS E and NHS Sussex to ensure allowing these parties to be content that the review will also support their respective review of the Trust's undertakings delivery.

The output from this work was presented to the Board and was weaved into the Trust's One UHSussex Strategic Ambition. The Board has received routine reports to its meeting in public tracking the delivery of these actions as part of the Chief Executive's updates on the delivery of the One UHSussex ambition. In the report to the Board on the 31 March 2026, the Trust has completed 7 of 21 actions, with many nearing assured completion and for those with a longer delivery timeframe the report showed a clear pathway to complete the remaining actions.

In July 2025 the CQC undertook its own Well Led review and their report was received in May 2026. The CQC judgement showed an improvement with the judgement of requires improvement from the prior Well Led assessment of inadequate.

Given the timing of the CQC review which was within a few months of the external developmental review their findings mirrored many of the same observations in that developmental review.

The Trust recognises that there remain two areas identified within both the developmental and CQC well led reviews where longer term attention is needed these relate to continuing to support staff to have confidence to utilise the established process to speak up and make improvements based on the Trust's Workforce Race Equality Standards information. Both of these areas are intrinsically linked to the Trust's cultural developmental programme which took a significant step forward with the launch of the Trust's reset behavioural framework and compass.

2.1.9 Emergency Preparedness, Resilience and Response

2025/26 has been a transitional year for the Emergency Preparedness, Resilience, and Response (EPRR) team with changes within the team and the external environment. Significant operational pressures within the Trust remained with a mandate for resident doctor industrial action leading to periods of strike action throughout the year and the mandate being continued into the middle of 2026.

The EPRR Team continued to deliver the EPRR portfolio throughout the year providing support across the Trust to ensure compliance with the NHS England EPRR Framework and the Trust is fully prepared to respond to any disruption or emergency event whether an internal or external issue/incident.

The outcome of the NHS England EPRR Assurance Process evidenced the Trust was substantially compliant with five advisories identifying partial compliance, some of which are not fully within the EPRR remit. The compliance was validated by the NHS Sussex EPRR Team who have a strong working relationship with the EPRR Team at the Trust and an action plan was developed to respond to the advisories from the assurance outcome.

Key themes focused on for the year where:

- Risk Management
- Business Continuity
- EPRR Assurance Framework
- Training and Exercising
- The Trust Strategy

The EPRR Team have maintained a mature suite of plans and policies responding to emergency planning and business continuity issues and work continues to ensure those plans remain current and align with all legislation that underpins the EPRR environment.

In May 2025, the Terrorism (Protection of Premises) Act came into legislation with reviews of plans and policies undertaken to understand the implications of the new legislation on the EPRR work programme, policies and plans. It is

noted guidance for the legislation was published by the Home Office in April 2026.

In September 2025, the Head of Service for EPRR retired and the team moved into a period of transition before the new Head of Service started in January 2026. During this time the team responded to periods of industrial action and other operational issues across the Trust and in early 2026 if was announced that NHS Sussex would be amalgamating with NHS Surrey leading to another period of transition and change.

Key recommendations from the EPRR annual report for 2025 included:

- Update the work programme for 2026 to ensure that work progresses on the advisories from the 2025 EPRR Assurance outcome.
- Undertake a gap analysis to identify any areas which may require Emergency Planning or Business Continuity engagement.
- Continue work on the Mass Casualty and Evacuation and Shelter Plans.
- Continue the work to support the Trust strategy of Excellent Care Everywhere with particular focus on the 'One UHSussex' theme and updating all plans to reflect this,

With the new Head of Service commencing in January 2026 a further update to the work programme has been undertaken with longer term aims of further enhancing the training and development portfolio with a robust eLearning offering and looking at both the physical and digital estate and ensuring they have robust emergency and business continuity plans and processes in place to support colleagues to deliver 'excellent care everywhere'.

Action plans for each of these recommendations have been developed with action owners with progress reported through the Health and Safety Committee.

2.1.10 Membership engagement

We have continued to keep under review the way we communicate with members and how we enable them to share their views.

In September 2025, we hosted our Annual General Meeting of the Council of Governors and Annual Members Meeting which was undertaken in the Lousia Martindale Building on the Royal Sussex County Hospital site. The Interim Chief Executive at that time, Dr Andy Heeps, reflected on the previous year and then concluded with the presentation of the Trust's Annual Report and Accounts.

Our e-newsletter, @UHSussex, is a popular channel for communicating with members. It contains news, event information, feedback methods and articles explaining how the Trust responds to suggestions from patients, carers and members.

During the latter part of 2024, members were invited to take part in the Big Conversation survey to share their insights and ideas about the future of UHSussex and their thoughts on shaping our new 5-year strategy for the organisation.

2.1.11 Disclosures to Auditors

The Directors are required under the NHS Health Service Act 2006 to prepare accounts for each financial year.

The Directors consider the annual report and accounts, taken as a whole, is fair, balances and understandable and provides the information necessary for patients, regulators, and stakeholders to assess the Trust's performance, business model and strategy.

Each Director of the Trust Board, at the time of approval of the Annual Report and Financial Statements, declares that:

- So far as they are aware, there is no relevant audit information of which the Trust's auditor is unaware; and
- The Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

2.1.12 Income Disclosures

The income from the provision of goods and services for the purposes of the health service in England is greater than the income from the provision of goods and services for any other purposes. Income from goods and services not for the purposes of the health service in England is required to at a minimum cover the full cost of delivery of the goods and services. Any surplus from these activities is reinvested and supports the provision of goods and services for the purposes of the health service in England.

2.1.13 Political Donations

The Trust did not make any donations to political parties during the year.

2.1.14 Better Payments Practice Code

The Trust's measure of performance in paying suppliers is the Better Payment Practice Code (BPPC). The Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust paid 53% in terms of volume of invoices and 73% in terms of value. The target for each is 95%.

In 2025/26 possible interest liabilities on invoices was £5.26m. The total amount of interest paid was £1,000 (see note 13.1 in the Notes to the Accounts)

Measure of Compliance	*2025/26 Number*	*2025/26 £'000*
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	267,639	967,815
Total Non-NHS Trade Invoices Paid Within Target	142,257	643,729
Percentage of Non-NHS Trade Invoices Paid Within Target	53.2%	66.5%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	4,623	326,162
Total NHS Trade Invoices Paid Within Target	1,711	300,719
Percentage of NHS Trade Invoices Paid Within Target	37.0%	92.2%
Total		
Total Invoices Paid in the Year	272,262	1,293,977
Total Invoices Paid Within Target	143,968	944,448
Percentage of Invoices Paid Within Target	52.9%	73.0%

2.1.15 Pharm@Sea Limited

Pharm@Sea Limited is a wholly owned subsidiary of the Trust and provides an Outpatient Dispensing service. As a trading company, subject to an additional legal and regulatory regime (over and above that of the Trust). A significant proportion of the company's revenue is internal trading with the Trust which is eliminated upon the consolidation of these group financial statements.

2.2 Governors' Report

2.2.1 Council of Governors

As a Foundation Trust University Hospitals Sussex has a Council of Governors (COG). The Board of the Trust is directly responsible for the performance and success of the Trust and satisfying the COG that the Board is achieving its aims and fulfilling its statutory obligations. Governors act as a vital link to the local community and report matters of concern raised with them to the Council, via Governor Patient Experience and Wider Engagement Committee. Governors also participate in other activities in support of the Trust's work.

2.2.2 Role of Governors

The COG has a number of statutory roles and responsibilities as follows;

- Appoint and, if appropriate, remove the Chair
- Appoint and, if appropriate, remove the other Non-Executive Directors
- Decide the remuneration and allowances and other terms and conditions of office of the chair and other Non-Executive Directors
- Approve (or not) any new appointment of a Chief Executive
- Approve and, if appropriate, remove the Trust's auditor

- Receive the Trust's Annual Accounts and Annual report at a general meeting of the COG
- Hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors
- Represent the interests of the members of the Trust
- Approve Significant Transactions as defined by NHS Improvement guidance
- Approve an application by the Trust to enter into a merger or acquisition
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose; and
- Approve amendments to the Trust's Constitution

2.2.3 Composition of the Council of Governors

Under the Trust's Constitution, an appointed Governor may hold office for a period of up to three years and at the end of each term they can, subject to satisfactory performance, be re-appointed for a further two terms of up to three years (i.e. 9 years in total).

The Council of Governors comprises the following Constituencies;

Elected public governors

The COG has 11 Governors (2 positions were vacant at the year end) elected from its membership that represent the public and patients including one Governor who represents patients who live out of the catchment area of the Trust. Public Governors are elected from within Local Authority areas. The number of elected Governors for each constituency is in proportion to the population within the area using the Trust's services.

Area (constituency)	**Number**
Adur	1
Arun	1
Brighton	2
Chichester	2*
East Sussex/Out of Area	1
Horsham	1
Mid Sussex	2
Worthing	1*
Total Elected Public and Patient Governors	**11**

**Includes one vacancy*

Staff Governors

There are 5 staff Governors (1 position was vacant at the year end) each drawn from one of the Trust's Hospital sites and elected by staff members from those areas.

Professional Area	**Number**
Royal Sussex County Hospital, Brighton	1
Worthing Hospital, Worthing	1

St Richard's Hospital, Chichester	1
Princess Royal Hospital, Haywards Heath	1*
Peripatetic, Community	1
Total Elected Staff Governors	**5**

**Includes one vacancy*

Stakeholder (Appointed) Governors

The Trust has a further five Governors who are appointed by partnership or stakeholder organisations.

Partner/Stakeholder Organisation	**Number**
West Sussex County Council	1
Brighton and Hove County Council	1
University of Brighton School of Nursing and Midwifery	1
Trust Inclusion Group	1
Voluntary Sector	1
Total Partner/Stakeholder Governors	**5**

During the year 1 April 2025 to 31 March 2026 attendance at Council of Governor meetings was as follows:

Constituency	**Full Name**	**End of Term of Office**	**Number of COG meetings attended**
Elected Governors			
Public – Adur	John Todd	30 June 2028	4 of 4
Public – Arun	Maria Rees	30 June 2025	1 of 1
Public - Arun	Yvonne Price	30 June 2028	1 of 2
Public – Brighton & Hove	Frances McCabe	30 June 2027	4 of 4
Public – Brighton & Hove	Alexander Leaney	31 July 2026	2 of 4
Public – Chichester**	Lindy Tomsett	30 September 2027	2 of 4
Public - Horsham	Joanne Richardson	31 July 2027	3 of 4
Public - Mid Sussex	Doug Hunt	30 June 2027	4 of 4
Public – Mid Sussex	Colin Holden	30 June 2026	2 of 4
Public – Worthing**	Pauline Constable	30 June 2025	0 of 1
Public - East Sussex / Out of Area	Patricia Percival	31 July 2027	2 of 4
Staff Governors			
St Richard's Hospital	Tomasz Makola	31 July 2027	3 of 4
Royal Sussex County Hospital	Zingiswa Thetho	31 March 2028	4 of 4
Worthing Hospital	Suzanne Shepherd	17 August 2025	1 of 2
Worthing Hospital	Cheryl Giles	31 July 2028	2 of 3
Peripatetic	Miranda Jose *	31 October 2027	2 of 4
Princess Royal Hospital**	Claire Bewick-Holmes	31 July 2025	1 of 1
Appointed Governors			
Brighton & Hove City Council	Mitchie Alexander	30 June 2028	0 of 3
University of Brighton School of Nursing & Midwifery	Professor Kathleen Galvin	30 June 2025	1 of 1

Constituency	Full Name	End of Term of Office	Number of COG meetings attended
University of Brighton School of Nursing & Midwifery	Dr Angela Glynn	30 June 2028	2 of 3
Voluntary Sector	Helen Rice	31 March 2027	0 of 4
West Sussex County Council	Councillor Alison Cooper	7 May 2026	1 of 4
Trust Inclusion	Kali Varadarajan	31 March 2027	3 of 4

***** *Non-voting*
*** Vacancies in these constituencies are subject to current elections with results expected at the end of June 2026*

It should be noted that during this year ill health affected some Governors ability to attend which is reflected within lower levels of attendance than in prior years.

2.2.4 Stakeholder (Appointed) Governors

Varadarajan Kalidasan, representing Trust Inclusion Groups, Helen Rice, representing the Voluntary Sector, Cllr Mitchie Alexander, Brighton and Hove City Council from 1 July 2025 (the post having been vacant since March 2025), Cllr Alison Cooper, West Sussex County Council, Professor Kathleen Galvin, Brighton and Sussex Medical School until June 2025 then succeeded by Dr Angela Glynn from June 2025.

2.2.5 Elected Governors.

In April, June and August 2025 elections were held for the constituencies of Arun, Adur, Chichester, Worthing and the positions of Staff Governors at the Royal Sussex County Hospital and Worthing and Southlands Hospitals.

These elections returned John Todd for Adur, Yvonne Price for Arun, Zingiswa Thetho for Royal Sussex County Hospital and Cheryl Giles for Worthing and Southlands Hospitals.

In February 2026 elections started for June 2026 elections for public constituencies of Brighton & Hove, Chichester, Mid Sussex, Worthing and the staff constituency Princess Royal Hospital.

2.2.6 Governor expenses

The Trust is required to disclose the value of expenses claimed by the Council of Governors during the financial year.

Governor expenses	***1 April 2025 to 31 March 2026***	***1 April 2024 to 31 March 2025***
Total number of governors in office (as at 31st March)	18	19
Number of governors receiving expenses	4	5
Aggregate sum of expenses paid to governors	£1,857.57	£1,655.29

The increase in expenses is in part as a result of a small number of governors taking a more active role in Patient Led Assessments of the Care Environment and Peer Reviews activities.

2.2.7 Lead Governor

NHS England recommends that a Council of Governors elects a Lead Governor to be the primary link with the Foundation Trust. A Lead Governor is elected by the full Council and would also be the formal link to NHS England if circumstance required direct communication between the Council of Governors and the Regulator. Lindy Tomsett, Public Governor for the constituency of Chichester was re-elected by the full Council as lead Governor in November 2024 to the position of Lead Governor.

2.2.8 Governor engagement

There were four Council of Governors meetings held in public in the year. The public were invited to attend the Council of Governor meetings in person but a link to view the meeting remotely was also provided. The agenda at each meeting includes reports from Governors in respect of their work on the Governor Committees and working groups. They also receive regular presentations from the Non-Executive Directors on their work and that of the Committees which they Chair. The Council also receive regular reports in respect of the Trust's financial and operational performance along with the Trust's delivery of its quality priorities.

In addition, the Board and Council met together to discuss key issues and developments. These meetings are augmented by assurance meetings held in private between the Governors and Non-Executive Directors only. In addition, the Chair and Chief Executive have held a number of briefing sessions for Governors during this financial year.

To support Governors in their role the Trust runs Governor Briefings on areas of interest. This year these included presentations on the My University Hospitals Sussex charity, Electronic Patient Records (EPR), Maternity, Wholly Owned Subsidiaries, the Trust Plan 2026/27 and Elective Care.

Complimenting these briefings there have also been presentations in more detail at the Patient Experience and Wider Engagement Committee meetings on Discharge, the Welcome Standards, Health & Inequalities, Research and the roll out of the new Visiting Policy.

The Council also has a Nomination and Remuneration Committee which meets as required during the year.

Governors are involved in many aspects of the Trust including improvement programme workgroups, Trust conferences, and undertaking Patient Led Assessments of the Care Environment (PLACE) visits and taking part in internal peer reviews of service areas.

2.2.9 Holding the Non-Executive Directors to account for the performance of the Trust Board

Governors have an important role in making an NHS Foundation Trust publicly accountable for the services it provides. They bring valuable perspectives and contributions to its activities. Importantly, Governors are expected to hold Non-Executive Directors to account for the performance of the Trust Board of Directors and the following sets out the principles of how Governors discharge this responsibility.

- To ensure that the process of holding to account is transparent and fulfils the statutory duties of the Council of Governors.
- To share successes and discuss any concerns that NEDs or Governors have.
- To reflect the NHS Improvement guidance that Governors should, through the NEDs, seek assurance that there are effective strategies, policies and processes in place to ensure good governance of the Trust.
- To work effectively together and make the best use of the time NEDs and Governors have together.

The Governors discharge this function through regular reports from the NEDs to the Council on their role as Committee Chairs and through the scheduled meetings held in private between the Governors and Non-Executive Directors only.

At no time during the period has the Council of Governors exercised its formal power to require a Non-Executive Director to attend a Council meeting and account for the performance of the Trust Board.

2.2.10 Appraisal and appointments

The Governors Nomination and Remuneration Committee (GNaRC) oversee these processes on behalf of the Council. The Chair and other Non-Executive Director appraisals for 2025/26 have been undertaken and reported to the Governor Nomination and Remuneration Committee on 18 June 2025 who then reported to the full Council in public on the 21 August 2025.

The Governors' Nomination and Remuneration Committee during 2025/26 received the:

- Chair and NEDs appraisals, including their compliance with the Fit and Proper Persons requirements;
- The outcome from the recruitment process for new Non-Executive Directors (NEDs) to allow them to approve the panel recommendations;
- The outcome from the recruitment process for the new Chief Executive to allow them to approve the appointment

It is the responsibility of the Governor Nomination and Remuneration Committee, with the Chair of University Hospitals Sussex NHS Foundation Trust, to consider appropriate Non-Executive Director succession planning. This was considered as part of the determination of the non-executive skills

and attributes that supported the Non-Executive Director recruitment process, in particular supporting the Chair in developing the skills and attributes required of potential candidates for the Audit Committee Chair and for the Clinical and Transformational Non-Executive Director appointments ahead of their recruitment that took place on 1 August 2025. The Committee has also been involved in the current process for the recruitment of the two non-executive director vacancies following their respective retirements at the end of January 2026.

The Committee also approved the recruitment of the Trust's Chief Executive in December 2025, the Committee commented positively on the open and inclusive process applied and the opportunity they had to be part of the various stakeholder panels.

2.2.11 Membership Delivery Plan

The Trust currently has a Membership and Engagement Delivery Plan which is updated annually with the help of the Governor's Patient Experience and Wider Engagement Committee. This Delivery Plan acknowledges that it is a responsibility of a Foundation Trust to recruit, communicate and engage with members as a means of ensuring service provision meets the needs of service users. The Trust's Delivery Plan aims to recruit a representative membership base that is actively engaged in working for the good of the Trust. It also considers and monitors engagement levels through annual surveys and by tracking response rates to in year activity. Other work includes targeting specific groups of members to ensure that the Trust membership is representative of the population it serves.

The Trust's Delivery Plan is supported by a full action plan which outlines how the strategic aims will be implemented and the objectives of the strategy achieved. Performance against this Delivery Plan will be overseen by the Council's Patient Experience and Wider Engagement Committee.

2.2.12 Keeping in touch with members

Governors are accessible to members via email and at the regular Council of Governors meetings. They also attend our Expert Talks and other public events (see Stakeholder Relations) and play an important role in recruiting new members. The Council continued participating in membership engagement events with other organisations and the ICB. These events allow Governors to describe the role of a Trust member and gather feedback on services across the Trust and its future plans. All feedback is then shared with our Patient Experience and Wider Engagement Committee to help us continue to improve services.

Governors can be contacted via a Trust generic email address which is advertised on the Trust website and through other communications sent to members.

An individual must be at least 16 years old to become a member of the Trust. At the 31st March 2026 the Trust had 8441 public members, the table below summarises the constituencies these public governors fall within.

Public Constituency	*Membership as at 31 March 2025*	*Membership as at 31 March 2026*
Adur	1046	1023
Arun	2152	2087
Brighton and Hove	657	667
Chichester	1847	1790
Horsham	575	568
Mid Sussex	250	267
East Sussex	227	236
Worthing	1365	1332
Patient/Out of Area	470	471
Totals	8,589	8,441

All staff are automatically enrolled as members on starting employment with the Trust.

2.2.13 Disclosures and declarations of interests

The Chair of the Council of Governors has not declared any other significant commitments that require disclosure. The Chair submits an Annual Declaration of Interest Statement and Fit and Proper Person Declaration.

Governors are required to complete a Declaration of Interest which is held on a Trust Register and is made publicly available on the Trust's website. This is available at https://www.uhsussex.nhs.uk/about/trust/statutory-documents/declarations/

2.2.14 Appointment of the Trust's External Auditors

In 2025/26 the Council of Governors did appoint the Trust's external auditors.

2.2.15 Resolution of disputes

The Trust Constitution sets out at Section 12 the process for dealing with any dispute between the Council of Governors and Trust Board. The Council of Governors and Trust Board continue to have a positive working relationship, and the process has not been used during the 2025/26 year.

2.3 Staff Report

University Hospitals Sussex NHS Foundation Trust employs nearly 20,000 people in a range of different roles across the organisation. By the end of March 2026, we employed 16,172 WTE substantive staff and engaged an additional 1,722 WTE temporary staff via bank and agency. Each and every member of our staff works to ensure our patients receive excellent quality care.

Our staff continue to consistently demonstrate their willingness to go over and above to ensure high quality care is delivered to the people of Sussex. We ensure that we take opportunities to thank our staff in a variety of ways including Star of the Month awards, an annual staff award ceremony and long service awards.

Average number of employees (WTE basis not actual staff employed) (subject to audit)

Average number of employees (WTE basis)	*2025/26 31 March 2026*			*2024/25 31 March 2025*		
Staff type	***Permanent***	***Other***	***Total***	***Permanent***	***Other***	***Total***
Medical and dental	2,632	177	2,809	2,523	210	2,733
Ambulance staff	16	N/A	16	15	N/A	15
Administration and estates	3,195	160	3,355	3,138	172	3,310
Healthcare assistants and other support staff	3,088	680	3,768	3,032	635	3,667
Nursing, midwifery, and health visiting staff	4,730	646	5,376	4,470	709	5,179
Nursing, midwifery, and health visiting learners	N/A	N/A	N/A	N/A	N/A	N/A
Scientific, therapeutic, and technical staff	1,967	102	2,069	1,836	90	1,926
Healthcare science staff	544	7	551	512	10	522
Social care staff	N/A	N/A	N/A	N/A	N/A	N/A
Other	N/A	N/A	N/A	N/A	N/A	N/A
Total average numbers	***16,172***	***1,772***	***17,944***	***15,526***	***1,826***	***17,352***
Of which:						
Number of employees (WTE) engaged on capital projects	82	25	107	64	16	80

Staffing costs (subject to audit)

Group	*2025/26*			*2024/25*		
£000	***Permanent***	***Other***	***Total***	***Permanent***	***Other***	***Total***
Salaries and wages	896,622	N/A	836,137	836,137	N/A	836,137
Social security costs	121,233	N/A	93,116	93,116	N/A	93,116
Apprenticeship levy	4,527	N/A	4,243	4,243	N/A	4,243
Employer's contributions to NHS pension scheme	172,811	N/A	156,619	156,619	N/A	156,619
Temporary staff	-	27,606	35,031	-	35,031	35,031
Total gross staff costs	**1,195,193**	**27,606**	**1,222,799**	**1,090,115**	**35,031**	**1,125,146**
Of which						
Costs capitalised as part of assets	6,067	3,054	9,121	3,451	1,974	5,425

2.3.1 Our Culture and People Priorities

Strategic Ambition

During 2025/26, we strengthened our organisational culture to ensure it supports the delivery of our vision of Excellent Care Everywhere. We recognise that a positive, values-led culture is fundamental to high-quality care, effective leadership and a safe, supportive working environment for all colleagues.

Values, Behaviours and Strategic Direction

The Trust's refreshed values – We are compassionate, We are inclusive, We are respectful – have provided a clear foundation for how we work with one another and care for patients. These values are being brought to life through a new Values & Behavioural Compass, which sets out the everyday standards expected of all colleagues, managers and leaders, and creates a consistent reference point for behaviour, decision-making and professional conduct.

A structured culture roadmap has been developed to embed these expectations across the organisation, and support managers and staff in ongoing development and improvement. This includes alignment with recruitment, induction, leadership development, people policies and staff experience, ensuring that values and behaviours consistently underpin the ways in which the Trust operates.

Leadership Accountability and Role-Modelling

The Trust has strengthened leadership expectations at all levels, with a clear emphasis on visible role-modelling, respectful and inclusive leadership, and accountability for creating the conditions in which colleagues can thrive.

Senior leaders have undertaken a behavioural reflection process to support consistent leadership practice and reinforce the Trust's cultural ambitions. A new, multi-module People Manager e-learning programme has also been introduced to support supervisors, managers and leaders at all levels.

Staff Engagement and Cultural Activation

The Trust has invested in approaches that enable colleagues to shape and influence cultural improvement. This includes staff-led behavioural experimentation, facilitated conversations within teams, and opportunities for colleagues to share learning and insights. These activities are designed to support a culture in which staff feel involved, valued and able to contribute to positive change.

Communication and engagement are currently being strengthened ahead of the programme activation through a coordinated programme of storytelling, leadership visibility, digital content and local engagement events – to ensure that colleagues understand the purpose, progress and impact of the cultural reset.

Governance, Assurance and Measurement

We have begun to establish a set of cultural indicators to monitor progress and provide assurance, building on the 'culture heatmap' developed from NHS Staff Survey data. These include awareness and use of the Behavioural Compass, uptake of leadership and management tools, participation in cultural development activities, and qualitative insights from staff engagement. This structured approach enables the Trust to track improvement, identify areas requiring further focus and maintain culture as a strategic organisational priority.

Future Ambition

The Trust is committed to building a culture that is optimistic, collaborative, empowered and responsive. This includes fostering an environment where colleagues feel safe to speak up, confident in the organisation's strategic direction and intent, and supported by consistent standards and shared purpose. Over the coming year we will continue to strengthen leadership capability, staff involvement and organisational learning to ensure culture remains a key enabler of excellent care.

Health & Wellbeing

We want everyone to feel healthy, supported and safe at work – because there is strong evidence that when staff feel well, patients receive the best care. During 2025/26 we continued to deliver our Three-Year Health & Wellbeing Strategy, which is aligned with the NHS Health & Wellbeing Framework to strengthen prevention, support and culture across the Trust. Work has begun on the next three-year strategy covering the period 2026-2029, which is expected to be published by Quarter 2 2026/27.

NHS Staff Survey 2025 – Wellbeing
The 2025 NHS Staff Survey showed clear signs of progress for People Promise 4: We are Safe and Healthy:

- Our 'Safe and Healthy' score showed a statistically significant improvement to 6.02 (out of 10), up from 5.80 in 2024 – narrowing the gap to the national average (6.07), which declined from 2024.
- We increased in all three sub-scores: Health and Safety Climate increased by 0.21, driven by increase in scores in all seven questions that comprise the sub-score. Significant increases (greater than +4%) were seen in Question (Q)3h and Q3i (*staff believing they have adequate equipment and enough staff to perform their roles properly*), closing the gap to the national benchmark Trust median, which declined in five of seven questions.
- Numbers of staff reporting of burnout and stress declined, in contrast the NHS benchmark group average score, which increased (worsened) in all areas.
- 70.64% of staff said their *manager takes a positive interest in their wellbeing* (Q9d) – this is a steady improvement from 2024 and remains slightly above the NHS average.
- The proportion of staff reporting *positive organisational action on Health & Wellbeing* (Q11a) has continued to increase since 2022 to 52.7%, against the backdrop of a decreasing (worsening) sector benchmark scores.
- Nationally, staff across the NHS experience violence, harassment and abuse from patients/service users and members of the public. Although overall the sub-score for negative experiences has improved, our scores in this area have broadly remained the same as last year. This remains a significant area of focus area for the Trust.

While these results are encouraging and show the progress against our health and wellbeing plans, we know experience varies between staff groups. Improving access and outcomes for everyone, ensuring culturally appropriate services, and reducing additional barriers to access for some groups remains a priority in 2026/27.

Healthy Physical Workplace

We continue to ensure staff have access to range of services to encourage health and wellbeing, including on-site exercise classes, signposting to free NHS weight loss programmes, and smoking cessation on-site support and individual appointments. Staff can access free physiotherapy across all our sites, with advice and self-help tools available via the wellbeing pages on StaffHub (Trust intranet) and new '*Working here'* single portal to provide easier access to relevant information.

The Trust Menopause Café, which launched in 2022, meets online on a quarterly basis, with an average attendance of 50-60 staff members. This is chaired by a GP specialising in Women's Health. A Trust-wide audit of staff core amenities for staff undertaken in 2024/25 across 800+ teams has enabled us to identify rest spaces areas that would benefit from some investment. To date a phased approach, supported through My University Hospitals Sussex Charity, has provided 33 staff rest spaces with updated equipment (kitchen equipment & furniture) totalling £40,000, and plans have been agreed at Capital Investment Group for Phase 2, which involves renovating nine rest spaces across the Trust.

The Trust's Strategy, Excellent Care Everywhere, includes a commitment to Excellent care for our People, and implementation of the national NHS Staff Standards Framework expected to be launched in 2026/27.

Mental Health and Staff Psychological Support Service

The link between the health and mental wellbeing of healthcare staff and the experience and outcomes for patients and service users is strong and well-established. Mental health and psychological support is therefore a critical enabler for patient care and our strategic ambition of Excellent Care Everywhere.

Demand for psychological support continues to rise year-on-year, mirroring national trends across the NHS and wider society. Over the reporting period, the dedicated in-house Staff Psychological Support Service (SPSS), which provides, counselling and psychotherapy, received an average of 95 referrals per month, resulting in a total of 1,323 referrals between April 2025 and March 2026. This represents an (18.5%) increase compared with the previous year – although this will also reflect work to improve awareness and accessibility of the service.

The SPSS team has delivered a broad range of therapeutic and organisational support interventions, including 98 sessions of CBT (Cognitive Behaviour Therapy), 163 sessions of EMDR (Eye Movement Desensitisation

and Reprocessing) therapy, 133 Single Sessions / Psychological Assessment (PA) sessions, 18 Team Debriefs and 186 hours of clinical supervision. These figures highlight both the diversity of the team's work and demonstrate a sustained commitment to supporting staff wellbeing through evidence-based therapeutic interventions, responsive debriefing support, and robust clinical supervision. The growth in referrals also underscores the essential role of the service and the importance of maintaining capacity to meet increasing organisational need.

Alongside its core therapeutic work, the SPSS team continued to deliver a comprehensive programme of mental health training aimed at equipping 10% of the workforce with enhanced skills and confidence in supporting mental wellbeing. This included the delivery of Managers Suicide Prevention resources and bespoke training, in line with the new (2025) national British Standards Institution standard; stress and resilience workshops; and a new 12 week targeted stress intervention for teams identified as experiencing higher levels of stress.

In addition, the SPSS Improving Attendance Project statistically evaluated the impact of providing additional, targeted mental health and 'upstream' wellbeing support to managers and staff, and is demonstrating reductions in mental health related absence.

Financial Wellbeing

The cost of living remains a challenge for many, and in 2025/26 we continued to provide a range of support, in partnership with the Trust Charity:

- The Trust was the first NHS organisation to partner with Credit Union to provide a dedicated Financial Wellbeing & Pensions Support Officer based at the Trust. The service saw 6,000 contacts with staff in 2024, which has grown to 10,000 contacts in 2025. Funding from My University Hospitals Sussex Charity has been agreed until August 2027.
- Staff have received support on budgeting, debt consolidation advice, accessing government entitlements, NHS Pensions process guidance, signposting to support services or financial awareness presentations. Support has included:
    - providing long term support for those applying for the Trusts Crisis Support Fund
    - continued support for 80 staff who have been victims of domestic/economic abuse
    - targeted support for Facilities and Estates staff and practical budgeting and money management presentations to newly qualified and international nursing staff
- Our Crisis Support Fund continues to provide targeted assistance, supporting over 3,000 applications to staff in need in three years from 2023-2025. Funding is currently in place until November 2026, with a review of future provision planned for early in 2026/27.
- In June 2025 the Trust introduced Stream. This platform enables substantive and bank staff to track their earned pay in real time, draw down pay in advance, save via salary sacrifice and access

budgeting and money management help. To date, 9% (1,500) staff have signed up to Stream, with 1,200 staff using the platform to start a savings pot.

Keeping colleagues safe and supported at work

Everyone should be able to work in an environment that is safe, respectful and free from violence, abuse, threats, sexual harassment or discrimination. However, across our hospital sites – and in common with the experience across the NHS – many colleagues face these challenges every day.

Managing unacceptable behaviour requires a careful and tailored approach. Our approach aims to be fair, reasonable and proportionate, taking account of clinical factors, patient mental health, capacity and individual circumstances, as required by law and NHS policy. Our commitment is that every incident will be taken seriously, recorded and followed up through our Violence, Prevention, Reduction and Sexual Safety Programme.

Violence Prevention & Reduction

Nationally, staff across the NHS experience violence, harassment and abuse from patients and service users, their relatives, and members of the public. Our NHS Staff Survey results show that more 17.4% of our staff have experienced at least one incident of physical violence at work from patients; across the NHS the median is 14.7% and the highest (worst) score 20.1%. A higher proportion of staff (28.5%) have experienced at least one incident of harassment, bullying or abuse from patients, relatives or members of the public – again, a pattern experienced across the NHS.

In 2025/26, we made further progress towards full compliance with the national NHS Violence Prevention & Reduction Standard. Key improvements included:

- Launched and refreshed communication materials, including posters and digital assets to replace 'No Excuse, For Abuse' and 'Zero Tolerance' messaging with our ‘Act with Kindness’ campaign to promote respectful behaviour. This is aligned to the Sussex-Wide Trauma-Informed Care Framework, which aims to remind patients, visitors and colleagues that our staff are here to care.
- Reinforced the Patient Acceptable Behaviours Agreements (ABAs) protocol, in partnership with clinical and the Trust Security teams.
- Embedded a Post-Incident Standard Operating Procedure for Staff Support within the Trust incident reporting system following an incident of Violence & Aggression – to ensure accessible information on early support, with learning and preventative measures.
- Expanded provision of Conflict Management & Physical Intervention training in identified high-incidence areas.
- Strengthened liaison and working partnership with Sussex Police, working towards automated incident reporting to the Police data system, and encouraged reporting of Hate Crimes.

- Introducing body-worn cameras within high-incidence areas, eg. Emergency Department (ED), managed through the Trust Security Team.

Sexual Safety in the Workplace

National NHS Staff Survey data has been collected since 2023, highlighting the significant prevalence of sexual misconduct within the healthcare sector and prompting the implementation of a national NHS Sexual Safety Charter.

In the 2025 Staff Survey, 10.74% of our staff reported experiencing unwanted sexual behaviour from patients or the public. While these figures are in line with national averages, we recognise that no level is acceptable, and any form of sexual abuse, violence, or harassment is inconsistent with our values of respect, compassion and inclusion; our expected behaviours; our vision of a workplace where everyone has the right to feel safe and respected; and the expectations of a healthy and safe workplace.

We recognise that this is a national NHS and wider societal issue. Our response framework continues to be strengthened to ensure staff feel protected and heard, and that learning from incidents is undertaken. Throughout 2025/26 we:

- Upskilled leaders with Active Bystander intervention training – targeted at teams with highest reported incidence of sexual misconduct with the aim of increasing awareness and recognising harm and microaggressions taking place.
- Rolled out essential IRIS (Learning Management Platform) eLearning training to understand Sexual Misconduct in the workplace, which has been designated as ‘essential’ training.
- Launched a Trust-wide Sexual Misconduct Awareness campaign to highlight the importance of a safe, respectful workplace and raise awareness of mechanisms for reporting.

2.3.2 Equality, Diversity and Inclusion

The Trust continues to prioritise creating a workplace where all colleagues feel they belong, and can contribute and thrive. A number of targeted interventions have been developed or expanded during 2025/26. These include inclusive recruitment controls, a career sponsorship scheme, career navigation support workshops, and the introduction of a centralised Reasonable Adjustments framework to improve consistency and timeliness of support for disabled staff.

- Early evaluation of the Career Sponsorship Scheme indicates strong demand and engagement, particularly among staff in Agenda for Change Bands 3 to 7 seeking progression and leadership opportunities. The scheme will be further developed in 2026/27, including seeking to recruit additional career sponsors.
- Work has also progressed in relation to pay gap reporting and action planning, including the integration of gender and ethnicity pay

gap indicators into reporting systems and implementing the new central government pay gap reporting guidance.
- The Trust has also undertaken tailored listening events with staff in areas of higher reported concerns of bullying, harassment and abuse.

Workforce Diversity Data

NHS organisations are required to publish a set of workforce equalities data established and reported against the national template and dataset. An expanded version of these data, including key priorities for action, are published in the Trust's Annual Equality Report which can found at www.uhsussex.nhs.uk/equality

Trust Board Diversity

As of the snapshot date in March 2026, two Board members (12.5%) identified as belonging to a minoritised ethnic group. This represents a decrease from three Board members (17%) last year. This compares to 9% of the population in Sussex and 28% of the Trust's overall workforce.

One executive director (6.3% of all Board members) did not have ethnicity recorded on their staff record. All remaining seven executive directors (44% of all Board members, 88% of executive Board members) identified as White, which is consistent with the position reported last year.

All Board members held voting rights; therefore, the analysis by voting membership mirrors the overall Board composition described above.
As of March 2026, eight (50%) of the 16 Board members were female. This compares to 52% of the population in Sussex and 72% of the Trust's overall workforce.

Among executive directors, five (63% of executive Board members) were female, while the remaining three were male. For Non-Executive Directors, three (38% of non-executive Board members) were female, while the remaining five were male.

Sex representation on the Board has become more representative of the resident population over the past year, during which period the total board membership has also decreased from last year.

Trust Senior Management Diversity

As of the snapshot date in March 2026, 11.3% of senior management staff identified as global majority, while 85.9% identified as White. (See table below for bands/grades included within 'senior management'). A further 2.8% did not disclose their ethnicity. The overall representation of global majority staff in senior bands has increased by one percentage point from last year (10.4% in 2025).

Representation varied significantly across different pay bands. In Agenda for Change (AfC) Band 8d, the proportion of senior managers from minoritised

ethnic backgrounds was 5.6%. The representation at AfC Band 8c increased substantially from 4.9% in 2025 to 10.8% in 2026. This information is reflected in the table below.

Table Showing Senior Management Ethnic Diversity

AfC Pay Band	Ethnic Group	2026 Count	2026 Percent (%)	2025 Percent (%)
Band 8a	Global majority	83	14.31%	12.79%
	White	486	83.79%	84.72%
Band 8b	Global majority	15	6.12%	8.15%
	White	228	93.06%	90.13%
Band 8c	Global majority	12	10.81%	4.90%
	White	96	86.49%	93.14%
Band 8d	Global majority	2	5.56%	5.56%
	White	33	91.67%	91.67%
Band 9	Global majority	4	10.81%	10.53%
	White	30	81.08%	78.95%
Very Senior Manager	Global majority	3	6.38%	7.50%
	White	34	72.34%	77.50%
Totals	**Global majority staff**	**119**	**11.27%**	**10.38%**
	White staff	**907**	**85.89%**	**86.56%**

Sex representation in senior management also showed variation by Band. Overall, 66.1% of senior management staff were female, compared to 33.9% male. While the overall representation of female staff in senior bands has remained the same as last year (66.2% in 2025), the representation at Very Senior Manager (VSM) level has increased substantially from 37.5% in 2025 to 48.9% in 2026.

The proportion of women in senior roles differed considerably by Band, with 71.4% of AfC Band 8a senior managers being female and 49.0% at Band 9. There was a small increase again at the VSM level (51.1%). This information is reflected in the table below.

Table Showing Senior Management Sex Diversity

AfC Pay Band	Sex	2026 Count	2026 Percent (%)	2025 Percent (%)
Band 8a	Female	414	71.38%	72.11%
	Male	166	28.62%	27.89%
Band 8b	Female	149	60.82%	62.23%
	Male	96	39.18%	37.77%
Band 8c	Female	74	66.67%	61.76%
	Male	37	33.33%	38.24%
Band 8d	Female	18	50.00%	55.56%
	Male	18	50.00%	44.44%
Band 9	Female	20	54.05%	55.26%
	Male	17	45.95%	44.74%
Very Senior Manager	Female	23	48.94%	37.50%
	Male	24	51.06%	62.50%
Totals	**Female staff**	**698**	**66.10%**	**66.21%**
	Male staff	**358**	**33.90%**	**33.79%**

Trust senior management and workforce diversity data is included within the Trust's Annual Equality Report, available on the Trust's website at www.uhsussex.nhs.uk/equality.

Workforce Race Equality and Disability Equality

As part of statutory and regulatory requirements, the Trust reports annually against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

In 2026, four WRES indicators improved, including likelihood of appointment from shortlisting and staff perceptions of equal opportunity for career progression. However, disparities remain in disciplinary processes, senior progression, experiences of discrimination and Board representation.

For WDES, three indicators improved, including workforce representation, access to Reasonable Adjustments and perceptions of opportunity. Disabled staff continue to experience inequity in capability processes, senior clinical progression and experiences of bullying and harassment.

These findings suggest that while targeted interventions are beginning to have an impact in some areas, structural inequalities persist across key workforce outcomes – and this reflects patterns in national NHS data. The Trust will continue to prioritise these areas through delivery of the Workforce Inclusion Programme in 2026/27, with a focus on measurable improvement, strengthened accountability and improved data quality.

Full reporting against WRES and WDES is included within the Trust's Annual Equality Report, available on the Trust's website at www.uhsussex.nhs.uk/equality.

2.3.3 Gender and Gender Pay Gap

Gender Pay Gap reporting shows the difference in average hourly pay and bonus payments between men **Gender Pay Gap** reporting shows the difference in average hourly pay and bonus payments between men and women. The Trust analyses the information to identify:

- the level of gender equality
- the balance of male and female employees in each of four salary range quartiles
- how effectively talent is being maximised and rewarded
- and to use this to identify any underlying root causes for the gender pay gap, aiming to implement remedial actions to address and mitigate this.

The Trust submits data annually to the Government's statutory gender pay gap reporting portal https://gender-pay-gap.service.gov.uk/employers/21657

Background information

This report follows the legal requirements for organisations with over 250 employees, as set out in the Equality Act 2010. It covers the pay period from 1 April 2025 to 31 March 2026 and includes data from 18,346 employees who were classed as 'relevant employees' for these calculations.

Six mandatory reported calculations:

1. Proportion of males and females in each pay quartile
2. Mean (average) gender pay gap for ordinary pay
3. Median gender pay gap for ordinary pay
4. Proportion of males and females receiving a bonus payment
5. Mean (average) gender pay gap for bonus pay
6. Median gender pay gap for bonus pay

What is the Gender Pay Gap?

The gender pay gap shows the difference in average earnings between men and women across the organisation. It is shown as a percentage of men's earnings.

Types of Pay Gap Calculations

- **Mean Pay Gap:** The average hourly pay for all men is compared to the average hourly pay for all women. Hourly pay includes basic pay and any allowances paid through payroll, but excludes overtime and expenses.
- **Median Pay Gap:** The hourly pay of the middle-paid man is compared to the hourly pay of the middle-paid woman when all employees are listed from highest to lowest pay. Hourly pay includes basic pay and allowances, but excludes overtime and expenses.

The gender pay gap is not the same as equal pay for doing the same job. The Trust uses a national pay system and job evaluation process for staff under Agenda for Change and medical/dental contracts.

Summary

As on the 31 March 2026:

- Women earned 98p for every £1 men earned (median hourly pay)
- Women made up 61.7% of employees in the highest paid quarter, compared with 70.1% in the lowest paid quarter. Relative to their representation in the lowest pay quartile, men were around 1.4 times more likely than women to be in the highest pay quartile
- 0.48% of women received bonus pay, compared with 2.14% of men
- Women's mean bonus pay was 26.57% lower than men's.

Summary table of pay gaps 2026

Measure	Mean	Median
Male	£27.06	£20.10
Female	£22.50	£19.78
Difference	£4.57	£0.32
Pay Gap %	16.87%	1.57%
For every £1 a man earns, a woman earns	£0.83	£0.98

Key points:

- The ordinary (hourly rates) pay gap has increased marginally
  In 2025/26, women earned £0.83 for every £1 earned by men, representing a one-penny decrease compared to the previous year. “Ordinary pay” refers to pay received in the pay period that includes the snapshot date, including basic pay, allowances and shift pay, but excluding bonus pay. Overall, the ordinary pay gap has remained broadly consistent over recent years, with limited movement. This gap is largely driven by the continued over representation of male staff in senior management and consultant roles, particularly within the highest pay quartile.
- Our gender bonus gap has increased and remains significant
  The proportion of male staff receiving a bonus was over 300% higher than the proportion of female staff. Male staff also received higher average and median bonus payments than female staff. As in previous years, this gap is primarily driven by eligibility for consultant level awards and legacy arrangements, including Discretionary Points and protected Clinical Excellence Awards, which historically benefit a greater proportion of male staff.
- Pay quartile representation has remained largely unchanged, but progression into higher pay levels remains uneven
  Gender representation across pay quartiles has shown minimal year-on-year movement. Despite women comprising the majority of the workforce, their representation decreases at higher pay levels, particularly within the top pay quartile.
- New national award schemes show early signs of improved balance for bonus outcomes.
  Because bonuses apply to a small and specific group of staff, relatively small changes in the number or type of awards can have a disproportionate effect on reported bonus pay gaps. More recent schemes, such as National Clinical Impact Awards, demonstrate a more balanced gender distribution and may support improved equity over time as historic arrangements phase out.

Gender Pay Gap: Representation

This section sets out how males and females are distributed across the workforce and pay quartiles, providing context for the Trust’s gender pay gap and the structural factors that influence it.

Headcount

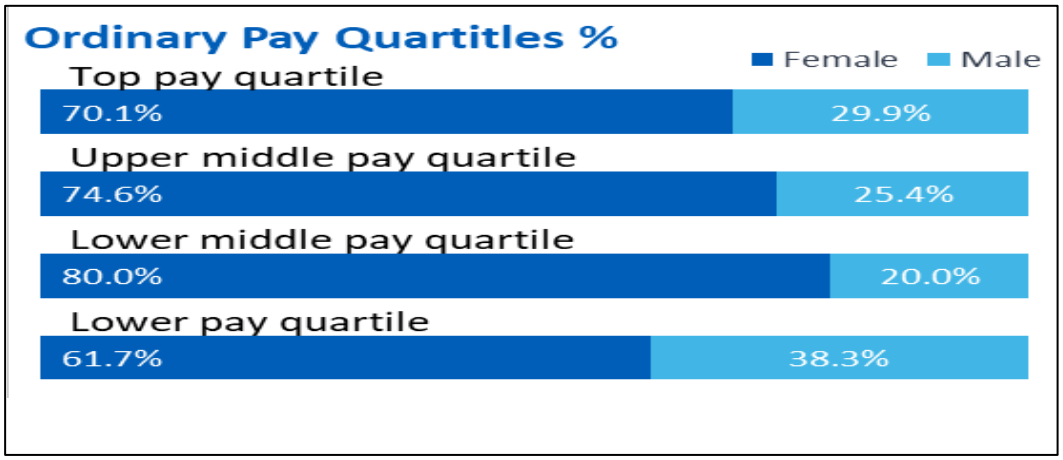
This section sets out the workforce profile used for statutory gender pay gap reporting, including the proportion of male and female staff within the Trust. In line with the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, this includes all relevant employees who are employed on the snapshot date and receive full pay, as defined by the regulations, and excludes those not receiving full pay due to, for example, long-term leave. The figures presented include substantive and bank staff who meet the statutory definition. Non-executive directors are not included, as they are not employees for the purposes of gender pay gap reporting.

The overall gender composition of staff counted for statutory pay gap reporting purposes, 71.6% (13,140) were female, and 28.4% (5,206) were male.

Additionally, outside of the scope of regulatory pay gap reporting, in the staff survey 2026, 34 out of 8,358 respondents (0.41%) identified as non-binary, and 18 (0.22%) preferred to self-describe.

Gender Representation by Ordinary Pay Quartiles

This section shows how males and females are distributed across pay quartiles, providing insight into how workforce composition influences the gender pay gap. To understand how males and females are distributed across different pay levels, all full-pay employees are divided into four equal groups (called quartiles), based on their earnings, from the lowest to the highest.



- 4,581 staff were in the lower pay quartile, of these 3,212 (61.7%) were female
- 4,475 staff were in the lower middle pay quartile, of these 3,337 (80%) were female
- 4,701 staff were in the upper middle pay quartile, of these 3,759 (74.6%) were female
- 4,589 staff were in the top pay quartile, of these 2,832 (70.1%) were female.

Our quartile pay representation has remained broadly consistent over recent years, indicating limited structural movement.

The data shows that women make up the majority of the workforce overall and are strongly represented across all quartiles. However, the proportion of female staff reduces at higher pay levels, with a corresponding increase in the proportion of male staff in the top pay quartile relative to the middle quartiles. This indicates that the gender pay gap is not driven by unequal pay for equal work, but by the distribution of men and women across different roles, pay bands, and seniority levels. In particular, male staff are comparatively more concentrated in higher paid roles than would be expected based on their overall representation in the workforce.

Male staff were 2.5 times more likely to be in the top pay quartile than female staff, compared to their representation in the upper middle pay quartile. This is up (worse) from 2.4 times in 2025 and 2.2 times in 2024.

The top-upper middle disparity ratio is calculated by dividing the relative representation of male staff by the relative representation of female staff. The relative representation is the number of staff in the top pay quartile divided by the number of staff in the upper middle pay quartile for each sex.

Actions in response

The Trust has established action plans (included below) to address these structural drivers, set out in the separate Workforce Equality Standards Reports. This includes targeted action on:

- Inclusive recruitment and selection at senior levels
- Career progression and talent management for women
- Addressing barriers in specific staff groups and professions where disparities are most pronounced
- Strengthening accountability through Workforce Inclusion Programme delivery and governance

All the pay gap findings should be read alongside those plans, which set out the specific interventions and measures of success. They can be found at www.uhsussex.nhs.uk/equality

Gender Pay Gap: Ordinary Pay

This section establishes the average and median differences in hourly rates of ordinary pay between male and female employees. As on the 31 of March 2026, the average hourly pay for male staff is £27.06. It is £22.50 for female staff. This makes our average gender pay gap 16.87% and the median gender pay gap is 1.57%.

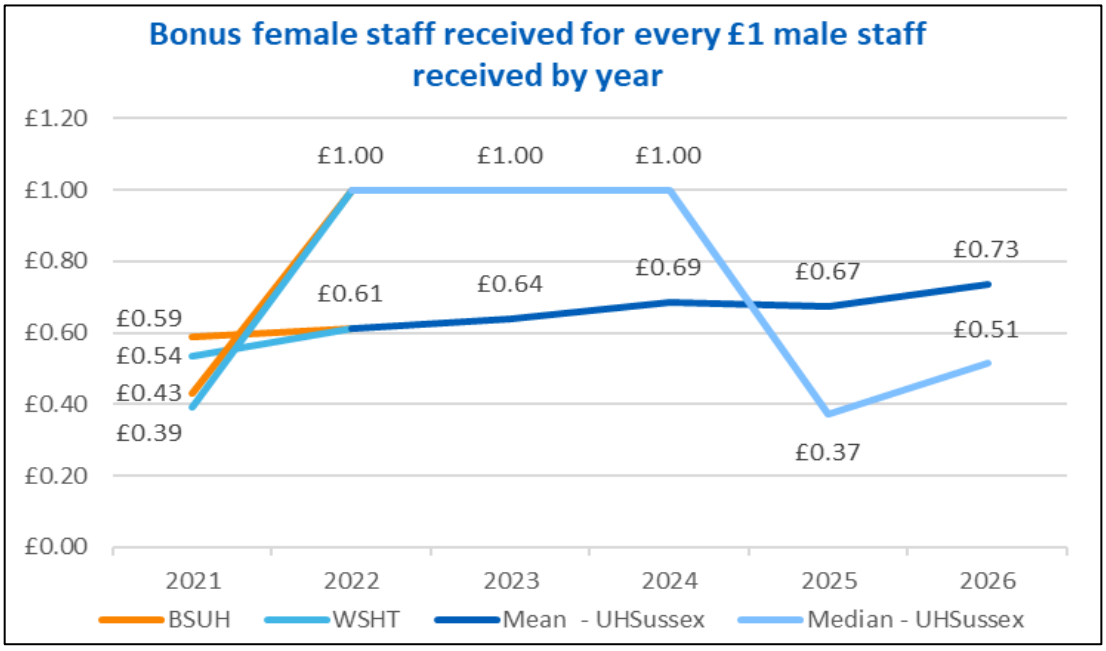
Comparing average hourly wages, women earned eighty-three pence for every £1 men earned, one penny less (worse) than in 2025. Comparing median hourly wages (accounting for the effect of outliers), women earned ninety-eight pence for every £1 men earned, one penny less (worse) than in 2025.

The table below shows how the gender hourly pay gap has changed over recent years, increasing marginally from 2023 to 2024, narrowing marginally in 2025, and widening again marginally in 2026; while the mean pay gap in 2026 approaches the 2024 level, the median shows a similar pattern with a less pronounced increase.

Table showing average mean and median hourly pay

Gender Hourly Pay Gap	Average (Mean) Hourly Pay				Median Hourly Pay			
	2023	2024	2025	2026	2023	2024	2025	2026
Male £	22.26	24.01	25.85	27.06	16.84	18.10	19.25	20.10
Female £	18.73	19.97	21.60	22.50	16.84	17.69	18.98	19.78
Difference	3.53	4.04	4.25	4.57	0.00	0.41	0.27	0.32
Pay Gap %	15.86 %	16.83 %	16.43 %	16.87 %	0.00%	2.29%	1.40%	1.57%

The chart below shows changes in the mean and median hourly pay gap over recent years, with limited movement and can largely be attributed to the higher proportion of male staff in senior management and consultant roles.

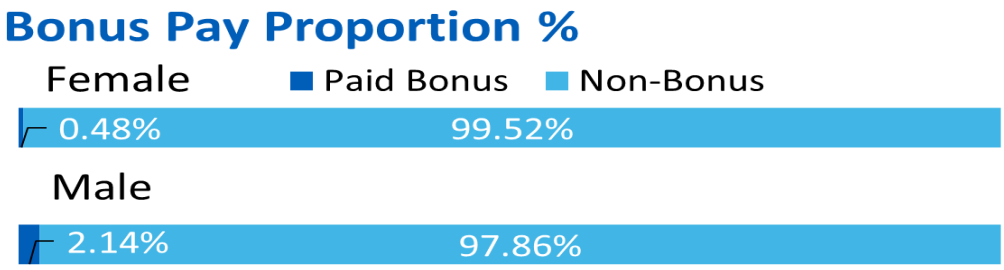


Gender Pay Gap: Bonuses

This section outlines differences between males and females in bonus payments given to eligible employees during the 12 months leading up to the 31 March 2026. Bonus pay is one or more of the following payments:

- Clinical Excellence Awards (CEA)
- National Clinical Impact Awards (NCIA)
- Discretionary pay for consultants with extra responsibilities

Staff who receive more than one type of bonus are counted only once.



Who Received Bonus Pay?

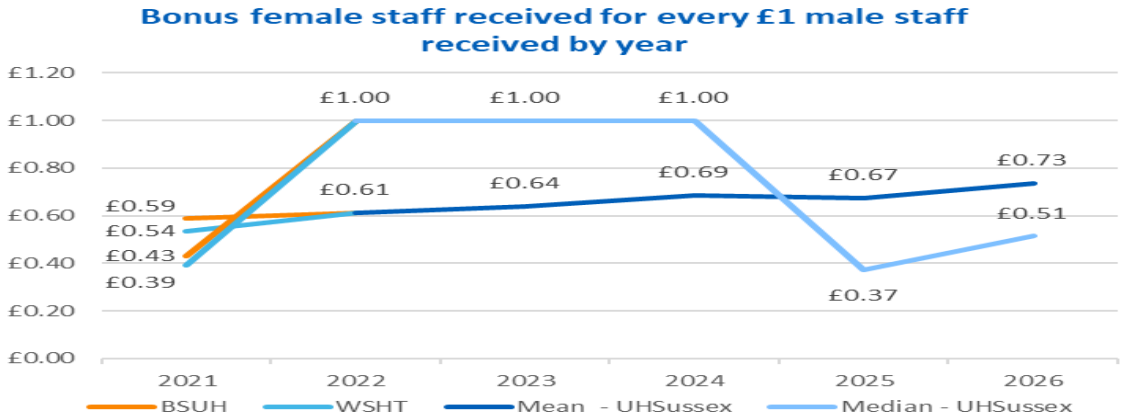
The chart below shows the percentage of male and female employees, all of whom were doctors, who received bonuses:

- 2.14% of male employees received a bonus
- 0.48% of female employees received a bonus
- This means the proportion of male employees receiving a bonus is over 340% higher than the proportion of female employees.
- 137 male and 75 female doctors received at least one type of bonus.

Percentages are calculated using all relevant employees in full pay on the snapshot date as the denominator.

Bonus Pay Differences

The chart below shows changes in the mean and median bonus pay gap historically; it shows that male staff continue to receive a higher overall amount in bonus pay compared to female staff. This disparity is primarily due to a greater proportion of male staff receiving bonuses, as well as some male



staff receiving multiple types of awards.

Female staff received lower average (£8,931.86) and median (£4,180.20) bonus pay than male staff (£12,164.13 and £ 8,143.20 respectively). This translates to an average pay gap of 26.57% and a median pay gap of 48.67%.

Discretionary Points Pay

Discretionary Points are legacy consultant payments awarded to consultants in recognition of additional responsibilities under previous national

arrangements and closed to new entrants. This was awarded to one male employee within the 12 months.

Clinical Excellence Award

Clinical Excellence Awards (CEAs) are intended to recognise consultants who make sustained contributions beyond the standard expectations of their role, including excellence in patient care, service development, teaching, research, and leadership. To be eligible, consultants must hold a substantive post and normally have completed at least one year of service at the Trust at the time of application. This includes:

- Local awards - granted by the Trust.
- National awards - granted by the Department of Health and Social Care but paid through the Trust's payroll.
- 129 (66%) male and 67 (34%) female staff received CEA-related payments within the 12-month reporting period.

There have been national changes to the CEA scheme for consultant medical staff. Local CEAs are no longer awarded, and no new CEAs have been made under post-2018 contract arrangements. However, consultants who received awards prior to these changes retain them on a protected basis until they leave NHS service.

National Clinical Impact Awards (NCIA)

National Clinical Impact Awards (NCIAs) are the current national scheme intended to recognise consultants who demonstrate clinical impact beyond their employing organisation, such as regional or national leadership, guideline development, research, education, or service transformation. NCIAs replaced national Clinical Excellence Awards for consultants on newer contract arrangements and are awarded through a nationally managed process. This includes:

- National awards - granted by the Department of Health & Social Care but paid through the Trust's payroll.
- 8 female (53%) and 7 male (47%) staff received a National Clinical Impact Award within the 12 months.

Gender Pay Gap: Menopause Action Plan

This section is included in line with current Government guidance on voluntary equality action plans alongside gender pay gap reporting. Employers with 250 or more employees may publish an action plan in conjunction with their gender pay gap data, and the guidance indicates that these plans may include actions to address the gender pay gap and to support employees experiencing menopause. This aligns with the Employment Rights Act 2025. Trust actions include:

- Menopause Support and Workplace Adjustments

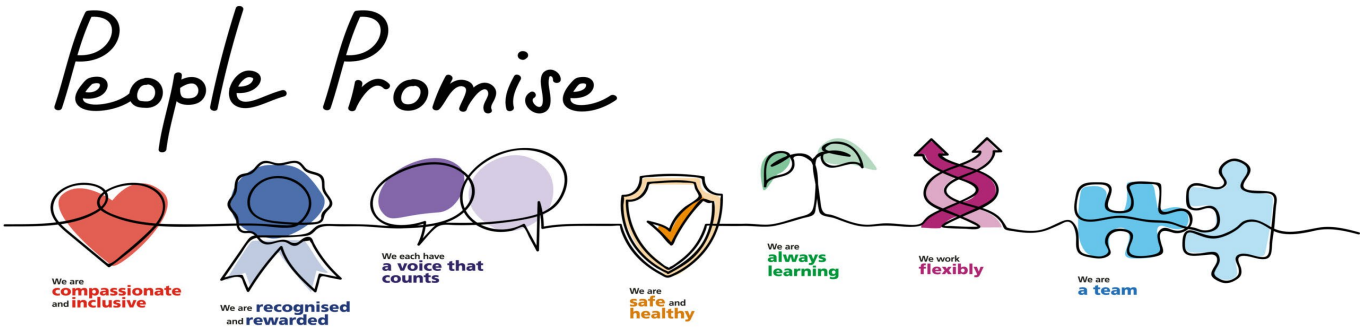
In response to evolving legislative expectations on equality and workplace support, including the Employment Rights Act 2025, this report includes initiatives to support colleagues experiencing menopause.

- Manager Confidence and Training
  Support for managers includes a menopause e-learning module, inclusion of menopause within the Mental Health Training for Managers programme, menopause-focused peer support sessions, and a managers' Menopause Guide. This guidance includes practical advice and information on recording menopause-related absence.
- Peer Support and Awareness
  The Trust has delivered a quarterly Menopause Café since 2024, with approximately 400 members and around 800 cumulative attendees to date. Sessions typically attract 60-70 colleagues and include specialist input on menopause-related topics. Resources are shared via the staff intranet, and Menopause Awareness Day is marked annually. Feedback indicates the initiative is valued for both information and peer support.
- Workplace Adjustments
- Menopause Guidance outlines a range of reasonable workplace adjustments to support colleagues, enabling flexibility and supporting staff to remain in work.

The Trust's published information on inclusion, diversity and equality, including gender pay gap reporting, can be found at www.uhsussex.nhs.uk/equality

2.3.4 The NHS People Promise

The national NHS People Promise describes what matters most to everyone working in the NHS – feeling recognised, supported, included and empowered at work. Built around seven themes, it sets out the compassionate, positive workplace we all want to be part of, regardless of role or background.



The Trust was selected to join Cohort 2 of the NHS People Promise Exemplar Programme (2024/25), working collaboratively with 116 organisations regionally and nationally. The Exemplar Programme aims to deliver the People Promise actions together in one place, seeking to achieve improved outcomes for staff, organisations, service users and carers, as well as optimum staff satisfaction and retention.

After taking part in the national 2024/25 People Promise Exemplar Programme, we have continued to collaborate with NHS organisations across the country to drive collective action and enhance staff experience throughout 2025/26.

As part of this work, we contributed a range of case studies and resources to NHS England to help shape and share best practice. These included:

- innovative self-rostering and self-preferencing rotas for doctors to support work–life balance
- enhanced support for internationally recruited registered staff and their managers
- strengthened financial wellbeing initiatives, including our Crisis Support Fund and Financial Support & Pensions Officer
- menopause support and cafés
- suicide awareness guidance
- flexible retirement toolkits
- infant feeding and expressing at work guidance
- resources to address sexual misconduct in the workplace

We have also presented our work at regional and national Community of Practice events.

During the Exemplar Programme, we adopted a more coordinated approach to delivering the People Promise, aligning projects across all seven themes. We are continuing to embed this approach in 2025/26, learning from national partners while building an approach that supports delivery of our strategic Ambitions and Priorities and reflects our Trust Values.

To strengthen delivery of our People and Culture work, programmes and projects have been mapped to the strategic Ambitions they support, and the People Promise themes they best align with. This ensures all aspects of the People Promise are addressed to maximise staff satisfaction and retention. We also publish a monthly People Promise Update featuring opportunities, events, successes, resources and support from across the People Directorate. The Update is structured around the seven elements of the People Promise, and a dedicated intranet page provides further information and resources.

2.3.5 Improving staff engagement

Improving staff engagement is the strategic ambition with our long-term objective is to achieve a staff engagement score that places the Trust in the top quartile of acute Trusts. It is recognised that high levels of staff engagement are linked to improved safety and productivity supporting high quality patient care and sustainable services.

The willingness of staff to raise issues confident that something the Trust has supported through the Freedom to Speak Up Guardian arrangements (more below) and work to publicise the ways in which staff can raise issues and developing expectations around how leaders and managers respond and

provide feedback to staff on those issues. The Trust will continue work on this in 2026/27.

Freedom to Speak Up Guardian

We want every colleague to feel safe, heard and supported and to know they can speak up when something's not right, or they have an idea for improvement. Raising concerns helps us learn, improve, and protect both staff and patients.

Speaking up can take many forms. For many colleagues, this starts with line managers or local leaders. But when staff feel they need a confidential, independent route, the Freedom to Speak Up Guardian (FSUG) service is available 24/7, 365 days a year to help.

Since August 2023, our FSUG service has been provided by The Guardian Service Ltd, a specialist external provider offering 24/7 access to trained, independent advisers. The Guardian Service is visible across our sites, with direct escalation routes to the Chief Executive, Trust Board Chair, FSUG Lead Non-Executive Director and Chief People Officer, and provides regular analytical and thematic reports to the People & Culture Committee.

Between April 2025 and March 2026, 264 cases were raised with the FSUG (an average of 22 cases per month). This was a slightly increase (6.5%) from 2024/25 (or one additional case per month). From these referrals:

- Most staff sought impartial support (48%, a reduction from 2024/25) or said they had not felt heard through other routes (31%, no change from 2024/25).
- Only 3% of cases raised related to patient safety (a reduction from 6% in 2024/25), however for these the FSUG provided a clear and rapid route for escalation.
- Most escalations from the Guardian received a manager response within one working day.

In 2025 we introduced two new local questions to the NHS Staff Survey, asking about the FSUG service. 72% of staff said they were aware of the FSUG service, and 64% said that if needed, they would speak to the service. As in 2025/26, the FSUGs are now undertaking a programme of in-reach support, targeted to the 50 teams with weaker speaking up scores (including awareness of the FSUG service). This will continue through 2026/27.

2.3.6 NHS Staff survey 2025

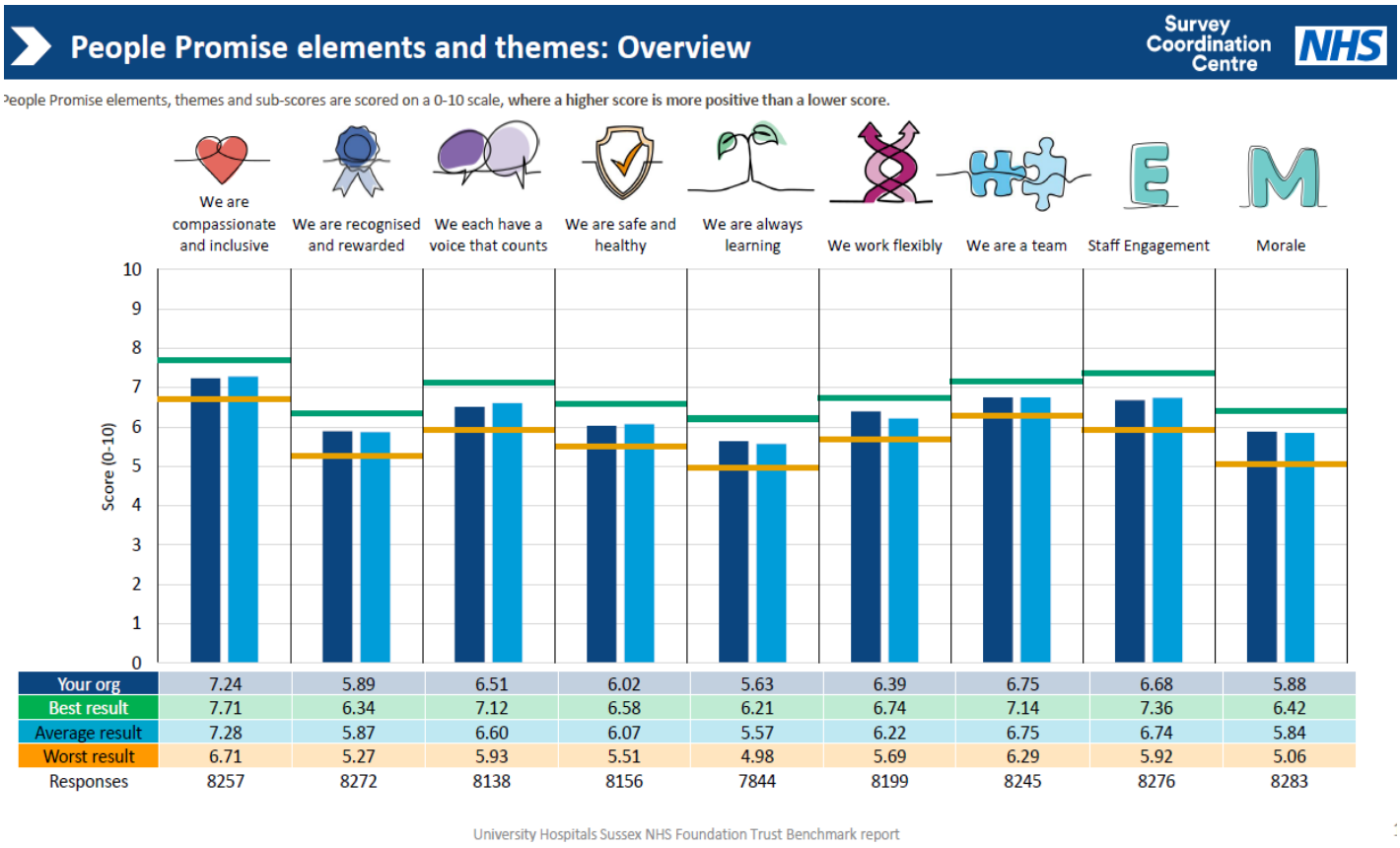
The NHS National Staff Survey (NSS) is one of the largest workforce surveys in the world. Each year, it provides powerful insight into how it feels to work at our Trust, helping us understand where we're doing well, and where change is needed. There is strong evidence that positive staff experience is closely linked to better care, stronger teamwork, and safer services.

We are grateful to every colleague who shared their views. The NSS offers one of the most comprehensive pictures of what it feels like to work here –

and we are committed to listening, learning and taking action that makes a difference for our people and for our patients.

Responses are benchmarked nationally and shared through our interactive digital dashboard to support local action across every site and service. NSS results cover the seven NHS People Promise elements and two themes (engagement and morale).

Chart below shows the benchmarked scores across the seven NHS People Promise Elements and two Themes (Engagement, Morale)



Response Rate

8,358 (46.5%) UHSussex staff responded to the 2025 Staff Survey. Although the response rate fell slightly from 2024 (47.0%) against the total number of eligible Trust staff, 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 continues to reflect 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.

What Our Staff Told Us

Survey questions are grouped under the NHS People Promise, which sets out what matters most to NHS staff at work. Overall, 2025 results for substantive staff found:

- 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.
- 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.
- 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 show opportunity for improvement.

The 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.

A number of areas of challenge remain, many of which mirror wider national trends:

- Speaking up measures improved but remain below NHS average, including: confidence to speak up and 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. The associated programme of work is overseen by a Violence Prevention & Reduction and Sexual Safety Steering Group, established in 2025.
- 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. A targeted roadshow and communications campaign is commencing in May 2026, targeting higher reporting teams, will include discussion on policies and processes plus support for staff.

Historic Scores

Trust NHS Staff Survey scores from 2022 to 2025, and comparisons with NHS benchmark group average, are as follows:

Indicators – People Promise Elements & Themes	2022		2023		2024		2025	
	Trust score	NHS Benchmark score	Trust score	NHS Benchmark score	Trust score	NHS Benchmark score	Trust score	NHS Benchmark score
We are compassionate and inclusive	7.04	7.18	↑ 7.12	7.24	↓ 7.10	7.21	↑ 7.24	7.28
We are recognised and rewarded	5.54	5.72	↑ 5.75	5.94	↑ 5.80	5.92	↑ 5.89	5.87
We each have a voice that counts	6.46	6.65	↑ 6.48	6.70	↓ 6.46	6.67	↑ 6.51	6.60
We are safe and healthy	5.60	5.88	↑ 5.84	6.08	↑ 5.86	6.09	↑ 6.02	6.07
We are always learning	5.20	5.35	↑ 5.41	5.62	↑ 5.48	5.64	↑ 5.63	5.57
We work flexibly	5.96	6.00	↑ 6.19	6.20	↑ 6.28	6.24	↑ 6.39	6.22
We are a team	6.52	6.64	↑ 6.64	6.75	↑ 6.69	6.74	↑ 6.75	6.75
Staff engagement	6.54	6.80	↑ 6.66	6.91	↓ 6.59	6.84	↑ 6.68	6.74
Morale	5.42	5.68	↑ 5.68	5.90	↑ 5.70	5.93	↑ 5.88	5.84

Key: ↑ Improved Trust score vs previous year, ↓ Worsened Trust score vs previous year

How We Are Responding – Staff Engagement & Feedback

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 nearly 2,000 individual freetext comments have also been analysed and will contribute towards local action planning and the continuing development of the Trust's Excellent Care Everywhere strategy.

Every Division develops a tailored Staff Survey Action Plan each year. These will build on their previous year's Staff Survey plans and will be aligned with the new Trust Operating Model launch in April 2026. These plans will build on local strengths and respond directly to what staff have told us.

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 safety.

Further information can be obtained at NHS workforce statistics - NHS Digital or the interactive NHS Staff Survey dashboard.

2.3.7 Education and supporting Workforce Development

At University Hospitals Sussex NHS Foundation Trust, we aim to foster an inclusive culture of education, training and development for all staff and are particularly proud of the career progression pathways we offer.

The Trust continues to work closely with a range local further education and higher education providers across a portfolio of clinical and non-clinical academic and vocational programmes. In 2024-25, we entered a more formalised academic partnership with the University of Chichester to validate a number of programmes within our clinical education portfolio.

The Trust receives both medical and non-medical educational tariff funding from NHS England (NHSE) and during 2024/25 this was used to support the Education, Training and Continuous Professional Development (CPD) of our students, trainees registered nurses and allied health professionals, advancing clinical practice and the development of new workforce roles. During 2024/25 we opened a new education facility including a clinical skills simulation suite at the Worthing site which has allowed us to bring together a range of services under one roof.

We continue to invest in the professional development of both clinical and non-clinical staff through the apprenticeship training pathways, and this includes a focus on lifelong learning which enables staff to gain the requisite qualifications in English and Maths before starting on their chosen apprenticeship pathway.

Within our Medical Education portfolio, UHSussex remains the largest provider of undergraduate and postgraduate training placements across Kent Surrey and Sussex. Our speciality programmes aim to produce high-quality clinicians with a broad range of skills that will enable them to practice as consultants. During 2024/25, we have focused on developing an enhanced support and training package for those doctors who are working within the category of Locally Employed Doctors (LED) and Speciality and Associate Specialist Doctors (SAS) and have appointed a Deputy Director of Medical Education to support this work.

Attendance on statutory and mandatory training continues to perform at a compliant training level as our March 2025 compliance is at 91%. This has improved on the year end position for March 2024 which was at 89.8% and has remained above 90% for the last 12 months. It should be noted that we have achieved this compliance whilst introducing a couple of new mandatory programmes including Prevent, Cyber Awareness. We still await the Part 2 commission from the ICB for the Oliver McGowan training on autism and learning disabilities.

2.3.8 Health and safety

University Hospitals Sussex NHS Foundation Trust meets its statutory duties under the Health and Safety at Work etc. Act 1974 through a defined Health and Safety Management System, executive accountability, and Board oversight, supporting the CQC Well-Led domain through effective governance, risk management, and organisational learning.
Board assurance is provided through the Health and Safety Committee, which meets quarterly to receive reports from groups and oversee actions reporting through the established governance reporting routes to the Audit Committee along with the Health and Safety Risks being reported to the Quality Governance Steering Group. Across the year the Audit Committee has been informed of assurance gaps and actions taken to address these.

A central Health and Safety Team oversees incident investigation, health and safety risk management, and compliance. Incidents, including RIDDOR events, are reported via Datix, with learning and actions tracked. Risk assessments and statutory compliance activity are managed through the Evotix system, enabling divisional oversight and escalation.

Health and safety training is mandatory for all staff on induction and then on a triennial cycle with compliance performance monitored as with all mandatory training at the Board's People Committee.

During 2025/26 the Trust engaged with multiple regulators including the Health and Safety Executive who reviewed the Trust's improved investigation process and actions and confirmed confidence in the quality of the investigation and the controls implemented. The Health and Safety Executive sought and received assurance over the actions taken in relation to a RIDDOR event in pathology.

Other visits included the Environment Agency to the Trust Radiology service, and both East and West Sussex Fire and Rescue Services continued to undertake their scheduled formal inspections and familiarisation visits, including that of the helipad at the Royal Sussex County Hospital. The Trust was served with a Fire Authority enforcement notice in respect of a small number of weaknesses at St Richards Hospital, these actions were addressed through a structured action plan, and the Fire Authority formally closed their enforcement notice within the year.

An internal audit of the Trust's Health and Safety processes was undertaken in the year and identified areas to strengthen risk assurance leading to revisions of the Health and Safety Management System and supporting policies, improved data quality, and strengthened executive oversight of high-risk areas, evidencing of this continuous improvement into 2026/ 27 will be reported to the Health and Safety Committee.

At the year end the Trust has no outstanding enforcement notices or notices of contravention.

2.3.9 Fraud, bribery and corruption statement

University Hospitals Sussex NHS Foundation Trust is committed to eliminating fraud, bribery and corruption within the NHS, freeing up public resources for better patient care. To this end, the Trust deploys a Local Counter Fraud Specialist (LCFS) function, to provide a comprehensive programme against fraud, bribery and corruption which is overseen by the Trust's Chief Finance Officer and Audit Committee.

The Committee received and approved the counter fraud plan to ensure that the Trust continued to develop its programme of deterrence, prevention, and detection, in line with NHS Counter Fraud Authority (NHSCFA) requirements and in response to emerging risks, both locally and throughout the healthcare sector inclusive of intelligence alerts and bulletins provided by the NHSCFA, which are disseminated via the LCFS. Additionally, the Committee received progress reports from the LCFS at each meeting during the year covering its workplan activities, and an annual report inclusive of the Counter Fraud Functional Standard Return (CFFSR).

The Trust expect all our staff and suppliers to operate in accordance with our values and policies, and to have the best interests of the NHS and our service users in mind. When entering into contracts with organisations the Trust follows the NHS standard terms and conditions of contract for the purchase of goods and supplies.

The Trust is committed to the elimination of fraud, bribery, and corruption, to the rigorous investigation of any such allegations and to taking appropriate action against such individuals that includes criminal prosecution and recovery of losses as a result of any criminal act. As such, we ask all who have dealings with the Trust, as employees, agents, trading partners, stakeholders, and patients, to help us in our fight against fraud, bribery, and corruption and to contact the LCFS in confidence if they have any concerns or suspicions.

The Trust is committed to complying with all anti-fraud, bribery, and corruption legislation. Although the Bribery Act permits offer of gifts and hospitality, all staff are required to consider on an individual basis whether accepting any hospitality offered is appropriate and should they then elect to take it, to record it within the Trust's Hospitality register (in line with the Receipt of Hospitality, Gifts, and Inducements Policy) so that it has been fully disclosed. It is a criminal offence to give, promise or offer a bribe, and to request, agree to receive, or accept a bribe. A bribe may take the form of any financial or other advantage, including offers of gifts or hospitality, to another person in order to induce a person to perform improperly.

2.3.10 Exit packages (subject to audit)

There were two exit packages in 2025/26 in the band of upto £10,000 and £150,001 - £200,000. (There were two exit packages in 2024/5 which were related to redundancies in the range of £10,000 - £25,000 and £50,000 - £100,000).

2.3.11 Off-payroll engagements

The Trust had 2 off-payroll engagements in the financial year. (There were 2 off payroll engagements in the prior year)

2.3.12 Statement on social responsibility

University Hospitals Sussex NHS Foundation Trust reflects its social responsibility through the way it undertakes its business and delivers services. This responsibility spans the recruitment, retention and development of our workforce; the accessibility and environmental sustainability of our services; and our duty to work with partners to safeguard patients, their families and carers, as described elsewhere in this Annual Report.

The Trust recognises and values its role as an anchor institution within Sussex. This role is reflected in procurement and commercial decision-making, ensuring that value is delivered not only for the Trust but also for the wider communities we serve. The Trust complies with all relevant regulations and policy requirements relating to social value, including the Social Value Act 2012, and applies the principles of corporate social responsibility across its procurement activity.

The Trust applies Procurement Policy Note 002: The Social Value Model, which requires social value considerations, including net zero, economic, social and environmental outcomes, to be aligned to the National Procurement Policy Statement and embedded within tender evaluation processes. In support of national and local priorities for small and medium-sized enterprises and third sector organisations, contracts are advertised locally and nationally where appropriate, including through the Central Digital Platform. Procurement processes are designed to be transparent, proportionate and accessible, enabling a broad and diverse range of suppliers to compete for Trust business.

As set out in last year's Annual Report, the Trust committed to supporting local businesses by introducing a key performance indicator during 2025/26 that at least 10% of total third-party supplier spend would be with businesses based within the local community. The Trust is pleased to report that this target was met and exceeded in every quarter of the year, demonstrating consistent delivery against its commitment to supporting the local economy. The Trust recognises its responsibilities under the Modern Slavery Act 2015 and operates a zero-tolerance approach to modern slavery and human trafficking within its supply chains and business operations. The Trust applies Procurement Policy Note 009: Tackling Modern Slavery in Government Supply Chains, alongside the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025, which will come into force on 17 May 2026. These place statutory requirements on NHS organisations to take reasonable and proportionate steps, based on assessed risk, to address and where possible eliminate the risk of modern slavery in the procurement of goods and services for the NHS.

In line with these requirements, the Trust undertakes modern slavery risk assessment at the pre-procurement stage and applies appropriate and proportionate controls throughout the procurement and contract lifecycle. This

includes supplier due diligence, the use of robust selection and award criteria, contractual terms, supplier assurance and ongoing contract management. All supplier's awarded contracts are required to comply with the NHS Terms and Conditions of Contract, which include obligations relating to good industry practice, labour standards, and the prevention of slavery and human trafficking within supply chains.

The Trust also aligns its approach to the NHS England Modern Slavery and Human Trafficking Annual Statement, published as a group statement on behalf of the NHS in England. The Trust supports the actions set out within this statement and demonstrates its commitment by aligning local policies, procurement practices and governance arrangements to the nationally defined approach.

The Trust is committed to fair, open and non-discriminatory procurement processes. All suppliers are provided with equal opportunity to compete for Trust business, and procurement policies and procedures are applied consistently and fairly. The Trust does not tolerate discrimination against suppliers or their employees and expects equivalent standards from those with whom it does business.

The Trust's commitment to supporting local communities is further strengthened through the work of its charitable partner, My Charity, which supports initiatives that enhance patient experience, staff wellbeing and community-based projects across Sussex. The Trust will continue to work alongside My Charity and other charities who support the Trust to maximise the positive impact of charitable investment for patients, staff and local communities.

Looking ahead to 2026/27, the Trust will build on the University Hospitals Sussex Strategy, launched in October 2025, and in particular its 'Communities: Improving lives together' strategic ambition. In support of this ambition, the Trust will work with local councils, other anchor public institutions and strategic partners to collaboratively review and strategically target the five national social value themes, enabling a more coordinated and focused place-based impact across Sussex.

The Trust will continue to embed social responsibility into its governance, procurement and commercial arrangements, ensuring that commitments are translated into measurable outcomes. Through alignment with national policy, partnership working and continuous improvement, the Trust remains focused on delivering ethical, sustainable and inclusive value for patients, staff and local communities.

25 June 2026

Dr Andy Heeps
Chief Executive

2.4 Remuneration Report

2.4.1 Annual statement on remuneration

It is the responsibility of the Appointment and Remuneration Committee of Non-Executive Directors to oversee the pay arrangements of Executive Directors and Very Senior Managers, details of the committee can be found within the 'How the Trust is Run' section of this report. During the period of this report where appointments have been made to the Executive and Very Senior Managers of the Trust salaries have been determined in accordance with national guidance and benchmarks.

2.4.2 Senior Managers Remuneration Policy

Initial salaries are determined on appointment with reference to the nature of the role, responsibilities, previous experience and expertise of candidates and the need to offer competitive remuneration that represents value for money for the taxpayer, informed by national guidance and benchmark pay ranges (with necessary opinion sought for any salaries over £170k per annum).

All Directors' performance is subject to an annual appraisal the outcome of which is reported to the Appointment and Remuneration Committee by the Chief Executive. This is prior to any decision being made on any increase to Executive remuneration.

For the Chief Executive Officer, their appraisal is undertaken by the Chair of the Trust with a report then submitted to the Appointment and Renumeration Committee.

The annual appraisal method is chosen as it is an effective way to assess performance against a range of performance targets and leadership responsibilities and includes feedback from Non-Executive Directors and peers as part of a 360 degree feedback process.

In coming to any decision on remuneration, the Committee takes account of the circumstances of the Trust, the size and complexity of the role, any changes in the Directors portfolio, the performance of the individual and any appropriate national guidance. Senior managers are remunerated based on these decisions. Any performance related pay award by the Committee is within the context of the NHS Very Senior Managers Pay Framework and guidance.

In considering Senior Managers Pay the Committee takes note of national benchmark data provided by NHS Providers and the requirement to consider any pay above a threshold of £170,000 per annum as per Cabinet Office guidance.

The Trust has complied with the Very Senior Managers (VSM) Framework.

2.4.3 Future policy table

The table overleaf details components of the remuneration package for senior managers:

Component of pay	Link to short and long-term strategic goals	How the Trust operates this in practice	Maximum limit	Performance measures
Base salary	To promote the long-term success of the Trust by attracting and retaining high calibre senior managers in a competitive marketplace.	The Committee reviews the following in setting remuneration for senior managers: • Role, responsibilities and accountabilities • Skills, experience and performance • Trust performance • Pay awards across the Trust • Local and national market conditions • Advice from NHSE/Ministerial opinion • Benchmarking The committee reserves the right to approve specific increases in exceptional cases, such as major changes to a senior manager's role.	Subject to the NHS Very Senior Manager pay framework. Some of our senior managers are paid more than £170,000 which is the amount above which Ministerial opinion on salary must be sought under NHS England guidance. In these instances, the Remuneration Committee has taken steps to assure itself that the pay received by these individuals is commensurate with market conditions, the responsibilities and duties of the role, and is regularly reviewed to ensure that the Trust is receiving value-for-money	Trust overall performance and individual appraisal (inc 360 feedback)
Taxable benefits		Senior managers' benefits include: Pension-related benefits Access to car lease and other schemes - the same as other staff.	There is no prescribed maximum limit.	Not applicable
Pension		The Trust operates the standard NHS Pension Scheme and a NEST scheme for those ineligible to join NHSPS.	As per standard NHS Pension Scheme.	Not applicable
Performance related pay	The Trust has not applied a performance related pay regime for 2025/26			

Base salaries are set in line with market information and are designed to ensure retention, or recruitment, of the calibre and experience required to deliver the aims of the Trust. Salaries are revised annually and uplifted only if:

- There is demonstrable evidence that an uplift is required to keep in line with the market, informed by any NHS/Ministerial guidance on pay uplifts including the recommendations of the Senior Salaries Review Body
- A change in portfolio necessitates an uplift.

2.4.4 Service contracts obligations and Policy on payment for loss of office

HM Treasury has issued specific guidance on severance payments within 'Managing Public Money' and special severance payments when staff leave requires Treasury approval.

All contracts are permanent with no fixed end date. There are no contractual provisions for payments on termination of contract.

The table here shows the date of contracts and notice periods during the last year.

Name	***Title***	***Date of Contract***	***Notice period from the Trust***	***Notice period to the Trust***
Dr George Findlay #	Chief Executive	1 June 2022	6 months	6 months
Dr Andy Heeps	Chief Executive	18 December 2025 **	6 months	6 months
Jonathan Reid	Chief Financial Officer from 1 November 2024	1 November 2024	6 months	6 months
Dr Maggie Davies	Chief Nurse	1 May 2019	6 months	6 months
Professor Catherine (Katie) Urch	Chief Medical Officer	1 December 2025 ***	3 months	3 months
Roxanne Smith	Chief Strategy Officer	1 June 2023	6 months	6 months
Nigel Kee	Interim Chief Operating Officer	10 March 2025	3 months	3 months
Helen Brown	Interim Chief Corporate Affairs Office	12 January 2026	1 month	1 month
Sarah-Jane Taylor	Interim Chief People Officer	16 February 2026	1 month	1 month
David Grantham #	Chief People Officer	14 June 2021	6 months	6 months
Sandi Drewett *#	Chief Culture & OD Officer	21 November 2023	6 months	6 months
Michelle Arrowsmith #	Interim Chief Corporate Affairs Office	13 October 2025	1 month	1 month

Notes
* non voting member of the Board
** prior to the Andy was Deputy Chief Executive and then Interim Chief Executive (contractual notice periods remained the same)
*** this reflects the application of retire and return and a new contract
# left during the year

2.4.5 Statement of consideration of employment conditions elsewhere in the Foundation Trust

In considering any decision on remuneration the Committee takes note of both the organisational and national context, and as described in section 2.4.3 national NHS (market) benchmarking provided from sources including NHS Providers

2.4.6 Salary and pension entitlements of senior managers Remuneration 2025/26
(subject to audit)

	Salary (Bands of £5,000) a	Expense payments (taxable) to nearest £100 b	Annual performance pay and bonuses (bands of £5,000) c	Long term performance pay and bonuses (bands of £5,000) d	All pension-related benefits (bands of £2,500) e	Total (a to e) (bands of £5,000) f
Dr George Findlay Chief Executive (To August 2025)	105 - 110	200	-	15 - 20	112.5 - 115	235 - 240
Dr Andy Heeps * Chief Executive (From September 2025)	250 - 255	300	-	-	202.5 - 205	455 - 460
Jonathan Reid Chief Financial Officer	215 - 220	-	-	-	125 - 127.5	340 - 345
Dr Maggie Davies Chief Nurse	185 - 190	1,600	-	-	-	185 - 190
Dr Catherine Urch Chief Medical Officer	250 - 255	-	-	-	-	250 - 255
David Grantham Chief People Officer (To 15 February 2026)	185 - 190	-	-	-	90 - 92.5	275 - 280
Roxanne Smith Chief Strategy Officer	165 - 170	-	-	-	45 - 47.5	210 - 215
Sandra Drewett Chief Culture and Organisational Development Officer (ended May 2025)	20 - 25	-	-	-	60 - 62.5	80 - 85
Michelle Arrowsmith Chief Corporate Affairs Officer-Interim (13 October 2025 to 9 January 2026)	45 - 50	-	-	-	-	45 - 50
Helen Brown Chief Corporate Affairs Officer-Interim (from 12 January 2026)	30 - 35	-	-	-	-	30 - 35
Nigel Kee Chief Operating Officer- Interim	190 - 195	600	-	-	1387.5 - 1390	1580 - 1585
Sarah-Jane Taylor Chief People Officer (From 16 February 2026)	25 - 30	-	-	-	-	25 - 30
Philippa Slinger Chair and Non Executive Director	70 - 75	4,400				75 - 80
Bindesh Shah Non-Executive Director	10 - 15	100				10 - 15
Professor Gordon Ferns Non-Executive Director	10 - 15	1,400				15 - 20
Jackie Cassell Non-Executive Director	15 - 20	-				15 - 20
Kate Steadman Non-Executive Director (term ended 31 January 2026)	5 - 10	-				5 - 10
Lucy Bloem Non-Executive Director	20 - 25	4,300				25 - 30
Mike Driver Non-Executive Director	10 - 15	-				10 - 15
Professor Paul Layzell Deputy Chair and Non-Executive Director	20 - 25	2,400				20 - 25
Philip Hogan Non-Executive Director	15 - 20	-				15 - 20
Wayne Orr Non-Executive Director (term ended 31 January 2026)	5 - 10	-				5 - 10

*Notes * Andy Heeps was interim CEO from 1 September before becoming substantive CEO from 15 December 2025*

Salary and pension entitlements of senior managers Remuneration 2024/25
(subject to audit)

	Salary (Bands of £5,000) a	Expense payments (taxable) to nearest £100 b	Annual performance pay and bonuses (bands of £5,000) c	Long term performance pay and bonuses (bands of £5,000) d	All pension-related benefits (bands of £2,500) e	Total (a to e) (bands of £5,000) f
Dr George Findlay Chief Executive	275 - 280	-	-	30 - 35	180 - 182.5	490 - 495
Dr Andy Heeps Deputy Chief Executive and Chief Operating Officer	210 - 215	-	-	-	37.5 - 40	250 - 255
Jonathan Reid Chief Financial Officer (From 1 November 2024)	85 - 90	-	-	-	-	85 - 90
Dr Maggie Davies Chief Nurse	180 - 185	-	-	-	0 - 2.5	180 - 185
Dr Catherine Urch Chief Medical Officer	245 - 250	-	-	-	27.5 - 30	275 - 280
David Grantham Chief People Officer	180 - 185	-	-	-	47.5 - 50	225 - 230
Darren Grayson Chief Governance Officer (Term ended 31 January 2025)	180 - 185	-	-	-	45 - 47.5	225 - 230
Roxanne Smith Chief Strategy Officer	160 - 165	-	-	-	25 - 27.5	185 - 190
Sandra Drewett Chief Culture and Organisational Development Officer	130 - 135	-	-	-	35 - 37.5	165 - 170
Karen Geoghegan Chief Financial Officer (Term ended 19 May 2024)	25 - 30	-	-	-	-	25 - 30
Clare Stafford Chief Financial Officer- Interim (Term 20 May 2024 to 31 October 2024)	105 - 110	-	-	-	-	105 - 110
Nigel Kee Chief Operating Officer (From 10 March 2025)	10 - 15	-	-	-	-	10 - 15
Alan McCarthy Chairman (Term ended 30 June 2024)	15 - 20	200				15 - 20
Philippa Slinger Chairman (From 1 July 2024)	50 - 55	2,900				55 - 60
Paul Layzell Non-Executive Director	20 - 25	-				20 - 25
Philip Hogan Non-Executive Director	15 - 20	1,400				15 - 20
Jackie Cassell Non-Executive Director	15 - 20	200				15 - 20
Lucy Bloem Non-Executive Director	15 - 20	-				15 - 20
David Curley Non-Executive Director	15 - 20	-				15 - 20
Bindesh Shah Non-Executive Director	10 - 15	100				10 - 15
Professor Malcolm Reed Non-Executive Director (Term ended 31 July 2024)	0 - 5	-				0 - 5
Wayne Orr Non-Executive Director	10 - 15	-				10 - 15
Gorden Ferns Non-Executive Director (From 1 August 2024)	5 - 10	200				5 - 10
Elizabeth Peers Non-Executive Director (Term ended 10 May 2024)	0 - 5	-				0 - 5

Notes *Clare Stafford held the role of Director of Finance prior to taking on the role of Chief Financial Officer. Also Clare Stafford's calculation for pension related benefits returned a negative number and is reported as nil in accordance with the Greenbury guidance.*

Pension Entitlements as at 31 March 2026 (subject to audit)

	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c)Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2025 (nearest £1,000)	(f) Real increase in Cash Equivalent Transfer Value (nearest £1,000)	(g) Cash Equivalent Transfer Value at 31 March 2026 (nearest £1,000)	(h) Employer's contribution to Stakeholder Pension
Dr George Findlay Chief Executive (To August 2025)	15 - 17.5	10 - 12.5	105 - 110	255 - 260	2,323	37	2,534	Nil
Dr Andy Heeps Chief Executive (From September 2025)	10 - 12.5	17.5 - 20	70 - 75	170 - 175	1,268	193	1,514	Nil
Jonathan Reid Chief Financial Officer	5 - 7.5	7.5 - 10	45 - 50	105 - 110	0	123	1,056	Nil
Dr Maggie Davies Chief Nurse	0 - 2.5	0	5 - 10	0	130	0	145	Nil
Dr Catherine Urch Chief Medical Officer	0	0	5 - 10	0	67	0	125	Nil
David Grantham Chief People Officer (To February 2026)	5 - 7.5	5 - 7.5	70 - 75	175 - 180	1,547	106	1,703	Nil
Roxanne Smith Chief Strategy Officer	2.5 - 5	0	15 - 20	0	136	20	179	Nil
Sandra Drewett Chief Culture and Organisational Development Officer (to May 2025)	5 - 7.5	0 - 2.5	40 - 45	90 - 95	849	26	932	Nil
Michelle Arrowsmith Chief Corporate Affairs Officer- Interim (from October 2025 to January 2026)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Helen Brown Chief Corporate Affairs Officer- Interim (from January 2026)	0	0	0	0	0	0	0	Nil
Nigel Kee Chief Operating Officer- Interim	60 - 62.5	175 - 177.5	60 - 65	175 - 180	0	29	45	Nil
Sarah-Jane Taylor Chief People Officer (From February 2026)	0	0	0	0	0	0	0	Nil

Notes

- *Andy Heeps was interim CEO from 1 September before becoming substantive CEO from 15 December 2025*
- Michelle Arrowsmith was on secondment. The Pensions entitlement will be disclosed by NHS Derby and Derbyshire ICB in their annual report
- Sarah-Jane Taylor has opted out from the NHS Pension Scheme

Pension Entitlements as at 31 March 2025 (subject to audit)

	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	© Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 31 March 2024 (nearest £1,000)	(f) Real increase in Cash Equivalent Transfer Value (nearest £1,000)	(g) Cash Equivalent Transfer Value at 31 March 2025 (nearest £1,000)	(h) Employer's contribution to Stakeholder Pension
Dr George Findlay Chief Executive	10 - 12.5	15 - 17.5	95 - 100	245 - 250	1,950	207	2,323	Nil
Dr Andy Heeps Deputy Chief Executive and Chief Operating Officer	2.5 - 5	0	60 - 65	145 - 150	1,133	33	1,268	Nil
Jonathan Reid Chief Financial Officer (From 1 November 2024)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dr Maggie Davies Chief Nurse	0 - 2.5	0	5 - 10	0	73	0	130	Nil
Dr Catherine Urch Chief Medical Officer	0 - 2.5	0	0 - 5	0	30	21	67	Nil
David Grantham Chief People Officer	2.5 - 5	0 - 2.5	65 - 70	165 - 170	1,376	56	1,547	Nil
Darren Grayson Chief Governance Officer (Term ended 31 January 2025)	2.5 - 5	0 - 2.5	85 - 90	240 - 245	1,998	49	2,211	Nil
Roxanne Smith Chief Strategy Officer	0 - 2.5	0	10 - 15	0	101	8	136	Nil
Sandra Drewett Chief Culture and Organisational Development Officer	2.5 - 5	0	35 - 40	90 - 95	1,093	27	849	Nil
Karen Geoghegan Chief Financial Officer (Term ended 19 May 2024)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Clare Stafford Chief Financial Officer- Interim (Term 20 May 2024 to 31 October 2024)	0	0	55 - 60	150 - 155	0	0	1,331	Nil
Nigel Kee Chief Operating Officer (From 10 March 2025)	0	0	0	0	0	0	0	Nil

Notes:

- *Jonathan Reid and Karen Geoghegan did not contribute to the NHS Pension scheme during the year.*
- *Nigel Kee is drawing down pension*
- *The figures above do not include future adjustment to the pension benefits and related CETVs do not allow for a potential future adjustment for some eligible employees arising from the McCloud judgement.*

Remuneration and Pension Table notes

As set out in paragraph 8(3) of the Regulations, where the calculations of any of these columns result in a negative value (other than in respect of a recovery or withholding), the result is expressed as zero in the relevant column in the table.

“a” is salary and fees (in bands of £5,000)

“b” is all taxable benefits (total to the nearest £100)

“c” is annual performance-related bonuses (in bands of £5,000)

“d” is long-term performance-related bonuses (in bands of £5,000). The long term performance bonus for Dr George Findlay relates to a Clinical Excellence Award

“e” is all pension–related benefits (in bands of £2,500). As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members. Information on accrued pension benefits is provided by the NHS Pensions Agency

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Where the calculation returns a negative value, a nil return is disclosed in accordance with the Greenbury guidance.

“f” is the total of items “a” to “e” (in bands of £5,000).

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accumulated benefits and any contingent spouse’s pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Total Pension Entitlement. The normal retirement age for the NHS Pension Scheme is either 60 (for members in the 1995 scheme) or 65 (for members in the 2008 scheme). On retirement members receive their accrued pension and members in the 1995 scheme receive a lump sum equal to three times their annual pension. Members may choose to retire from work before their normal pension age and draw their benefits although these will be reduced because they will be paid earlier than expected. Further information about scheme rules and entitlements is available from http://www.nhsbsa.nhs.uk/pensions.

Payments to past senior managers (subject to audit)

The following payments were made to individuals who were senior managers (Board Members) during the financial year:

Payments to past senior managers	Bandings in £000's
Sandra Drewett	80 - 85
Dr George Findlay	330 - 335

Notes

Sandi Drewett remained with the Trust for a further 5 months supporting with the Trust cultural and organisational development programme

Geroge Findlay remained working for the Trust undertaking work for both the Trust and the wider NHS on processes for securing improvement. It should be noted that the paymenrt above also includes his contractual notice period payment.

Fair Pay Multiple (median pay) (subject to audit)

NHS foundation Trusts are required to disclose the relationship between the remuneration of the highest-paid Director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid Director in the organisation in the financial year 2025-26 was £305k - £310k (2024-25: £305k - £310k). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2025-26 was from £24k to £392k (2024-25: £24k to £399k). The percentage change in average employee remuneration (based on total for all employees on an

annualised basis divided by full time equivalent number of employees) between years is 6%. 15 employees received remuneration in excess of the highest-paid Director in 2025-26.

2025/26	*% change for highest paid Director*	*% change for employees as a whole*
Salary and allowances	-1%	6%
Performance pay/bonuses	0%	0%

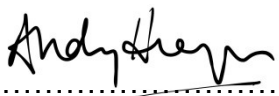
2024/25	*% change for highest paid* Director	*% change for employees as a* whole
Salary and allowances	23%	3%
Performance pay/bonuses	0%	0%

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid Director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

From the percentiles reported below, the salary of staff has improved in 2025/26 relative to the highest paid director. All employees received the mandated pay award for 2025/26.

2025/26	*25th percentile*	*Median*	*75th percentile*
Salary component of pay	£31,734	£44,017	£58,342
Total pay & benefits excluding pension benefits	£31,735	£44,057	£58,377
Total pay & benefits excluding pension: Pay ratio for highest paid Director	10:0	7:1	5.1
Salary: Pay ratio for highest paid Director	10:0	7:1	5.1

2024/25	*25th* percentile	*Median*	*75th percentile*
Salary component of pay	£30,428	£42,338	£56,006
Total pay & benefits excluding pension benefits	£30,435	£42,366	£56,016
Total pay & benefits excluding pension: Pay ratio for highest paid Director	10:1	7:1	6.1
Salary: Pay ratio for highest paid Director	10:1	7:1	6.1



…… 25 June 2026

Dr Andy Heeps, Chief Executive

2.5 Regulatory ratings

The Trust has entered into a series of licence undertakings with NHS England. These undertakings cover an agreement to improve operational performance and improvements to the Trust's quality governance processes. Operational performance improvements have been overseen by both the

Board's Systems and Partnerships Committee and through the Tier 1 meetings with NHS England. The quality governance process improvements have been overseen by a dedicated Single Improvement Programme Committee of the Board across 2024/25. Also, both elements of these undertakings feed into the routine provider assurance meetings with NHS Sussex and NHSE Region.

The Trust received an enforcement notice in 2022/23 in relation to Upper GI Cancer Surgery where the Trust has a restriction on its registration in respect of the provision of specific surgical procedures. The Trust is compliant with this notice in that it does not undertake these procedures with patients being treated at neighbouring Trusts. Therefore, the Trust through this action is complaint with its CQC registration.

2.6 Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of University Hospitals Sussex NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England, has given Accounts Directions which require University Hospitals Sussex NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Sussex NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care's Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements

- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance

- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation Trust's performance, business model and strategy and

- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Signed…… 25 June 2026

Dr Andy Heeps,
Chief Executive

2.7 Annual Governance Statement for the period 1 April 2025 to 31 March 2026

1. Scope of responsibility

1.1 As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also

acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

1.2 The Trust's Standing Orders and Scheme of Delegated Authority outline the accountability arrangements and scope of responsibility of the Board of Directors ('the Board'), Executive Directors and Trust officers.

1.3 The Trust's constitution was subject to periodic review with the last review having been undertaken in March 2025 where only minor changes were made to bring further clarity to the document.

1.4 Reports on the Trust's compliance with the Trust's Standing Financial Instructions are presented to the Audit Committee and through the work of Internal and External Audit especially in respect of the Trust's financial control framework there have been no issues identified that required any updates to these documents or the scheme of delegation.

1.5 The Board receives regular reports from each of the nominated Committee Chairs at each of its Board meetings allowing the Board to assess the operation of its committees. During December 2025 and January 2026 each Committee conducted a review of their own effectiveness. They considered the outcome of the review at their respective meetings at the end of January and reported this to the Board in February as part of their routine Committee Chair's reports. As a result of this work minor changes were agreed to the respective Committee Terms of Reference by the Board. Through the routine Committee Chair reporting and this annual review undertaken by each Committee the Board has been assured over the effectiveness of its Committees.

1.6 The Trust continues to work in close partnership with other Health and Social Care organisations within the Integrated Care System along with attending both the West Sussex County Council and Brighton and Hove City Council Health and Adult Social Care Scrutiny Committees. The Trust Chair over the year has chaired a Sussex side acute provider collaborative meeting and Trust Executives are regular attendees at ICS meetings and forums. In addition, The Chairman attends the regular ICS Chairs' meetings chaired by the ICB Chair. These arrangements allow the Trust to play an active and positive role in the ICS. The Board has established a Committee in Common, which meets with the similar Committees established by other Sussex providers and NHS Sussex, with a focus on system strategy formulation and delivery.

2. The purpose of the system of internal control

2.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of University Hospitals

Sussex NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in University Hospitals Sussex NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

3.1 *Trust Board*

3.2 The Trust has a Risk Management Strategy and Policy, endorsed by the Board of Directors. The Board of Directors recognise that risk management is an integral part of good management practice and to be most effective should be embedded in the Trust's culture. This recognition is embodied within the Strategy and Policy as this documents the Board's risk appetite and the processes applied across the Trust which see the oversight of the Trust's key risks assigned to a Board Committee with each key risk have a named executive lead. The Board is committed to ensuring that risk management is embedded as part of the Trust's philosophy, practice and planning and is not viewed or practiced as a separate programme and that responsibility for implementation is accepted at all levels of the organisation.

3.3 Each Board Committee received reports on the Trust's key risks at their meetings, these reports support the Committee's review of their assigned element of the Trust's Board Assurance Framework and the Committee's reporting to the Board.

3.4 The Trust has recognised that work is needed to strengthen its overall systems of risk management and the Board has charged the Chief Executive through the Chief Corporate Affairs Officer to oversee this improvement programme. This work includes a review of the Trust's Risk Management Strategy and Policy, the structure and focus of the Trust's Board Assurance Framework and the establishment of a clearly delineated Trust Risk Register that identifies key organisational wide risks, or risks requiring specific oversight from Trust Executives. As part of this work the Board has refreshed its risk appetite and tolerance statements and recalibrated its strategic risks to its 'Excellent Care Everywhere' strategy which was launched in the late summer of 2025. Oversight of this work is provided through an established Executive Risk and Governance Group and to the Audit Committee.

3.5 *Board Committees*

3.6 The Audit Committee has overall responsibility for ensuring there is effective risk management process employed across the Trust. The Audit Committee receive information annually from the Trust's internal auditors through their work which supports the Board Assurance Framework and through this work the Committee supports the Board to be assured over the robustness of the Trust's application of internal control processes. To enable the Audit Committee to fulfil its role its membership is drawn from the Non-

Executive Member Chairs of each of the other Board Committees providing a clear link to and from the Audit Committee's oversight of the Board Assurance Framework and the work undertaken in each Committee in respect of the key risks they have assigned oversight for.

3.7 The other key Board Committees of Patient and Quality, People and Culture, Finance and Performance, and Research, Innovation and Digital Strategy at each of their meetings receive and consider the Trust's key risks within each domain alongside consideration of the strength of assurances reflected within the Board Assurance Framework and the actions being taken to manage risks that are outside the Board's stated risk appetite. Each Committee reports the outcome of their review of the Board Assurance Framework to the next Board meeting.

3.8 The Board considers the views of each of its committees when it receives and considers the Board Assurance Framework, and makes a positive decision on the strength of control and thus the reported risk scores.

3.9 *Non-Executive Directors*

3.10 All Committees are chaired by a nominated Non-Executive Director. The Audit Committee which plays a pivotal role in providing assurance on the risk management processes of the Trust has a membership of only Non-Executive Directors. Through the Non-Executive Committee chairs who all form the Audit Committee membership along with the Non-Executive Audit Committee Chair they all have a responsibility to challenge robustly the effective management of risk and to seek reasonable assurance over the adequacy of the documented controls.

3.11 The Audit Committee at each of its meetings considers the Board Assurance Framework. The current Audit Committee Chair has provided valuable feedback as to the desired content of the Trust's Board Assurance Framework document that will support the Committee's reinstatement of complementary risk deep dives to provide deeper assurance to the Board on the underlying system of risk management and internal control.

3.12 The Audit Committee maintained an overview of the Trust's systems of internal control through the receipt and consideration of both management assurance and assurance from Internal Audit that the underpinning risk management processes operated within the Trust remained in place across the year.

3.13 *Interim Chief Corporate Affairs Officer*

3.14 Following the promotion of the Deputy Chief Executive to interim Chief Executive in the summer of 2025, the position of Chief Corporate Affairs Officer was created. This role has responsibility for the development and oversight reporting of the Trust overall risk management processes. Following both internal and external observations on the Trust's system of risk an improvement plan has been developed to further strengthen the Board and

Management's ability to assess the impact of actions taken on the Trust risk profile against the Board's stated risk appetite statements.

3.15 *Chief Nurse*

3.16 The Chief Nurse is responsible for ensuring there is a robust system in place for monitoring compliance with quality standards and the Care Quality Commission (CQC) Registration legal requirements.

3.17 The Chief Nurse is also responsible for managing patient and non-patient safety, complaints, patient experience and medical legal matters.

3.18 *Chief Financial Officer*

3.19 The Chief Financial Officer oversees the adoption and operation of the Trust's Standing Financial Instructions including the rules relating to budgetary control, procurement, banking, losses and controls over income and expenditure transactions, and is the lead for counter fraud.

3.20 The Chief Financial Officer and the Trust's Director of Operational Finance Director attend the Trust's Audit Committee and both liaise with internal audit, external audit and counter fraud services, who undertake programmes of audit utilising a risk based approach.

3.21 *Risk Management Training and Learning*

3.22 Risk management training forms part of the essential training package that all staff are required to complete. All new members of staff attend a mandatory induction covering key elements of risk management, supplemented by local induction. The organisation provides mandatory and statutory training that all staff must attend. The Trust has ab established a corporate team to support Divisions utilisation of the Trust's risk management system.

3.23 The established Risk Oversight Group offers a forum for Divisions, both clinical and corporate to seek support on the delivery of actions to reduce risks to allow the timely management of risk. This Group supports the Trust's drive for enhancing its culture of learning by ensuring it is having a the positive impact the Trust's overall risk profile.

3.24 During 2025/26 the new Chief Executive established an Executive Risk and Governance Group (ERaGG). ERaGG provides overall Executive oversight of the Trust's Governance, risk management and compliance processes, including the risk management improvement plan referenced above. This includes the enhancement of the Trust's risk management training programme to ensure that its content become more focused on the systematic management of risk and not just on the capture and recording of risks.

3.25 Complementary work continues in respect of developing the Trust Datix IQ (risk system) reports and dashboards to the Divisions. This work has been absorbed into the risk improvement project.

4. The risk and control framework

4.1 The Board of Directors has established a robust corporate governance framework in which is detailed within the Annual Report section 'How the Trust is run'. The corporate governance structure is designed to ensure appropriate oversight and scrutiny and to ensure good corporate governance practice is followed.

4.2 In support of the Trust's corporate governance processes the Trust has continued to apply its clinical divisional governance processes. The clinical operating model sees the Trust's clinical divisions aligned to the two principal streams of planned and unscheduled care. Each Clinical Division is led by a triumvirate of a Divisional Director of Operations, a Chief of Service and a Head of Nursing. Each division reports through the Quality Governance Steering Group to the Board's Quality Committee.

4.3 The Trust has a Risk Management Strategy which contains the Trust's risk appetite and the Trust's processes for identifying, reporting and managing risk.

4.4 Risk management training forms part of the essential training package that all staff are required to complete. All new members of staff attend a mandatory induction event which covers key elements of risk management. This training continues to be supported through bespoke training provided by the central risk and assurance team. As noted above, this training programme will be updated in 2026/2027 to provide a greater focus on controlling risk and greater clarity on roles, responsibilities and escalation of risk where local actions are not able to reduce risk to a satisfactory level.

4.5 Risks are raised and captured to a central risk management database known as DatixIQ. Reports from this system flow through the Trust from the respective operational teams to the Divisions, through both the Risk Oversight Group and the Quality Governance Steering group before being presented to the appropriate Board Committees and the Board. Complementing this is the dedicated central risk and assurance team that support the Trust to enhance its risk literacy and operational risk management processes within both corporate and clinical divisions.

4.6 All staff are responsible for responding to incidents, hazards, complaints and near misses in accordance with appropriate Trust policies. Divisional management teams oversee local risk registers and the management and escalation, as appropriate, of risks through to the Risk Oversight Group and the Quality Governance Steering Group. With a defined process established for the escalation and subsequent de-escalation of operational risks to the Executive.

4.7 The Trust has an established Board Assurance Framework (BAF), through which the Board is provided with a mechanism for satisfying itself that its responsibilities are being discharged effectively; and informs the Board where the delivery of Trust's principal objectives are at risk due to a gap in control and/or assurance.

4.8 The BAF records that the Trust has been managing 11 strategic risks, with five of these risks at the year-end exceeding their determined target score for the year and of the 11 strategic risks, four of these risks remain rated as significant at the year end.

4.9 For each of these risks there is a detailed series of mitigations and for those risks not achieving their target score these will continue to be implemented throughout 2026/27. The delivery of these mitigations and their impact on the risks is monitored through the appropriate Committees of the Board, with reports provided form these Committees to the Board.

4.10 Across the year oversight was maintained as to the risk mitigations, with reporting to the Board summarised below.

4.11 Through the reporting via the Finance and Performance Assurance Committee the Board recognised that whilst action was taken during the year in respect of the key financial sustainability risks, given the degree of operational pressures on the Trust and the degree of financial delivery risk in the second half of the Trust's annual plan this risk remained significantly scored across the year.

4.12 Through the reporting to the People and Culture Assurance Committee and that provided directly to the Board it was recognised during quarter 4 of the year that the actions in respect of culture strategic risk were beginning to take effect, enabling a marginal reduction in the risk score. The ongoing delivery of improvement to the Trust's culture will continue to be reported to the People and Culture Assurance Committee over 2026/27.

4.13 The Patient and Quality Assurance Committee maintained a focus on the management of the Trust's key quality risks. The Board recognised that whilst the Trust had developed and was delivering improvements in both its quality internal control environment and its assurance reporting there remained significant work to conclude this work sufficiently to reduce the risk and as such the risk remained significantly scored across the year.

4.14 With regard to the key constitutional targets the Trust has prioritised the treatment of patients according to their clinical needs, in line with national guidance. Like the majority of NHS providers, the Trust has taken action to see those patients waiting the longest focusing on those waiting over 65 weeks, and has delivered its RTT plan. By the year end this strategic risk reduced marginally in line with annual target score of moderate. Although there has been an Improvement in Ambulance Handover Performance and 12 hour ED waits, and despite ongoing improvement work, performance against the 4 hour ED standard has remained well below standard. The Trust is

commissioning a major programme of support to improve patient flow and ensure timely access to emergency care to commence in April 2026. The Patient and Quality Assurance Committee maintained a complementary review of the Trust's processes to manage the quality risks for patients waiting through the receipt of information on the outcome of harm reviews.

4.15 The Board has established a Research, Innovation and Digital Assurance Committee to provide oversight of the Trust's research and digital risks. Through the oversight of this Committee the Board recognised that the relative immaturity of the Trust's digital infrastructure meant neither of the two digital strategic risk reduced over the year. However, an EPR business case was approved and a clear set of actions are in place for 2026/2027 with an expectation that significant progress will be made over the next two years to significantly reduce this risk.

4.16 The Board established a dedicated Strategy and Major Projects Committee to oversee the development and the establishment of a Strategy Delivery Plan, this Committee over saw the risk mitigations in relation to the Trust's partnership working.

4.17 The Trust has continued to invest time and executive oversight into the enhancement of the Trust's reporting of its highly scored risks, in particular into the creation of a separate Trust risk register from the highly scored tactical / operations risks. The development of this was overseen by the established Executive Risk and Governance Group and is to form the bedrock of the revised Board Assurance Framework and Committee reporting for 2026/27.

4.18 The Trust has weaved into its risk management improvement plan recommendations made through the Trust's Well Led developmental review and a specific external review of the Trust's risk management processes.

Processes for Managing Cyber Security Risk

4.19 We manage our online security pro-actively through a series of technical tools. The Trust is fully onboarded with Microsoft Defender for Endpoint across the entire Trust and have deployed the solution on both the client devices and server estates. We use Microsoft Defender for Endpoint on all Trust Client Devices as this give us greater interoperability with the ATP solution. This solution allows us to actively monitor the devices on our network and have very early detection of any malware or other cyber threats that enter our estate. We use the Threat and Vulnerability Management tools within the ATP solution to identify any potential issues across our Estate. We have been undertaking a series of tasks to 'harden' our desktop. This process uses the ATP Vulnerability Management tools to identify areas of improvement that can decrease the number of attack vectors open to potential Cyber criminals. We continue to act on every National CareCERT alert that we receive and update NHS Digital of our follow-up actions and progress.

4.20 The popularity of the staff Cyber Awareness online virtual training continues to improve and is being promoted by the Trust's Senior Information Risk Owner (SIRO) to ensure take-up. Cyber training improves staff knowledge by building awareness of real-world threats and reinforcing safe behaviours that protect patient data and systems. During 2026/27, NHS is bringing Information Governance (IG) and cyber security training together because staff now need a single, integrated understanding of how to handle information safely and keep systems secure, rather than learning these topics in isolation.

4.21 We are currently to working with a Cyber partner company to carry out cyber related audits. These audits will focus on our patient facing communications systems that are in use across our sites. The recommendations from these audits will provide guidance on how to further protect our IT environment against attack.

4.22 The Trust Board has continued to invest in toolsets that Corporate IT Services use to combat threats. We have a dedicated management and vulnerability tool to monitor and manage our server estate within our data centres. This tool allows greater visibility, reporting and remediation options for any security vulnerability. The fluid nature of the Cyber Security threat landscape requires continued investment through the capital programme.

4.23 The Trust has been awarded the "standards met" rating for its 2024/25 Data Security and Protection Toolkit, providing an externally validated level of assurance over its core data security processes.

Processes for assuring the Board that staffing processes are safe, sustainable and effective

4.24 There are a number of ways in which the Trust ensures that short, medium and long term workforce needs are identified and staffing systems that are applied to assure the Board that staffing is safe, sustainable and effective. Workforce plans are developed at specialty and divisional level and include recruitment, retention and workforce transformation and efficiency plans, informed by clinical strategies and aligned to operational and financial planning. As for all NHS organisations, staffing to the level of demand to meet activity requirements remains challenging. In 2025/26 the Trust has further improved (reduced) turnover and vacancy levels with an improvement in overall staff engagement as reported within the NHS staff survey.

4.25 NHS National Quality Board standards, NICE guidance, NHSE guidance, Model Hospital data and recommendations from Royal Colleges and the output of national reviews on workforce are used to inform the staffing levels required to deliver high quality and safe services in acute hospital environments. Any changes to staffing profiles (numbers and skills) are subject to Quality Impact Assessment at divisional level and reviewed by the Chief Medical Officer and Chief Nurse prior to implementation. In particular assessment of the nursing establishment and skill mix is reported to the Board twice a year, in accordance with National Quality Board guidance.

4.26 Through regular reporting to the Board and its People & Culture Assurance Committee, workforce and safer staffing reports are provided and are triangulated against quality and other metrics to ensure our staffing processes are safe, sustainable and effective. Workforce risks are identified and monitored in the Board Assurance Framework and local risk registers. An internal audit programme includes periodic checks on workforce areas such as recruitment or processes such as rostering.

4.27 The Trust has a Guardian for Safe Working Hours roles, who work closely with educational and clinical supervisors to ensure that the health, wellbeing and safety of resident doctors is maintained. The reporting on exception reports and other matters and concerns raised by junior doctors to the People and Culture Assurance Committee, which monitors how those are being addressed.

4.28 During 2025/26, the health and wellbeing of our staff has remained a key priority with an extensive number of interventions to support the physical, emotional and financial health needs of our workforce. This has included action to support staff in financial hardship with support from the Trust charity MyUHSussex Charity. The work is led by a health and wellbeing steering group and regular updates to the People and Culture Assurance Committee provide assurance over the impact of this work. The key area of focus for the Committee has related to continued high levels of violence and aggression experienced by staff. The Committee has been a keen supporter of improved conflict resolution training for our staff and the enhanced support provided by our security staff and has sought assurance on the support provided to staff who have experienced incidents of violence and aggression.

4.29 Daily reporting of staffing capacity, including absence, is in place through the use of e-rostering systems now deployed. These provide visibility of staffing and the ability to adjust deployment reflecting any changes in activity levels or acuity of patients. The systems also allow monitoring of any use of additional staffing (bank and agency) and the reasons. During periods of pressure, such as industrial action or critical incident the Trust's business continuity arrangements provide for the re-call and re/deployment of staff as required. The Trust is completing the roll-out of rostering and job planning for its medical workforce.

4.30 There are robust governance structures in place that oversee the efficiency and effectiveness of our staffing systems that ultimately report into the Patient & Quality and People & Culture Assurance Committees of the Board. Maintaining workforce capacity and capability to ensure it is safe and appropriate is a key feature of risk management at divisional and Trust level. This is supported by daily service safety huddles and processes overseeing the deployment of staff. The Trust's BAF in 2025/26 has provided oversight of the assurances in respect of risks around staffing, including the pressure on staff, general morale and the impact of industrial action, along with reported improvements in people scorecard performance metrics covering staff wellbeing, reduction in turnover and improvement in the NHS staff survey results.

4.31 The Trust has continued with the deployment of an independent Guardian Service to support staff being able to raise any concerns they do not feel able to raise internally. The service is available 24/7 365 days a year and has arrangements to escalate any immediate patient safety concerns, including any issues regarding safe staffing. The Guardian reports to the People and Culture Assurance Committee quarterly.

4.32 NHS employment checks standards are applied to recruitment of staff and were last subject to an internal audit in 2021/22. CQC last reviewed the Trust's application of the Fit and Proper Person Test in July 2025 (Well led inspection report awaited) and their feedback at the conclusion of their review was that they were satisfied these were being applied.

4.33. A key pillar of the Trust's new Excellent Care Everywhere Strategy is 'Excellent Care for our People. Achieving that is supported by several programmes of work including the Trusts culture programme, its People Plan for 2025/26 developed to support improvement in the NHS people promises and EDI plans. Divisions are also supported to develop their own improvement plans based on staff survey results and local engagement. These programmes are monitored by the Board through its People and Culture Assurance Committee.

Processes for managing regulatory risk

4.34 University Hospitals Sussex NHS Foundation Trust is rated as "required improvement" by the CQC. During 2023/24 the Trust entered into a series of Provider Licence Undertakings with NHS England. These undertakings included a commitment to delivering both CQC improvements and performance improvements. The Trust undertook a self-assessment against the delivery of these undertaking in December 2025 and made a submission to NHS England for a formal review of progress. NHS England noted that substantial progress has been made and has approved closure of the 2023/2024 Undertakings. A new set of Undertakings relating to Constitutional Access standards and ongoing improvement in the Trust's Governance are being finalised. The Trust remains complaint with the requirement from the CQC to cease to undertake elective Upper GI Cancer Surgery. With this reduction in service in place the Trust remains fully compliant with the registration requirements of the Care Quality Commission.

4.35 The Patient and Quality Assurance Committee supported the Board by maintaining a focus on the Trust's actions in respect of the mandated maternity metrics through the receipt of regular and comprehensive maternity performance dashboards alongside dedicated reports in respect to the Trust's own assessment against the nationally recommended improvements to all NHS Maternity Services.

4.36 During the period of this report the Trust regrettably had nine (five in the prior year) Never Events, and received one (four in the prior year) Prevention

of Future Deaths (PFD) notification the PFD was in relation to Royal Sussex County Hospital.

4.37 Since December 2023 the Trust has implemented the new NHSE Patient Safety Incident Response Framework (PSIRF) reporting all serious incidents as Patient Safety Incident Investigations (PSII). A full investigation is undertaken and the outcome and recommendations reported to the Trust Board for each serious incident, never event and Corner Inquiry. All serious incidents including Never Events were reported as required to the Care Quality Commission, NHS Sussex, NHS Improvement and to NHS England.

4.38 The Trust has maintained and published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance. This register records the details of the Trust senior decision makers, including Board members and Trust Directors.

4.39 As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

4.40 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

4.41 The foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

4.42 The foundation trust engages with the public where changes to any services are being considered and engages with the ICB on public consultations led by them. Where risks are identified then the Trust ensures these are understood and mitigated through such changes, this was evident in the work undertaken in respect of the Stroke Service reconfiguration led by the ICB in the prior year.

4.43 The Trust entered into the National Provider Improvement Programme in March 2026. The first phase of this programme is to conduct an assessment of the Trust's improvement plan to ensure there are no elements missing and to identify where through accessing targeted support the Trust will be able to accelerate its improvement, with a particular focus on Constitutional access standards and continued work to strengthen Board effectiveness.

5. Review of economy, efficiency and effectiveness of the use of resources

5.1 The Board receives a monthly report from the Chief Financial Officer on financial performance. Financial performance is reviewed at the Trust Executive Committee to ensure that all senior leaders have visibility on the position and the actions required. Financial performance is scrutinised in detail at the Finance and Performance Assurance Committee.

5.2 The Trust has maintained a robust structure for the identification and delivery of efficiency programmes. This is supported by a Programme Management Office and oversight provided by an Executive led efficiency and workforce steering group. Reports are also provided monthly to Finance and Performance Assurance Committee.

5.3 Through the establishment of a Planned Care Improvement plan and the activity performance meetings with NHS England in respect of RTT and Cancer the Trust is maintaining its focus on meeting its provider licence undertakings. The outcome of this work is both reported internally to the Board and Governors along with externally to the NHS Sussex and NHS England through the established provider oversight meetings.

6. Information governance

6.1 In line with standing guidance from NHS Digital on the reporting and classification of Data Protection and Security Incidents, the Trust is reported two (there were five in the prior year (2024/25)) incidents to the Information Commissioner's Office, these related to two subject access requests where the investigation facilitated improved processes for identify checking and for ensuring where irrelevant information is removed this is removed from all copies of the records. In respect of each of these incidents, no regulatory action was taken.

6.2 Each year the Trust completes and submits the Data Security and Protection Toolkit (DSPT) to demonstrate its compliance against NHS Cyber Security Assessment Framework. NHS England set a deadline of 30 June 2026 for submission, and the Trust is projected to retain a 'standard met' assessment in 2025/26.

7. Data Quality and Governance

7.1 The Trust has a comprehensive suite of near real time daily reports, which allow detailed patient level review at an operational level, allowing for trend analysis. There is a validation process undertaken by teams for patients who exceed four and twelve hours in department and the outcome of this is submitted nationally each respective day. The Trust captures daily A&E breach information on 4 hourly site reports which are cross referenced against electronic A&E data capture which helps ensure understanding and reconciliation of any discrepancies between daily performance reporting and

that observed by site management teams. In 2024/25 an external audit was undertaken where a number of recommendations have been made, these recommendations have been incorporated and tracked through the Trust's Urgent and Emergency Care (UEC) programme.

7.2 Since 2023/24 the Trust invested in its Business Intelligence reporting development which has led to production of reports and Trust wide portal using the web-based PowerBI platform. This has enhanced accessibility, enabled staff to drill down to various analyses, and is helping the wider trust and BI team to further focus on Data Quality improvements from data entry to reporting, to improve empirical decision making. The work continued across 2025/26 to rebuild and standardise cross site reports to ensure consistency and efficiency of how data is made available to Teams.

7.3 For Referral to Treatment (RTT) performance, there is a validation process undertaken, underpinned by the patient access policy and RTT Rules Suite, whereby longest waiters are reviewed and tracked at a patient level for their accuracy, and the validated cohort of patients are updated daily up to the point at which monthly reporting is finalised (approximately 10th of subsequent month). This is supported by divisional and corporate weekly meetings where trends and anomalies are tracked and rectified. The Trust continues to submit a weekly National patient level dataset which has inbuilt quality measures to drive target data quality improvements. The Trust is in the top quartile nationally for these metrics. The Trust also provides weekly long waiters monitoring for NHS England regional and ICS colleagues, which has further enhanced the Data Quality review for this cohort of patients.

7.4 For cancer, patient level information is reviewed daily as part of MDT meetings and tracking processes, captured in detail on the National Somerset system, with a range of daily updated performance and operational tracking reports to support patient pathway management. The Trust has also developed merged reporting processes.

7.5 More widely, the Trust access the national Secondary User System Clinical Data Set data quality dashboards which provide assurance around completeness of key administrative data items (patient details) broken down by main activity types (A&E, inpatient and outpatient activities) where the Trust has performed well above target level in terms of completeness of records. The data quality team proactively undertake data cleansing activities on the Patient Administration System daily, acting on a suite of automated reports and results from the trace files sent to the national Personal Demographic Serves (PDS).

7.6 The Trust continues to develop a data quality kite marking process which visually shows the quality of the underlying data across a number of elements, including the timeliness of the data, the strength of internal independent validation etc. This process was applied to the key performance indicators reported to the Trust's Committee and the Board through the Integrated Performance Report.

7.7 The Trust continues to review current information relating to key constitutional standards, so as to be able to provide an aggregated view of the Trust. This provides a continuous opportunity to review definitions and align methods of collection to improve consistency. Development of a data warehouse as a repository for combined information allows efficient and direct comparison of performance and key drivers across Trust sites, across various dimensions.

7.8 In 2025/26 The Trust has continued with its established Trust wide governance Group to support Data Quality which is jointly chaired by the Director of Performance and Business Intelligence and the Chief Information Officer. This has cross organisation representation and will continue to drive the wider Trust Data Quality improvements leading into the planned EPR procurement.

7.9 The Trust undertakes performance reviews at a divisional level on a fortnightly basis, which allows executive level scrutiny of performance trends providing another layer of assurance in terms of performance (and its associated data quality). The process adopts a review of key performance metrics. This is an opportunity to cover data quality concerns alongside key operational constraints, or demand pressures.

8. Review of effectiveness

8.1 As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework.

8.2 *Head of Internal Audit Opinion*

8.3 Internal audit provide an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives.

8.4 Based on work undertaken during 2025/26 the Head of Internal Audit has stated in their Head of Internal Audit Opinion that there were generally satisfactory with improvements required in some areas. Commenting that overall, the controls in the areas they examined were found to be suitably designed and operating effectively to achieve the specific risk management, control and governance arrangements. However, they did identify some areas where weaknesses and/or non-compliance were identified and therefore may put the achievement of the Trust’s objectives at risk.

8.5 In forming their opinion they took into account that management had been proactive in directing internal audit to review areas of known risk and therefore through the recommendations made been able to progress with the control improvements. In the year no audits provided no assurance and the majority

of audits provided substantial or moderate assurance in the design and effectiveness of controls, including the key audits of financial systems, digital transformation and health and safety. Whist two audits did provide limited assurance for operational effectiveness of the designed controls, and one audit provided limited assurance for both the design and effectiveness of the controls. Internal Audit noted that for these three areas they were directed to look at these know areas of concern to assist in the identification of the improvements required. In respect of the limited assurance opinions provided. Internal Audit reported that management had responded positively to the recommendations made.

8.6 Internal Audit also reflected that the Trust has a reasonable record in implementing internal audit recommendations, albeit these were less timely than in prior years. At the year end where action had not been completed Internal Audit have confirmed action was in progress and these did not pose any unaddressed significant risk.

8.7 *External Audit*

8.8 External Audit report to the Trust on the findings from their audit work, in particular their audit of the financial statements and the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources (the Value for Money Commentary). For 2025/26 an unqualified audit opinion has been issued in respect of the financial statements. Within the Value for Money Commentary the External Auditors provide a conclusion within three areas these being financial sustainability, governance and improving economy, efficiency, and effectiveness. Within all three areas their commentary reflects there are significant weakness, with two key recommendations being made.

8.9 *Counter-fraud*

8.10 The Trust is required under Service Condition 24 of the Standard NHS Commissioning Contract to ensure appropriate counter fraud measures are in place.

8.11 The Local Counter Fraud Specialist (LCFS) adopts a risk-based approach to counter fraud work, identifying areas of potential vulnerability. Relevant local proactive exercises (LPEs) are consequently built into the Trust's annual counter fraud work plan, which includes activity relating to the four main NHS Counter Fraud Authority (CFA) standards: Strategic Governance, Inform and Involve, Prevent and Deter, and Hold to Account and which is overseen by the Audit Committee. The LCFS helps to foster an anti-fraud culture within the Trust through delivery of an ongoing training programme across a wide range of staff groups. This features regular presentations on counter fraud and on compliance with the UK Bribery Act 2010. The LCFS attends each meeting of the Audit Committee to present a report on their work.

8.12 The LCFS has not identified any significant control weaknesses during their work. Where improvements have been identified progress against recommendations is tracked and reported to the Audit Committee.

8.13 Health and Safety

8.14 The Health and Safety Executive (HSE) sought information from the Trust in respect of a small number of areas over the year, specifically in relation to a Trust reported incident that took place at the St Richards laboratory. Their review of the information provided concluded they were satisfied with the Trust's own improvement actions implemented as part of the incident action plan and did not seek any formal enforcement action.
8.15 The Trust continues with the delivery of the actions in respect of Formalin management. The HSE has been kept informed of the progress being made, recognising that the delay has been due to commissioning bespoke equipment.

8.16 The oversight of Health and Safety risks is provided by the Trust's Health and Safety Committee which reports directly to the Audit Committee and from the latter quarter of the year also to the Executive Risk and Governance Group.

8.17 Board Committees

8.18 The Board and its Committees form an important aspect of control and I have been advised during my review by the work of the Audit Committee where the results of the work of the Trust's auditors are received along with the work of the Patient and Quality, People and Culture, Finance and Performance and Research, Innovation and Digital Strategy Assurance Committees during 2025/26.

8.19 Each Committee, is chaired by a Non-Executive Director each provide me and the Board with a flow of assurance over the effectiveness of the established systems of internal control, risk management and operational performance delivery and reporting.

8.20 During the year the Patient and Quality Assurance Committee received regular reports on the Trust's patient experience and quality performance and risks, learning from complaints and investigations into untoward incidents along with regular maternity perinatal performance dashboards. The Patient & Quality Assurance Committee has also received information from the Non-Executive and Executive champions for Maternity who are the Patient and Quality Assurance Committee Chair and Chief Nurse respectively. The Committee supported the assurance flow to the Board that key quality risks have been managed during the year and that appropriate action is taken when incidents and concerns have arisen over the year. The Committee has also continued with its oversight of delivery of CQC recommendations.
8.21 During the year the Finance and Performance Assurance Committee has received regular reports on the Trust's financial position, the management of its cash position and the delivery of the Trust's capital programme, along with

the delivery of the Trust's efficiency programme and reports covering workforce, procurement, IM&T and the Trust's environmental sustainability strategy, along with receipt of the regular reports on the delivery of the Trusts performance measures and received a series of more in depth reports covering specific aspects of performance and improvement projects. This Committee supports the Board secure assurance over the Trust's delivery against its performance undertakings and NHS England Tier One improvement plans.

8.22 The People and Culture Assurance Committee across the year received regular reports on the Trust's people key performance indicators, staff wellbeing initiatives and the Trust's developed leadership and organisational development programme. This Committee has supported the Board with its assurance flow that the Trust's key people risks are being managed during the year whilst recognising the operational pressures have impacted on the Trust key people risks. The Committee also consider the delivery of the Equality, Diversity and Inclusion Strategy as well as oversight of the Trust's staff well being activities. The Committee has also received routine reports on the actions delivered in respect of the Trust's cultural development programme including the launch of the Trust's Values and Behaviours framework and Behavioural Compass.

8.23 The Research, Innovation and Digital Strategy Assurance Committee across the year received regular report on the Trust's delivery against its established research strategy, along with information on the Trust's actions to improve its digital maturity. The Committee supported the assurance flow to the Board that the research, innovation and digital strategic risks are being managed.

8.24 *Board Assurance Framework*

8.25 During the year covered by this report the Board Assurance Framework reporting framework has been maintained which has seen the structured flow of assurance reporting to the Board on the controls managing the Trust's key risks to the delivery of the Trust's strategic objectives. This process plays a key role in articulating where gaps in control exist and the tracking of devised actions to mitigate these.

8.26 *Wider processes*

8.27 My review is also informed by the Trust's processes for:

- monitoring the delivery of improvements flowing from the receipt of the outcome of the Annual Staff Survey
- monitoring the delivery of improvements from the learning identified from complaints and the investigation of untoward incidents
- tracking the outcomes from the programme of work undertaken by internal and external auditors a well as Counter Fraud and

- delivering improvements from the outcomes of external reviews and external assurance visits across the Trust's services
- delivering improvements aligned to the delivery of the Trust's provider licence undertakings.

8.28 These processes culminate in reporting to the Board through the established Divisional and Executive governance processes on the state of the Trust's systems of internal control.

8.31 I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, the patient and quality, people and culture, research, innovation and digital, and the finance and performance committees along with the NHS England and ICB assurance meetings. Where improvements have been highlighted then and a plan to address weaknesses and ensure continuous improvement of the system is in place.

9. Conclusion

9.1 I have considered the factors described in the NHS Improvement guidance on the 2024/25 annual governance statement in respect of significant issues.

9.2 During the period 1 April 2025 to 31 March 2026 and up to the time of signing the accounts I recognise there are a number of significant control weaknesses in relation to operational performance, aspects of quality governance, and the maturity of elements of our risk management arrangements. The Trust has established an active improvement programme aligned to the Trust's annual strategy delivery plan. The programme is overseen by the Executive Management Committee and delivery is reported to the Board. These improvements are reflected in the Trust's undertakings with NHS England and delivery of improvements in these areas, especially in respect of performance is also being monitored through the National Provider Improvement Programme.

9.3 Oversight of all Improvement actions continues at the Board and through its committees with each being assured that the Trust has applied its resources to address the key risks to the delivery of its objectives, with a particular focus on improving access to care and ensuring an effective overall quality governance framework. The Board through the Finance and Performance Assurance Committee has ensured finance and workforce control improvements within have progressed in line with agreed action plans. The delivery of these improvements and those relating to operational performance are reported formally to both the ICB and NHS England as part of the routine quarterly oversight meetings. Operational Performance (RTT and UEC) improvement is also reported to NHS England within the established tier one oversight meetings.

9.4 The People and Culture Assurance Committee has overseen the development and delivery of our cultural development programme that covers the key recommendations made within the Trust's Well Led Developmental Review. The reporting from this Committee is complemented by a report directly to the Board on the delivery of the Trust's One UHSussex ambition within our Excellent Care Everywhere strategy which encompasses the cultural improvement plan.

9.5 Where wider opportunities for improvement have been identified I have overseen actions to ensure that we continue to improve the systems of internal control we operate for the benefits of our patients, staff and the wider community we serve. Oversight of this work has been strengthened through the introduction of the Executive Risk and Governance Group, which I chair and forms part of the revised Executive Management Committee meetings.

Signed (by order of the Board of Directors)

Dr Andy Heeps
Chief Executive Date: 25 June 2026

University Hospitals Sussex NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

Foreword to the accounts

University Hospitals Sussex NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by University Hospitals Sussex NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Dr Andy Heeps**

Job title **Chief Executive**

Date **25 June 2026**

Consolidated Statement of Comprehensive Income

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Operating income from patient care activities	4	1,673,771	1,572,407	1,673,771	1,572,407
Other operating income	5	147,045	125,966	148,434	127,197
Operating expenses	8,10	(1,840,821)	(1,711,268)	(1,838,943)	(1,710,571)
Operating deficit from continuing operations		**(20,005)**	**(12,895)**	**(16,738)**	**(10,967)**
Finance income	12	3,097	3,487	2,794	2,951
Finance expenses	13	(5,109)	(5,751)	(5,107)	(5,748)
PDC dividends payable		(22,781)	(25,952)	(22,782)	(25,952)
Net finance costs		**(24,793)**	**(28,216)**	**(25,095)**	**(28,749)**
Other gains / (losses)	14	1,972	(34)	1,732	-
Corporation tax expense		(60)	(259)	-	-
Deficit for the year		**(42,886)**	**(41,404)**	**(40,101)**	**(39,716)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	9	(16,353)	2,720	(16,353)	2,720
Revaluations	19	38,368	13,272	38,359	13,272
Total comprehensive expense for the period		**(20,871)**	**(25,412)**	**(18,095)**	**(23,724)**
Deficit for the period attributable to:					
University Hospitals Sussex NHS Foundation Trust		(42,886)	(41,404)		
Total		**(42,886)**	**(41,404)**		
Total comprehensive expense for the period attributable to:					
University Hospitals Sussex NHS Foundation Trust		(20,871)	(25,412)		
Total		**(20,871)**	**(25,412)**		

Note that the Group Accounts include the consolidation of My University Hospitals Sussex (Registered charity No. 1050864) and Pharm@Sea Limited (wholly owned subsidiary).

Statements of Financial Position

	Note	Group 31 March 2026 £000	Group 31 March 2025 £000	Trust 31 March 2026 £000	Trust 31 March 2025 £000
Non-current assets					
Intangible assets	15	29,505	32,328	29,265	32,328
Property, plant and equipment	16,17	1,031,797	983,377	1,031,070	982,545
Right of use assets	20	29,132	39,261	29,098	39,217
Other investments / financial assets	21	8,121	10,510	1,101	1,101
Receivables	25	8,486	8,739	8,518	8,779
Total non-current assets		**1,107,041**	**1,074,215**	**1,099,052**	**1,063,970**
Current assets					
Inventories	24	26,788	23,473	25,655	22,013
Receivables	25	86,605	54,064	85,877	52,648
Non-current assets held for sale	27	633	-	633	-
Cash and cash equivalents	28	3,117	3,089	2,843	2,389
Total current assets		**117,143**	**80,626**	**115,008**	**77,050**
Current liabilities					
Trade and other payables	29	(167,625)	(147,991)	(168,270)	(147,598)
Borrowings	31	(10,250)	(11,039)	(10,219)	(11,013)
Provisions	32	(955)	(929)	(955)	(929)
Other liabilities	30	(14)	(1,305)	(14)	(1,305)
Total current liabilities		**(178,844)**	**(161,264)**	**(179,458)**	**(160,845)**
Total assets less current liabilities		**1,045,340**	**993,577**	**1,034,602**	**980,175**
Non-current liabilities					
Borrowings	31	(103,529)	(117,618)	(103,511)	(117,591)
Provisions	32	(4,486)	(4,771)	(4,365)	(4,771)
Total non-current liabilities		**(108,015)**	**(122,389)**	**(107,876)**	**(122,362)**
Total assets employed		**937,325**	**871,188**	**926,726**	**857,813**
Financed by					
Public dividend capital		1,173,507	1,086,499	1,173,507	1,086,499
Revaluation reserve		147,943	132,390	147,929	132,385
Income and expenditure reserve		(392,149)	(358,854)	(394,710)	(361,071)
Charitable fund reserves	23	8,024	11,153	-	-
Total taxpayers' equity		**937,325**	**871,188**	**926,726**	**857,813**

Note that the Group Accounts include the consolidation of My University Hospitals Sussex (Registered charity No. 1050864) and Pharm@Sea Limited (wholly owned subsidiary).

The notes on pages 9 to 83 form part of these accounts.

Name **Dr Andy Heeps**

Position **Chief Executive**

Date **25 June 2026**

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**1,086,499**	**132,390**	**(358,854)**	**11,153**	**871,188**
Deficit for the year	-	-	(42,488)	(398)	**(42,886)**
Other transfers between reserves	-	(5,542)	5,542	-	**-**
Impairments	-	(16,353)	-	-	**(16,353)**
Revaluations	-	38,368	-	-	**38,368**
Transfer to retained earnings on disposal of assets	-	(920)	920	-	**-**
Public dividend capital received	87,008	-	-	-	**87,008**
Other reserve movements	-	-	2,731	(2,731)	**-**
Taxpayers' and others' equity at 31 March 2026	**1,173,507**	**147,943**	**(392,149)**	**8,024**	**937,325**

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**1,027,188**	**121,180**	**(324,197)**	**13,118**	**837,289**
Surplus/(deficit) for the year	-	-	(42,513)	1,109	**(41,404)**
Other transfers between reserves	-	(4,782)	4,782	-	**-**
Impairments	-	2,720	-	-	**2,720**
Revaluations	-	13,272	-	-	**13,272**
Public dividend capital received	59,311	-	-	-	**59,311**
Other reserve movements	-	-	3,074	(3,074)	**-**
Taxpayers' and others' equity at 31 March 2025	**1,086,499**	**132,390**	**(358,854)**	**11,153**	**871,188**

Note that the Group Accounts include the consolidation of My University Hospitals Sussex (Registered charity No. 1050864) and Pharm@Sea Limited (wholly owned subsidiary).

Statement of Changes in Equity for the year ended 31 March 2026

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**1,086,499**	**132,385**	**(361,071)**	**857,813**
Deficit for the year	-	-	(40,101)	**(40,101)**
Other transfers between reserves	-	(5,542)	5,542	**-**
Impairments	-	(16,353)	-	**(16,353)**
Revaluations	-	38,359	-	**38,359**
Transfer to retained earnings on disposal of assets	-	(920)	920	**-**
Public dividend capital received	87,008	-	-	**87,008**
Taxpayers' and others' equity at 31 March 2026	**1,173,507**	**147,929**	**(394,710)**	**926,726**

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**1,027,188**	**121,175**	**(326,137)**	**822,226**
Deficit for the year	-	-	(39,716)	**(39,716)**
Other transfers between reserves	-	(4,782)	4,782	**-**
Impairments	-	2,720	-	**2,720**
Revaluations	-	13,272	-	**13,272**
Public dividend capital received	59,311	-	-	**59,311**
Taxpayers' and others' equity at 31 March 2025	**1,086,499**	**132,385**	**(361,071)**	**857,813**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve

This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 23.

Statements of Cash Flows

	Note	Group 2025/26 £000	Group 2024/25 £000	Trust 2025/26 £000	Trust 2024/25 £000
Cash flows from operating activities					
Operating deficit		(20,005)	(12,895)	(16,738)	(10,967)
Non-cash income and expense:					
Depreciation and amortisation	8.1	66,711	62,363	66,501	62,313
Net impairments	9	55,119	18,056	55,120	18,056
Income recognised in respect of capital donations	5	(8,073)	(6,009)	(9,061)	(7,576)
(Increase) / decrease in receivables and other assets		(31,453)	(1,913)	(31,562)	(1,596)
(Increase) / decrease in inventories		(3,315)	(1,871)	(3,642)	(1,431)
Increase / (decrease) in payables and other liabilities		7,572	(12,923)	8,761	(14,679)
Decrease in provisions		(557)	(4,349)	(678)	(4,325)
Movements in charitable fund working capital		730	(1,308)	-	-
Tax paid		(328)	(259)	-	-
Net cash flows from operating activities		**66,401**	**38,892**	**68,701**	**39,795**
Cash flows from investing activities					
Interest received		2,858	2,897	2,564	2,850
Purchase of intangible assets		(9,209)	(7,341)	(8,969)	(7,341)
Purchase of PPE and investment property		(126,117)	(81,166)	(126,055)	(80,459)
Sales of PPE and investment property		7,038	-	7,038	-
Initial direct costs or up front payments in respect of new right of use assets (lessee)		(325)	(152)	(322)	(152)
Receipt of cash donations to purchase assets		8,073	6,009	9,061	7,576
Finance lease receipts (principal and interest)		-	136	8	142
Net cash flows from charitable fund investing activities		278	492	-	-
Net cash flows used in investing activities		**(117,404)**	**(79,125)**	**(116,675)**	**(77,384)**
Cash flows from financing activities					
Public dividend capital received		87,008	59,311	87,008	59,311
Movement on loans from DHSC		(3,429)	(3,740)	(3,429)	(3,740)
Movement on other loans		802	-	802	-
Capital element of lease liability repayments		(4,099)	(5,302)	(4,075)	(5,270)
Capital element of PFI, LIFT and other service concession payments		(3,362)	(2,460)	(3,362)	(2,460)
Interest on loans		(991)	(1,081)	(991)	(1,081)
Other interest		(62)	(1)	(62)	(1)
Interest paid on lease liability repayments		(742)	(712)	(740)	(709)
Interest paid on PFI, LIFT and other service concession obligations		(1,975)	(2,074)	(1,975)	(2,074)
PDC dividend paid		(24,748)	(23,667)	(24,748)	(23,667)
Net cash flows from charitable fund financing activities		2,629	1,458	-	-
Net cash flows from / (used in) financing activities		**51,031**	**21,732**	**48,428**	**20,309**
Increase / (decrease) in cash and cash equivalents		**28**	**(18,501)**	**454**	**(17,280)**
Cash and cash equivalents at 1 April - brought forward		**3,089**	**21,590**	**2,389**	**19,669**
Cash and cash equivalents at 31 March	28	**3,117**	**3,089**	**2,843**	**2,389**

Note that the Group Accounts include the consolidation of University Hospitals Sussex Charity, which operates as My University Hospitals Sussex (Registered charity No. 1050864) and Pharm@Sea Limited (wholly owned subsidiary).

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern
The annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

The future cashflow projection of My University Hospitals Charity provides the corporate trustee with a reasonable expectation that the charitable activity will continue for the foreseeable future. The Charity has investments it can readily drawdown if required. For this reason, the corporate trustee has adopted the going concern basis in preparing the accounts.

Pharm@Sea Limited remained operational throughout the year. The financial year 2025/26 has seen the volume of patients and prescriptions increase week on week as well as the expansion of the drugs dispensing service within Sussex. This remains closely monitored and supply chains planned accordingly. The company has been profitable throughout the year. The Board of directors have a reasonable expectation that the services provided by the company will continue to be provided for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts.

Note 1.3 Consolidation
The entities included in these accounts are University Hospitals Sussex NHS Foundation Trust (Parent entity), My University Hospitals Sussex (Registered charity No. 1050864) and Pharm@Sea Limited (wholly owned subsidiary).

All three organisations have a coterminous year end of 31 March 2026 with aligned accounting policies.

Any intra group balances have been eliminated on consolidation.

NHS Charitable Fund
Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' returns, where those funds are determined to be material. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

The Trust is the Corporate Trustee to My University Hospitals Sussex (Registered charity No. 1050864). The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable funds and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Other subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity, and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. Any intra group balances have been eliminated on consolidation.

The amounts consolidated are drawn from the published financial statements of Pharm@Sea Limited for the year.

Associates

Associate entities are those over which the Trust has the power to exercise a significant influence. The Trust has no associates.

Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method. The Trust has no joint ventures.

Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses. The Trust does not have joint operations.

Note 1.4 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- The Trust is not required to disclose information regarding performance obligations that are part of a contract that has an original expected duration of one year or less,
- The Trust is not required to disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date;
- The FReM has mandated the exercise of the practical expedient offered in the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of revenue for the Trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15.

Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied.

In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Other income
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Group accrues income relating to performance obligations satisfied in that year. Where the Group’s entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

There are no material contracts for which the performance obligation has not been satisfied as at 31 March 2026.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The

cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period. Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.
The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

No employees are members of the Local Government Superannuation Scheme.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Neither the group nor Trust have discontinued operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back-office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence.

In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model, estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

Department of Health guidance specifies that the Group's specialised land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore, the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets. In determining the MEA, the Trust has to make assumptions that are practically achievable; however, the Trust is not required to have any plans to make such changes.

The Group is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust, and would not impact on service delivery or the level and volume of service provided. The Group does not intend to implement any of the theoretical assumptions that underpin the MEA valuation.

For the purpose of the MEA valuation, the Trust has defined the Princess Royal Hospital, St Richard's Hospital, the combined Royal Sussex County Hospital and Worthing Hospital, and Southlands Hospital (including the Community Diagnostics Centre) as specialised healthcare facilities. The MEA valuation assumes that these services could be delivered from alternative sites located within the wider vicinity of their existing catchments, reflecting operational requirements rather than exact current locations. Specifically, the Princess Royal Hospital is assumed to be located on the periphery of Haywards Heath; St Richard's Hospital and Southlands Hospital are assumed to be located in the Bognor Regis area (with Southlands on a separate site); and the combined Royal Sussex County Hospital and Worthing Hospital is assumed to be located in Worthing. In all cases, the modern equivalent facilities are assumed to be provided within single, more efficient hospital buildings on tighter sites, reflecting contemporary design and utilisation standards.

Under the MEA approach, Trust sites will be multi-story hospital blocks built to a smaller footprint compared to the existing estate (similar to the 3Ts development). Following the delivery of the Louisa Martindale (3Ts Phase 1) which added 62,082 m2 to the estate, The Group have identified that 20,924m2 could be reduced from the Royal Sussex County Hospital MEA site, 1,292m2 from the Princess Royal Hospitals site and 394m2 from the Southlands Site At St Richard's, the CMEC building (3,246m2) occupied by a third party on a long peppercorn lease was removed from the Trust's valuation on MEA grounds.

Under the MEA approach, the Trust has assumed VAT will be recovered on a new build at a similar rate to the 3Ts project.

Valuation guidance issued by the Royal Institute of Chartered Surveyors (RICS) states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13 if it does not meet the requirements of IAS 40 or IFRS 5.

Depreciation

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised. Freehold land is considered to have an infinite life and is not depreciated.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Property, plant, and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, in accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

They are valued, depreciated, and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets.

Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

Government grant and other grant funded assets

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust.
Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received
- Repayment of the finance lease liability, including finance costs, and
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The cost of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI assets, liabilities, and finance costs

The PFI assets are initially measured using the principles of IFRS 16. Subsequently, the assets are measured at current value in existing use per the policies applied under IAS 16.

A PFI liability equal to the capital value of the contract is recognised at the same time as the PFI assets are recognised. This does not include service elements and interest charges within the PFI contract which are expensed in accordance with IFRIC 12 as adapted and interpreted by the FReM and as detailed below.

An annual finance cost is calculated by applying the implicit interest rate in the contract to the opening PFI liability for the period and is charged to 'Finance Costs' within the Statement of Comprehensive [Income / Net Expenditure].
An element of the annual unitary payment is therefore allocated as a financing cost when repaying the PFI liability over the life of the contract.

Where there is a change in future lease payments resulting from a change in an index or a rate used to determine those payments, including for example a change to reflect changes in market rental rates following a market rent review. The entity remeasures the PFI liability to reflect those revised payments only when there is a change in the cash flows (i.e. when the adjustment to the payments takes effect). The entity shall determine the revised payments for the remainder of the PFI arrangement based on the revised contractual payments. As subsequent measurement of the PFI asset is per IAS 16 than IFRS 16, the opposite entry to adjustment of the PFI liability for such remeasurements is charged to Finance Costs.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

	Min life Years	**Max life Years**
Land	-	-
Buildings, excluding dwellings	2	87
Dwellings	11	67
Plant & machinery	2	35
Transport equipment	-	-
Information technology	2	11
Furniture & fittings	2	15

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Internally generated intangible assets

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets e.g. goodwill, brands, mastheads, publishing titles, customer lists and similar items are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The Trust intends to complete the intangible asset and use it;
- The Trust has the ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial, and other resources to complete the intangible asset and sell or use it; and
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

	Min life Years	Max life Years
Intangible assets		
Information technology	4	10
Software Licences & trademarks	3	10

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.12 Investment properties

Neither the Group nor Trust have investment properties.

Note 1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.14 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.
Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.
The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease

term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation at the end of the reporting period.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates.

The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution (the trading name of the NHS Litigation Authority NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 32.3 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Note 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets but are disclosed in Note 32 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 33, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

Note 1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care.

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

The PDC dividend calculation is based upon the Trust's group accounts (i.e. including subsidiaries) but excluding consolidated charitable funds.

Note 1.19 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.20 Corporation tax

Corporation tax disclosed in the group accounts relates to tax on the activities of the wholly owned subsidiary, Pharm@Sea Limited. Tax is charged at 25% on the taxable profits of Pharm@Sea Limited. Deferred tax has been provided on the remaining unwound capital allowances.

The Trust has determined that it has no corporation tax liability as it does not operate any commercial activities that are not part of core health care delivery.

Note 1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.22 Foreign exchange

The functional and presentational currencies of the Trust are pounds sterling and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. The Trust has not entered into any material foreign exchange transactions and has no assets or liabilities held in foreign currencies.

Note 1.23 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.24 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

As at 31 March 2026 no gifts were made.

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26.

IFRS 18 Presentation and Disclosure in Financial Statements
The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures
The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets.
The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £797m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for some of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore, the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £773m at 31 March 2026.

IFRS 9 Financial Instruments
Amendments to IFRS 9 were issued in May 2024, for adoption from 2026/27. These amendments have not yet been adopted by the FreM so the impact on the public sector is not yet known. The key amendment that may impact NHS bodies relates to a clarification of the date of recognition and derecognition of some financial assets and liabilities, with a new exception for some financial liabilities settled through an electronic cash transfer system. This could impact the timing of when payables and cash are derecognised on making a payment and may require a change to current practices relating to bank reconciliations.

Note 1.28 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Asset valuation
The total balance of intangible, tangible fixed assets and right of use assets for the Group as at 31 March 2026 is £1,091m. (2024/25 £1,055m) of which £797.3m (2024/25 £797.2m) relates to revalued estate assets (Land, buildings and dwellings). The value of right of use assets included in the valuation is £4.6m this year.

The value and remaining useful lives of estate assets are estimated by the Trust's valuer, Newmark Gerald Eve LLP, 'Newmark'. Valuations are carried out annually and are performed in accordance with the Royal Institute of Chartered Surveyors' RICS Valuation – Global Standards ('Red Book Global Standards') and other relevant RICS guidance notes, primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. In particular, land and building assets at each site are valued as a single combined hospital facility ('single alternative site model') with Worthing and RSCH combined into a combined single site,

as described in the previous section. The composition of this alternative replacement model requires the operation of significant levels of professional estimation by the valuer.

The performance of the 31 March 2026 update valuation was based on a RICS Building Cost Information Service Build Costs published on 31 March 2026 and no significant correction to this is anticipated. The Trust's valuation also depends on the BCIS Location Factor applied, and an estimation of external / economic obsolescence levels. If varied by 2 - 3%, these would generate changes in the valuation of the buildings circa 2 – 3%.
Buildings valuation

The MEA valuations used by the Group, as described in note 1.9, have been provided to the Group by the external valuers, Newmark. The Group has used component lives based upon contractual information provided by Newmark to depreciate buildings and dwellings on a component basis.

Under the MEA approach, the Trust has assumed VAT will be recovered on a new build at a similar rate to the 3Ts project. The value without the VAT adjustment is £820.0m compared to £797.3m with the VAT adjustment.

Cost Data: For the specialised estate which makes up the majority of the value of the Group's land and buildings, the valuer utilises cost data that is adjusted to account for price fluctuations since the construction date and any variances between these costs and the estimated costs of constructing a modern equivalent asset. The valuer primarily relies on published construction price data where actual costs are not available or do not reflect the instant build guidance. This published price data serves as an estimation of the potential costs for constructing a modern equivalent asset, which may differ from the actual costs incurred. Should the cost data reflect a 2.5% increase (mid-point between 2%-3%), it would result in a £18.7 million increase in the value of specialised properties as recorded on the Statement of Financial Position (SoFP). However, this is not considered to be material.

The estimated economic lives of each class of asset are disclosed in notes 1.9, and the carrying values of property, plant and equipment in notes 16 to 17.

Note 1.29 Reconciliation of accounting performance to adjusted performance (control total basis)

This note shows how the Trust performance is measured by NHS England compared to the accounting surplus/(deficit).

Note 2 Reconciliation of accounting performance to adjusted performance (control total basis)

	Group	
	2025/26	**2024/25**
Adjusted financial performance (control total basis):	**£000**	**£000**
Deficit for the period per SOCI	(42,886)	(41,404)
Remove impact of consolidating NHS charitable fund	3,129	1,965
Remove net impairments not scoring to the departmental expenditure limit	55,119	18,056
Remove I&E impact of capital grants and donations	(7,472)	(6,252)
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis	4,605	4,957
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis	(7,577)	(7,320)
Adjusted financial performance surplus / (deficit)	**4,918**	**(29,998)**

Note 3 Operating Segments

Consistent with previous years, the Group and Trust take the view that there is a single operating segment – the provision of healthcare.

Note 4 Operating income from patient care activities (Group and Trust)

Note 4.1 Income from patient care activities (by nature)

	Group and Trust	
	2025/26	2024/25
	£000	£000
Acute services		
Income from commissioners under API contracts - variable element*	361,005	370,590
Income from commissioners under API contracts - fixed element*	1,030,970	885,969
High cost drugs income from commissioners	131,664	116,246
Other NHS clinical income	34,445	50,184
Mental health services		
Income from commissioners under API contracts*	732	7,131
Community services		
Income from commissioners under API contracts*	22,226	39,102
Income from other sources (e.g. local authorities)	9,289	8,965
All services		
Private patient income	9,191	8,585
National pay award central funding***	-	4,237
Additional pension contribution central funding**	68,097	61,851
Other clinical income	6,152	19,547
Total income from activities	**1,673,771**	**1,572,407**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 4.2 Income from patient care activities (by source)

	Group and Trust	
	2025/26	2024/25
Income from patient care activities received from:	**£000**	**£000**
NHS England	243,836	401,541
Integrated care boards	1,404,878	1,133,580
Department of Health and Social Care	73	10
Other NHS providers	87	-
NHS other	195	146
Local authorities	9,289	8,965
Non-NHS: private patients	9,191	8,585
Non-NHS: overseas patients (chargeable to patient)	2,534	745
Injury cost recovery scheme	3,507	3,081
Non NHS: other	181	15,754
Total income from activities	**1,673,771**	**1,572,407**
Of which:		
Related to continuing operations	1,673,771	1,572,407

Note 4.3 Overseas visitors (relating to patients charged directly by the provider (Group and Trust)

	2025/26	2024/25
	£000	**£000**
Income recognised this year	2,534	745
Cash payments received in-year	880	572
Amounts added to provision for impairment of receivables	-	657
Amounts written off in-year	531	142

Note 5 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	9,772	-	**9,772**	7,792	-	**7,792**
Education and training	68,381	2,060	**70,441**	63,546	2,038	**65,584**
Non-patient care services to other bodies	16,943	-	**16,943**	11,795	-	**11,795**
Income in respect of employee benefits accounted on a gross basis	8,813	-	**8,813**	7,253	-	**7,253**
Receipt of capital grants and donations and peppercorn leases	-	8,073	**8,073**	-	6,009	**6,009**
Charitable and other contributions to expenditure	-	4,427	**4,427**	-	3,433	**3,433**
Revenue from operating leases	-	1,727	**1,727**	-	1,544	**1,544**
Charitable fund incoming resources	-	1,451	**1,451**	-	2,244	**2,244**
Other income*	22,334	3,064	**25,398**	20,299	13	**20,312**
Total other operating income	**126,243**	**20,802**	**147,045**	**110,685**	**15,281**	**125,966**
Of which:						
Related to continuing operations			147,045			125,966

*Other income includes revenue streams such as; Car parking income, staff accommodation rental income, non NHS Pharmacy sales & Clinical Excellence Awards income.

Other income (Group)	**2025/26**	**2024/25**
	£000	**£000**
Car Parking income	5,033	4,715
Catering	496	683
Pharmacy sales	9,144	8,141
Staff accommodation rental	2,153	1,792
Staff contribution to employee benefit schemes	23	45
Crèche services	1,362	1,160
Clinical tests	1,568	1,191
Clinical excellence awards	1,903	1,907
Other income generation schemes (recognised under IFRS 15)	257	420
Other income not already covered (recognised under IFRS 15)	395	245
Other	3,064	13
Total before consolidation of charitable funds	25,398	20,312
Elimination of 'other income' on consolidation of charitable funds	-	-
Total after consolidation of charitable funds	**25,398**	**20,312**

Note 5.1 Other operating income (Trust)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	9,772	-	**9,772**	7,792	-	**7,792**
Education and training	68,381	2,060	**70,441**	63,546	2,038	**65,584**
Non-patient care services to other bodies	17,279	-	**17,279**	12,055	-	**12,055**
Income in respect of employee benefits accounted on a gross basis	9,484	-	**9,484**	7,913	-	**7,913**
Receipt of capital grants and donations and peppercorn leases	-	9,061	**9,061**	-	7,576	**7,576**
Charitable and other contributions to expenditure	-	5,499	**5,499**	-	4,280	**4,280**
Revenue from operating leases	-	1,727	**1,727**	-	1,544	**1,544**
Other income*	22,107	3,064	**25,171**	20,040	413	**20,453**
Total other operating income	**127,023**	**21,411**	**148,434**	**111,346**	**15,851**	**127,197**
Of which:						
Related to continuing operations			148,434			127,197

*Other income includes revenue streams such as; Car parking income, staff accommodation rental income, non NHS Pharmacy sales & Clinical Excellence Awards income.

Other income (Trust)	**2025/26**	**2024/25**
	£000	**£000**
Car Parking income	5,033	4,715
Catering	496	683
Pharmacy sales	8,916	7,883
Staff accommodation rental	2,153	1,792
Staff contribution to employee benefit schemes	23	45
Crèche services	1,362	1,160
Clinical tests	1,568	1,191
Clinical excellence awards	1,903	1,907
Other income generation schemes (recognised under IFRS 15)	257	420
Other income not already covered (recognised under IFRS 15)	396	244
Other	3,064	413
Total	**25,171**	**20,453**

Note 6 Additional information on contract revenue (IFRS 15) recognised in the period

	2025/26 £000	2024/25 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,305	2,123
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 6.1 Income from activities arising from commissioner requested services

The Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26 £000	2024/25 £000
Income from services designated as commissioner requested services	1,648,714	1,535,121
Income from services not designated as commissioner requested services	172,102	163,252
Total	**1,820,816**	**1,698,373**

Note 6.2 Fees and charges (Group and Trust)

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where full cost from that service exceeds £1 million and is presented as the aggregate of such cost. The income associated with the service that incurred the expenditure is also disclosed.

	2025/26 £000	2024/25 £000
Income	-	3,522
Full cost	-	(1,422)
Surplus	**-**	**2,100**

There were no services in 2025/26 where the individual full cost exceeded £1 million.

Note 7 Operating leases - University Hospitals Sussex NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where University Hospitals Sussex NHS Foundation Trust is the lessor.

The Trust leases space to third parties to provide food, beverages and newspapers, the swimming pool on the St Mary's Hall site in Brighton, office space and use of sites for the location of aerials. The Trust also leases space to the wholly owned subsidiary, Pharm@Sea Limited, Hyperbaric unit to Qinetiq and Nursery/childcare facility to The Co-operative Nursery. The terms of these leases vary between one and fifteen years.

Note 7.1 Operating leases income (Group and Trust)

	2025/26 £000	2024/25 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	1,727	1,544
Total in-year operating lease income	**1,727**	**1,544**

Note 7.2 Future leases receipts (Group and Trust)

	31 March 2026 £000	31 March 2025 £000
Future minimum lease receipts due in:		
- not later than one year	1,435	1,488
- later than one year and not later than two years	987	1,323
- later than two years and not later than three years	968	1,322
- later than three years and not later than four years	968	1,322
- later than four years and not later than five years	968	707
- later than five years	251	130
Total	**5,577**	**6,292**

Note 8.1 Operating expenses

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,397	5,588	4,397	5,588
Purchase of healthcare from non-NHS and non-DHSC bodies	25,932	35,198	25,927	35,001
Staff and executive directors costs	1,174,281	1,083,328	1,172,194	1,081,767
Remuneration of non-executive directors	219	226	219	226
Supplies and services - clinical (excluding drugs costs)	156,954	152,735	157,019	152,735
Supplies and services - general	15,931	16,311	15,892	16,230
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	170,442	165,560	173,570	168,570
Inventories written down	1,384	903	1,384	903
Consultancy costs	-	-	-	-
Establishment	6,697	9,798	6,731	9,726
Premises	59,746	59,775	59,985	59,701
Transport (including patient travel)	3,196	4,192	3,352	4,166
Depreciation on property, plant and equipment	54,679	51,747	54,469	51,697
Amortisation on intangible assets	12,032	10,616	12,032	10,616
Net impairments	55,119	18,056	55,120	18,056
Movement in credit loss allowance: contract receivables / contract assets	(2,316)	627	(2,316)	627
Movement in credit loss allowance: all other receivables a	(50)	(929)	(50)	(929)
Increase/(decrease) in other provisions	193	(3,610)	72	(3,586)
Change in provisions discount rate(s)	(125)	15	(125)	15
Fees payable to the external auditor				
audit services- statutory audit*	246	228	246	228
other auditor remuneration (primary external auditor only)	-	6	-	6
other auditor remuneration (subsidiary and charity external auditor)	65	57	-	-
Internal audit costs	165	162	165	162
Clinical negligence	44,762	47,207	44,762	47,207
Legal fees	937	683	937	684
Insurance (as a policy holder)	1,298	1,269	1,276	1,252
Research and development	10,680	10,192	10,526	10,192
Education and training	37,231	35,334	36,431	35,319
Redundancy	-	31	-	31
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,412	1,376	1,412	1,376
Charges to operating expenditure for off-SoFP PFI / LIFT s	-	-	-	-
Car parking & security	34	17	30	17
Hospitality	-	-	-	-
Losses, ex gratia & special payments	62	164	62	164
Other services, eg external payroll	1,835	1,867	1,834	1,867
Other NHS charitable fund resources expended	2,343	1,570	-	-
Other	1,040	969	1,390	957
Total	**1,840,821**	**1,711,268**	**1,838,943**	**1,710,571**
Of which:				
Related to continuing operations	1,840,821	1,711,268	1,838,943	1,710,571

*The audit fee payable to Grant Thornton is £205k plus VAT (2024/25: £190k plus VAT).

Note 8.2 Other auditor remuneration (Primary Auditor)

	2025/26 £000	2024/25 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	6
Total	**-**	**6**

Note 8.3 Other auditor remuneration (Subsidiary and Charity)

	2025/26 £000	2024/25 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	53	54
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	12	3
Total	**65**	**57**

Note 8.4 Limitation on auditor's liability (Group and Trust)

The limitation on auditor's liability for external audit work is £2m (2024/25: £2m).

Note 9 Impairment of assets (Group and Trust)

	2025/26 £000	2024/25 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	55,119	18,056
Total net impairments charged to operating deficit	**55,119**	**18,056**
Impairments charged to the revaluation reserve	16,353	(2,720)
Total net impairments	**71,472**	**15,336**

The impairment due to changes in market price relates to a change in the value of the Trust's estate following the annual review carried out by the external valuer Newmark Gerald Eve LLP.

Note 10 Employee benefits

	Group		Trust	
	2025/26 Total £000	2024/25 Total £000	2025/26 Total £000	2024/25 Total £000
Salaries and wages	896,622	836,137	894,920	834,820
Social security costs	121,233	93,116	121,030	92,992
Apprenticeship levy	4,527	4,243	4,527	4,243
Employer's contributions to NHS pensions	172,811	156,619	172,720	156,556
Temporary staff (including agency)	27,606	35,031	27,515	34,974
Total gross staff costs	**1,222,799**	**1,125,146**	**1,220,712**	**1,123,585**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**1,222,799**	**1,125,146**	**1,220,712**	**1,123,585**
Of which				
Costs capitalised as part of assets	9,121	5,425	9,121	5,425

Senior staff salary and pension disclosures have been included within the Remuneration Report.
Head count disclosures have been included within the Staff Report.

Note 10.1 Retirements due to ill-health (Group)

During 2025/26 there were 15 early retirements from the Trust agreed on the grounds of ill-health (11 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £1,476k (£2,344k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 11 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".
An outline of these follows:

Note 11.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Note 11.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 11.3 National Employers Savings Trust (NEST)

The Pensions Act 2008 and 2001 Automatic Enrolment Regulations required all employers to enrol workers meeting certain criteria into a pension scheme and pay contributions toward their retirement. Employees who are unable to join the NHS Pensions Scheme are covered by the NEST.

The auto enrolment "staging" date for the Trust compliance was 1 July 2013. This was followed by a re-enrolment date of 1 July 2016 and then again on the 1 July 2019. For those staff not entitled to join the NHS Pension Scheme, the Trust utilised an alternative pension scheme called NEST to fulfil its automatic enrolment obligations. NEST is a defined contribution pension scheme established by law to support the introduction of auto enrolment.

Contributions are taken from qualifying earnings, which are currently from £6,240 up to £50,270 but are reviewed every year by the government. The initial contribution was 1% of qualifying earnings, with an employer contribution of 1%. This has been increased by the stages below which were set by the government.

Date	Employee Contribution	Employer Contribution	Total Contribution
1st March 2013	1%	1%	2%
6th April 2018	3%	2%	5%
6th April 2019	5%	3%	8%

Note 12 Finance income

Finance income represents interest received on assets and investments in the period.

	Group		Trust	
	2025/26	**2024/25**	**2025/26**	**2024/25**
	£000	**£000**	**£000**	**£000**
Interest on bank accounts	2,819	2,992	2,793	2,947
Interest income on finance leases	-	3	1	4
NHS charitable fund investment income	278	492	-	-
Total finance income	**3,097**	**3,487**	**2,794**	**2,951**

Note 13 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

Group	2025/26 £000	2024/25 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	981	1,071
Interest on lease obligations	742	712
Interest on late payment of commercial debt	62	1
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	1,975	2,074
Remeasurement of the liability resulting from change in index or rate	1,051	1,478
Total interest expense	**4,811**	**5,336**
Unwinding of discount on provisions	298	415
Total finance costs	**5,109**	**5,751**

Trust	2025/26 £000	2024/25 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	981	1,071
Interest on lease obligations	740	709
Interest on late payment of commercial debt	62	1
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	1,975	2,074
Remeasurement of the liability resulting from change in index or rate	1,051	1,478
Total interest expense	**4,809**	**5,333**
Unwinding of discount on provisions	298	415
Total finance costs	**5,107**	**5,748**

Note 13.1 The late payment of commercial debts (interest) Act 1998 (Group and Trust)

	2025/26 £000	2024/25 £000
Total liability accruing in year under this legislation as a result of late payments	5,257	5,970
Amounts included within interest payable arising from claims made under this legislation	62	1
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 14 Other (losses) / gains

	Group		Trust	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Gains on disposal of assets	1,732	-	1,732	-
Total gains on disposal of assets	**1,732**	**-**	**1,732**	**-**
Fair value gains / (losses) on charitable fund investments & investment properties	240	(34)	-	-
Total other gain / (losses)	**1,972**	**(34)**	**1,732**	**-**

Note 15.1 Intangible assets (Group) - 2025/26

Group	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**28,618**	**23,165**	**-**	**51,783**
Additions	372	5,965	2,872	**9,209**
Reclassifications	13	428	(441)	**-**
Disposals / derecognition	(5,733)	(8,522)	-	**(14,255)**
Cost at 31 March 2026	**23,270**	**21,036**	**2,431**	**46,737**
Amortisation at 1 April 2025 - brought forward	**11,651**	**7,804**	**-**	**19,455**
Provided during the year	5,338	6,694	-	**12,032**
Disposals / derecognition	(5,733)	(8,522)	-	**(14,255)**
Amortisation at 31 March 2026	**11,256**	**5,976**	**-**	**17,232**
Net book value at 31 March 2026	**12,014**	**15,060**	**2,431**	**29,505**
Net book value at 1 April 2025	**16,967**	**15,361**	**-**	**32,328**

Note 15.2 Intangible assets (Trust) - 2025/26

Trust	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**28,618**	**23,165**	**-**	**51,783**
Additions	372	5,965	2,632	**8,969**
Reclassifications	13	428	(441)	**-**
Disposals / derecognition	(5,733)	(8,522)	-	**(14,255)**
Cost at 31 March 2026	**23,270**	**21,036**	**2,191**	**46,497**
Amortisation at 1 April 2025 - brought forward	**11,651**	**7,804**	**-**	**19,455**
Provided during the year	5,338	6,694	-	**12,032**
Disposals / derecognition	(5,733)	(8,522)	-	**(14,255)**
Amortisation at 31 March 2026	**11,256**	**5,976**	**-**	**17,232**
Net book value at 31 March 2026	**12,014**	**15,060**	**2,191**	**29,265**
Net book value at 1 April 2025	**16,967**	**15,361**	**-**	**32,328**

Note 15.3 Intangible assets - 2024/25

Group and Trust	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	**27,129**	**16,418**	**995**	**44,542**
Additions	862	4,195	2,284	**7,341**
Reclassifications	727	2,552	(3,279)	**-**
Disposals / derecognition	(100)	-	-	**(100)**
Valuation / gross cost at 31 March 2025	**28,618**	**23,165**	**-**	**51,783**
Amortisation at 1 April 2024 - brought forward	**6,284**	**2,655**	**-**	**8,939**
Provided during the year	5,467	5,149	-	**10,616**
Disposals / derecognition	(100)	-	-	**(100)**
Amortisation at 31 March 2025	**11,651**	**7,804**	**-**	**19,455**
Net book value at 31 March 2025	**16,967**	**15,361**	**-**	**32,328**
Net book value at 1 April 2024	**20,845**	**13,763**	**995**	**35,603**

Note 16.1 Property, plant and equipment - 2025/26

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**46,428**	**740,027**	**6,156**	**39,082**	**170,388**	**-**	**79,853**	**589**	**1,082,523**
Additions	-	61,773	11	49,568	18,262	-	7,637	-	**137,251**
Impairments charged to operating expenses	(12,882)	(54,332)	-	-	-	-	-	-	**(67,214)**
Impairments charged to the revaluation reserve	(12,669)	(21,583)	-	-	-	-	-	-	**(34,252)**
Reversals of impairments credited to operating expenses	2	12,646	1	-	-	-	-	-	**12,649**
Reversals of impairments credited to the revaluation reserve	79	17,580	97	-	-	-	-	-	**17,756**
Revaluations	14,783	167	214	-	-	-	-	-	**15,164**
Reclassifications	-	141	-	(153)	12	-	-	-	**-**
Transfers to / from assets held for sale	(312)	(326)	-	-	-	-	-	-	**(638)**
Disposals / derecognition	(2,067)	(3,292)	-	-	(10,952)	-	(15,361)	(131)	**(31,803)**
Valuation/gross cost at 31 March 2026	**33,362**	**752,801**	**6,479**	**88,497**	**177,710**	**-**	**72,129**	**458**	**1,131,436**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**-**	**-**	**-**	**61,445**	**-**	**37,266**	**435**	**99,146**
Provided during the year	-	23,109	148	-	13,320	-	13,571	46	**50,194**
Impairments charged to operating expenses	-	-	-	-	-	-	-	-	**-**
Impairments charged to the revaluation reserve	-	-	-	-	-	-	-	-	**-**
Reversals of impairments credited to operating expenses	-	-	-	-	-	-	-	-	**-**
Reversals of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(23,054)	(148)	-	-	-	-	-	**(23,202)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	(5)	-	-	-	-	-	-	**(5)**
Disposals / derecognition	-	(50)	-	-	(10,952)	-	(15,361)	(131)	**(26,494)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**-**	**63,813**	**-**	**35,476**	**350**	**99,639**
Net book value at 31 March 2026	**33,362**	**752,801**	**6,479**	**88,497**	**113,897**	**-**	**36,653**	**108**	**1,031,797**
Net book value at 1 April 2025	**46,428**	**740,027**	**6,156**	**39,082**	**108,943**	**-**	**42,587**	**154**	**983,377**

Note 16.2 Property, plant and equipment - 2024/25

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**46,419**	**726,573**	**5,417**	**25,394**	**158,781**	**17**	**69,163**	**589**	**1,032,353**
Additions	-	36,522	39	26,435	13,273	-	1,907	-	**78,176**
Impairments charged to operating expenses	-	(26,386)	-	-	-	-	-	-	**(26,386)**
Impairments charged to the revaluation reserve	-	(7,230)	-	-	-	-	-	-	**(7,230)**
Reversals of impairments credited to operating expenses	9	8,932	-	-	-	-	-	-	**8,941**
Reversals of impairments credited to the revaluation reserve	-	9,393	667	-	-	-	-	-	**10,060**
Revaluations	-	(8,789)	33	-	-	-	-	-	**(8,756)**
Reclassifications	-	1,012	-	(12,747)	282	-	11,453	-	**-**
Disposals / derecognition	-	-	-	-	(1,948)	(17)	(2,670)	-	**(4,635)**
Valuation/gross cost at 31 March 2025	**46,428**	**740,027**	**6,156**	**39,082**	**170,388**	**-**	**79,853**	**589**	**1,082,523**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**-**	**-**	**-**	**51,123**	**17**	**27,748**	**406**	**79,294**
Provided during the year	-	21,899	128	-	12,270	-	12,188	29	**46,514**
Impairments charged to operating expenses	-	500	-	-	-	-	-	-	**500**
Impairments charged to the revaluation reserve	-	75	-	-	-	-	-	-	**75**
Reversals of impairments credited to operating expenses	-	(500)	-	-	-	-	-	-	**(500)**
Reversals of impairments credited to the revaluation reserve	-	(75)	-	-	-	-	-	-	**(75)**
Revaluations	-	(21,899)	(128)	-	-	-	-	-	**(22,027)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(1,948)	(17)	(2,670)	-	**(4,635)**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**-**	**61,445**	**-**	**37,266**	**435**	**99,146**
Net book value at 31 March 2025	**46,428**	**740,027**	**6,156**	**39,082**	**108,943**	**-**	**42,587**	**154**	**983,377**
Net book value at 1 April 2024	**46,419**	**726,573**	**5,417**	**25,394**	**107,658**	**-**	**41,415**	**183**	**953,059**

Note 16.3 Property, plant and equipment financing - 31 March 2026

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	33,090	716,288	6,479	76,264	104,812	-	36,630	37	**973,600**
On-SoFP PFI contracts and other service concession arrangements	-	28,193	-	-	-	-	-	-	**28,193**
Owned - donated/granted	272	8,320	-	12,233	9,085	-	23	71	**30,004**
NBV total at 31 March 2026	**33,362**	**752,801**	**6,479**	**88,497**	**113,897**	**-**	**36,653**	**108**	**1,031,797**

Note 16.4 Property, plant and equipment financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	45,863	709,660	6,156	33,932	100,159	-	42,552	57	**938,379**
On-SoFP PFI contracts and other service concession arrangements	-	20,785	-	-	-	-	-	-	**20,785**
Owned - donated/granted	565	9,582	-	5,150	8,784	-	35	97	**24,213**
NBV total at 31 March 2025	**46,428**	**740,027**	**6,156**	**39,082**	**108,943**	**-**	**42,587**	**154**	**983,377**

Note 16.5 Property, plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	-	-	-	-	-	-	-	-
Not subject to an operating lease	33,362	752,801	6,479	88,497	113,897	-	36,653	108	**1,031,797**
NBV total at 31 March 2026	**33,362**	**752,801**	**6,479**	**88,497**	**113,897**	**-**	**36,653**	**108**	**1,031,797**

Note 16.6 Property, plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	-	-	-	-	-	-	-	-
Not subject to an operating lease	46,428	740,027	6,156	39,082	108,943	-	42,587	154	**983,377**
NBV total at 31 March 2025	**46,428**	**740,027**	**6,156**	**39,082**	**108,943**	**-**	**42,587**	**154**	**983,377**

Note 17.1 Property, plant and equipment - 2025/26

Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2025 - brought forward	**46,428**	**739,561**	**6,156**	**39,082**	**169,607**	**-**	**79,834**	**589**	**1,081,257**
Additions	-	61,769	11	49,568	18,204	-	7,637	-	**137,189**
Impairments charged to operating expenses	(12,882)	(54,333)	-	-	-	-	-	-	**(67,215)**
Impairments charged to the revaluation reserve	(12,669)	(21,583)	-	-	-	-	-	-	**(34,252)**
Reversals of impairments credited to operating expenses	2	12,646	1	-	-	-	-	-	**12,649**
Reversals of impairments credited to the revaluation reserve	79	17,580	97	-	-	-	-	-	**17,756**
Revaluations	14,783	302	214	-	-	-	-	-	**15,299**
Reclassifications	-	141	-	(153)	12	-	-	-	**-**
Transfers to / from assets held for sale	(312)	(326)	-	-	-	-	-	-	**(638)**
Disposals / derecognition	(2,067)	(3,292)	-	-	(10,952)	-	(15,361)	(131)	**(31,803)**
Valuation/gross cost at 31 March 2026	**33,362**	**752,465**	**6,479**	**88,497**	**176,871**	**-**	**72,110**	**458**	**1,130,242**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**-**	**-**	**-**	**61,011**	**-**	**37,266**	**435**	**98,712**
Provided during the year	-	22,965	148	-	13,291	-	13,567	46	**50,017**
Impairments charged to operating expenses	-	-	-	-	-	-	-	-	**-**
Impairments charged to the revaluation reserve	-	-	-	-	-	-	-	-	**-**
Reversals of impairments credited to operating expenses	-	-	-	-	-	-	-	-	**-**
Reversals of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(22,910)	(148)	-	-	-	-	-	**(23,058)**
Transfers to / from assets held for sale	-	(5)	-	-	-	-	-	-	**(5)**
Disposals / derecognition	-	(50)	-	-	(10,952)	-	(15,361)	(131)	**(26,494)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**-**	**63,350**	**-**	**35,472**	**350**	**99,172**
Net book value at 31 March 2026	**33,362**	**752,465**	**6,479**	**88,497**	**113,521**	**-**	**36,638**	**108**	**1,031,070**
Net book value at 1 April 2025	**46,428**	**739,561**	**6,156**	**39,082**	**108,596**	**-**	**42,568**	**154**	**982,545**

Note 17.2 Property, plant and equipment - 2024/25

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**46,419**	**726,524**	**5,417**	**25,394**	**158,282**	**17**	**69,163**	**589**	**1,031,805**
Additions	-	36,522	39	25,747	13,273	-	1,888	-	**77,469**
Impairments charged to operating expenses	-	(26,386)	-	-	-	-	-	-	**(26,386)**
Impairments charged to the revaluation reserve	-	(7,230)	-	-	-	-	-	-	**(7,230)**
Reversals of impairments credited to operating expenses	9	8,932	-	-	-	-	-	-	**8,941**
Reversals of impairments credited to the revaluation reserve	-	9,393	667	-	-	-	-	-	**10,060**
Revaluations	-	(8,789)	33	-	-	-	-	-	**(8,756)**
Reclassifications	-	606	-	(12,059)	-	-	11,453	-	**-**
Disposals / derecognition	-	(11)	-	-	(1,948)	(17)	(2,670)	-	**(4,646)**
Valuation/gross cost at 31 March 2025	**46,428**	**739,561**	**6,156**	**39,082**	**169,607**	**-**	**79,834**	**589**	**1,081,257**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**-**	**-**	**-**	**50,695**	**17**	**27,748**	**406**	**78,866**
Provided during the year	-	21,899	128	-	12,264	-	12,188	29	**46,508**
Impairments charged to operating expenses	-	500	-	-	-	-	-	-	**500**
Impairments charged to the revaluation reserve	-	75	-	-	-	-	-	-	**75**
Reversals of impairments credited to operating expenses	-	(500)	-	-	-	-	-	-	**(500)**
Reversals of impairments credited to the revaluation reserve	-	(75)	-	-	-	-	-	-	**(75)**
Revaluations	-	(21,899)	(128)	-	-	-	-	-	**(22,027)**
Disposals / derecognition	-	-	-	-	(1,948)	(17)	(2,670)	-	**(4,635)**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**-**	**61,011**	**-**	**37,266**	**435**	**98,712**
Net book value at 31 March 2025	**46,428**	**739,561**	**6,156**	**39,082**	**108,596**	**-**	**42,568**	**154**	**982,545**
Net book value at 1 April 2024	**46,419**	**726,524**	**5,417**	**25,394**	**107,587**	**-**	**41,415**	**183**	**952,939**

Note 17.3 Property, plant and equipment financing - 31 March 2026

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	33,090	719,309	6,479	76,264	104,436	-	36,615	37	**976,230**
On-SoFP PFI contracts and other service concession arrangements	-	24,836	-	-	-	-	-	-	**24,836**
Owned - donated / granted	272	8,320	-	12,233	9,085	-	23	71	**30,004**
Total net book value at 31 March 2026	**33,362**	**752,465**	**6,479**	**88,497**	**113,521**	**-**	**36,638**	**108**	**1,031,070**

Note 17.4 Property, plant and equipment financing - 31 March 2025

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	45,863	709,194	6,156	33,932	99,812	-	42,533	57	**937,547**
On-SoFP PFI contracts and other service concession arrangements	-	20,785	-	-	-	-	-	-	**20,785**
Owned - donated / granted	565	9,582	-	5,150	8,784	-	35	97	**24,213**
Total net book value at 31 March 2025	**46,428**	**739,561**	**6,156**	**39,082**	**108,596**	**-**	**42,568**	**154**	**982,545**

Note 17.5 Property, plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease		39							**39**
Not subject to an operating lease	33,362	752,426	6,479	88,497	113,521	-	36,638	108	**1,031,031**
Total net book value at 31 March 2026	**33,362**	**752,465**	**6,479**	**88,497**	**113,521**	**-**	**36,638**	**108**	**1,031,070**

Note 17.6 Property, plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	47	-	-	-	-	-	-	-	**47**
Not subject to an operating lease	46,381	739,561	6,156	39,082	108,596	-	42,568	154	**982,498**
Total net book value at 31 March 2025	**46,428**	**739,561**	**6,156**	**39,082**	**108,596**	**-**	**42,568**	**154**	**982,545**

Note 18 Donations of property, plant and equipment

The value of assets donated during the year was £9,061k. Details of values donated by Charity are listed below.

Charity	£'000
Salix Grant	7,083
My UHSx	984
Air Ambulance charity HELP	358
Sussex Cancer Fund	150
Sussex Heart Charity	112
Friends of Chichester Hospital	99
League of Worthing Hospitals	72
League of Friends (PRH)	51
League of Friends (Southlands)	49
The Rocking Horse Childrens Charity	44
Friends of Lewes Victoria Hospital	34
Department of Health And Social Care	13
Dr's Mess Fund	6
Friends of Brighton & Hove Hospitals	6
Total	**9,061**

There are no restrictions or conditions imposed by the donations.
There is no difference between the cash provided and the fair value of the assets acquired.

Note 19 Revaluations of property, plant and equipment

The Trust undertakes an estates revaluation annually. This year a desktop update valuation with targeted inspection of major new schemes was carried out as at 31 March 2026 by the external valuer, Newmark Gerald Eve LLP, 'Newmark', a regulated firm of Chartered Surveyors. The valuation was carried out in accordance with the requirements of the RICS valuation - Global Standards (December 2024 edition) and the national standards and guidance set out in the UK national supplement (October 2023 edition), and the International Valuation Standards and IFRS as adapted and interpreted by the Financial Reporting Manual (FReM).

Assets which are held for their service potential (i.e. operational assets) and are in use were measured at Current Value in Existing Use, which is defined in the RICS Red Book as Existing Use Value. For specialised operational assets, current value in existing use is derived using the Depreciated Replacement Cost method subject to the assumption of continuing use.

Most of the Trust's assets qualify as specialised operational assets and therefore fall to be assessed using the Depreciated Replacement Cost method and have been valued on an optimal site modern equivalent asset basis. That is the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation. For the 31 March 2024 valuation, Phase 1 of the 3Ts project, known as the Louisa Martindale building, had entered operation adding over 62,000 square metres of floor space to the Royal Sussex County Hospital site. The Trust has moved various services and operations from the existing estate into the new building and as part of an emerging estates strategy has identified areas within the existing Royal Sussex County Hospital site and across the rest of the Trust estate that would not form part of the modern equivalent hospital. The valuer has taken this building optimisation into account in both the 31 March 2025 valuation and also the current valuation, and this has decreased the value of the existing Royal

Sussex County Hospital and Worthing buildings and to a lesser extent the Princess Royal Hospital, Southlands and St Richards buildings compared to a non-optimised valuation.

Non-operational assets, including surplus land, are valued on the basis of Fair Value as the property is no longer required for existing operations, which have ceased. Fair value is determined as the price that would be received to sell an asset, or paid to transfer a liability, in an orderly transaction between participants at the measurement date.

For the avoidance of doubt, the valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards.

The estimated remaining lives of the buildings have been adjusted in line with the Newmark 's valuation. The estimated remaining lives of the Trust's assets are shown in accounting policies note 1.9.
The Group and Trust revaluation value for 2025/26 £38,370k (2024/25 £13,272k) is shown within section "Other comprehensive income, will not be reclassified to income and expenditure" on the Consolidated Statement of Comprehensive Income. Included within the valuation are peppercorn right of use assets of £4,635k (2024/25 £4,568k) that were valued in accordance with IFRS 16.

Note 20 Leases - University Hospitals Sussex NHS Foundation Trust as a lessee

This note details information about leases for which University Hospitals Sussex NHS Foundation Trust is a lessee.

The Trust has leasing arrangements including building leases, vehicle leases, and implicit equipment leases within Managed Equipment Services (MES) contracts.

The Trust leases the following properties;

- Sussex House, Brighton
- Freshfield, Brighton
- Preston Road, Brighton
- Radiotherapy centre, Eastbourne
- Ridgeworth House, Worthing
- 74 - 80 Park Road, Worthing
- Farncombe Road, Worthing

The value of right of use assets included in the valuation is £4.6m (2024/25 £4.6m). This applies to peppercorn assets, where there is not a readily available market value to determine the value under the cost model under IFRS 16.

Note 20.1 Right of use assets - 2025/26

Group	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**65,788**	**2,267**	**68,055**	**22,073**
Additions	370	866	**1,236**	-
Remeasurements of the lease liability	(4,589)	(967)	**(5,556)**	(6,741)
Impairments	(32)	-	**(32)**	-
Reversal of impairments	175	-	**175**	-
Revaluations	(636)	-	**(636)**	-
Disposals / derecognition	(2,297)	(404)	**(2,701)**	(56)
Valuation/gross cost at 31 March 2026	**58,779**	**1,762**	**60,541**	**15,276**
Accumulated depreciation at 1 April 2025 - brought forward	**28,166**	**628**	**28,794**	**3,991**
Provided during the year	3,989	496	**4,485**	844
Impairments	554	-	**554**	-
Reversal of impairments	-	-	**-**	-
Revaluations	(638)	-	**(638)**	-
Disposals / derecognition	(1,382)	(404)	**(1,786)**	(56)
Accumulated depreciation at 31 March 2026	**30,689**	**720**	**31,409**	**4,779**
Net book value at 31 March 2026	**28,090**	**1,042**	**29,132**	**10,497**
Net book value at 1 April 2025	**37,622**	**1,639**	**39,261**	**18,082**

Net book value of right of use assets leased from other NHS providers	5,823
Net book value of right of use assets leased from other DHSC group bodies	4,674

Note 20.2 Right of use assets - 2024/25

Group	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**62,817**	**9,074**	**71,891**	**20,611**
Additions	655	423	**1,078**	-
Remeasurements of the lease liability	3,616	(5,467)	**(1,851)**	1,462
Impairments	(124)	-	**(124)**	-
Reversal of impairments	14	-	**14**	-
Revaluations	(735)	-	**(735)**	-
Disposals / derecognition	(455)	(1,763)	**(2,218)**	-
Valuation/gross cost at 31 March 2025	**65,788**	**2,267**	**68,055**	**22,073**
Accumulated depreciation at 1 April 2024 - brought forward	**24,192**	**1,712**	**25,904**	**2,634**
Provided during the year	4,554	679	**5,233**	1,357
Impairments	611	-	**611**	-
Revaluations	(736)	-	**(736)**	-
Disposals / derecognition	(455)	(1,763)	**(2,218)**	-
Accumulated depreciation at 31 March 2025	**28,166**	**628**	**28,794**	**3,991**
Net book value at 31 March 2025	**37,622**	**1,639**	**39,261**	**18,082**
Net book value at 1 April 2024	**38,625**	**7,362**	**45,987**	**17,977**

Net book value of right of use assets leased from other NHS providers	13,584
Net book value of right of use assets leased from other DHSC group bodies	4,498

Note 20.3 Right of use assets - 2025/26

Trust	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**65,717**	**2,235**	**67,952**	**22,073**
Additions	370	843	**1,213**	-
Remeasurements of the lease liability	(4,589)	(967)	**(5,556)**	(6,741)
Impairments	(32)	-	**(32)**	-
Reversal of impairments	175	-	**175**	-
Revaluations	(636)	-	**(636)**	-
Disposals / derecognition	(2,297)	(372)	**(2,669)**	(56)
Valuation/gross cost at 31 March 2026	**58,708**	**1,739**	**60,447**	**15,276**
Accumulated depreciation at 1 April 2025 - brought forward	28,166	569	**28,735**	3,991
Provided during the year	3,967	485	**4,452**	844
Impairments	554	-	**554**	-
Reversal of impairments	-	-	**-**	-
Revaluations	(638)	-	**(638)**	-
Disposals / derecognition	(1,382)	(372)	**(1,754)**	(56)
Accumulated depreciation at 31 March 2026	**30,667**	**682**	**31,349**	**4,779**
Net book value at 31 March 2026	**28,041**	**1,057**	**29,098**	**10,497**
Net book value at 1 April 2025	**37,551**	**1,666**	**39,217**	**18,082**

Net book value of right of use assets leased from other NHS providers	5,823
Net book value of right of use assets leased from other DHSC group bodies	4,674

Note 20.4 Right of use assets - 2024/25

Trust	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**62,817**	**9,042**	**71,859**	**20,611**
Additions	584	423	**1,007**	-
Remeasurements of the lease liability	3,616	(5,467)	**(1,851)**	1,462
Impairments	(124)	-	**(124)**	-
Reversal of impairments	14	-	**14**	-
Revaluations	(735)	-	**(735)**	-
Disposals / derecognition	(455)	(1,763)	**(2,218)**	-
Valuation/gross cost at 31 March 2025	**65,717**	**2,235**	**67,952**	**22,073**
Accumulated depreciation at 1 April 2024 - brought forward	**24,192**	**1,697**	**25,889**	**2,634**
Provided during the year	4,554	635	**5,189**	1,357
Impairments	611	-	**611**	-
Revaluations	(736)	-	**(736)**	-
Disposals / derecognition	(455)	(1,763)	**(2,218)**	-
Accumulated depreciation at 31 March 2025	**28,166**	**569**	**28,735**	**3,991**
Net book value at 31 March 2025	**37,551**	**1,666**	**39,217**	**18,082**
Net book value at 1 April 2024	**38,625**	**7,345**	**45,970**	**17,977**

Net book value of right of use assets leased from other NHS providers	13,584
Net book value of right of use assets leased from other DHSC group bodies	4,498

Note 20.5 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 30.1.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April	**55,502**	**63,054**	**55,448**	**63,039**
Lease additions	911	926	891	855
Lease liability remeasurements	(5,556)	(3,176)	(5,556)	(3,176)
Interest charge arising in year	742	712	740	709
Early terminations	(1,186)	-	(1,186)	-
Lease payments (cash outflows)	(4,841)	(6,014)	(4,815)	(5,979)
Carrying value at 31 March	**45,572**	**55,502**	**45,522**	**55,448**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 8.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 20.6 Maturity analysis of future lease payments at 31 March 2026

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	4,637	938	4,606	938
- later than one year and not later than five years;	12,164	3,754	12,144	3,754
- later than five years.	38,054	7,047	38,054	7,047
Total gross future lease payments	**54,855**	**11,739**	**54,804**	**11,739**
Finance charges allocated to future periods	(9,283)	(846)	(9,281)	(846)
Net lease liabilities at 31 March 2026	**45,572**	**10,893**	**45,523**	**10,893**
Of which:				
Current	3,987	813	3,956	813
Non-current	41,585	10,080	41,567	10,080

Note 20.7 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	4,848	1,418	4,820	1,418
- later than one year and not later than five years;	15,402	5,669	15,372	5,669
- later than five years.	45,460	12,813	45,461	12,813
Total gross future lease payments	**65,710**	**19,900**	**65,653**	**19,900**
Finance charges allocated to future periods	(10,208)	(1,508)	(10,205)	(1,508)
Net finance lease liabilities at 31 March 2025	**55,502**	**18,392**	**55,448**	**18,392**
Of which:				
Current	4,122	1,223	4,096	1,223
Non-current	51,380	17,169	51,353	17,169

Note 21 Other investments / financial assets (non-current)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**10,510**	**12,002**	**1,101**	**1,101**
Movement in fair value through income and expenditure	240	(34)	-	-
Disposals	(2,629)	(1,458)	-	-
Carrying value at 31 March	**8,121**	**10,510**	**1,101**	**1,101**

£1,101k represents the cost of investment in Pharm@Sea Limited, the wholly owned subsidiary of the Trust. The company is registered in the UK, company no. 08842973 with a share capital of 1,101,000 of £1 each. The company trades as an outpatients dispensary services based at the Royal Sussex County Hospital and Princess Royal Hospital sites. The figures in the note above are based on the audited accounts to the 31 March 2026.

£8,121k is the investments of My University Hospitals Sussex (Registered charity No. 1050864).

Note 22 Disclosure of interests in other entities

The Trust's investment of £1,101k represents the cost of investment in Pharm@Sea Limited, the wholly owned subsidiary of the Trust. The company is registered in the UK, company no. 08842973 with a share capital of 1,101,000 of £1 each. The company trades as an outpatients dispensary service at the Royal Sussex County Hospital and Princess Royal Hospital sites.

Note 23 Analysis of charitable fund reserves

The Trust has consolidated the My University Hospitals Sussex Charity draft accounts as at 31 March 2026 as part of these accounts. The analysis of funds is noted below.

	31 March 2026	31 March 2025
	£000	£000
Unrestricted funds:		
Unrestricted income funds	6,886	9,783
Restricted funds:		
Endowment funds	471	471
Other restricted income funds	667	899
	8,024	**11,153**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 24 Inventories

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Drugs	9,922	9,598	8,789	8,138
Consumables	16,866	13,875	16,866	13,875
Total inventories	**26,788**	**23,473**	**25,655**	**22,013**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £343,327k (2024/25: £306,366k). Write-down of inventories recognised as expenses for the year were £1,384k (2024/25: £903k). The write down of inventories relates primarily to expired and damaged drugs.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 25.1 Receivables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Contract receivables	67,925	37,386	67,918	37,312
Allowance for impaired contract receivables / asse	(653)	(3,627)	(653)	(3,627)
Allowance for other impaired receivables	(905)	(955)	(905)	(955)
Deposits and advances	90	456	90	456
Prepayments (non-PFI)	11,167	11,136	11,105	11,083
Interest receivable	253	292	250	289
Finance lease receivables	-	-	9	9
PDC dividend receivable	1,453	-	1,452	-
VAT receivable	3,811	4,844	3,247	3,897
Other receivables	3,020	3,509	3,364	4,184
NHS charitable funds receivables	444	1,023	-	-
Total current receivables	**86,605**	**54,064**	**85,877**	**52,648**
Non-current				
Prepayments (non-PFI)	6,781	6,807	6,781	6,808
Finance lease receivables	-	-	32	39
Other receivables	1,705	1,932	1,705	1,932
Total non-current receivables	**8,486**	**8,739**	**8,518**	**8,779**
Of which receivable from NHS and DHSC group bodies:				
Current	44,354	18,740	44,353	18,741
Non-current	1,705	1,932	1,705	1,932

Note 25.2 Allowances for credit losses - 2025/26

	Group		Trust	
	receivables and contract assets	All other receivables	receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2025 - brought forward	**3,627**	**955**	**3,627**	**955**
New allowances arising	755	125	755	125
Changes in existing allowances	(3,071)	(175)	(3,071)	(175)
Utilisation of allowances (write offs)	(658)	-	(658)	-
Allowances as at 31 Mar 2026	**653**	**905**	**653**	**905**

Note 25.3 Allowances for credit losses - 2024/25

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2024 - brought forward	**3,240**	**1,884**	**3,240**	**1,884**
New allowances arising	635	49	635	49
Changes in existing allowances	-	(978)	-	(978)
Reversals of allowances	(8)	-	(8)	-
Utilisation of allowances (write offs)	(240)	-	(240)	-
Allowances as at 31 Mar 2025	**3,627**	**955**	**3,627**	**955**

Note 25.4 Exposure to credit risk

In accordance with IFRS 9, the Trust is required to measure the loss allowance of lifetime expected credit losses at initial recognition of the debt being raised.

The expected credit loss is only applied to Non NHS debt. NHS organisations are excluded from the calculation as NHS transactions are considered to be part of DHSC group accounts eliminated on consolidation.

The Trust has used the ageing profile to assess the level of risk. The percentages applied to each class derives from both historic data accumulated as well as current and future projections.

Note 26 Finance leases (University Hospitals Sussex NHS Foundation Trust as a lessor)

This note discloses future lease payments receivable from lease arrangements classified as finance leases where the University Hospitals Sussex NHS Foundation Trust is the lessor.

The Trust has entered various sublease arrangements.

Note 26.1 Reconciliation of the carrying value of finance lease receivables (net investment in the lease)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Finance lease receivables at 1 April	**-**	**1,458**	**48**	**1,500**
Additions	-	-	-	11
Interest arising (unwinding of discount)	-	3	1	4
Remeasurements of lease receivables	-	(1,325)	-	(1,325)
Lease receipts (cash payments received)	-	(136)	(8)	(142)
Finance lease receivables at 31 March	**-**	**-**	**41**	**48**

Note 26.2 Finance lease receivables maturity analysis as at 31 March 2026

	Group		Trust	
	Total	leased to DHSC group bodies:	Total	leased to DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
	£000	£000	£000	£000
Undiscounted future lease receipts receivable in:				
not later than one year;	-	-	9	-
later than one year and not later than two years;	-	-	9	-
later than two years and not later than three years;	-	-	6	-
later than three years and not later than four years;	-	-	6	-
later than four years and not later than five years;	-	-	6	-
later than five years.	-	-	6	-
Total future finance lease payments to be received	**-**	**-**	**42**	**-**
Unearned interest income	-	-	(1)	-
Net investment in lease (net lease receivable)	**-**	**-**	**41**	**-**
of which:				
Leased to other NHS providers		-		-
Leased to other DHSC group bodies		-		-

Note 26.3 Finance lease receivables maturity analysis as at 31 March 2025

	Group		Trust	
	Total	leased to DHSC group bodies:	Total	leased to DHSC group bodies:
	31 March 2025 £000	31 March 2025 £000	31 March 2025 £000	31 March 2025 £000
Undiscounted future lease receipts receivable in:				
not later than one year;	-	-	9	-
later than one year and not later than two years;	-	-	9	-
later than two years and not later than three years;	-	-	9	-
later than three years and not later than four years;	-	-	6	-
later than four years and not later than five years;	-	-	6	-
later than five years.	-	-	11	-
Total future finance lease payments to be received	**-**	**-**	**50**	**-**
Unearned interest income	-	-	(2)	-
Net investment in lease (net lease receivable)	**-**	**-**	**48**	**-**
of which:				
Leased to other NHS providers		-		-
Leased to other DHSC group bodies		-		-

Note 27 Non-current assets held for sale and assets in disposal groups and cash equivalents movements

	Group		Trust	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**	**-**	
Assets classified as available for sale in the year	633	-	633	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**633**	**-**	**633**	**-**

Note 28 Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**3,089**	**21,590**	**2,389**	**19,669**
Net change in year	28	(18,501)	454	(17,280)
At 31 March	**3,117**	**3,089**	**2,843**	**2,389**
Broken down into:				
Cash at commercial banks and in hand	81	18	13	11
Cash with the Government Banking Service	3,036	3,071	2,830	2,378
Total cash and cash equivalents as in SoCF	**3,117**	**3,089**	**2,843**	**2,389**

Note 29.1 Trade and other payables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Trade payables	59,963	41,908	61,242	42,410
Capital payables	31,828	20,694	31,828	20,694
Accruals	29,593	42,646	29,298	42,160
Social security costs	14,221	11,689	14,200	11,675
Other taxes payable	14,214	14,238	14,174	14,165
PDC dividend payable	-	514	-	514
Pension contributions payable	15,156	13,854	15,138	13,854
Other payables	2,386	2,335	2,390	2,126
NHS charitable funds: trade and other payables	264	113	-	-
Total current trade and other payables	**167,625**	**147,991**	**168,270**	**147,598**
Of which payables from NHS and DHSC group bodies:				
Current	9,318	11,663	8,125	11,663

Note 29.2 Early retirements in NHS payables above

The Trade and other payables note above does not include amounts in relation to early retirements.

Note 30 Other liabilities

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Deferred income: contract liabilities	14	1,258	14	1,258
Other deferred income	-	47	-	47
Total other current liabilities	**14**	**1,305**	**14**	**1,305**

Note 31.1 Borrowings

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Loans from DHSC	3,237	3,559	3,237	3,559
Other loans	802	-	802	-
Lease liabilities	3,987	4,122	3,956	4,096
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	2,224	3,358	2,224	3,358
Total current borrowings	**10,250**	**11,039**	**10,219**	**11,013**
Non-current				
Loans from DHSC	30,485	33,602	30,485	33,602
Lease liabilities	41,585	51,380	41,567	51,353
Obligations under PFI, LIFT or other service concession contracts	31,459	32,636	31,459	32,636
Total non-current borrowings	**103,529**	**117,618**	**103,511**	**117,591**

Note 31.2 Reconciliation of liabilities arising from financing activities

Group - 2025/26	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2025	**37,161**	**-**	**55,502**	**35,994**	**128,657**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,429)	802	(4,099)	(3,362)	**(10,088)**
Financing cash flows - payments of interest	(991)	-	(742)	(1,975)	**(3,708)**
Non-cash movements:					
Additions	-	-	911	-	**911**
Lease liability remeasurements	-	-	(5,556)	-	**(5,556)**
Remeasurement of PFI / other service concession liability resulting from change in index or rate				1,051	**1,051**
Application of effective interest rate	981	-	742	1,975	**3,698**
Early terminations	-	-	(1,186)	-	**(1,186)**
Carrying value at 31 March 2026	**33,722**	**802**	**45,572**	**33,683**	**113,779**

Group - 2024/25	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2024	**40,911**	**-**	**63,054**	**36,976**	**140,941**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,740)	-	(5,302)	(2,460)	**(11,502)**
Financing cash flows - payments of interest	(1,081)	-	(712)	(2,074)	**(3,867)**
Non-cash movements:					
Additions	-	-	926	-	**926**
Lease liability remeasurements	-	-	(3,176)	-	**(3,176)**
Remeasurement of PFI / other service concession liability resulting from change in index or rate				1,478	**1,478**
Application of effective interest rate	1,071	-	712	2,074	**3,857**
Carrying value at 31 March 2025	**37,161**	**-**	**55,502**	**35,994**	**128,657**

Trust - 2025/26	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2025	**37,161**	**-**	**55,449**	**35,994**	**128,604**
Cash movements:					
Financing cash flows - payments of interest	(3,429)	802	(4,075)	(3,362)	**(10,064)**
Non-cash movements:					
Lease liability remeasurements	-	-	891	-	**891**
Change in effective interest rate	981	-	740	1,975	**3,696**
Other changes	-	-	-	1,051	**1,051**
Carrying value at 31 March 2026	**34,713**	**802**	**53,005**	**35,658**	**124,178**

Trust - 2024/25	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2024	**40,911**	**-**	**63,040**	**36,976**	**140,927**
Cash movements:					
Financing cash flows - payments and receipts of principal	(3,740)	-	(5,270)	(2,460)	**(11,470)**
Financing cash flows - payments of interest	(1,081)	-	(709)	(2,074)	**(3,864)**
Non-cash movements:					
Additions	-	-	855	-	**855**
Lease liability remeasurements	-	-	(3,176)	-	**(3,176)**
Remeasurement of PFI / other service concession liability resulting from change in index or rate				1,478	**1,478**
Application of effective interest rate	1,071	-	709	2,074	**3,854**
Carrying value at 31 March 2025	**37,161**	**-**	**55,449**	**35,994**	**128,604**

Note 32.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	**792**	**2,365**	**149**	**2,394**	**5,700**
Change in the discount rate	(16)	(109)	-	(131)	**(256)**
Arising during the year	-	-	194	266	**460**
Utilised during the year	(117)	(207)	-	(136)	**(460)**
Reversed unused	(23)	-	(132)	(255)	**(410)**
Unwinding of discount	96	202	-	109	**407**
At 31 March 2026	**732**	**2,251**	**211**	**2,247**	**5,441**
Expected timing of cash flows:					
- not later than one year;	116	207	211	421	**955**
- later than one year and not later than five years;	427	765	-	121	**1,313**
- later than five years.	189	1,279	-	1,705	**3,173**
Total	**732**	**2,251**	**211**	**2,247**	**5,441**

Pension costs are based upon known amounts that will have to be paid to the NHS Pension Agency in respect of staff who have retired early. By their very nature, provisions are estimates, though informed. For the calculation of pension and injury benefit liabilities, government actuary figures for expected mortality have been used and for legal claims, data is provided by the NHS Litigation Authority.
The provision for Injury Benefits is for the reimbursement of injury benefit allowances to the NHS Pensions Agency and the timing of these payments is based the on age of the recipients.

Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in this tax year (2019/20) faced a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold. They were able to have this charge paid by the NHS Pension Scheme (by completing and returning a 'Scheme Pays' form before 31 July 2021). The Trust estimated that all consultants would take advantage of this offer. NHS England has used information provided by the Government Actuaries Department and NHS Business Services Authority to calculate an 'average discounted value per nomination'. A provision broadly equal to the tax charge owed by clinicians who want to take advantage of the 2019/20 Commitment. This will be offset by the commitment from NHS England and the Government to fund the payments to clinicians as and when they arise. This has been disclosed under other provisions.

The provision for Legal Claims provides for the Liability to Third Party Schemes (LTPS) and Public & Employers Liability Scheme (PES). This provision covers the excess amount payable by the Trust and not the full liability of claims which is covered by NHS Resolution under the non-clinical risk pooling scheme. The timings of the cash flows are based on estimated dates for the finalisation of the claims.

Note 32.2 Provisions for liabilities and charges analysis (Trust)

Trust	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	**792**	**2,365**	**149**	**2,394**	**5,700**
Change in the discount rate	(16)	(109)	-	(131)	**(256)**
Arising during the year	-	-	194	136	**330**
Utilised during the year	(117)	(207)	-	(136)	**(460)**
Reversed unused	(23)	-	(132)	(246)	**(401)**
Unwinding of discount	96	202	-	109	**407**
At 31 March 2026	**732**	**2,251**	**211**	**2,126**	**5,320**
Expected timing of cash flows:					
- not later than one year;	116	207	211	421	**955**
- later than one year and not later than five years;	427	765	-	-	**1,192**
- later than five years.	189	1,279	-	1,705	**3,173**
Total	**732**	**2,251**	**211**	**2,126**	**5,320**

Note 32.3 Clinical negligence liabilities (Group and Trust)

At 31 March 2026, £564,781k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of University Hospitals Sussex NHS Foundation Trust (31 March 2025: £560,901k).

Note 33 Contingent assets and liabilities

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Value of contingent liabilities				
Employment tribunal and other employee related litigation	(974)	(1,097)	(974)	(1,097)
Gross value of contingent liabilities	**(974)**	**(1,097)**	**(974)**	**(1,097)**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**(974)**	**(1,097)**	**(974)**	**(1,097)**
Net value of contingent assets	**-**	**-**	**-**	**-**

The contingent liability for Legal Claims. The timings of the cash flows are based on estimated dates for the finalisation of the claims.

Note 34 Contractual capital commitments

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	51,850	50,327	51,850	50,292
Total	**51,850**	**50,327**	**51,850**	**50,292**

Note 35 Other financial commitments

The Group and Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
not later than 1 year	392	393	392	393
after 1 year and not later than 5 years	-	392	-	392
paid thereafter	-	-	-	-
Total	**392**	**785**	**392**	**785**

Note 36 Defined benefit pension schemes

Neither the Group nor the Trust has any defined benefit pension schemes.

Note 37 On-SoFP PFI, LIFT or other service concession arrangements

PFI scheme details	
Contract start date	10-Jun-04
Contract end date	08-Jun-34
Length of project	30 years

The PFI Scheme relates to the Royal Alexandra Children's Hospital. The Trust is entitled to provide healthcare services within the facility for the period of the PFI arrangement. The contract contains payment mechanisms providing for deductions in the unitary payment made by the Trust for poor performance and unavailability. The unitary charge for the scheme is subject to an annual uplift for future price increases. The operator Kajima is responsible for providing a managed maintenance service for the length of the contract, after such time these responsibilities revert to the Trust. During the reported period there were no changes to the contractual arrangements of the scheme.

Note 37.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Gross PFI, LIFT or other service concession liabilities	**42,622**	**46,573**	**42,622**	**46,573**
Of which liabilities are due				
- not later than one year;	4,031	5,276	4,031	5,276
- later than one year and not later than five years;	20,370	20,332	20,370	20,332
- later than five years.	18,221	20,965	18,221	20,965
Finance charges allocated to future periods	(8,939)	(10,579)	(8,939)	(10,579)
Net PFI, LIFT or other service concession arrangement obligation	**33,683**	**35,994**	**33,683**	**35,994**
- not later than one year;	2,224	3,358	2,224	3,358
- later than one year and not later than five years;	14,960	14,307	14,960	14,307
- later than five years.	16,499	18,329	16,499	18,329

Note 37.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**79,191**	**87,181**	**79,191**	**87,181**
Of which payments are due:				
- not later than one year;	8,809	8,535	8,809	8,535
- later than one year and not later than five years;	37,493	36,327	37,493	36,327
- later than five years.	32,889	42,319	32,889	42,319

Note 37.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group		Trust	
	2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Unitary payment payable to service concession operator	**8,478**	**8,221**	**8,478**	**8,221**
Consisting of:				
- Interest charge	1,975	2,074	1,975	2,074
- Repayment of balance sheet obligation	3,362	2,460	3,362	2,460
- Service element and other charges to operating expenditure	1,412	1,376	1,412	1,376
- Capital lifecycle maintenance	1,729	2,311	1,729	2,311
Total amount paid to service concession operator	**8,478**	**8,221**	**8,478**	**8,221**

Note 38 Off-SoFP PFI, LIFT and other service concession arrangements

Neither the group not Trust has any off-SoFP PFI, LIFT and other service concession arrangements.

Note 39 Financial instruments

Note 39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has some powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2026 are in receivables from customers, as disclosed in the trade and other receivables note to the accounts.

Liquidity risk
The Trust's operating costs are incurred under contracts with Integrated Care Boards (ICBs) [formally Clinical Commissioning Groups (CCGs)], which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from a combination of its own self-generated funds and capital investment loans with reference to NHS Improvement's Continuity of Services Risk Rating. The Trust is not, therefore, exposed to significant liquidity risks.

Note 39.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	71,345	-	-	**71,345**
Cash and cash equivalents	3,049	-	-	**3,049**
Consolidated NHS Charitable fund financial assets	512	8,121	-	**8,633**
Total at 31 March 2026	**74,906**	**8,121**	**-**	**83,027**

Note within Consolidated NHS Charitable and financial assets held at amortised cost of £510k, £68k is cash.

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	38,537	-	-	**38,537**
Cash and cash equivalents	3,082	-	-	**3,082**
Consolidated NHS Charitable fund financial assets	1,030	10,510	-	**11,540**
Total at 31 March 2025	**42,649**	**10,510**	**-**	**53,159**

Note within Consolidated NHS Charitable and financial assets held at amortised cost is £7k cash.

Note 39.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	71,720	-	-	**71,720**
Other investments / financial assets	-	-	1,101	**1,101**
Cash and cash equivalents	2,843	-	-	**2,843**
Total at 31 March 2026	**74,563**	**-**	**1,101**	**75,664**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	39,183	-	-	**39,183**
Other investments / financial assets	-	-	1,101	**1,101**
Cash and cash equivalents	2,389	-	-	**2,389**
Total at 31 March 2025	**41,572**	**-**	**1,101**	**42,673**

Note 39.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	33,722	-	**33,722**
Obligations under leases	45,572	-	**45,572**
Obligations under PFI, LIFT and other service concessions	33,683	-	**33,683**
Other borrowings	802	-	**802**
Trade and other payables excluding non financial liabilities	119,498	-	**119,498**
Consolidated NHS charitable fund financial liabilities	264	-	**264**
Total at 31 March 2026	**233,541**	**-**	**233,541**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	37,161	-	**37,161**
Obligations under leases	55,502	-	**55,502**
Obligations under PFI, LIFT and other service concessions	35,994	-	**35,994**
Trade and other payables excluding non financial liabilities	101,703	-	**101,703**
Consolidated NHS charitable fund financial liabilities	113	-	**113**
Total at 31 March 2025	**230,473**	**-**	**230,473**

Note 39.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	33,722	-	**33,722**
Obligations under leases	45,523	-	**45,523**
Obligations under PFI, LIFT and other service concessions	33,683	-	**33,683**
Other borrowings	802	-	**802**
Trade and other payables excluding non financial liabilities	120,486	-	**120,486**
Total at 31 March 2026	**234,216**	**-**	**234,216**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	37,161	-	**37,161**
Obligations under leases	55,449	-	**55,449**
Obligations under PFI, LIFT and other service concessions	35,994	-	**35,994**
Trade and other payables excluding non financial liabilities	101,510	-	**101,510**
Total at 31 March 2025	**230,114**	**-**	**230,114**

Note 39.6 Fair values of financial assets and liabilities

Fair value of loans from DHSC as at 31 March 2026 is £33,722k.

Note 39.7 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
In one year or less	132,936	116,035	133,629	115,701
In more than one year but not more than five years	44,840	48,832	44,820	48,802
In more than five years	75,907	88,968	75,907	88,970
Total	**253,683**	**253,835**	**254,356**	**253,473**

Note 40 Losses and special payments

Group and trust	2025/26 Total number of cases Number	2025/26 Total value of cases £000	2024/25 Total number of cases Number	2024/25 Total value of cases £000
Losses				
Cash losses	29	30	86	43
Fruitless payments and constructive losses	-	-	1	107
Bad debts and claims abandoned	216	627	221	197
Stores losses and damage to property	5	1,384	1	903
Total losses	**250**	**2,041**	**309**	**1,250**
Special payments				
Compensation under court order or legally binding arbitration award	21	299	36	148
Ex-gratia payments	95	43	94	85
Special severance payments	1	4	-	-
Total special payments	**117**	**346**	**130**	**233**
Total losses and special payments	**367**	**2,387**	**439**	**1,483**
Compensation payments received				

The individual case for £903k in 2024/25 in Stores losses and damage to property, relates to damaged and expired pharmacy stock.

These amounts are reported on an accruals basis but excluding provisions for future losses.

Note 41 Gifts

As at 31 March 2026 no gifts were made (31 March 2025, £Nil).

Note 42 Related parties

Group
There were no related party transactions with individuals reported during the year.

The Department of Health and Social Care is regarded as the parent Department of the Trust and is therefore a related party. During the year University Hospitals Sussex NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

These being:

- NHS England
- Health Education England
- East Sussex Healthcare NHS Trust
- NHS Sussex ICB
- Sussex Community NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- Portsmouth Hospitals University NHS Trust
- NHS Resolution

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Brighton and Hove City Council, East Sussex County Council and West Sussex County Council in respect of clinical services.

The Group comprises the Trust, Pharm@Sea Limited and My University Hospitals Sussex Charity.
The Trust has share capital of £1,101k with Pharm@Sea Limited.
Transactions with related parties are on a normal commercial basis and outlined below.

	Income 2025/26 £000	Expenditure 2025/26 £000
Pharm@Sea	351	26,662
My University Hospitals Sussex Charity	1,702	-
Total	**2,053**	**26,662**

Balances at year end	Receivables 2025/26 £000	Payables 2025/26 £000
Pharm@Sea	-	4,660
My University Hospitals Sussex Charity	345	-
Total	**345**	**4,660**

Note 43 Events after the reporting date (Group and Trust)

There were no events after the reporting period.

Independent auditor's report to the Council of Governors of University Hospitals Sussex NHS Foundation Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of University Hospitals Sussex NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2026, which comprise the Consolidated Statement of Comprehensive Income, the Statements of Financial Position, the Consolidated Statement of Changes in Equity, the Statements of Cash Flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2026 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2025-26 that the group's and the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and the Trust. In doing so we had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and the Trust and the group's and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2025/26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025/26; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2025/26, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of their services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).
- We enquired of management and the audit committee, concerning the group's and the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the group's and the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and fraud in revenue recognition. We determined that the principal risks were in relation to journal entries that altered the financial performance for the year and potential management bias in determining accounting estimates for revenue accruals.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - testing of income and year end receivables to invoices and cash payments or other supporting evidence;
  - journal entry testing, with a focus on journals meeting a range of criteria defined as part of our risk assessment;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations; and
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including potential for fraud in revenue recognition and significant accounting estimates relating to property, plant and equipment. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the group and Trust audit team members included consideration of their:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation;
  - knowledge of the health sector and economy in which the group and the Trust operates;
  - understanding of the legal and regulatory requirements specific to the group and the Trust including:
    - the provisions of the applicable legislation;
    - NHS England's rules and related guidance;
    - the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The group's and the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation process, expected financial statement disclosures and business risks that may result in risks of material misstatement;
  - The group's and the Trust's control environment, including the policies and procedures implemented by the group and the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in respect of the above matter except we identified 3 significant weaknesses in arrangements for the year ended 31 March 2026.

- A continuing significant weakness in respect of how the Trust plans and manages its resources to ensure it can continue to deliver its services. In 2025/26, the Trust failed to fully identify, develop and approve £128.6m in efficiency savings to deliver its 2025/26 budget requirement. This significant weakness was first reported for the year ended 31 March 2024. In respect of the continuing significant weakness, we recommended the Trust must:
  - ensure that recurrent schemes to deliver the 2026/27 efficiency target are worked up earlier in the year and a pipeline of multi-year savings is developed to meet future year targets
  - ensure that the oversight and challenge through the Financial Recovery Delivery Board should increase to keep pace with the increased savings required, with sufficient assurance provided to the Finance & Performance Committee that savings delivery is on track with escalations to the Board clearly set out to enable slippage and non-delivery risks to be appropriately managed.
- A continuing significant weakness in respect of the Trust's arrangements for governance. In 2025/26 the Trust has made progress in developing its Behavioural Compass and Leadership Framework which is now being implemented, but there is more work to do to progress the Well-Led development review actions and improve cultural impact metrics. This significant weakness was first reported for the year ended 31 March 2024. In respect of the continuing significant weakness, we recommended the Trust must:
  - strengthen its improvement arrangements by developing and implementing a refreshed Integrated Improvement Plan that consolidates:
    - NHSE requirements (including any revised undertakings if issued),
    - its actions to improve culture, and
    - the National Provider Improvement Programme findings.
  - assure delivery of the Integrated Improvement Plan through robust challenge and oversight, with consistent assurance reporting on delivery progress, risks, dependencies and benefits realisation, and timely escalation where slippage or continued non-compliance emerges.
- A new significant weakness in the Trust's arrangements for improving economy, efficiency, and effectiveness. The Trust continues to experience significant performance challenges against key performance metrics and has been placed in NHS National Oversight Framework NOF4 as well as the National Provider Improvement Programme. In respect of the current significant weakness, we recommended the Trust develop and deliver a refreshed Integrated Improvement Plan to address performance concerns.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for University Hospitals Sussex NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Darren Wells

Darren Wells, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London
25 June 2026